Application for

Section 1915(b)(4) Waiver
Fee-for-Service
Selective Contracting Program

v1.0

Table of Contents

Application for Section 1915(b)(4) Waiver
Fee-for-Service (FFS) Selective Contracting Program

Facesheet

The **State** of Connecticut requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is 1915(b)(4) waiver for case management services for the Connecticut Home Care Program for Elders 1915(c) waiver, the Connecticut Home Care 1915(i) program, and the Personal Care Assistance 1915(c) waiver.
(List each program name if the waiver authorizes more than one program.).

Type of request. This is:
___ an initial request for new waiver. All sections are filled.
___ a request to amend an existing waiver, which modifies Section/Part ____
_X_ a renewal request

Section A is:
___ replaced in full
X carried over with no changes
___ changes noted in **BOLD**.

Section B is:
___ replaced in full
X_ changes noted in **BOLD**.

Effective Dates: This waiver/renewal/amendment is requested for a period of _5_ years beginning _7/1/2025___and ending _6/30/2030_____.

State Contact: The State contact person for this waiver is Christine Weston and can be reached by telephone at (203) 525-0697 , or fax at (860) 424-4963, or e-mail at christine.weston@ct.gov.
(List for each program)

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:
Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

Connecticut seeks input from the two federally-recognized tribes, the Mashantucket Pequot Tribal Nation and the Mohegan Tribe, through written electronic communications. Prior to submission of a State Plan amendment, waiver, waiver amendment, or demonstration project proposal submitted to the Centers for Medicare & Medicaid Services (CMS), the Department of Social Services (DSS) sends a copy of the public notice to both tribes via email.

Program Description:
Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver.

The Connecticut Home Care Program for Elders (CHCPE) waiver, the CHCPE 1915(i) program, and the Personal Care Assistance (PCA) waiver, operated by DSS, provide a wide range of medical and non-medical support services to individuals age 65 or older and at risk of institutionalization. The CHCPE waiver and the CHCPE 1915(i) program serve over 15,000 members and offer services and supports which include: Adult Day Health, Care Management, Homemaker, Personal Care Assistant, Respite, Adult Family Living, Assisted Living, Assistive Technology, Bill Payer, Care Transitions, Chore Services, Chronic Disease Self-Management Program, Companion, Environmental Accessibility Adaptations, Home Delivered Meals, Mental Health Counseling, Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE), Personal Emergency Response Systems, Recovery Assistant, Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE), and Transportation.

The PCA waiver serves over 1,000 individuals under the age of 65 with physical disabilities. The intent of the program is to prevent institutionalization through home and community-based services (HCBS) which include: Adult Day Health, Agency-Based Personal Care Assistant, Care Management, Adult Family Living, Assistive Technology, Environmental Accessibility Adaptations, Home Delivered Meals, Mental Health Counseling, Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE), Personal Emergency Response System (PERS), and Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE).

Case Management services are currently contracted with four entities, which operate six Access Agencies in six regions, to deliver case management services to 1915(c) waiver and 1915(i) clients. The Access Agencies are responsible for assisting clients with receiving 1915(c) and 1915(i) HCBS through care coordination and case management. These responsibilities include:

- Conducting initial comprehensive assessments and developing person-centered service plans;
- Conducting comprehensive re-assessments and updating person-centered service plans;
- Conducting status reviews when a client is in a hospital or nursing facility setting to reevaluate the total service plan needs upon discharge;
- Facilitating referrals to either the fiscal intermediary or a provider agency for client-directed service options;
- Monitoring the ongoing provision of services in the client's service plan and continually monitoring that the client's health and safety needs are being addressed;
- Providing quality case management services; and
- Implementing a quality assurance program, including reporting critical incidents, reviewing client records, and monitoring client satisfaction with HCBS through the utilization of the HCBS CAHPS survey.

This waiver seeks to limit freedom of choice of case management providers and allow members living in the catchment areas of the Access Agencies to continue to be assigned by town and coverage area.

Waiver Services: Case management for 1915(i) state-plan participants are provided through this selective contracting waiver.

