Table of Contents

State/Territory Name: CT

State Plan Amendment (SPA) #: 23-0005-A

This file contains the following documents in the order listed:

1) Approval Letter
2) Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

May 11, 2023

William Woolston, Director
State of Connecticut, Department of Social Services
Division of Health Services
55 Farmington Avenue
Hartford, CT 06105

RE: TN 23-0005-A: ARPA Section 9817 home and community-based services (HCBS) state plan amendment (SPA) - §1915(i) and §1915(k)

Dear Mr. Woolston:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's request to amend its 1915(k) Community First Choice and two 1915(i): the Connecticut Home Care Program for Elders (CHCPE) and the Connecticut Housing Engagement and Support Services (CHESS) state plan home and community-based services (HCBS) benefit, transmittal number TN 23-0005-A. The effective date for this amendment is May 12, 2023. With this amendment, the state is implementing provisions approved in the 9817 ARPA Spending Plan, including reimbursement increases (rate increases, performance based supplemental payments, infrastructure payments); as well as expanding coverage provisions to continue services previously approved under disaster relief SPAs.

Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Attachment 3.1-I, Pages 53a-53h; Page 54
- Attachment 4.19-B Pages 22-24, 29a, 29b, 43-48

The state has identified its intent to use money realized from section 9817 of the American Rescue Plan (ARP). Approval of this action does not constitute approval of the state's spending plan. The state must have an approved spending plan to use the money realized from section 9817 of the ARP.

It is important to note that CMS' approval of this change to the state's 1915(i) HCBS state plan benefit solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of

Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.
If you have any questions concerning this information, please contact me at (410) 786-7561. You may also contact Karen Walsh at Karen.Walsh@cms.hhs.gov or (617) 565-1237.

Sincerely,

George P. Failla Jr -S

Digitally signed by George P. Failla Jr -S
Date: 2023.05.11 12:57:46 -04'00'

George P. Failla, Jr., Director
Division of HCBS Operations and Oversight

Enclosure

cc:
Joel Norwood, CT DSS
Jennifer Cavallaro, CT DSS
Cynthia Nanes, CMS DHCBSO
Karen Walsh, CMS DHCBSO
Deanna Clark, CMS DLTSS
Marie DiMartino, CMS DPO
Nancy Grano, CMS DPO
Karen Hatcher, CMS DPO
Mary Holly, CMS DPO
Jerica Bennett, CMS FMG
Elisa Jacobs, CMS FMG

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER
2 3 — 0 0 0 5A

2. STATE
CT

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT
(●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
May 12, 2023

5. FEDERAL STATUTE/REGULATION CITATION
Social Security Act Sections 1915(i) and 1915(k); 42 CFR 441, Subparts K and M

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ ~~129,937~~ 185,246
b. FFY 2024 $ ~~345,160~~ 399,832

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-i, Pages 53a-53h (NEW pages)
~~Attachment 3.1-i, Page 33; Attachment 3.1-K, Page 7~~
Attachment 3.1-i, ~~Pages 54a-54m~~ Page 54
Attachment 4.19-B, Pages 22-24, ~~28~~, 43-46
Attachment 4.19-B, ~~Pages 29a, 29b, 47-48~~
Pages 29a(NEW), 29b(NEW), 47-48(NEW)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-i, ~~Page 33, Attachment 3.1-K, Page 7~~ Page 54
~~NEW~~
Attachment 4.19-B, Pages ~~22-26~~, 43-46, 22-24
~~NEW~~

9. SUBJECT OF AMENDMENT
HCBS Spending Plan for Implementation of ARPA sec. 9817. 1915(i) CT Home Care Program for Elders (CHCPE) & CT Housing Engagement and Support Services (CHESS) and 1915(k) Community First Choice (CFC). As detailed in SPA pages, coverage expansions and reimbursement increases (rate increases, performance-based supplemental payments, infrastructure payments).

