Application for

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

June, 2012

v1.0

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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 Connecticut Housing Engagement and Support Services (CHESS)
(List each program name if the waiver authorizes more than one program.).

Type of request. This is:
_X_ an initial request for new waiver. All sections are filled.
___ a request to amend an existing waiver, which modifies Section/Part ____
___ a renewal request
Section A is:
___ replaced in full
___ carried over with no changes
___ changes noted in **BOLD**.
Section B is:
___ replaced in full
___ changes noted in **BOLD**.

Effective Dates: This waiver/renewal/amendment is requested for a period of 5 years beginning August 16, 2021 and ending August 15, 2026.

State Contact: The State contact person for this waiver is Dawn Lambert and can be reached by telephone at (860) 424-4897, or fax at (___) _____, or e-mail at Dawn.Lambert@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 advice from the two federally-recognized tribes in Connecticut, the Mashantucket Pequot Tribal Nation and the Mohegan Tribe, through periodic meetings with tribal health representatives and by ongoing written/electronic communications. Prior to submission of a State Plan Amendment, waiver, waiver amendment, or demonstration project proposal submitted to CMS, the Department of Social Services (DSS), which is Connecticut's single state Medicaid agency, sends a copy of the public notice to both tribes by email. If the submission does not require public notice, DSS sends a brief summary of the proposed change to both tribes, again, via email.

On July 22, 2020, DSS sent notification to tribal representatives for the two tribes referenced above for this waiver (with a summary, plus the draft waiver application and the public notice attached).

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 Housing and Engagement Support Services (CHESS) program, which is a State Plan Home and Community-Based Services (HCBS) program pursuant to section 1915(i) of the Social Security Act, aims to identify Medicaid Participants who are experiencing homelessness and a higher rate of hospitalizations than would otherwise be expected based on their diagnoses and other risk factors. Once the Participant is identified, services under CHESS are designed to support the participant with a range of housing stabilization services, healthcare coordination services, services to support community participation, ongoing engagement, and housing maintenance.

CHESS is a new program beginning implementation on the effective date set forth in the Medicaid State Plan (Attachment 3.1-i), which is also the same effective date as this waiver, but is based on the State’s long successful history with supportive housing initiatives as well as the State's Money Follows the Person Demonstration (MFP). Both the previously existing supportive housing initiatives and MFP demonstration work with providers who assist with housing search and stabilization. The selective provider contracting program for CHESS is based on the State’s existing processes for Requests for Proposals for supportive housing providers, which have been procured using the State’s existing process and will be re-procured on a periodic basis in accordance with the State’s standard contracting rules and procedures to ensure a robust, quality

network of skilled providers. Additionally, for the federal Department of Housing and Urban Development (HUD) supportive services funding, providers were selected using a procurement process that adheres to HUD requirements.

The procurement process is designed to ensure that the selected providers meet high standards of quality. More specifically, providers have a minimum of 5 years of experience providing housing supports to persons experiencing homelessness who are diagnosed with a mental health and/or substance use disorder, organizational capacity sufficient to address the estimated demand for services in their geographic area, project planning skills, community engagement, involvement of peers and other factors that are associated with high quality service delivery. The State contracts with the selected providers and outlines the expectations and requirements within the standard state approved contract template. The State also conducts monitoring visits to ensure that providers are adhering to the contract requirements and provide quality services to the participants. Agencies that do not meet monitoring standards must complete an action plan to address deficiencies. The State determines the towns that each contractor will serve. This assures choice for CHESS participants and also limits the number of CHESS providers in each town so that CHESS agencies can maintain high enough caseloads to be cost efficient and so that CHESS providers will stay current with the many requirements of providing CHESS services.

As detailed in the Medicaid State Plan (Attachment 3.1-i), the State projects that CHESS will serve approximately 50 individuals in year 1, 150 individuals in year 2, and 300 individuals in year 3. These estimates are based on anticipated delays in locating individuals choosing to enroll in CHESS. Once fully implemented, the State projects that CHESS may serve approximately 850 individuals annually.

Waiver Services:
Please list all existing State Plan services the State will provide through this selective contracting waiver.

