APPENDIX K: Emergency Preparedness and Response

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendment to its approved waiver. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be completed retroactively as needed by the state.

Appendix K-1: General Information

General Information:

A. State: **Connecticut**

B. Waiver Title:

Home and Community Based Services Waiver for Elders
Personal Care Assistance Waiver
CT ABI Waiver
Home and Community Supports Waiver for Persons with Autism
CT ABI Waiver II
Mental Health Waiver
Katie Beckett Waiver

C. Control Number:

CT.0140.R07.03
CT.0301.R05.05
CT.0302.R05.01
CT.0993.R01.04
CT.1085.R01.04
CT.0653.R02.04
CT.4110.R08.01

D. Type of Emergency (The state may check more than one box):

X	**Pandemic or Epidemic**
O	**Natural Disaster**
O	**National Security Emergency**
O	**Environmental**
O	**Other (specify):**

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

Coronavirus Disease (COVID 19) pandemic.

Federal public health emergency continues to exist as a result of the COVID-19 pandemic.

This Appendix K is additive to the previously approved Appendix Ks and includes the following modifications:

1. Increased Provider Rates. Rate sufficiency is imperative to quickly build supply of HCBS workers needed.
    a. Supplemental rate funding for value-based payment increased from 1% to 2% value-based payment (VBP) as approved under the ARPA reinvestment plan, effective 7/1/2021, with the VBP increase contingent on: participation in race-equity training; connection to the state's health information exchange (HIE); and reporting of quality and financial data.
    b. Supplemental rate funding for certain improvements in meaningful use of data

Acknowledging the payments listed in this Appendix K are time-limited payments the State understands that its ability to make payments under the Appendix K authority will end six months following the conclusion of the Federal public health emergency. The State will be responsible to seek other authority, such as amending the 1915(c) HCBS base waivers, for the continuation of these payments beyond the termination date of the Appendix K.

F. Proposed Effective Date: Start Date: 3/16/2020 Anticipated End Date: Six months after the conclusion of the Federal public health emergency.

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID 19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply across the waivers to all individuals impacted by the COVID-19 pandemic.

I. Description of State Disaster Plan (if available) ***Reference to external documents is acceptable*****:**

Not applicable.

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a. __ Access and Eligibility:

i. __ Temporarily increase the cost limits for entry into the waiver.
[Provide explanation of changes and specify the temporary cost limit.]

ii.___ Temporarily modify additional targeting criteria.
[Explanation of changes]

b.___ Services

i.___ Temporarily modify service scope or coverage.
[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. ___Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.
[Explanation of changes]

iii.__Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).
[Complete Section A-Services to be Added/Modified During an Emergency]

iv. ___Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches) Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:

[Explanation of modification, and advisement if room and board is included in the respite rate]:

v.___ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

c.___ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

d.___ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i.___ Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

ii.___ Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the. provider type for each service].

iii.___ Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

e. ___Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

f. X Temporarily increase payment rates

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider].

The following increases are based on a rate development method that is different from the methods previously approved by CMS for these waivers:

Up to 2% enhanced supplemental value-based payment (VBP)– performance based fully funded through ARPA

Nature of the payments that are made and the waiver services for which these payments are made: Payments are supplemental payments based on performance for all waiver services other than those specifically excluded as described below. Payments are based on prior period of claims submitted for the performance period. Payments defined as benchmark payments as described under 'Payment Methodology' are payable at 1% of claims submitted during the prior period. Payments defined as outcome payments as described under 'Payment Methodology' are payable at up to 4% of claims submitted during the prior period.

Payment methodology:

Benchmark supplemental payments

November 2022 benchmark payments are based on 1% of expenditures from July 1, 2022 through October 31, 2022. For the November 2022 payment, benchmarks must be met no later than November 1, 2022, and are as follows:

1) Participation in Department of Social Services' racial equity training; identification and participation of a 'champion' for racial equity service delivery change.

2) Completion of HIE stakeholder input tool; identification and participation of individual who will 'champion' delivery system change.