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):

   _X_ **1915(b)(4) - FFS Selective Contracting program**

2. **Sections Waived.** The State requests a waiver of these sections of 1902 of the Social Security Act:

   a.___ **Section 1902(a)(1) - Statewideness**
   b.___ **Section 1902(a)(10) (B) - Comparability of Services**
   c._X_ **Section 1902(a)(23) - Freedom of Choice**
   d.___ **Other Sections of 1902** – (please specify)

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

   ___ the same as stipulated in the State Plan
   _X_ is different than stipulated in the State Plan

Access Agencies will receive a one-time payment of $324.88 per client for an initial assessment. The per-client reimbursement rates for reassessments and client status review will be $238.88 and $107.21 respectively. For ongoing case management services,

Connecticut will use a per diem rate methodology developed based on cost reports submitted by the Access Agencies. Cost reports submitted to DSS include a line-item budget of all operating costs associated with case management. The per diem is payable for all 1915(c) waiver / 1915(i) program clients for each day that the client is receiving care in a community setting. The per diem rate is not payable for days spent in institutional care. Per diem reimbursement is also broken down into three tiers based on client use of services. The first tier is the lowest rate, which reimburses for clients who utilize fewer services, the second tier (the "regular rate") reimburses for the majority of average utilizers, and the third tier is higher and reimburses for higher utilizers.

Four Access Agencies (AA) receive a regular per diem, per client case management rate that was negotiated for each AA. This regular rate ranges between $4.99 and $5.34 through the end of the contract, June 30, 2026. The first and third tier reimbursement rates for these AAs range from $4.59 to $5.08 and $5.21 to $5.49 respectively. Rates for the initial assessment range from $296.35 to $324.88. Rates for future years will be developed as part of the next competitive procurement.

Access Agencies can also receive performance incentive payments to reward quality outcomes for clients. Incentive payments will be made from a "performance pool" created by DSS and allocated to Access Agencies based on quality outcomes. The "performance pool" will total $250,000 annually through the end of the contract.

2. **Procurement**. The State will select the contractor in the following manner:

_X_ **Competitive** procurement
___ **Open** cooperative procurement
___ **Sole source** procurement
___ **Other** (please describe)

Connecticut will be contracting with Access Agencies selected through a competitive procurement to cover six regions of the state. As noted previously, Connecticut currently has contracts with four entities that operate six Access Agencies covering six different regions of the state. When the current contracts expire, Connecticut will re-procure these services using a competitive procurement.

Bidding entities will be required to provide detail on their organizational structure, case management experience, staff quality, and coordination ability with direct service providers, as well as capacity to comply with program requirements, regulations, reporting requirements, and quality assurance requirements.

C. Restriction of Freedom of Choice

1. **Provider Limitations**.

_X_ Beneficiaries will be limited to a single provider in their service area.
___ Beneficiaries will be given a choice of providers in their service area.

(NOTE: Please indicate the area(s) of the State where the waiver program will be implemented)

The waiver will be implemented statewide, and clients must use the Access Agency serving their region, but they will have the option to receive a different case manager from the applicable Access Agency if they are dissatisfied with their case manager. 1915(c) waiver / 1915(i) program clients will continue to be able to choose providers of other HCBS. This 1915(b)(4) waiver does not impact clients' freedom of choice of providers for other HCBS covered by the 1915(c) waiver / 1915(i) program.

2. **State Standards.**

   Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents.

There will be no changes to the State standards currently applied to case management under the 1915(c) waiver and the 1915(i) program as a result of this waiver. State standards will be applied in the same manner as those outlined in the existing 1915(c) waiver and 1915(i) State Plan coverage and reimbursement documents, including, but not limited to, State regulations, the contracts with Access Agencies, the 1915(c) waiver, the 1915(i) State Plan amendment, and DSS' policies and procedures. Access Agencies and case managers will continue to be expected to comply with all applicable State standards, such as qualifications for case managers, requirements for case management services, maintaining client clinical records, complying with the Access Agency's quality assurance program, having a grievance process, maintaining sufficient qualified staff, and submitting required information and reports to DSS.

Case managers assist clients in gaining access to needed waiver and other State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case managers are also responsible for monitoring the ongoing provision of services in the client's service plan as well as monitoring fulfillment of client's health and safety needs. Case managers complete the initial and annual assessment and reassessment of an individual's needs in order to develop a comprehensive service plan. They confirm the initial level of care determination completed by DSS, reassess the level of care annually, and maintain documentation for Department review. Case managers also explain opportunities on client-directed service options.

