

APPENDIX K: Emergency Preparedness and Response

Background:

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

Appendix K-1: General Information

General Information:

A. State: Connecticut

B. Waiver Title: Comprehensive Supports Waiver, Individual and Family Support Waiver, Employment and Day Supports Waiver

C. Control Number: CT.0437.R03.11 CT.0426.R03.11, CT.0881.R02.04

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

<input checked="" type="radio"/>	Pandemic or Epidemic
<input type="radio"/>	Natural Disaster
<input type="radio"/>	National Security Emergency
<input type="radio"/>	Environmental
<input type="radio"/>	Other (specify):

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

COVID-19 Pandemic.

Federal public health emergency continues to exist as a result of the coronavirus pandemic.

This Appendix K is retroactive to February 1, 2023 and, utilizing section 9817 of the American Rescue Plan (ARP), is additive to the previously approved Appendix Ks and modifies the language in Appendix K approved March 17, 2022. It includes the following modifications:

- Stabilization payments for certain qualified provider types covered under the waivers listed in this Appendix K.
- Payments for qualified provider types covered under the waivers listed in this Appendix K to modernize billing processes and systems.
- Funding incentive-based outcome payments for any qualified residential provider covered under the waivers listed in this Appendix K that transitions a waiver participant from a congregate residential setting toward a more integrated community-based setting; and
- Temporary rate increases for specific employment and residential waiver service authorizations covered under the waivers listed in this Appendix K that move a waiver participant toward a more independent residential setting or toward competitively-based employment.

New language includes:

1. Incentive-based outcome payments to any qualified residential or day provider covered under the waivers listed above that submits a transition plan that is approved by DDS.
2. Incentive-based outcome payments to any qualified residential or day provider covered under the waivers listed above that transitions a waiver participant from a congregate residential setting toward a more integrated community-based setting or a waiver participant from a congregate day setting toward a more community-based employment setting, as identified in the approved transition plan.
3. Incentive-based outcome payments to any qualified residential or day provider covered under the waivers listed above that completes one of the following objectives, as part of the approved transition plan to the satisfaction of DDS.
4. An incentive payment for any DDS qualified provider that completes the National Core Indicator IDD State of the Workforce Survey
5. An incentive payment for any DDS qualified providers that meet the articulated criteria on training expectations consistent with professional standards from accepted accreditation or certification entities such as the

Connecticut Association of People Supporting Employment First (CTAPSE), Association of Community Rehabilitation Educators (ACRE), or other similarly recognized organizations.

6. An incentive payment for any DDS qualified providers that meet the articulated criteria for training expectations consistent with Technology First SHIFT LLC, Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) Assistive Technology professional or other similarly recognized organizations that focus on utilization of assistive technology.
7. Temporary enhanced rate/rate increases for specific employment and residential waiver service authorizations covered under the waivers listed above.

Acknowledging these are time-limited payments which are not anticipated to extend beyond March 2025, the State understands that its ability to make payments under the Appendix K authority will end six months following the conclusion of the Federal public health emergency. The State will be responsible to seek other authority, such as amending the 1915(c) HCBS waivers, for the continuation of these payments beyond the termination date of the Appendix K for all of Connecticut's home and community-based services waivers.

F. Proposed Effective Date: Start Date: March 16, 2020 Anticipated End Date: Six months after public health emergency ends

G. Description of Transition Plan.

Emergency Plan and Transition Plan

COVID-19 pandemic. This amendment will apply waiver-wide for each waiver included in this Appendix K, to all individuals impacted by the virus or the response to the virus (e.g., closure of day programs, etc.)

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

H. Geographic Areas Affected:

These actions will apply across the waiver to all individuals impacted by the COVID-19 virus and are being implemented statewide.

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

Not applicable.

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

Temporary or Emergency-Specific Amendment to Approved Waiver:

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

a. ___ Access and Eligibility:

i. ___ Temporarily increase the cost limits for entry into the waiver.

[Provide explanation of changes and specify the temporary cost limit.]

ii. ___ Temporarily modify additional targeting criteria.

[Explanation of changes]

b. ___ Services

i. ___ Temporarily modify service scope or coverage.

[Complete Section A-Services to be Added/Modified During an Emergency.]

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

[Explanation of changes]

iii. ___ Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).

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

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

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

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

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

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

i. ___ Temporarily modify provider qualifications.

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

ii. ___ Temporarily modify provider types.

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

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

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

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

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f. X Temporarily increase payment rates

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

Effective February 1, 2023:

For stabilization payments for certain qualified day or residential provider types covered under the waivers listed in this Appendix K.