March 2023 benchmark payments are based on 2% of expenditures from November 1, 2022 through February 28, 2023. For the March 2023 payment, benchmarks must be met no later than February 15, 2022, and are as follows:

1) Participation in Department of Social Services' racial equity training and related learning collaboratives

2) Participation in the Department of Social Services' workforce retention recruitment survey

3) Identification and enrollment of HIE administrator; participation in training, accessing data within the HIE; and participation in data use learning collaboratives.

July 2023 benchmark payments are based on 2% of expenditures from March 1, 2023 through June 30, 2023. For the July 2023 payment, benchmarks must be met no later than June 15, 2023, and are as follows:

1) Participation in Department of Social Services' racial equity training and participation in related learning collaboratives.

2) Accessing data within the HIE and viewing baseline participation in data use learning collaboratives and training.

November 2023 benchmark payments are based on 2% of expenditures from July 1, 2023 through October 31, 2023. For the November 2023 payment, benchmarks must be met no later than October 15, 2023, and are as follows:

1) Department of Social Services' racial equity training required component of all new staff orientation. Participation in related learning collaboratives

2) Accessing data within the HIE and viewing baseline participation in data use learning collaboratives and training.

Payment methodology for **benchmark** payments: Payments are based on 1% of expenditures for the 4 months that immediately precede the payment if benchmarks are met for the November 2022 payment and 2 % for payments beginning March 2023. For example, the November 2022 payment is 1% of expenditures from July 1, 2022 through October 31, 2022.

Outcome Based Supplemental Payments

Beginning in March 2024, the value-based payment will change from progressive benchmark payments to outcome-based payments.

Outcomes are as follows:

1) Decrease in avoidable hospitalization;
2) Increase in percent of people who need ongoing services discharged from hospital to community in lieu of nursing home; and
3) Increase in probability of return to community within 90 days of nursing home admission.

Payment methodology for ongoing **outcome** payments: Payments are based on up to 2% of expenditures for the 6 months that immediately precede each payment other than the first outcome payment which will be based on the 4 months that immediately precede the first payment. The higher limit of 2 % will be based on availability of funds as approved within the ARP 9817 spending plan. If 2% payout exceeds availability of funds as approved, the payment will be prorated accordingly. If 2% payout is less than total funds available, excess funds will be prorated up to a maximum limit of 4% and paid to providers who qualify for the outcome payment. The 4 months preceding the first payment are further defined as the first performance period. For example, the March 2024 payment is up to 2% of expenditures (performance period) from November

1, 2023 through February, 2024. The 6 months preceding all payments other than the first payment are further defined as subsequent performance periods. For example, the September 2024 payment is up to 2% of expenditures based on the performance period from March 1, 2024 through August 31, 2024.

The types of waiver providers that receive such payments: All provider types covered under these 1915(c) waivers active as of the issuance date of the respective payment are eligible for the 1% enhanced supplemental payment other than those provider types and services specifically excluded. *Excluded providers and services: Assistive Technology; Environmental Accessibility Modifications, Personal Response System, Skilled Chore, Specialized Medical Equipment, Individual Goods and Services, and all Self-Directed Services.*

Specify the source of the non-federal share of the supplemental or enhanced payments: The source for this supplemental payment is the state general fund as supported under Connecticut's American Rescue Plan Act Spending Plan and Narrative.

Specify that providers eligible to receive the supplemental or enhanced payment must be able to retain 100% of the total computable expenditure claimed by the Medicaid agency to CMS: All providers eligible to receive the supplemental or enhanced payment will be permitted to retain 100% of the total computable expenditure claimed by the Medicaid agency to CMS.

Supplemental rate funding for certain improvements in meaningful use of data further defined as 'Quality Supplemental Payment'

Nature of the payments that are made and the waiver services for which these payments are made: Payments are supplemental payments based on performance for all waiver services, by providers who are participating in the value-based payment initiative, other than those specifically excluded as described below. Supplemental payments are three one-time payments based on achieving quality metrics including, but not limited to, establishment of an electronic health record for members, team-based care coordination and service delivery focused on member goal, integration of admission, discharge and transfer data into member service planning. Three one-time payments will be made as described below based on provider attainment of benchmark. Member satisfaction surveys are required.