The services are set forth in the Medicaid State Plan (Attachment 3.1-i). This initiative is being added to the State Plan through an initial Medicaid State Plan Amendment with the same effective date as this section 1915(b)(4) selective provider contracting waiver. Any future changes to the Medicaid State Plan through later SPAs are incorporated by reference into this waiver, as this waiver will continue to follow the services as set forth in Attachment 3.1-i of the Medicaid State Plan.

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:

_X_ the same as stipulated in the State Plan
___ is different than stipulated in the State Plan (please describe)

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

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

C. Restriction of Freedom of Choice

1. **Provider Limitations**.

___ Beneficiaries will be limited to a single provider in their service area.
_X_ 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)

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.

The state standards are the same as those set forth in the Medicaid State Plan. This initiative is being added to the State Plan through an initial Medicaid State Plan Amendment with the same effective date as this section 1915(b)(4) selective provider contracting waiver. Any future changes to the Medicaid State Plan through later SPAs are incorporated by reference into this waiver, as this waiver will continue to follow the standards as set forth in the Medicaid State Plan.

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
_X_ 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
___ Poverty Level Pregnant Women
___ Individuals with other insurance
___ 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?

The State proposes to measure the timeliness of providers' services to Medicaid Participants by monitoring key performance targets, including, but not limited to: 1) First contact with Participant within 3 days of referral; 2) First face-to-face meeting with Participant within 10 days of referrals; 3) Service plan submitted for approval within 30 days of referrals; 4) Lease-up of housing within 90 days of approved service plan. Additional details are set forth in the quality assurance section of Attachment 3.1-i of the Medicaid State Plan.

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.

The State proposes ongoing monitoring of all agencies for compliance with the provider performance targets. Reports will be generated monthly. Corrective action plans will be developed and implemented for those providers who fail to meet performance targets. Providers who, after corrective action, fail to meet performance targets will be disenrolled as Medicaid providers. Additional details are set forth in the quality assurance section of Attachment 3.1-i of the Medicaid State Plan.

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.

There are 45 providers that were selected through the competitive procurement processes for the providers that are currently serving the State's pre-existing non-Medicaid Supportive Housing program. Providers are geographically disbursed across the State and are further organized within the State's Coordinated Access Network (CAN). The CAN ensures local coordination and coverage to address the needs of the homeless population at a local level. The CHESS program aims to serve 850 people by the end of year 3, which represents a 25% growth in the demand for housing services across the state. The State meets with providers on an ongoing basis and has built capacity with additional training and enrollment supports. Qualifications for staff who provide services under CHESS were developed in partnership with the providers. The distribution of CHESS participants to providers is 18:1 based on 850 participants and 45 providers at the end of year 3. All of these parameters are sufficient to assure capacity, which the State will continue to monitor as set forth in detail in Attachment 3.1-i of the Medicaid State Plan.

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.

As previously stated and in accordance with Attachment 3.1-i of the Medicaid State Plan, the current network of 45 providers is geographically disbursed across the State and is more than adequate to support the increase in demand for service anticipated upon implementation of CHESS. The State will ensure ongoing appropriate distribution of providers and timely access to CHESS throughout the State by continual monitoring of key performance targets. Providers are required to contact

Participants within 3 days of referral, provide the first face-to-face contact within 10 days of referral, submit services plans within 30 days of referral, provide and document ongoing services aligned with the approved service plan, support lease-up of Participant within 90 days of approved plan, etc. Providers who cannot meet the standards of timeliness will participate in corrective action. Providers who do not meet corrective action requirements will be terminated as CHESS Medicaid providers.

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 staff and the State's Medicaid Behavioral Health (BH) Administrative Services Organization (BH-ASO) staff assume responsibility for utilization management functions. All new person-centered recovery service plans are reviewed by BH-ASO licensed behavioral health clinicians. Additionally, BH-ASO staff conduct electronic record audits of the provider's Participant records. The appropriateness of the person-centered recovery service plan is compared to the identified needs. Clinical notes in the electronic system are reviewed to ensure documentation of activities as defined in the plan. BH-ASO supervisors conduct ongoing utilization review as they evaluate clinical records. Review of assessed needs and service plans is supported by electronic systems that automate reports.

