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State/Territory Name: Connecticut

State Plan Amendment (SPA) #: 14-0004MM4

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

June 18, 2014

Roderick L. Bremby, Commissioner
Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033

Dear Commissioner Bremby:

We are pleased to enclose a copy of approved State plan amendment (SPA) No. 14-0004MM4 with an effective date of January 1, 2014, as requested by your Agency. This SPA establishes the single state agency and entities responsible for determinations of eligibility and appeals/fair hearings in accordance with the Affordable Care Act.

If there are questions, please contact Robert Cruz. He can be reached at (617) 565-1257.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Enclosure

cc:
Raymond Singleton Jr., Deputy Commissioner
Marc Shok, Adult Services Program Manager

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **Connecticut**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

CT-14-0004

Proposed Effective Date

01/01/2014 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Affordable Care Act; 42 CFR Part 435

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

Single State Agency

Governor's Office Review

- (●) **Governor's office reported no comment**
- ( ) **Comments of Governor's office received**

  Describe:

- ( ) **No reply received within 45 days of submittal**
- ( ) **Other, as specified**

  Describe:

Signature of State Agency Official

Submitted By:	**Marc Shok**
Last Revision Date:	**Mar 31, 2014**
Submit Date:	**Mar 31, 2014**

Date Received: 3/31/14

Plan Approved - One Copy Attached

Date Approved: 6/18/14

Effective Date of Approved Material: 1/1/14

Signature of Regional Official:

/s/

Typed Name: Richard R. McGreal

Division of Medicaid and Children's Health Operations, Boston Regional Office

SUPERSEDING PAGES OF STATE PLAN MATERIAL		
TRANSMITTAL NUMBER: CT-14-0004	**STATE:** Connecticut	
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: A1 – A3	**COMPLETE PAGES SUPERSEDED:** Section 1, pages 1-8 Attachment 1.1-A Attachments 1.2A-C	**PARTIAL PAGES SUPERSEDED:** Section 1; page 8a and 9
Section 1, page 9		Section 1, page 8a and 9
A2	Notwithstanding any other provisions of the Medicaid State Plan, the agencies designated in A2 will determine eligibility for coverage to the extent specified in A2 – Not applicable.	

Medicaid Administration

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

State Plan Administration Designation and Authority	A1

42 CFR 431.10

Designation and Authority

State Name: Connecticut

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Name of single state agency: Connecticut Department of Social Services

Type of Agency:

- ○ Title IV-A Agency
- ○ Health
- ○ Human Resources
- ◉ Other

Type of Agency: Both the Title IV-A Agency and Human Resources Agency

The above named agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

The state statutory citation for the legal authority under which the single state agency administers the state plan is:

Conn. General Statutes Section 17b-260 and 17b-264

The single state agency supervises the administration of the state plan by local political subdivisions.

○ Yes ◉ No

☑ The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

An attachment is submitted.

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

The single state agency administers the entire state plan under title XIX (i.e., no other agency or organization administers any portion of it).

◉ Yes ○ No

The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:

- ☒ The Medicaid agency
- ☐ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

The entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

- ☒ The Medicaid agency
- ☐ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ☐ The Federal agency administering the SSI program

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

- ☒ Medicaid agency
- ☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ☐ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

○ Yes ◉ No

State Plan Administration
Organization and Administration

A2

42 CFR 431.10
42 CFR 431.11

Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

The Department of Social Services (DSS) administers and delivers a wide variety of services to children, families, adults, people with disabilities and the elderly. DSS' services include health care coverage, child care, child support, long-term care and supports, energy assistance, food and nutrition aid, and program grants. DSS administers myriad state and federal programs and one-third of the state budget, currently serving more than 825,000 individuals in nearly 525,000 households (March 2014 data). By statute, DSS is the state agency responsible for administering a number of programs under federal legislation, including the Food Stamp Act, the Older Americans Act, and the Social Security Act.

The Department of Social Services is part of the Executive Branch of Connecticut state government. Pursuant to state law, the Commissioner of Social Services, like other state agency heads, is appointed by the Governor, with the advice and consent of the Connecticut General Assembly. The department also has two deputy commissioners for administration and programs. The agency delivers most of its programs through 12 field offices (including three benefits centers available by phone) located throughout the state, with central administrative offices located in Hartford. In addition, many services funded by the agency are available through community-based agencies and partner contractors. The agency has outstationed employees at hospitals to expedite Medicaid/

HUSKY applications, and also works with community service providers to facilitate program applications.

