

## **Table of Contents**

**State/Territory Name: Connecticut**

**State Plan Amendment (SPA) #: 24-0015**

This file contains the following documents in the order listed:

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

## CT - Submission Package - CT2024MS0003O - (CT-24-0015) - Eligibility

Summary Reviewable Units Versions Correspondence Log Analyst Notes **Approval Letter** Transaction Logs News Related Actions

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Medicaid and CHIP Operations Group  
601 E. 12th Street, Room 355  
Kansas City, MO 64106



### Center for Medicaid & CHIP Services

November 15, 2024

Andrea Barton Reeves  
Commissioner  
DSS  
55 Farmington Avenue  
Hartford, CT 06105

Re: Approval of State Plan Amendment CT-24-0015

Dear Commissioner Reeves,

On September 30, 2024, the Centers for Medicare and Medicaid Services (CMS) received Connecticut State Plan Amendment (SPA) CT-24-0015, in which the state proposed to memorialize certain changes to the payment calculations of its state supplement program.

We approve Connecticut State Plan Amendment (SPA) CT-24-0015 with an effective date(s) of July 01, 2024.

If you have any questions regarding this amendment, please contact Marie DiMartino at [marie.dimartino@cms.hhs.gov](mailto:marie.dimartino@cms.hhs.gov)

Sincerely,  
James G. Scott  
Director of Program Operations  
Center for Medicaid & CHIP Services

# CT - Submission Package - CT2024MS0003O - (CT-24-0015) - Eligibility

Summary   Reviewable Units   Versions   Correspondence Log   Analyst Notes   Approval Letter   Transaction Logs   News   Related Actions

## Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | CT2024MS0003O | CT-24-0015

CMS-10434 OMB 0938-1188

### Package Header

Package ID	CT2024MS0003O	SPA ID	CT-24-0015
Submission Type	Official	Initial Submission Date	9/30/2024
Approval Date	11/15/2024	Effective Date	N/A
Superseded SPA ID	N/A		

### State Information

State/Territory Name:	Connecticut	Medicaid Agency Name:	DSS
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### Submission Component

- ☒ State Plan Amendment
- ☒ Medicaid
- ☐ CHIP

## Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | CT2024MS0003O | CT-24-0015

### Package Header

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<b>Approval Date</b>	11/15/2024	<b>Effective Date</b>	N/A
<b>Superseded SPA ID</b>	N/A		

### SPA ID and Effective Date

**SPA ID** CT-24-0015

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Optional Eligibility Groups	7/1/2024	CT-24-0003
Optional State Supplement Beneficiaries	7/1/2024	CT-24-0003

## Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | CT2024MS00030 | CT-24-0015

### Package Header

Package ID	CT2024MS00030	SPA ID	CT-24-0015
Submission Type	Official	Initial Submission Date	9/30/2024
Approval Date	11/15/2024	Effective Date	N/A
Superseded SPA ID	N/A		

### Executive Summary

**Summary Description Including Goals and Objectives** The Department of Social Services (DSS) plans to submit the following Medicaid State Plan Amendment (SPA) (CT-24-0015) to the U.S. Centers for Medicare & Medicaid Services (CMS), which is summarized below.  
Medicaid Eligibility Adjustment Based on State Supplement COLA changes: This SPA will change how the COLA affects Medicaid eligibility for individuals who receive State Supplement benefits by increasing the personal needs allowance (PNA) by the amount of the COLA, thereby allowing individuals to experience the intended benefit of the COLA increase without jeopardizing Medicaid eligibility.

### Federal Budget Impact and Statute/Regulation Citation

#### Federal Budget Impact

	Federal Fiscal Year	Amount
First	2024	\$0
Second	2025	\$0

#### Federal Statute / Regulation Citation

State Supplement 17b-106

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
Fiscal Impact Statement CT-24-0015 Increase to the PNA for State Supplement	8/26/2024 3:34 PM EDT	

# Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | CT2024MS00030 | CT-24-0015

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## Governor's Office Review

- ☒ No comment
- ☐ Comments received
- ☐ No response within 45 days
- ☐ Other

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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.