10. GOVERNOR'S REVIEW *(Check One)*
(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[signature]

12. TYPED NAME
Andrea Barton Reeves, J.D.

13. TITLE
Commissioner

14. DATE SUBMITTED
April 13, 2023

15. RETURN TO
State of Connecticut
Department of Social Services
55 Farmington Avenue – 9th floor
Hartford, CT 06105
Attention: Ginny Mahoney

FOR CMS USE ONLY

16. DATE RECEIVED
April 14, 2023

17. DATE APPROVED
May 11, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
May 12, 2023

19. SIGNATURE OF APPROVING OFFICIAL
George P. Failla Jr -S
Digitally signed by George P. Failla Jr -S
Date: 2023.05.11 12:58:13 -04'00'

20. TYPED NAME OF APPROVING OFFICIAL
George P. Failla

21. TITLE OF APPROVING OFFICIAL
DHCBSO Director

22. REMARKS

Pen and ink changes requested by state to box 6 update 2023/2024 budget impact and boxes 7/8 to update page numbers.

FORM CMS-179 (09/24)

Instructions on Back

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:	
Service Title:	Training and Counseling Services for Unpaid Caregivers Supporting Participants
Service Definition (Scope)*:*	
Training and Counseling Services for Unpaid Caregivers Supporting Participants is an inter-professional model delivered through a structured number of visits by a team comprised of a Care of Persons with Dementia in their Environments (COPE) certified occupational therapist (OT) and a COPE certified nurse (RN) to a participant as defined in the participant's person-centered plan. The service may include assessment and the development of a home treatment/support/action plan for this service, training and technical assistance to carry out the plan and monitoring of the individual and implementation of the service action plan. Each visit from the OT or RN provides training, support and consultative services to the unpaid caregiver with the aim of assisting the unpaid caregiver in meeting the needs of the participant. Training may include instruction about treatment regimens, medication management, use of equipment specified in the action plan, lifting, and transferring and updates as necessary to safely maintain the participant at home. This service may include counseling aimed to support the unpaid caregiver and improve their knowledge and skills for managing daily care challenges of the participant. The service focuses on the abilities of the participant and on the participant's ongoing engagement in daily activities and participation in community. This service may not be provided in order to train paid caregivers. These services are not otherwise covered by the Medicaid state plan (outside of this section of the Medicaid state plan for 1915(i) CHCPE) and are necessary to improve the individual's independence and inclusion in their community. Billable services include the provision of training, counseling, and technical assistance. Billable services are limited to additional services not otherwise covered under the state plan (outside of this section of the Medicaid state plan for 1915(i) CHCPE), including EPSDT, but consistent with 1915(i) CHCPE objectives of avoiding institutionalization.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
None	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☒	Categorically needy *(specify limits):*

	Training and Counseling services are subject to prior authorization based on the individual needs of the participant. COPE set of services may not be authorized more than once within a calendar year, which may be exceeded with prior authorization based on medical necessity. The qualifications for OTs and RNs to participate as providers of this service are different from the qualifications required for OT and RN in the state plan and therefore there is no duplication of service.
☒	Medically needy *(specify limits):*
	Training and Counseling services are subject to prior authorization based on the individual needs of the participant. COPE set of services may not be authorized more than once within a calendar year, which may be exceeded with prior authorization based on medical necessity. The qualifications for OTs and RNs to participate as providers of this service are different from the qualifications required for OT and RN in the state plan and therefore there is no duplication of service.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home Health Agencies (RN,OT)	Licensed by the Department of Public Health	COPE Certificate	Agency must use registered nurses and occupational therapists licensed in the State of Connecticut. Each nurse and occupational therapist must also have a certificate in COPE.
Private Occupational Therapy (RN, OT	Licensed by the Department of Public Health	COPE Certificate	Provider entity must use registered nurses and occupational therapists licensed by the Department of Public Health. Each nurse and occupational therapist must also have a certificate in COPE.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home Health Agencies (RN,OT)	State's Fiscal Intermediary	Upon enrollment and every two years thereafter
Private Occupational Therapy (RN, OT	State's Fiscal Intermediary	Upon enrollment and every two years thereafter