Divisions Within the Department

-Affirmative Action
-Aging Services Division
-Economic Security
-Eligibility Policy and Program Support (see description in Integrated Services, below)
-Energy, Refugee and Community Services
-Family Services
-Field Operations - This Division supports the Department's modernized approach to providing services to clients, including the establishment of benefit centers and other service delivery upgrades as described in "Modernization – Eligibility and Service Delivery" below.
-Finance and Administration - This Division supports the Department through a full range of financial oversight and operational functions. These financial management activities are provided through the following four key service groups: the Budget Group, the Federal Reporting and Accounting Services Group, the Fund Management and Reporting (FMR) Group, the Actuarial Research and Analytical Support Unit.
-Division of Health Services and Health Management (see description below)
-Human Resources
-Integrated Services (see description below)
-MIS-IT Support
-Office of Legal Counsel, Regulations and Administrative Hearings (see hearings description below)
-Office of Public Affairs
-Organizational and Skill Development
-Quality Assurance - This Office is responsible for ensuring the fiscal and programmatic integrity of all programs administered by the Department. It includes four divisions each with unique program integrity functions: Fraud & Recoveries, Provider Audit/ Grants & Contracts, Quality Control, and Special Investigations.
-SNAP
-Social Work & Prevention Services
-Strategic Planning

Division of Health Services and Health Management - Overview

The Division oversees administration of the Medicaid program with the exception of eligibility policy. The Division is made up of 10 units, including:

o Alternate Care Unit (ACU): manages the Connecticut Home Care Program for Elders, the Connecticut Home Care Program for Adults with Disabilities, the Katie Beckett waiver, Ascend level of care determination process for Medicaid payment of nursing facility stays, and the 1915(i) State Plan home and community-based services option and provides administrative oversight of Medicaid waivers operated by DDS and DMHAS.

o Behavioral Health Unit: manages behavioral health services for Medicaid eligible individuals. The unit is responsible for the behavioral health Administrative Services Organization (ASO) and staffs the Behavioral Health Partnership Oversight Council

o Dental Unit: manages the dental ASO, helps to coordinate dental benefits among different providers, reviews clinical materials for administrative hearings, staffs the Dental Policy Advisory Committee as well as provides oversight of the lead abatement and healthy homes programs

o Enrollment Unit: acts as liaison on Health Insurance Exchange activities and replacement of the Eligibility Management System (EMS) and manages Husky B (CHIP)

o Money Follows the Person Unit (MFP): leads the state's "re-balancing" efforts to shift the focus of spending on long-term services and supports from institutional settings to home and community-based options

o Medical Care Management Unit: manages the medical ASO, Person-Centered Medical Home (PCMH) initiative, NEMT and

Rewards to Quit

o Pharmacy Unit: manages the pharmacy benefits for all clients enrolled in Connecticut Medical Assistance programs. This includes management of the preferred drug list, pharmacy prior authorization, drug rebate invoicing/collection, coordination with Medicare Part D, processing of eligibility/enrollment in the Connecticut AIDS Drug Assistance Program (CADAP) and more.

o Certificate of Need (CON) and Rate Setting Unit: establishes payment rates for medical and residential services covered under the Medicaid and State Supplement/Aged, Blind and Disabled (SSABD) programs, performs cost report auditing, and performs certificate of need (CON) reviews for nursing facility, residential care home and ICF-MR development, facility renovation projects and capacity expansions/contractions. The unit is also instrumentally involved with nursing facility receiverships and bankruptcies (restructuring, transfers to new owners, closures).

o Medical Operations Unit: manages how all medical programs are operationalized to reimburse providers via the Medicaid Management Information System (MMIS), including fiscal agent services provided through a contract with HP Enterprise Services (HP). These services include credentialing and enrollment of providers, coding and rule configuration in the MMIS to govern how claims for services are processed (including rules to prevent inappropriate payments), financial and other reporting on such processing, and management of processes that support these functions (e.g., call centers, provider communication, provider relations, etc.) A large component of Med Ops' work revolves around implementing new initiatives; specifically, supporting other units in the work of documenting program details and directing HP in how such details must be aligned to support payment for new services or changes to existing services. In addition, Med Ops is responsible for the Medicaid Electronic Health Record (EHR) Incentive program and related Health Information Technology (HIT) initiatives which complement other health care reform efforts.

o Medical Policy Unit: interprets federal and state statutes and regulations toward development of Department policies and procedures; creates and updates fee schedules; determines Department health program coverage guidelines; provides staff support to the State Plan Amendment process.

o Medical and Clinical Review Team: Provides clinical consultation to all DSS activities as well as assists clinical review of the medical ASO.

