**Addendum to CT Home Care Program for Elders Case Management Freedom of Choice Waiver**

**Part I: Program Overview**

**Tribal Consultation (continued):**

After email notifications have been sent, the State determines that the tribes do not have any questions or concerns regarding the proposal if comments or questions are not received within two (2) weeks. In addition to the aforementioned notification and consultation process, the State will also arrange for a meeting or teleconference with the tribal representatives to discuss the proposed change for State Plan Amendments that may have a unique or particular impact on tribal members.

For this 1915(b)(4) waiver application, DSS emailed a “Notice of Intent to Renew the Home and Community Based Services Waiver” to the medical directors and their respective designees of both tribes on January XX, 2020. Specifically, the notice was sent to Carrie Janus and Connie Hilbert with the Mohegan Tribe and Barbara Poirer and Shanna Reels with the Mashantucket Pequot Tribal Nation. CMS was also alerted to the tribal notification. In the time since the notice was sent, DSS has not received questions or comments from either tribe on the 1915(b)(4) waiver application. Since this time period has exceeded two (2) weeks, DSS has determined that the tribes do not have any questions or concerns regarding the proposal.

**Program Description (continued):**

The program is funded through State-only and Medicaid funds. Medicaid funding for the program is authorized through a 1915(c) Home and Community Based Services (HCBS) waiver and though 1915(i) State Plan HCBS. There are approximately 13,500clients in the 1915(c) waiver for Elders,and estimated 425 and clients in the 1915(i) State Plan HCBS benefit and approximately 1,000 persons served under the PCA Waiver. The programs offer three tiers of care management with varied reimbursement rates driven by the frequency of care management interventions.

DSS currently contracts 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 the following activities:

* 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.

1. **Delivery Systems**
2. **Reimbursement (continued)**

Access Agencies will receive a one-time payment of $281.73, per client for an initial assessment. The per-client reimbursement rates for reassessments and client status review will be $211.30 and $93.19 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) 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 receive a regular per diem, per client case management rate of $4.85 through the end of the contract, June 30, 2025. The first and third tier reimbursement rates for these Access Agencies are $4.49 and $5.05respectively. Rates for the initial assessment are up to $304.75

Rates for future years will be developed as part of the next competitive procurement. DSS is initiating a rate rebasing study in calendar year 2020. This service with be included in the rate review.

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.

1. **Procurement (continued)**

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 Access Agencies 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.

1. **Restriction of Freedom of Choice**
2. **State Standards (continued)**

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

**Part II: Access, Provider Capacity and Utilization Standards**

1. **Timely Access Standards (continued)**
2. 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)/1915(i) 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, and 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 it’s electronic client management data base.

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.

1. 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 (Connecticut General Statutes Sec. 17b-342) 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.

**C. Utilization Standards (continued)**

1. 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 also are required to complete a representative sample of HCBS surveys for each program. The results are captured in a data base and the results are compiled annually by the University of CT. Center on Aging and provided to the Department.

**Part III: Quality**

1. **Quality Standards and Contract Monitoring (continued)**

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.