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Participant Training and Engagement to Support Goal Attainment and Independence
Service Definition (Scope)*:*	
This service implements services to the member utilizing the Community Aging in Place, Advancing Better Living for Elders (CAPABLE) program model. The CAPABLE program is a set of highly individualized, person-centered services that use the strengths of the 1915(i) participant to improve her/his safety and independence. The CAPABLE program services engage participants to develop action plans with the aim of achieving goals related to increasing functional independence, improving safety, decreasing depression and improving motivation as defined in the person-centered plan. This includes addressing barriers to achieve and maintain maximum functional independence in their daily lives. Participants receive a structured set of home visits conducted by a CAPABLE certified multidisciplinary team consisting of a CAPABLE certified occupational therapist (OT), a CAPABLE certified registered nurse (RN), and a CAPABLE certified handy person whose services are covered under the 'Environmental Modifications' service category. The OT and RN who perform the service must do so under an entity licensed to provide the CAPABLE program. The participant and OT work together to identify areas of concern using a 'Participant Training and Engagement' assessment tool. Areas evaluated include ADLs, IADLs, environmental modifications, and maintaining health and community engagement. Based on the assessment, the OT may recommend strategies that can be implemented by the handy person specialist to increase home safety and mitigate conditions that pose a risk or barrier to safe, independent daily functioning, such as changes necessary for fall prevention. Using a motivational interviewing approach, the OT engages the participant to develop goals based on difficulties found in the self-report, observations during the assessment, and what the participant identifies is meaningful activity for the participant in order to preserve their independence and prevent institutionalization. The participant and OT develop an action plan for addressing these goals. At each visit, the participant reviews their goals, refines them as desired, and practices the action plan with the OT. Each visit includes training the participant to harness their motivation to work toward their goals. Complementing the OT work, the RN addresses medical issues that inhibit daily function, such as pain, mood, medication adherence and side effects, strength and balance, and communication with healthcare providers. RN visits focus on goals set by the participant rather than on adherence to medical regimens unless this is the participant's goal. Each member of the multidisciplinary team focuses on the participant's identified goals to customize the service according to the action plan. Accordingly, this service includes coordination between the OT and the RN to ensure services are targeted to meet the goals identified by the participant. The services are limited to additional services not otherwise covered under the state plan (outside of this section of the Medicaid state plan for 1915(i) CHCPE), including EPSDT, but consistent with 1915(i) CHCPE objectives of avoiding institutionalization.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
None	

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒ Categorically needy *(specify limits):*

CAPABLE services are subject to prior authorization based on the individual needs of the participant. CAPABLE set of services may not be authorized more than once within a calendar year, which may be exceeded with prior authorization based on medical necessity. The qualifications for OTs and RNs to participate as providers of this service are different from the qualifications required for OTs and RNs in the state plan and therefore there is no duplication of service.

☒ Medically needy *(specify limits):*

CAPABLE services are subject to prior authorization based on the individual needs of the participant. CAPABLE set of services may not be authorized more than once within a calendar year, which may be exceeded with prior authorization based on medical necessity . The qualifications for OTs and RNs to participate as providers of this service are different from the qualifications required for OTs and RNs in the state plan and therefore there is no duplication of service.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home Health Agencies (RN, OT)	Licensed by Department of Public Health CAPABLE License		All providers must be employed by or subcontractors of the agency licensed to provide CAPABLE services. All nurses and occupational therapists must complete 14 hours of CAPABLE training. In addition, nurses must be registered nurses licensed by the Department of Public Health; occupational therapists must be licensed by the Department of Public Health.
Private Occupational Therapy (RN,OT)	Licensed by Department of Public Health CAPABLE License		All providers must be employed by or subcontractors of the agency licensed to provide CAPABLE services. All nurses and occupational therapists must complete 14 hours of CAPABLE training. In addition, nurses must be registered nurses licensed by the Department of Public Health; occupational therapists must

			be licensed by the Department of Public Health.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home Health Agencies (RN, OT)	State's Fiscal Intermediary	Upon enrollment and every two years thereafter
Private Occupational Therapy (RN,OT)	State's Fiscal Intermediary	Upon enrollment and every two years thereafter

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Environmental Adaptations

Service Definition (Scope)*:*

Environmental Adaptations are those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). All services must be provided in accordance with applicable state or local building codes. The services are limited to additional services not otherwise covered under the state plan (outside of this section of the Medicaid state plan for 1915(i) CHCPE), including EPSDT, but consistent with 1915(i) CHCPE objectives of avoiding institutionalization.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any

individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home Health Agencies (handy-person)	Licensed by Department of Public Health CAPABLE License		The handy-person who performs environmental modifications under the CAPABLE program will be a subcontractor or employee of the agency licensed to provide CAPABLE services and must complete 2 hours of CAPABLE training in working with older adults (unless already trained through Certified Aging in Place Specialist/CAPS or similar national program) . As part of the license, the handy-person must complete person centered training focused on how to support member goal achievement through working as a team In addition, the handy-person must: 1. provide all services, materials, and labor that are necessary to complete the project/minor home modification(s) as indicated. 2. be registered with the Department of Consumer Protection to do business in the State of Connecticut. 3. provide evidence of a valid home improvement registration and evidence of workers' compensation (if applicable) and liability insurance, at the time they provide an estimate for the project. 4. must apply for, obtain, and pay for all permits (if applicable). All work