Division of Integrated Services - Overview

The Division is responsible for providing residents of Connecticut with coordinated and comprehensive access to social services and programs. The Division is comprised of the following teams:

-Eligibility Policy and Program Support;
-Economic Security;
-Child Support; and
-Social Work and Community Services

The Eligibility and Program Support team is responsible for the administration of Medicaid eligibility policy.

Modernization – Eligibility and Service Delivery

To improve access for Connecticut residents, DSS has undertaken a major initiative to modernize and upgrade service delivery. The ConneCT initiative allows clients real-time access to their case information through online and interactive voice-response systems, including an online service eligibility pre-screening tool. Streamlined document management and modernized service centers are also key elements of the initiative.

The Department also implemented a new business model. All eligibility work is getting processed in one of three types of centers: 1) service centers - dedicated staff in 12 Service Centers providing face-to-face services with walk-in clients; 2) processing centers - processors in the 12 centers processing work that comes in via the web and the mail via the workflow; and 3) benefits centers – representatives in three Benefits Centers available to clients and processing eligibility work via the phone.

In addition, the Department is planning for the replacement of the agency's outdated eligibility management system and is working in partnership with Access Health CT, the state's new health insurance exchange. The Department has developed systems,

policies, and procedures to support the requirements for the various insurance affordability programs in the federal Affordable Care Act (ACA).

MAGI-related eligibility determinations (parent and caretakers, pregnant women, single adults, children) and former foster care coverage group determinations are made in the Access Health CT System. The system is shared by the Department and Access Health CT and uses a shared rules engine.

Any questions or discrepancies on determinations made by the AHCT system are addressed by a DSS employee, either an eligibility worker in one of the Department's service, processing or benefits centers or a member of the Eligibility and Program Support team. Also, DSS uses a contractor for data entry of eligibility information for MAGI Medicaid, but any determination or action that requires the exercise of discretion would be either sent to a DSS employee in one of the service or benefit centers for action. Also, the Eligibility and Program Support team maintains an onsite presence at the contractor's office.

Eligibility determinations for non-MAGI Medicaid populations are made by the workers in the 3 types of centers described above. In 2013, the Department launched four Long-Term Care Application Centers. The Centers will receive and process nursing home and Medicaid waiver applications from within their designated catchment areas.

Hearings Process

Applicants for and recipients of benefits provided under Department of Social Services programs may contest actions taken by the Department, including actions (denial, termination, suspension, reduction) related to Medicaid and CHIP eligibility and benefits. The Office of Legal Counsel, Regulations and Administrative Hearings established a separate MAGI hearings unit that also has jurisdiction over eligibility determinations related to Advance Payments of Premium Tax Credits and Cost Sharing Reductions for Qualified Health Plans.

Administrative hearings are conducted by hearing officers, who are impartial employees of the Department of Social Services and are designees of the Commissioner of Social Services. A hearing officer conducts the hearing, reviews the hearing record, researches the law and issues written decisions based on the facts and applicable state and federal law.

The MAGI hearings unit normally holds hearings by telephone, but clients may request a hearing by video conference. While relatively informal in nature, the hearing process affords clients an opportunity to explain on the record why they disagree with the Department's action. Once the hearing has been held and the record has been closed, the hearing officer issues a written decision and sends it to the client by certified mail.

If the client does not agree with the hearing officer's decision, the client has the right to ask the Department to reconsider it. A reconsideration request must be made within 15 days of the mailing date of the hearing officer's decision. The client may also appeal the hearing officer's decision to the Superior Court within 45 days. The client may appeal the hearing officer's decision to Superior Court without first asking for reconsideration.

Upload an organizational chart of the Medicaid agency.

An attachment is submitted.