The state is removing the language stating:

Explanation of payments: CT Department of Developmental Services will pay a series of four one-time payments to providers over the ARPA period. The payments are expected to cover the following time periods: 7/1/2021-3/31/2022, 4/1/2022-6/30/2022, 7/1/2022-6/30/2023, and 7/1/2023-3/31/2024. The first two Payments are expected to be paid in March 2022 (pending approval of this appendix K). The subsequent two payments are targeted for September of 2022 and 2023. Payments are estimated at 3.2% of each period's expenditures based on the \$57,159,340 budget for these initiatives.

Staffing shortages have been identified statewide in all facets of the DDS provider network. To this end, funds will be distributed proportionally to all current qualified providers proportional to the authorizations of the individuals supported by such providers. The intent of the payments is to assist qualified providers impacted by the pandemic, as well as to assist with recruitment and retention of provider staff. Payments would be made based on Appendix K and subsequent waiver amendment approvals. The state will require qualified providers in receipt of such payments to attest that such funds were used for the purposes outlined in this Appendix K.

The state is amending the previously approved language (identified above) to the following:

Explanation of payments: CT Department of Developmental Services pays a series of payments to providers over the ARPA period. The first payment was made March 2022, the next payment was made September into October 2022 and another payment is expected to be made in September of 2023. Payments totaling an estimated \$68,871,516 for these initiatives will be paid across the ARPA period. This budget is the DDS portion of the total state funding as referenced in page 4 of the Initial HCBS Spending Plan Projection section of the approved CT ARPA spending plan. The \$68,871,516 will be distributed proportionally across all provider types covered under this waiver.

Staffing shortages have been identified statewide in all facets of the DDS provider network. To this end, funds will be distributed proportionally to all current qualified providers proportional to the authorizations of the individuals supported by such providers. The intent of the payments is to assist qualified providers impacted by the pandemic, as well as to assist with recruitment and retention of provider staff. The state will require qualified providers in receipt of such payments to attest that such funds were used for the purposes outlined in this Appendix K.

For payments for qualified day or residential provider types covered under the waivers listed in this Appendix K to modernize billing processes and systems.

The state is removing the language stating:

Explanation of payment: Payment will allow providers to purchase necessary technology and

make improvements to current technology in order to modernize business systems. Payments will be made through a series of four one-time payments to providers over the ARPA period. The payments are expected to cover the following time periods: 7/1/2021-3/31/2022, 4/1/2022-6/30/2022, 7/1/2022-6/30/2023, and 7/1/2023-3/31/2024. The first two Payments are expected to be paid in March 2022 (pending approval of this appendix K). The subsequent two payments are targeted for September of 2022 and 2023.

The funding referenced in this provision is the DDS portion of the state funding as referenced on page 4 of the Initial HCBS Spending Plan. Projection section of the approved CT ARPA spending plan.

The remainder of this budget will go toward technology improvements that include software replacement to improve public reporting of HCBS metrics and, if necessary, updating system licenses. This remainder will be a part of what DDS already claims for administrative costs because the expenditures would be state agency based administrative costs.

The state is amending the previously approved language (identified above) to the following:

Explanation of payment: CT Department of Developmental Services pays a series of payments to providers over the ARPA period. The first payment was made March 2022, the next payment was made September into October 2022 and the last payment is expected to be made in September of 2023. Payments totaling \$36,000,000 to be paid out over the ARPA period to support over 10,000 DDS individuals served by over 135 qualified providers. Payments will be made proportionally to DDS providers for the purchase of technology and to make improvements to current technology in order to modernize business, based on previous service payments to ensure all providers receive a fair share of these funds. The state will require qualified providers in receipt of such payments to attest that such funds were used for the purposes outlined in this Appendix K.

The funding referenced in this provision is the DDS portion of the state funding as referenced on page 4 of the Initial HCBS Spending Plan. Projection section of the approved CT ARPA spending plan.

The remainder of this budget will go toward technology improvements that include software replacement to improve public reporting of HCBS metrics and, if necessary, updating system licenses. This remainder will be a part of what DDS already claims for administrative costs because the expenditures would be state agency based administrative costs.

For funding incentive-based outcome payments for any qualified residential provider covered under the waivers listed in this Appendix K that transitions a waiver participant from a congregate residential setting toward a more integrated community-based setting; and implementing temporary rate increases for specific employment and residential waiver service authorizations covered under the waivers listed in this Appendix K that move a waiver participant toward a more independent residential setting or toward competitively-based employment.