			done must be done per applicable codes, regulations and standards of construction, including American National Standards Institute (ANSI) standards for barrier-free access and safety requirement. 5. warranty all work, including labor and materials, for one year from the date of acceptance and thereafter, one year from the date of completion of the project.
Private Occupational Therapy (handy-person)	Licensed by Department of Public Health CAPABLE License		The handy-person who performs environmental modifications under the CAPABLE program will be a subcontractor or employee of the agency licensed to provide CAPABLE services and must complete 2 hours of CAPABLE training in working with older adults (unless already trained through Certified Aging in Place Specialist/CAPS or similar national program). In addition, the handy person must: 1. provide all services, materials, and labor that are necessary to complete the project/minor home modification(s) as indicated. 2. be registered with the Department of Consumer Protection to do business in the State of Connecticut. 3. provide evidence of a valid home improvement registration and evidence of workers' compensation (if applicable) and liability insurance, at the time they provide an estimate for the project. 4. must apply for, obtain, and pay for all permits (if applicable). All work done must be done per applicable codes, regulations and standards of construction, including American National Standards Institute (ANSI)

			standards for barrier-free access and safety requirement. 5. warranty all work, including labor and materials, for one year from the date of acceptance and thereafter, one year from the date of completion of the project.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home Health Agencies (Handy Person)	State's Fiscal Intermediary	Upon enrollment and every two years thereafter
Private Occupational Therapy (Handy Person)	State's Fiscal Intermediary	Upon enrollment and every two years thereafter

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

2. ☒ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Program regulations specify policies regarding the provision of program services by relatives.

Relatives are defined in the regulations as follows: "Relative" means spouse, natural parent, child, sibling, adoptive child, adoptive parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, sister-in-law, grandparent and grandchild. Effective July 1, 2015, self-directed PCA services are not available under the CHCPE section 1915(i) because they are instead available under the state's Community First Choice program option in the Medicaid State Plan pursuant to section 1915(k).

Family members may provide adult family living/foster care services but only under the auspices of a provider agency. The agency is responsible to ensure that the services are in fact being rendered. The care manager, as part of the person-centered planning process, ensures that the provision of the service by a relative is in the best interest of the individual. An example might be a situation where the client has dementia and is resistant to care provided by someone they are unfamiliar with. The care manager monitors the appropriateness and effectiveness of the services provided as part of their required monthly monitoring contact.

The Department does not pay legally liable relatives or relatives of conservators of person (COP) or conservators of estate (COE) to provide care.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (*Select one):*

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☒	HCBS Case Management	
	Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and non-governmental providers of CHCPE section 1915(i) state plan HCBS. The agency's fee schedule rates were set as of May 12, 2023 are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program Website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the Connecticut Home Care Program for Elders fee schedule.	
☒	HCBS Homemaker	
	Same as HCBS Case Management above	
☐	HCBS Home Health Aide	
☐	HCBS Personal Care	
☒	HCBS Adult Day Health	
	Same as HCBS Case Management above	
☐	HCBS Home Health Aide	
☒	HCBS Respite Care	
	Same as HCBS Case Management above	
For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☒	Other Services (specify below)	
	HCBS Companion: Same as HCBS case management above	
	HCBS Chore: Same as HCBS case management above	
	HCBS Assisted Living: Same as HCBS Case Management above	