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

Executive Branch - Overview

Connecticut's Governor heads the Executive branch. In addition to the Governor and Lieutenant Governor, there are four other elected offices established in the Connecticut Constitution: Secretary of State, Comptroller, Treasurer and Attorney General. There are several executive departments: Administrative Services, Agriculture, Banking, Children and Families, Consumer Protection, Correction, Economic and Community Development, Developmental Services, Construction Services, Education, Emergency Management and Public Protection, Energy & Environmental Protection, Higher Education, Insurance, Labor, Mental

Health and Addiction Services, Military, Motor Vehicles, Public Health, Public Utility Regulatory Authority, Public Works, Revenue Services, Social Services, Transportation, and Veterans Affairs. In addition to these departments, there are other independent bureaus, offices and commissions.
While the Department of Social Services is the single state agency for administration of the Medicaid program, the Department works closely with other executive branch health and human services agencies, including the Department of Children and Families, the Department of Developmental Services, the Department of Mental Health and Addiction Services and the Department of Public Health.

The Department collaborates with these agencies on a number of Medicaid waivers for their children and adult populations. DSS also collaborates with the Departments of Children and Families and Mental Health and Addiction Services on the Connecticut Behavioral Health Partnership. The CT BHP is a Partnership that consists: of the Department of Children and Families (DCF), the Department of Social Services (DSS), the Department of Mental Health and Addiction Services (DMHAS), a contracted Administrative Services Organization and a legislatively mandated Oversight Council. Expanded in 2011 to include DMHAS, the partnership is designed to create an integrated behavioral health service system for Connecticut's Medicaid populations that provides access to a more complete, coordinated, and effective system of community based behavioral health services and support. DCF, DMHAS, and DDS also provide certain services such as targeted case management, inpatient psychiatric services for individuals under age twenty-one, and ICF/IIDs through state-operated and/or privately contracted providers that are covered under Medicaid, some of which are funded using a certified public expenditure methodology.
DSS also works closely with the Department of Public Health, which administers Connecticut's Title V program, the WIC program and many other public health programs.

Access Health CT - Connecticut's State Based Marketplace

The Connecticut Health Insurance Exchange was established by Connecticut Public Act 11-53. The Exchange is a quasi-public agency created to fulfill the requirements of the federal Affordable Care Act. The Exchange does business under the name "Access Health CT." The power of the Exchange is vested in a 14 member board. Under the Exchange's statutory authority, the Governor and legislative leadership have responsibility for the appointment of several board members with differing backgrounds and expertise. The statutory authority also provides that several Executive Branch officials, including the Commissioner of Social Services, serve as Ex-Officio voting members of the Board.

MAGI-related eligibility determinations (parent and caretakers, pregnant women, single adults, children) and former foster care coverage group determinations are made in the Access Health CT System. The system is shared by the Department and Access Health CT and uses a shared rules engine.

Access Health CT and the Department maintain a very close working relationship in order to achieve the goals of the ACA. The Department of Social Services and AHCT entered into a Memorandum of Agreement to address a number of issues, including but not limited to cost allocation, system integration, responsibility for hearings and appeals, data sharing and security.

Entities that determine eligibility other than the Medicaid Agency (if entities are described under Designation and Authority)

Remove

Type of entity that determines eligibility:

- ○ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ○ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ○ The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Add

Entities that conduct fair hearings other than the Medicaid Agency (if are described under Designation and Authority)

Remove

Type of entity that conducts fair hearings:

- ○ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ○ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Add

Supervision of state plan administration by local political subdivisions (if described under Designation and Authority)

Is the supervision of the administration done through a state-wide agency which uses local political subdivisions?

○ Yes ○ No

State Plan Administration Assurances — A3

42 CFR 431.10
42 CFR 431.12
42 CFR 431.50

Assurances

- ☑ The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.
- ☑ All requirements of 42 CFR 431.10 are met.
- ☑ There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.
- ☑ The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

Assurance for states that have delegated authority to determine eligibility:

- ☐ There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

Assurances for states that have delegated authority to conduct fair hearings:

- ☐ There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).

☐ When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.

Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:

☐ The Medicaid agency does not delegate authority to make eligibility determinations or to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: CONNECTICUT

Tribal Consultation Requirements

Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

The State uses the following process to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. The State includes information about the frequency, inclusiveness and process for seeking such advice below:

> The State seeks advice from the two Connecticut federally-recognized tribes, the Mashantucket Pequot Tribal Nation and The Mohegan Tribe, through periodic meetings with tribal health representatives and by ongoing written and electronic communications. Prior to submission of a State Plan Amendment, waiver, waiver amendment or other change, or demonstration project proposal to CMS, the Department sends a copy of the public notice for the amendment or other submission. If the amendment or submission does not require public notice, the State sends a brief summary of the proposed change.
>
> The State sends the notices via e-mail. If the State has not received comments or questions concerning the State Plan Amendment, waiver or other submission within 2 (two) weeks, the State determines that the tribe does not have any questions or concerns regarding the proposal. In addition to this consultation process, for State Plan Amendments that may have a unique or particular impact on tribal members, for example, a program or plan change that exempts tribal members from a requirement or provision, the State will also arrange for a meeting or teleconference with the tribal representatives to discuss the proposed change.