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 and the BH-ASO will monitor automated reports and information from Participant databases to identify failures in service delivery. Specifically, DSS and BH-ASO will monitor timeliness of all performance targets and will conduct on-site audit reviews providers as necessary. If providers fail to meet the needs of Participants, as well as the provider requirements, the BH-ASO will implement a corrective action plan to ensure that problems are corrected. Providers who do not meet corrective action requirements will be dis-enrolled as CHESS Medicaid providers.

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.

The Department of Mental Health and Addition Services (DMHAS) is responsible for the competitive procurement and has contracts with each of the providers to ensure compliance with performance requirements. CHESS incorporates the DMHAS performance requirements and additional Medicaid performance requirements within the Medicaid provider enrollment criteria. DSS and the BH-ASO will monitor providers to ensure compliance with provider enrollment criteria and quality standards. The BH-ASO will coordinate with DMHAS to ensure sharing and coordination of contractor/provider performance requirements. Specifically, the BH-ASO monitors utilization and compliance two times per quarter through an electronic transactional database and on-site record reviews, self-assessments, and fiscal audits. Corrective action plans are also described in the previous section.

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 BH-ASO monitors providers using a variety of methods described above and, as needed, CHESS providers are required to develop improvement plans to report progress on timely correction. When correction is not timely or when the noncompliance is pervasive, the BH-ASO develops a corrective action plan to ensure that problems are corrected. If the issues identified are still not corrected, a compliance agreement is developed that include sanctions such as limiting referrals and withholding funds until correction is verified. If no correction can be verified, the provider's enrollment in CHESS is terminated and Participants will be directed to choose a provider from the remaining network of providers. Alternatively, if the provider fails to meet the contract requirements of DMHAS and the State ends the contractual relationship, DSS will accordingly terminate the provider's enrollment in Medicaid for CHESS since that provider will no longer meet that qualification.

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.

Coordination and continuity of care is ensured through the ongoing monitoring and quality management process described above. In addition, if any provider is terminated from CHESS for any reason, the Participant will be contacted immediately by the BH-ASO and offered choice of the remaining qualified enrolled providers. Participant records will be transferred to the new provider selected by the Participant. Providers will review the service plan with the Participant, review goals and activities within 10 days of reassignment to ensure continuity of care.

Part IV: Program Operations

A. Beneficiary Information

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

Participants will receive information about the selective contracting program through a "no wrong door" approach. Print materials and web-based information will ensure continuity of information. Entry points to get information include: the CAN, the Medicaid program's medical and behavioral health ASOs, existing section 1915(c) waiver programs, the state's Money Follows the Person (MFP) program, the state's 211 social service information referral system, hospitals, homeless outreach programs, and other referral sources.

B. Individuals with Special Needs.

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

The State process in place for persons with special needs is based on the development of the Person-Centered Recovery Plan. Each service plan is designed to meet the unique needs of each Participant. Staff receive training on cultural competency including disability competency.

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.

Rates are statewide and set based on cost. Limiting the number of providers to those selected through DMHAS's competitive procurement enables the state to administer the system more efficiently by reducing administrative costs, specifically by: limiting the number of contracts developed and monitored, the number of staff trained, and other administrative activities, which all will result in lower administrative costs. At the same time, the competitive procurement also ensures a high level of competency, capacity within the provider agency, and overall quality.

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

Year 1 from: 08/16/2021 to 08/15/2022

Trend rate from current expenditures (or historical figures): 0%

Projected pre-waiver cost $209,682
Projected Waiver cost $190,619
Difference: $19,063

Year 2 from: 08/16/2022 to 08/15/2023

Trend rate from current expenditures (or historical figures): 3%

Projected pre-waiver cost $942,651
Projected Waiver cost $856,955
Difference: $$85,696

Year 3 (if applicable) from: 08/16/2023 to 08/15/2024
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)
Projected pre-waiver cost $2,275,172
Projected Waiver cost $2,068,338
Difference: $206,834

Year 4 (if applicable) from: 08/16/2024 to 08/15/2025
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost $4,277,607
Projected Waiver cost $3,888,733
Difference: $388,874

Year 5 (if applicable) from: 08/16/2025 to 08/15/2026
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost $6,826,998
Projected Waiver cost $6,206,362
Difference: $620,636