	HCBS Assistive Technology: Manual pricing is used for assistive technology equipment or other services such as home modifications that require manual pricing. These services are, however, capped at the limit set forth in Attachment 3.1-i of the Medicaid State Plan. Rates for assistive technologies are case-specific and not published in the fee schedule. Reimbursement for assistive technology is based on actual service contracts for the services rendered. The fiscal intermediary reimburses the contractor. The fiscal intermediary is reimbursed through the MMIS based upon submitted claims.
	HCBS Environmental Accessibility Adaptations: Manual pricing is used for home modifications that require manual pricing. These services are, however, capped at the limit set forth in Attachment 3.1-i of the Medicaid State Plan. Minor home modifications required by the individual's plan of care which are necessary to ensure health, welfare and safety of the individual to function with greater independence in their home and without which the individual would require institutionalization. Such adaptations may include the installation of handrails and grab bars in the tub area, widening of doors and installation of ramps. Excluded are those adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the individual such as carpeting, roof repair or air conditioning. Adaptations which add to the total square footage of the home are excluded from this benefit. All services must be provided in accordance with applicable state or local building codes. Adaptations are excluded if the residence is owned by someone other than the client and the adaptations would be the responsibility of the owner/landlord. Rates for environmental modifications are case-specific and not published in the fee schedule. Reimbursement for environmental modifications is based on the lower of at least two bids from licensed contractors. The fiscal intermediary reimburses the contractor. The fiscal intermediary is reimbursed through the MMIS based upon submitted claims. This service is subject to Department prior authorization
	HCBS Home-Delivered Meals: Same as HCBS case management above
	HCBS Adult Family Living: Same as HCBS case management above
	HCBS Mental Health Counseling: Same as HCBS case management above
	HCBS Personal Emergency Response Systems: Same as HCBS case management above
	HCBS Non-Medical Transportation: Same as HCBS case management above
	HCBS Bill Payer: Same as HCBS case management above
	HCBS Chronic Disease Self-Management Programs: Same as HCBS case management above
	HCBS Recovery Assistant: Same as HCBS case management above
	HCBS Agency Based Personal Care Assistant: Same as HCBS case management above
	HCBS Care Transitions: service will not be billed until the individual is discharged from the institution. Otherwise, same as HCBS case management above
	HCBS Training and Counseling Services for Unpaid Caregivers Supporting Participants: Same as HCBS case management above
	HCBS Participant Training and Engagement to Support Goal Attainment and Independence: Same as HCBS case management above
	HCBS Environmental Adaptations: Same as HCBS case management above

Rate Increases and Supplemental Payments to Enhance, Expand, and/or Strengthen Home and Community-Based Services (HCBS): Implemented in accordance with the state's Spending Plan for Implementation of the American Rescue Plan Act of 2021, Section 9817, as updated (ARPA HCBS Spending Plan): General Requirements: All rate increases set forth below apply only to providers actively enrolled on the date payment is issued. Providers and services excluded from these rate increases are: assistive technology; environmental accessibility modifications, personal response systems, and skilled chore services. As applicable, payments may be proportionally reduced to the extent necessary to remain within available funding approved under the ARPA HCBS Spending Plan.

(a) Performance Supplemental Payments: i. On or before July 31, 2023, benchmark payments will be paid to 1915(i) CHCPE providers effective for and calculated based on 2% of expenditures from March 1, 2023 through June 30, 2023. Benchmarks must be met no later than June 15, 2023, and are as follows: (a) Participation in Department of Social Services' racial equity training and related learning collaboratives; (b) Accessing and viewing data within the HIE and participation in data use learning collaboratives and training. ii. On or before November 30, 2023, benchmark payments will be paid to 1915(i) CHCPE providers effective for and calculated based on 2% of expenditures from July 1, 2023 through October 31, 2023. Benchmarks must be met no later than October 15, 2023, and are as follows: (a) Department of Social Services' racial equity training required component of all new staff orientation. Participation in related learning collaboratives; (b) Accessing and viewing data within the HIE and participation in data use learning collaboratives and training. iii. Beginning with payments to be made on or before March 31, 2024, and every six months thereafter, payments will be paid to 1915(i) CHCPE providers who meet the following outcomes: (a) Decrease in avoidable hospitalization; (b) Increase in percent of people who need ongoing services discharged from hospital to community in lieu of nursing home; and (c) Increase in probability of return to community within 100 days of nursing home admission. 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). If the total cost of the 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. This higher limit of 4% will be based on availability of funds as approved within the ARPA HCBS Spending Plan. Providers who meet all of the performance measures will receive a full payment. Providers who meet fewer than the maximum possible number of performance measures will receive a partial payment based on the number of performance measures that they meet, in which meeting each measure is associated with a pro rata equal share of the total payment for the provider.