In addition to the ongoing consultation process on SPAs and waivers, the State tribal leads for the HUSKY and CHIP programs also meet with tribal representatives at least once annually to update the representatives on developments in the Medicaid and CHIP programs. These meetings include a discussion of program changes, including, but not limited to, waivers, demonstration projects and State Plan Amendments.

The consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved is described below.

The process that led to the development of this State Plan Amendment included introductory meetings with tribal representatives in May 2010 to describe the State Plan Amendment process and the tribal consultation requirement. The State met with the health directors for the two federally recognized tribes. At the meetings, the Department's tribal leads described the Medicaid State Plan Amendment process and discussed the method of consultation and communication that would best serve the tribal representatives' needs. The tribal representatives agreed to a process in which the Department sends copies of the public notice for proposed State Plan Amendments via e-mail prior to submission to CMS.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of CONNECTICUT

ATTORNEY GENERAL'S CERTIFICATION

I certify that:

The Department of Social Services is the single State agency

responsible for:

[x] administering the plan.

The legal authority under which the agency administers the plan on a Statewide basis is

Section 17b-260 and Section 17b-264 of the Connecticut General Statutes
(statutory citation)

[ ] supervising the administration of the plan by local political subdivisions.

The legal authority under which the agency supervises the administration of the plan on a Statewide basis is contained in

_____
(statutory citation)

The agency's legal authority to make rules and regulations that are binding on the political subdivisions administering the plan is