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# CT - Submission Package - CT2024MS0003O - (CT-24-0015) - Eligibility

## Medicaid State Plan Eligibility

### Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | CT2024MS0003O | CT-24-0015

CMS-10434 OMB 0938-1188

### Package Header

Package ID	CT2024MS0003O	SPA ID	CT-24-0015
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Approval Date	11/15/2024	Effective Date	7/1/2024
Superseded SPA ID	CT-24-0003		
User-Entered			

### A. Options for Coverage

The state provides Medicaid to specified optional groups of individuals.
















☒ Yes ☐ No

The optional eligibility groups covered in the state plan are (elections made in this screen may not be comprehensive during the transition period from the paper-based state plan to MACPro):

#### Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Optional Coverage of Parents and Other Caretaker Relatives		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Reasonable Classifications of Individuals under Age 21		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Children with Non-IV-E Adoption Assistance		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	CONVERTED
Independent Foster Care Adolescents		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	CONVERTED
Optional Targeted Low Income Children		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals above 133% FPL under Age 65		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Needing Treatment for Breast or Cervical Cancer		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Eligible for Family Planning Services		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	CONVERTED
Individuals with Tuberculosis		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	CONVERTED
Individuals Electing COBRA Continuation Coverage		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW

## Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Individuals Eligible for but Not Receiving Cash Assistance		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Eligible for Cash Except for Institutionalization		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Optional State Supplement Beneficiaries		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="radio"/>	APPROVED
Individuals in Institutions Eligible under a Special Income Level		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
PACE Participants		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Receiving Hospice		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Children under Age 19 with a Disability		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Age and Disability-Related Poverty Level		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Work Incentives		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Ticket to Work Basic		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Ticket to Work Medical Improvements		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Family Opportunity Act Children with a Disability		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Receiving State Plan Home and Community-Based Services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Receiving State Plan Home and Community-Based Services Who Are Otherwise Eligible for HCBS Waivers		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	APPROVED



# Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | CT2024MS00030 | CT-24-0015

## Package Header

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User-Entered			

## B. Medically Needy Options for Coverage



The state provides Medicaid to specified groups of individuals who are medically needy.

☒ Yes ☐ No

The medically needy eligibility groups covered in the state plan are:

### 1. Mandatory Medically Needy:

#### Families and Adults



Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Medically Needy Pregnant Women		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Medically Needy Children under Age 18		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW

#### Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Protected Medically Needy Individuals Who Were Eligible in 1973		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW

### 2. Optional Medically Needy:

#### Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Medically Needy Reasonable Classifications of Individuals under Age 21		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Medically Needy Parents and Other Caretaker Relatives		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW

#### Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Medically Needy Populations Based on Age, Blindness or Disability		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW

# Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | CT2024MS00030 | CT-24-0015

## Package Header

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## C. Additional Information (optional)

### Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

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# CT - Submission Package - CT2024MS0003O - (CT-24-0015) - Eligibility

## Medicaid State Plan Eligibility

### Eligibility Groups - Options for Coverage

#### Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | CT2024MS0003O | CT-24-0015

Individuals who receive an optional state supplementary payment.

CMS-10434 OMB 0938-1188

#### Package Header

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The state covers the Optional State Supplement Beneficiaries eligibility group in accordance with the following provisions:

#### A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Receive an optional state supplement that meets the conditions described in sections C and D.
2. Except for income, would be eligible for:

☐ a. SSI

☒ b. The mandatory eligibility group for 209(b) states
3. Do not have gross income exceeding 300% of the SSI Federal Benefit Rate (FBR).

# Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | CT2024MS0003O | CT-24-0015

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## B. Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

- ☒ Yes
- ☐ No

# Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | CT2024MS00030 | CT-24-0015

## Package Header

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User-Entered			

## C. Optional State Supplement Program

1. The optional state supplement program is administered:
- ☐

a. Solely by the federal government. The state has an agreement with the Social Security Administration under section 1616 of the Act regarding the administration of optional state supplementary payments.
- ☐

b. By a combination of federal and state administration. The state has an agreement with the Social Security Administration under section 1616 of the Act regarding the administration of optional state supplementary payments for some classifications of individuals, while state supplementary payments for other classifications of individuals are administered by the state.
- ☒

c. Solely by the state.
2. Payments under the optional state supplement program are:
- a. Based on need and paid in cash on a regular basis;

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for supplement; and

c. Available to all individuals in each population selected in section B.

Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | CT2024MS0003O | CT-24-0015

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D. Income Standard of Optional State Supplement Program

1. The income standard for the optional state supplement:
- a. Varies by political subdivision.
- ☐ Yes
- ☒ No
- b. Varies by payment classification.
- ☒ Yes
- ☐ No

The payment classifications used are:

- ☐ i. All individuals age 65 or older, regardless of living arrangement.
- ☐ ii. All individuals who have blindness, regardless of living arrangement.
- ☐ iii. All individuals who have a disability, regardless of living arrangement.
- ☐ iv. Independent living.
- ☐ v. Living in household of another.
- ☐ vi. Independent living and receiving non-medical care outside the home.
- ☐ vii. Living in household of another and receiving non-medical care outside the home.
- ☐ viii. Living in a domiciliary facility or other group living arrangement.
- ☒ ix. Other payment classification.

Name of Classification	Description:
Independent Living (Level 1)	For independent living arrangements (Level 1), the Standard of Assistance includes a fixed amount for personal needs of \$197.35 for a single person and an allowance for shelter. The shelter component of the standard is the actual cost, as paid, up the specific maximum of \$400.00 for a single individual living alone. There is a no income standard for a couple as Level 1 indicates living alone. System would not allow entry of 0.00

Individual	Couple
\$597.35	\$0.01
Name of Classification	Description:
Independent Living (Level 2)	For independent living arrangements (Level 2), the Standard of Assistance includes a fixed amount for personal needs of \$198.55 for a married person living with

his or her spouse and an allowance for shelter. The shelter component of the standard is the actual cost, as paid, up the specific maximum of \$200.00

**Individual**

\$398.55

**Name of Classification**

New Horizons (unshared)

**Couple**

\$797.10

**Description:**

For the New Horizons living arrangement (unshared), the Standard of Assistance includes a fixed amount for personal needs of \$156.82 and an allowance for the charge to the individual for shelter set by the Department in accordance with State law. The maximum standard of assistance for New Horizon living arrangement is \$2318 for an individual living alone. There is no income standard for a couple as unshared indicates living alone.

**Individual**

\$2318.00

**Name of Classification**

New Horizons shared with unrelated person

**Couple**

\$0.01

**Description:**

For the New Horizons living arrangement, the Standard of Assistance includes a fixed amount for personal needs of \$156.82 and an allowance for the charge to the individual for shelter set by the Department in accordance with State law. The maximum standard of assistance for New Horizon living arrangement is \$2250.10 for an individual living with an unrelated person. There is no income standard for a couple as shared with an unrelated person indicates not married.

**Individual**

\$2250.10

**Name of Classification**

New Horizon shared w/related person/two eligible

**Couple**

\$0.01

**Description:**

For the New Horizons living arrangement, the Standard of Assistance includes a fixed amount for personal needs of \$156.82 and an allowance for the charge to the individual for shelter set by the Department in accordance with State law. The maximum standard of assistance for New Horizon living arrangement is \$2318 for an individual living with a related person and \$4636 for a couple with 2 eligible members.

**Individual**

\$2318.00

**Name of Classification**

New Horizon shared w/related person/one eligible

**Couple**

\$4636.00

**Description:**

For the New Horizons living arrangement, the Standard of

Assistance includes a fixed amount for personal needs of \$156.82 and an allowance for the charge to the individual for shelter set by the Department in accordance with State law. The maximum standard of assistance for New Horizon living arrangement is \$2,318 for an individual living alone or with a related person and \$5,147 for a couple with one eligible member

**Individual**

\$2318.00

**Couple**

\$5147.00

**Name of Classification**

Domiciliary with one eligible member

**Description:**

For domiciliary living arrangements, the standard includes a fixed amount for personal needs of \$34.75 and an allowance for the charge to the individual for room and board set by the Department in accordance with State law. The maximum standard of assistance for domiciliary living arrangements is \$2410.30 for an individual and \$5239.30 for a couple with one eligible member

**Individual**

\$2410.30

**Couple**

\$5239.30

**Name of Classification**

Domiciliary with two eligible members

**Description:**

For domiciliary living arrangements, the standard includes a fixed amount for personal needs of \$34.75 and an allowance for the charge to the individual for room and board set by the Department in accordance with State law. The maximum standard of assistance for domiciliary living arrangements is \$2410.30 for an individual and \$4820.60 for a couple with two eligible member.

**Individual**

\$2410.30

**Couple**

\$4820.60



Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | CT2024MS0003O | CT-24-0015

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