(b) Quality Infrastructure Supplemental Payments: Payments will be made on or before July 31, 2023, November 30, 2023, and March 31, 2024 to 1915(i) CHCPE providers who meet the benchmarks set forth below effective during and based on the greater of 5% of expenditures during the four calendar months that immediately precede the month in which the payment is made or $5,000. For purposes of determining the applicability of the $5,000 in lieu of the percentage, expenditures used as the basis of the payment are total HCBS expenditures for the provider across all programs. The following benchmarks apply and must be met no later than the first day of the month in which the payment is made: (a) Benchmark for July 2023 payment – Providers have met requirements to improve member service delivery documented and contracts in place with vendors to modify delivery system; providers have member satisfaction survey drafted; (b) Benchmark for November 2023 payment – Providers have delivery system modifications complete; (c) Benchmark for March 2024 payment – Providers have delivery system implemented and integrated into member service planning; member satisfaction survey complete.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Connecticut

Community First Choice State Plan Option Pursuant to Section 1915(k) of the Social Security Act

Rate Increases and Supplemental Payments to Enhance, Expand, and/or Strengthen Home and Community-Based Services (HCBS), Implemented in Accordance with the state's Spending Plan for Implementation of the American Rescue Plan Act of 2021, Section 9817, as updated (ARPA HCBS Spending Plan):

General Requirements: All rate increases set forth below apply only to providers actively enrolled on the date payment is issued. The only CFC providers eligible to receive these rate increases are providers of assessment services and agency-based support and planning coach services. As applicable, payments may be proportionally reduced to the extent necessary to remain within available funding approved under the ARPA HCBS Spending Plan.

(a) Performance Supplemental Payments:
i. On or before July 31, 2023, benchmark payments will be paid to eligible CFC providers effective for and calculated based on 2% of expenditures from March 1, 2023 through June 30, 2023. Benchmarks must be met no later than June 15, 2023, and are as follows: (a) Participation in Department of Social Services' racial equity training and participation in related learning collaboratives; (b) Accessing and viewing data within the HIE and participation in data use learning collaboratives and training.
ii. On or before November 30, 2023, benchmark payments will be paid to eligible CFC providers effective for and calculated based on 2% of expenditures from July 1, 2023 through October 31, 2023. Benchmarks must be met no later than October 15, 2023, and are as follows: (a) Department of Social Services' racial equity training required component of all new staff orientation. Participation in related learning collaboratives; (b) Accessing and viewing data within the HIE and participation in data use learning collaboratives and training.
iii. Beginning with payments to be made on or before March 31, 2024, and every six months thereafter, payments will be paid to eligible CFC providers who meet the following outcomes: (a) Decrease in avoidable hospitalization; (b) Increase in percent of people who need ongoing services discharged from hospital to community in lieu of nursing home; and (c) Increase in probability of return to community within 100 days of nursing home admission. 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). If the total cost of the 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. This higher limit of 4% will be based on availability of funds as approved within the ARPA HCBS Spending Plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Connecticut

Community First Choice State Plan Option Pursuant to Section 1915(k) of the Social Security Act

Providers who meet all of the performance measures will receive a full payment. Providers who meet fewer than the maximum possible number of performance measures will receive a partial payment based on the number of performance measures that they meet, in which meeting each measure is associated with a pro rata equal share of the total payment for the provider.

(b) Quality Infrastructure Supplemental Payments

Payments will be made on or before July 31, 2023, November 30, 2023, and March 31, 2024 to eligible CFC providers who meet the benchmarks set forth below effective during and based on the greater of 5% of expenditures during the four calendar months that immediately precede the month in which the payment is made or $5,000. For purposes of determining the applicability of the $5,000 in lieu of the percentage, expenditures used as the basis of the payment are total HCBS expenditures for the provider across all programs. The following benchmarks apply and must be met no later than the first day of the month in which the payment is made: (a) Benchmark for July 2023 payment – Providers have met requirements to improve member service delivery documented and contracts in place with vendors to modify delivery system; providers have member satisfaction survey drafted; (b) Benchmark for November 2023 payment – Providers have delivery system modifications complete; (c) Benchmark for March 2024 payment – Providers have delivery system implemented and integrated into member service planning; member satisfaction survey complete.

**Reimbursement Methodology for Connecticut Housing Engagement and Support Services (CHESS)
State Plan HCBS Benefit Under Section 1915(i)**

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☐	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☒	Other Services (specify below)
	Care Plan Development and Monitoring: $207.00 per care plan annually. If for any reason a provider is no longer participating in the CHESS program, the alternative provider selected by the participant may then receive the payment of $207.00 for review and development of a new care plan (in addition to the payment for the care plan that was already made to the initial provider). Modifications of care plans within one year of plan approval due to significant change in the status of the participant may be eligible for additional payment based on prior approval from the BH-ASO. The state assures that this rate does not include costs for room and board or non-allowable facility costs.