Payment methodology:

March 23, 2023 benchmark payments are based on the greater of 5% of expenditures from November 1, 2022 through February 28, 2023 or $5,000. Expenditures used as the basis of the payment are total HCBS expenditures for the provider across all programs. For the March 2023 payment, benchmarks must be met no later than March 1, 2023, and are as follows:

1) Phase 1 benchmark – Providers have requirements to improve member service delivery documented and contracts in place with vendors to modify delivery system; providers have member satisfaction survey drafted

July 2023 benchmark payments are based on the greater of 5% of expenditures from March 1, 2023 through June 30, 2023 or $5,000. For the July 2023 payment,

benchmarks must be met no later than June 15, 2023, and are as follows:

1) Phase 2 benchmark – Providers have delivery system modifications complete

November 2023 benchmark payments are based on the greater of 5% of expenditures from July 1, 2023 through October 31, 2023 or $5,000. For the November 2023 payment, benchmarks must be met no later than October 15, 2023, and are as follows:

1) Phase 3 – Providers have delivery system implemented and integrated into member service planning; member satisfaction survey complete

The types of waiver providers that receive such payments: All provider types covered under these 1915(c) waivers active as of the issuance date of the respective payment and participating in the state's VBP as defined above are eligible for the quality supplemental payment other than those provider types and services specifically excluded. *Excluded providers and services: Assistive Technology; Environmental Accessibility Modifications, Personal Response System, Skilled Chore, Specialized Medical Equipment, Individual Goods and Services, and all Self-Directed Services.*

Specify the source of the non-federal share of the supplemental or enhanced payments: The source for this supplemental payment is the state general fund as supported under Connecticut's American Rescue Plan Act Spending Plan and Narrative.
Specify that providers eligible to receive the supplemental or enhanced payment must be able to retain 100% of the total computable expenditure claimed by the Medicaid agency to CMS: All providers eligible to receive the supplemental or enhanced payment will be permitted to retain 100% of the total computable expenditure claimed by the Medicaid agency to CMS.

g.___ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

h.___ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

i.___ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.
[Specify the services.]

j.___ Temporarily include retainer payments to address emergency related issues.
[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

k.___ Temporarily institute or expand opportunities for self-direction.
[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards]

l.___ Increase Factor C.
[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m.___ Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name: Jennifer

Last Name	Cavallaro
Title:	Director, Community Options - Operations
Agency:	Department of Social Services
Address 1:	55 Farmington Avenue
Address 2:	9th Floor
City	Hartford
State	Connecticut
Zip Code	06105
Telephone:	860-424-5743
E-mail	jennifer.cavallaro@ct.gov
Fax Number	860-424-4963

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Click or tap here to enter text.
Last Name	Click or tap here to enter text.
Title:	Click or tap here to enter text.
Agency:	Click or tap here to enter text.
Address 1:	Click or tap here to enter text.
Address 2:	Click or tap here to enter text.
City	Click or tap here to enter text.
State	Click or tap here to enter text.
Zip Code	Click or tap here to enter text.
Telephone:	Click or tap here to enter text.
E-mail	Click or tap here to enter text.
Fax Number	Click or tap here to enter text.

8. Authorizing Signature

Signature: **Date:**

State Medicaid Director or Designee

First Name:	William
Last Name	Woolston
Title:	Medicaid Director
Agency:	Department of Social Services
Address 1:	55 Farmington Avenue
Address 2:	9th Floor

City	Hartford
State	CT
Zip Code	06005
Telephone:	860-424-5077
E-mail	William.Woolston@ct.gov
Fax Number	860-424-4963

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification					
Service Title:					
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
Service Definition (Scope)**:**					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☐	Agency. List the types of agencies:

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☐	Provider managed

[i] Numerous changes that the state may want to make necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.