The state is removing the language stating:

Incentive-based outcome payments to any qualified residential provider covered under the waivers listed in this Appendix K that transitions a waiver participant from a congregate residential setting (community living arrangements (CLA), community residential supports (CRS)) toward a more integrated community-based setting (own home, family home or community companion homes). - DDS will require a minimum stay of at least 60 days in the community-based setting in order for the CLA or CRS provider to receive the outcome payment. The payments will cease once all the funds, as noted below, are expended.

Explanation of payment: One-time incentive-based outcome payments totaling \$2,500,000 to be paid out over the ARPA period proportionally across the relevant services as long as the criteria outlined above is met. This is the DDS portion of the total state funding as referenced on page 4 of the Initial HCBS Spending Plan Projection section of the approved CT ARPA spending plan. Payments are expected to be made to providers within 90 days of when the above criteria is met.

Services impacted: Payments will be provided to qualified residential providers of community living arrangements and community residential supports that meet the criteria outlined above.

Temporary rate increases for specific employment and residential waiver service authorizations covered under the waivers listed in this Appendix K that created a vacancy because of a move by a waiver participant to a more independent residential setting or toward competitively-based employment.

Explanation of rate increase: Increases totaling \$25,000,000 to be paid out over the ARPA period. This is the DDS portion of the total state funding as referenced on page 4 of the Initial HCBS Spending Plan Projection section of the approved CT ARPA spending plan. Temporary rate increases will be based on a combination of the individuals' current and previous authorizations specific to the services outlined below. This rate increase will apply immediately upon transition and apply to the following scenarios:

- The existing qualified residential providers of congregate settings (service types listed below) that meet the criteria above, for the amount of time it takes to fill the vacancy with individuals identified as in emergency need of residential supports or the time it takes to restructure the current setting to meet the needs of those on the residential waiting list. For group settings, a single provider can only receive the enhanced rate for one transition per individual during the ARPA period. If an individual's provider received an enhanced rate as part of a different individual moving and the program restructuring, and the individual, then subsequently transitions to a more independent setting, the provider will receive an enhanced rate.
- The qualified residential provider accepting the individual into a more independent residential setting (service types listed below) that meet the criteria above, for an identified, limited time period to acclimate the individual into the new setting.
- The existing day/employment provider (service types listed below) that meet the criteria above, for an identified, limited time needed to restructure the current program. Rates will temporarily be increased for the remaining participants of the program.
- The employment provider (service types listed below) accepting the individual into a more competitively-based employment service.

Service rates impacted by increase: This impacts all employment and day program service rates, as well as rates for community living arrangements, community residential supports and qualified provider types for services provided in own home, family home or community companion homes.

The State is amending the previously approved language (identified above) to the following:

1. Incentive-based outcome payments to any qualified residential or day provider covered under the waivers listed above that submits a transition plan that is approved by DDS. The transition plan must include transitioning waiver participants from a congregate residential setting (community living arrangements (CLA), community residential supports (CRS)) toward a more integrated community-based setting (own home, family home or community companion homes) or a waiver participant from a congregate day setting (Day Support Option (DSO), Group Supported Employment, Transitional Services (TS) toward a more community and integrated, employment-based setting.

All approved transition plans will promote the independence of the individual and will articulate an anticipated result in at least one of the following outcomes:

- 1) Moving out of a congregate residential setting into a more independent setting that meets the final settings rule or are solely independent residential settings, that they no longer require DDS funds
- 2) Moving into a non-congregate residential setting
- 3) Adding a remote support service or increasing the hours of residential service in a non-congregate residential setting to focus on skill-based training to ensure continued independence and avoid movement to a more restrictive congregate setting
- 4) Moving out of a non-employment day setting into a setting that works toward competitive integrated community employment
- 5) Moving into a setting that works towards competitive integrated community employment
- 6) Moving out of a group employment setting toward a more independent competitive integrated community employment-based setting
- 7) Increasing the support hours of a day setting that works towards competitive integrated community employment to ensure continued independence
- 8) Transitioning support hours from a non-employment day setting with the intent of moving such hours toward a setting that works toward competitive integrated community employment

DDS will require the qualified provider to submit the plan through the authorized template. A qualified provider that submits a plan after 2/1/2023 and before 9/30/2024 and is approved by DDS will be eligible for the outcome payment. The payments will cease once all the funds, as noted below, are expended.

Explanation of payment: A one-time incentive-based outcome payment will be based on the scope of the plan. Providers that submit a plan for transforming one residential, employment or day program within their agency will receive a payment of \$7,500. A provider that submits a plan for transforming two programs within the agency will receive a payment of \$12,500. A provider that submits a plan for transforming three or more programs within

their agency will receive a payment of \$17,500. The maximum total amount of \$1,000,000 is to be paid out over the ARPA period across the relevant services as long as the criteria outlined above is met. This is the DDS portion of the total state funding as referenced on page 4 of the Initial HCBS Spending Plan Projection section of the approved CT ARPA spending plan. Payments are expected to be made to providers within 90 days of when the above criteria is met.