Reimbursement Methodology for Connecticut Housing Engagement and Support Services (CHESS) State Plan HCBS Benefit Under Section 1915(i)

	Pre-Tenancy Supports: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and non-governmental providers of CHESS 1915(i) state plan HCBS pre-tenancy supports. The agency's fee schedule rates were set as of May 12, 2023 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule. In addition, the state will pay the CHESS provider a one-time lump sum add-on payment that will be paid within 30 days after the participant's lease-up based on the provider's performance on the outcome measures set forth below. Collectively, the total rate (including both the fee schedule rate and the maximum potential rate add-on) was calculated based on the average salary and related costs for relevant provider staff and the average amount of services that is anticipated to be provided to the participant. Specific outcome measures for pre-tenancy supports and the applicable one-time add-on payment are as follows: Lease-up in housing equal to or less than 90 days of approved PCRP: $947.63 Lease-up in housing between 91 and 120 days of approved PCRP: $631.75 Lease-up in housing between 121 and 150 days of approved PCRP: $315.88 Lease-up in housing between 151 and 180 days of approved PCRP: $221.11 Lease-up after 180 days of approved PCRP: No payment above base payment. The state assures that this rate does not include costs for room and board or non-allowable facility costs.
	Tenancy Sustaining Supports: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and non-governmental providers of CHESS 1915(i) state plan HCBS tenancy sustaining supports. The agency's fee schedule rates were set as of May 12, 2023 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule. In addition, the state will pay the CHESS provider a quarterly add-on payment of up to $568.59 per participant who, for a rolling three-month period that ended during the calendar quarter, was receiving tenancy sustaining supports from that provider for that three-month period and who was continuously enrolled in CHESS for that three-month period. This rate add-on payment will be paid based on the provider's performance on specified outcome measures in accordance with the schedule set forth below for each participant described in this paragraph. Collectively, the total rate (including both the fee schedule rate and the maximum potential rate add-on) was calculated based on the

Reimbursement Methodology for Connecticut Housing Engagement and Support Services (CHESS) State Plan HCBS Benefit Under Section 1915(i)

	average salary and other applicable costs for relevant provider staff and the average amount of services that is anticipated to be provided to the participants. For each of the following performance measures, 25% of the quarterly add-on payment amount listed above will be made if the provider meets each measure, with no payment made for each performance measure if it is not met (for a maximum potential total quarterly add-on payment of 100% of the amount listed above per applicable participant): (1) Successfully assisting the participant in managing medical and behavioral health conditions, including coordinating with all applicable services that are medically necessary for the participant: For the first three quarters, this measure is met if there is evidence of at least one visit scheduled with the participant's primary care provider or outpatient behavioral health provider occurring at some point in the 12 months after the participant first enrolls in CHESS. For the fourth and subsequent quarters, this measure is met if there is evidence in Medicaid claims data that the participant has seen their primary care provider or outpatient behavioral health provider at least once in the past 12 months; (2) Successfully addressing the assessed needs of the participant as defined in the PCRP: For the each of the first three quarters of each twelve-month period starting after the participant enters housing, this measure is met if the provider's activities in the case management notes match the approved PCRP. For the fourth and each subsequent quarter starting after the participant enters housing, this measure is met if: (a) the case management notes match service plan as reviewed by DSS and the participant has a minimum score of 26 across 5 domains of the Housing Assessment (Housing and Lease; Arrears and Debts, Income and Benefits; Support Services and Resources, Health) and not decreased by more than one point from previous assessment and (b) the provider's activities in the case management notes match the approved PCRP; (3) Successfully assisting the participant in maintaining housing: For each quarter, this measure is met if the participant remains in housing, as documented in the state Department of Housing's quarterly report; and (4) Successfully assisting the participant with maintaining access to food: For each quarter, this measure is met if the participant remains enrolled in the Supplemental Nutrition Assistance Program (SNAP) as documented in the records of the Department of Social Services. The state assures that this rate does not include costs for room and board or non-allowable facility costs.
	Non-Medical Transportation: Mileage is reimbursed at the IRS published standard mileage rate adjusted annually. Monthly bus passes are purchased at the standard retail

Reimbursement Methodology for Connecticut Housing Engagement and Support Services (CHESS) State Plan HCBS Benefit Under Section 1915(i)

	rate that is charged to the general public. The state assures that this rate does not include costs for room and board or non-allowable facility costs.