D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

1. **Included Populations**. The following populations are included in the waiver:

   ___ Section 1931 Children and Related Populations
   ___ Section 1931 Adults and Related Populations
   _X_ Blind/Disabled Adults and Related Populations
   ___ Blind/Disabled Children and Related Populations
   _X_ Aged and Related Populations

___ Foster Care Children
___ Title XXI CHIP Children

2. **Excluded Populations.** Indicate if any of the following populations are excluded from participating in the waiver:

___ Dual Eligibles
_X_ Poverty Level Pregnant Women
___ Individuals with other insurance
_X_ Individuals residing in a nursing facility or ICF/MR
___ Individuals enrolled in a managed care program
___ Individuals participating in a HCBS Waiver program
___ American Indians/Alaskan Natives
___ Special Needs Children (State Defined). Please provide this definition.
___ Individuals receiving retroactive eligibility
___ Other (Please define):

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.,* what constitutes timely access to the service?

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program?

Through regulations and its contracts with Access Agencies, Connecticut has established standards for timely client access to case management services. Per State regulation (Regulations of Connecticut State Agencies, Section 17b-342-1), an Access Agency "shall have a communication system adequate to receive requests and referrals for service, including the capacity to respond to clients and health professionals in emergencies on a 24-hour basis." This requirement is included in the contract with Access Agencies. In addition, the contract requires each Access Agency to provide a case manager on call who can respond to client emergencies 24 hours a day on weekends and holidays. The contract also requires the Access Agencies to maintain one operation facility in each service region that is open five days a week, Monday through Friday, 8:00 AM to 4:30 PM.

The contract requires the Access Agencies to contact the program applicant/applicant's representative within one business day of receiving the referral from DSS to schedule a face-to-face interview. The Access Agencies must complete the assessment process, including development of the service plan, within ten days of receiving the referral from DSS. An exception exists for client-centered reasons for not complying with the requirement. The Access

Agencies must arrange to have HCBS delivery ready to begin when the applicant has been determined to be eligible for the 1915(c) waiver / 1915(i) program and has accepted HCBS. The Access Agency must provide advance notice to DSS if services cannot start within seven business days of the Access Agency's submission of the assessment and service plan.

Access Agencies must also complete reassessments in a timely fashion. DSS provides ample lead time to complete the reassessments. Specifically, DSS provides Access Agencies a list of reassessments six weeks prior to when the reassessments are due through its electronic client management database.

Additionally, on-site reviews of each Access Agency are conducted by DSS staff every 12 months, which includes a randomized audit of client records and evaluation of service delivery timeliness, service plan development and compliance with all other contractual requirements.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion.

DSS' electronic HCBS client database is used to track completion of reassessments, with prompt notification of reassessment reports that are overdue. DSS is also able to identify if an Access Agency is not meeting the required service timelines through this database. If DSS identifies trends in late initial assessments, reassessments, or required services, the Department will implement a corrective action plan with the Access Agency. A corrective action plan includes a report of needed improvements, as well as follow-up monitoring activities to ensure the Access Agency is correcting the deficiencies identified.

There are also client-centered corrective actions that can be taken. As noted above, clients have the option to receive a different case manager if they are dissatisfied with their current case manager. Per State regulation (Regulations of Connecticut State Agencies, Section 17b-342-1) and the Access Agency contract, Access Agencies must establish a client grievance process, which would apply to both timely access to services as well as the provider capacity standards in Part II, section B of this application. The Access Agencies are required to establish a grievance process for clients who are "aggrieved by adverse decisions of the access agency." Under the grievance process, the Access Agency must respond with a decision within 15 calendar days of receipt of the grievance. Clients can request a fair hearing by DSS if the issue is not resolved within the Access Agency.

B. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for

non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program.

In the contract with DSS, the Access Agencies are required to "meet the needs of clients and estimated caseloads of the [region] through the maintenance of a sufficient staffing pattern by providing a full time Director and such other administrative staff as may be required by the [State] regulations or needed to adequately administers the [CHCPE], as well as any other programs the Contractor may operate."