_____
(statutory citation)

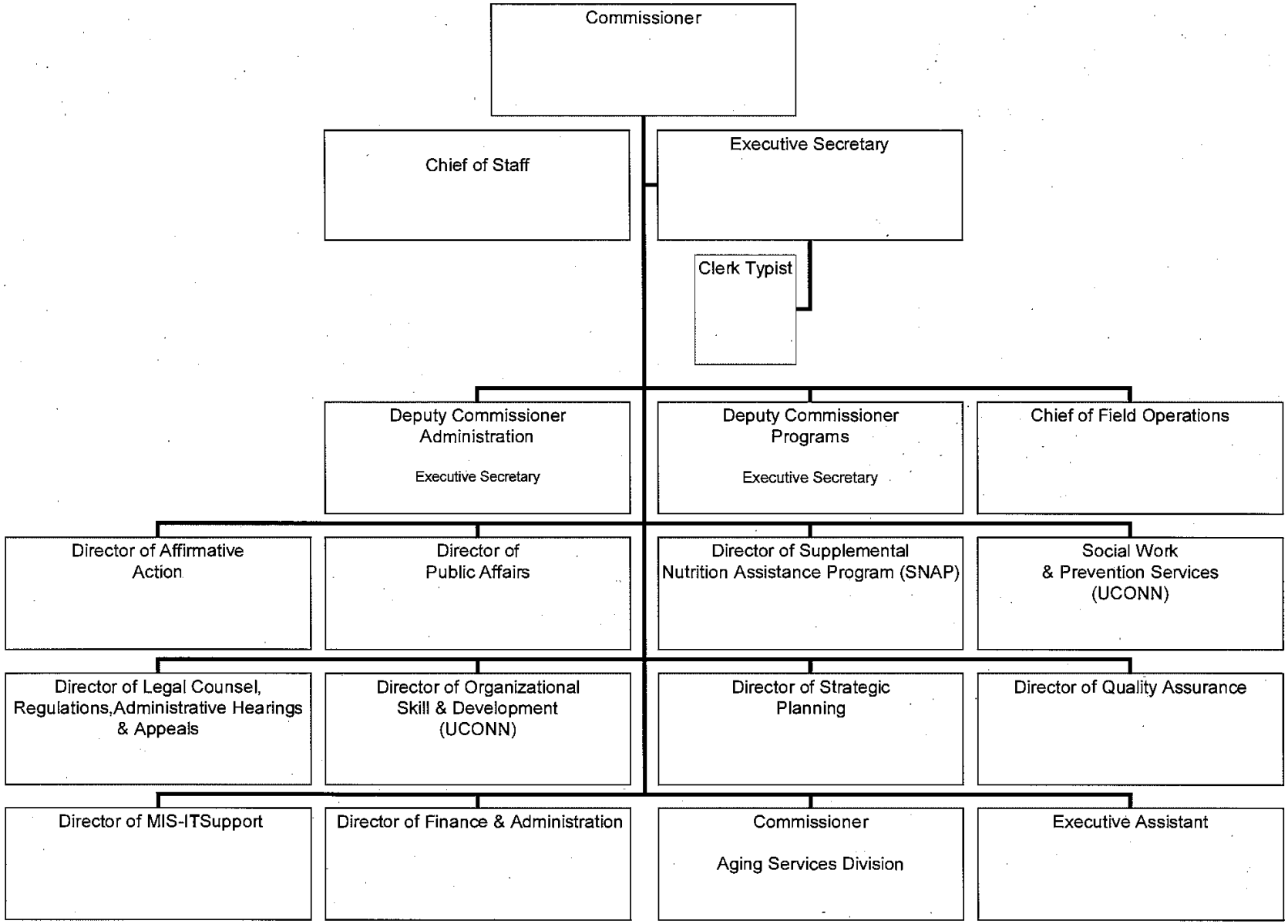
/s/

April 10, 2008
Date

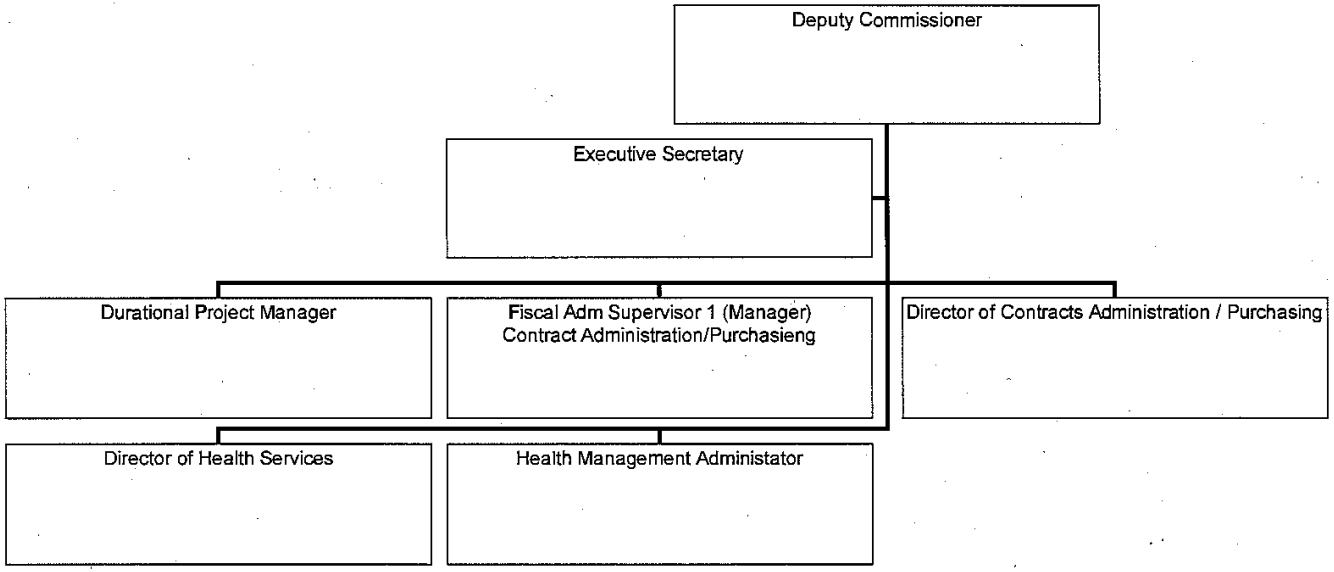
Signature

Richard Blumenthal, Attorney General, by Hugh Barber Assistant Attorney General, State of Connecticut, Counsel to Commissioner of Department of Social Services
Title

DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE COMMISSIONER
AS OF MARCH 1, 2014



DEPARTMENT OF SOCIAL SERVICES
ADMINISTRATION
AS OF MARCH 1, 2014



DEPARTMENT OF SOCIAL SERVICES
PROGRAMS
AS OF MARCH 1, 2014