Reimbursement Methodology for Connecticut Housing Engagement and Support Services (CHESS) State Plan HCBS Benefit Under Section 1915(i)

Rate Increases and Supplemental Payments to Enhance, Expand, and/or Strengthen Home and Community-Based Services (HCBS), Implemented in accordance with the state's Spending Plan for Implementation of the American Rescue Plan Act of 2021, Section 9817, as updated (ARPA HCBS Spending Plan):

General Requirements: All rate increases set forth below apply only to providers actively enrolled on the date payment is issued. As applicable, payments may be proportionally reduced to the extent necessary to remain within available funding approved under the ARPA HCBS Spending Plan.

i. On or before July 31, 2023, a one-time supplemental payment will be paid to CHESS providers calculated at 1% of expenditures from August 16, 2021 through October 31, 2022 for each qualifying provider that meets the following standards on or before June 15, 2023: (a) Participation in Department of Social Services' racial equity training and identification and participation of an individual who will 'champion' racial equity service delivery change, (b) Provider has executed a data sharing agreement with the state's Health Information Exchange (HIE), (c) signing, at a minimum, the HIE Empanelment Use Case, (d) action plan detailing how the provider sends their client roster in an approved format to the state's HIE, and (e) Completion of HIE stakeholder input tool and identification and participation of an individual who will 'champion' delivery system change.

ii. On or before July 31, 2023, benchmark payments will be paid to 1915(i) CHESS providers effective for and calculated based on 2% of expenditures from March 1, 2023 through June 30, 2023. Benchmarks must be met no later than June 15, 2023, and are as follows: (a) Participation in Department of Social Services' racial equity training and participation in related learning collaboratives; (b) Accessing and viewing data within the HIE and participation in data use learning collaboratives and training.

iii. On or before November 30, 2023, benchmark payments will be paid to 1915(i) CHESS providers effective for and calculated based on 2% of expenditures from July 1, 2023 through October 31, 2023. Benchmarks must be met no later than October 15, 2023, and are as follows: (a) Department of Social Services' racial equity training required component of all new staff orientation. Participation in related learning collaboratives; (b) Accessing and viewing data within the HIE and participation in data use learning collaboratives and training.

iv. Beginning with payments to be made on or before March 31, 2024, and every six months thereafter, payments will be paid to 1915(i) CHESS providers who meet the following outcomes: (a) Decrease in avoidable hospitalization; (b) Increase in percent of people who need ongoing services discharged from hospital to community in lieu of

Reimbursement Methodology for Connecticut Housing Engagement and Support Services (CHESS) State Plan HCBS Benefit Under Section 1915(i)

nursing home; and (c) Increase in probability of return to community within 100 days of nursing home admission. 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). If the total cost of the 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. This higher limit of 4% will be based on availability of funds as approved within the ARPA HCBS Spending Plan. Providers who meet all of the performance measures will receive a full payment. Providers who meet fewer than the maximum possible number of performance measures will receive a partial payment based on the number of performance measures that they meet, in which meeting each measure is associated with a pro rata equal share of the total payment for the provider.

(b) Quality Infrastructure Supplemental Payments

Payments will be made on or before July 31, 2023, November 30, 2023, and March 31, 2024 to 1915(i) CHESS providers who meet the benchmarks set forth below effective during and based on the greater of 5% of expenditures during the four calendar months that immediately precede the month in which the payment is made or $5,000. For purposes of determining the applicability of the $5,000 in lieu of the percentage, expenditures used as the basis of the payment are total HCBS expenditures for the provider across all programs. The following benchmarks apply and must be met no later than the first day of the month in which the payment is made: (a) Benchmark for July 2023 payment – Providers have met requirements to improve member service delivery documented and contracts in place with vendors to modify delivery system; providers have member satisfaction survey drafted; (b) Benchmark for November 2023 payment – Providers have delivery system modifications complete; (c) Benchmark for March 2024 payment – Providers have delivery system implemented and integrated into member service planning; member satisfaction survey complete.

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