To fulfill this obligation, the Access Agencies must meet certain staffing quality and staff ratio standards. State regulation (Regulations of Connecticut State Agencies, Section 17b-342-1) and the Access Agency contracts require that case managers meet certain staffing and quality standards. Through regulation and contracts, Access Agencies must ensure the selection of qualified staff with certain education and clinical experience. Specifically, case managers are required to be either a registered nurse licensed in the State of Connecticut or a social services worker who is a graduate of a four-year college or university, and have a minimum of two years of experience in health care or human services (a bachelor's degree in certain related fields may be substituted for one year of experience). Access Agencies are also required to maintain a staffing ratio of 80:1.

DSS' HCBS client database is also used to track staffing ratios. The database captures staffing data from the Access Agencies. DSS uses this database to issue quarterly reports that outline the hours of case management provided to clients, which is used to determine appropriate case manager staff levels at Access Agencies based on the volume of new assessments. The Access Agencies also adjust staffing based on clients with high case management needs.

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program.

If staffing requirements are not being met, as identified by the HCBS client database, DSS will implement a corrective action plan with the Access Agency. Like the efforts to correct deficiencies in timeliness of services, a corrective action plan will include a report of needed improvements, as well as follow-up monitoring activities to ensure the Access Agency is correcting the deficiencies identified.

As noted above, there are also client-centered corrective actions that can be taken. For example, clients have the option to receive a different case manager if they are dissatisfied with their current case manager or can file a grievance. The DSS client database provides delay reports both on an individual and aggregate basis that allows DSS to track compliance with timely assessments and reassessments.

C. Utilization Standards

Describe the State's utilization standards specific to the selective contracting program.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above?

Both DSS HCBS staff and Access Agency staff assume responsibility for utilization management functions. All new person-centered service plans are reviewed by DSS staff nurses. Additionally, DSS staff conduct record audits of the Access Agencies' client records, and the appropriateness of person-centered service plans is also compared to the identified needs. Access Agency supervisors conduct ongoing utilization review as they evaluate clinical records. DSS has a formal process for the Access Agencies to report the data captured in the supervisory record reviews.

The State expects the Access Agencies to demonstrate that they are adequately serving clients in their region. Specifically, Access Agencies are required to submit the following reports on service utilization to DSS:

- "Annual Length of Stay Report," due within 90 days of the end of the fiscal year.
- "Annual Grievance and Appeals Report" that includes a list of filed grievances, actions taken by the Access Agency and final resolutions. The report is due within 90 days after the end of each fiscal year.
- "Semi-Annual Client List" prepared for each region served. The report is due by December 31 and June 30 of each contract year.
- Agencies are required to complete a representative sample of HCBS surveys for each program. The results are captured in a database and the results are compiled annually by the University of Connecticut Center on Aging and provided to the Department.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above.

DSS will monitor these reports and information from the HCBS client database to identify failures in case management. Specifically, DSS will monitor timeliness of initial client assessments and reassessments and will conduct onsite audit reviews of each Access Agency every 18 months. If Access Agencies are failing to meet the needs of clients, as well as the contractual requirements, DSS will implement a corrective action plan to ensure that problems are corrected.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program.

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

i. Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.
ii. Take(s) corrective action if there is a failure to comply.

There are many DSS procedures and policies in place to uphold Access Agency quality standards. Specifically, DSS monitors Access Agency performance through comprehensive client record reviews and on-site or desk audit reviews. Compliance with State and Federal law as well as contractual compliance is also monitored. The Department also reviews all assessment outcomes on new client admissions to verify level of care and, ultimately, authorize the service plan. Additionally, the Department manages the waiver expenditures against the approved levels of care by comparing the information with past paid claims data reports.

Access Agencies are required to implement a "Quality Assurance Program" to monitor adherence to policies and procedures, including quality of case management services. DSS reviews and approves all "Quality Assurance Programs" prior to adoption. At a minimum, the Quality Assurance Program includes a review of client records by professionals not employed by the Access Agencies, development and implementation of client satisfaction survey and incident reporting, and cooperation with the DSS client record and administrative reviews. For client satisfaction reviews, Access Agencies are responsible for monitoring and taking corrective action on client satisfaction problems. The mandated survey utilized is the HCBS CAHPS. The Department maintains a robust incident management system that allows individual and systemic review and remediation to track trends and allow for systemic interventions.

Again, if quality standards are not being met, DSS will implement a corrective action plan to ensure that quality failures are corrected.

2. Describe the State's contract monitoring process specific to the selective contracting program.

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

i. Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.
ii. Take(s) corrective action if there is a failure to comply.

The Access Agencies and fiscal intermediary are contractually obligated to report to DSS either monthly, quarterly, semiannually or annually on quality assurance reports, which are reviewed by DSS staff for trends and the possible need for a corrective action plan. Client service quality is monitored through Access Agency client record audits in each of the six regions. Specifically, clinical staff with DSS' Division of Quality Assurance reviews client charts using a tracking tool

that measures care documentation compliance. DSS then generates a formal report to the Access Agency on the findings. If the Access Agency is found to be non-compliant with regulations or contractual obligations, a corrective action plan is implemented.

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program.

One of the core responsibilities of the Access Agencies outlined in State regulation (Regulations of Connecticut State Agencies, Section 17b-342-1) is to establish working relationships with existing service providers, which helps support coordination and continuity of care. Under the contract agreements, Access Agencies are required to coordinate the delivery of all services in the service plan regardless of the provider or source of reimbursement to avoid duplication and overlapping of services. It is not anticipated that well-established coordination and continuity of care will be interrupted by the selective contracting program. However, DSS will monitor overall effectiveness of the Access Agencies, including the extent to which selective contracting impacts coordination and continuity of care.

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program.

Per State regulation (Regulations of Connecticut State Agencies, Section 17b-342-1), an Access Agency is required to develop a written "bill of rights" that outlines services and protections, which will be distributed to the beneficiary at the time of enrollment in the 1915(c) waiver / 1915(i) program. Specifically, the "bill of rights" must clarify the right to be fully informed about all services, including case management, charges and choices available through the Access Agency.

As prescribed in the aforementioned State regulation, beneficiaries will receive information about the selective contracting program when they are screened for services, receive an assessment, or are reassessed.

B. Individuals with Special Needs.

_X_ The State has special processes in place for persons with special needs (Please provide detail).

All 1915(c) and 1915(i) clients have special needs. To meet these needs, the person-centered service plan is a requirement of case management services. Therefore, by virtue of its operation,

the programs, through the person-centered service plan, meet the special needs of 1915(c) and 1915(i) clients.

Per State regulation (Regulations of Connecticut State Agencies, Section 17b-342-1), the Access Agencies are also required to employ staff and implement a strategy that will serve clients with special needs including, but not limited to, individuals whose primary language is not English and individuals who are hearing or visually impaired.

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State's efficient and economic provision of covered care and services.

Contracting with a single entity for case management services in a given region will result in the efficient and economic provision of case management services. By having a single entity serve a given region, duplication of services is reduced, communication is streamlined, and administrative costs are managed more efficiently. Any potential cost impact of changing case management structures will also be avoided by using the existing delivery structure.

2. Project the waiver expenditures for the upcoming waiver period.

Year 1 from: **_07_/_01_/_2025__** to **_06_/_30_/_2026__**

Trend rate from current expenditures (or historical figures): **__8___**%

Projected pre-waiver cost **__$32.32 million**
Projected Waiver cost **__$32.32 million**
Difference: **___0_____**

Year 2 from: **_07_/_01_/_2026__** to **_06_/_30_/_2027__**

Trend rate from current expenditures (or historical figures): **__8___**%

Projected pre-waiver cost **__$34.90 million __**
Projected Waiver cost **__$34.90 million __**
Difference: ___0_____

Year 3 (if applicable) from: **_07_/_01_/_2027__** to **_06_/_30_/_2028___**
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)
Projected pre-waiver cost **__$37.70 million __**
Projected Waiver cost **__$37.70 million __**
Difference: ___0_____

Year 4 (if applicable) from: **_07_/_01_/_2028__** to **_06_/_30_/_2029___**
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost __$**40.71 million** __
Projected Waiver cost __$**40.71 million** __
Difference: ___0_____

Year 5 (if applicable) from: **_07_/_01_/_2029__** to **_06_/_30_/_2030___**
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost __$**43.97 million** __
Projected Waiver cost __$**43.97 million** __
Difference: ___0_____