Services impacted: This impacts all qualified residential and employment and day program providers as applicable that meet the criteria outlined above.

2. Incentive-based outcome payments to any qualified residential or day provider covered under the waivers listed above that transitions a waiver participant from a congregate residential setting (community living arrangements (CLA), community residential supports (CRS)) toward a more integrated community-based setting (own home, family home or community companion homes) or a waiver participant from a congregate day setting (Day Support Option (DSO), Group Supported Employment, Transitional Services (TS) toward a more community based employment setting, as identified in the approved transition plan.

All transitions will promote the independence of the individual and will result in at least one of the following outcomes:

1. Moving out of a congregate residential setting into a more independent setting that meets the final settings rule or are solely independent, in that they no longer require DDS funds.
2. Moving out of a non-employment day setting into a setting that works toward competitive integrated community employment
3. Moving out of a group employment setting toward a more independent competitive integrated community employment-based setting

DDS will require a minimum stay of at least 60 days in the community-based setting in order for the CLA or CRS provider to receive the outcome payment. DDS will require a minimum stay of 60 days in the community-based employment setting in order for the congregate day provider to receive the outcome payment. The payments will cease once all the funds, as noted below, are expended.

Explanation of payment: One-time incentive-based outcome payments totaling \$6,600,000 to be paid out over the ARPA period across the relevant services as long as the criteria outlined above is met. This is the DDS portion of the total state funding as referenced on page 4 of the Initial HCBS Spending Plan Projection section of the approved CT ARPA spending plan. Payments are expected to be made to providers within 90 days of when the above criteria is met.

Services impacted: This impacts all qualified residential and employment and day program providers as applicable that meet the criteria outlined above.

3. Incentive-based outcome payments to any qualified residential or day provider covered under the waivers listed above that completes one of the following objectives, as part of the approved transition plan to the satisfaction of the Department.

Defined objectives include the following:

1. Restructuring of a residential setting to support new individuals with specialized or complex medical, behavioral or clinical needs and are in need of residential support (as defined by our residential wait list, an unmet residential need or the residential move better aligns to meet the needs of the individual).
2. Restructuring a day program to provide new supports that now focus on employment-based services.
3. Restructuring a day program to support new individuals with specialized or complex medical needs and are in need of a day support (as defined as an unmet day need).
4. Ending a subminimum wage arrangement for individuals supported in the program to minimum wage arrangement.

Explanation of payment: A qualified provider that successfully achieves and is verified by DDS one of the listed objectives after 2/1/2023 and before 3/31/2025 will be eligible for the outcome payment. A provider that achieves one of the listed objectives will receive a payment of \$33,000. The maximum total amount of \$1,000,000 is to be paid out over the ARPA period across the relevant services as long as the criteria outlined above is met. This is the DDS portion of the total state funding as referenced on page 4 of the Initial HCBS Spending Plan Projection section of the approved CT ARPA spending plan. Payments are expected to be made to providers within 90 days of when the above criteria is met.

Services impacted: This impacts all residential and employment and day program providers as applicable that meet the criteria outlined above.

- 4. An incentive payment for any DDS qualified provider that completes the National Core Indicator IDD State of the Workforce Survey.** This does NOT need to be a component of an approved plan. Payment for completion will be a flat payment of \$2,500 once verification of completion is received by the department.

Explanation of payment: A qualified provider that successfully submits the NCI Survey after 2/1/2023 and before 3/31/2025 for each of the surveys completed for the respective year of the annual survey and is verified by DDS will be eligible for an outcome payment. A provider that submits the annual survey will receive a payment of \$2,500. The maximum total amount of \$500,000 is to be paid out over the ARPA period across the relevant services as long as the criteria outlined above is met. This is the DDS portion of the total state funding as referenced on page 4 of the Initial HCBS Spending Plan Projection section of the approved CT ARPA spending plan. Payments are expected to be made to providers within 90 days of when the above criteria is met.

Services impacted: This impacts all qualified providers that meet the criteria outlined above.

- 5. An incentive payment for any DDS qualified provider for each job coach or job developer that completes training expectations consistent with professional standards from accepted accreditation or certification entities such as the Association of People Supporting Employment First (APSE), Association of Community Rehabilitation Educators (ACRE), or other similarly recognized organizations.** This does NOT need to be a component of an approved plan. Payment for completion will be a flat outcome payment of \$3,000 per employee trained up to a total of \$30,000 per qualified provider agency, once verification of completion is

received by the department. The incentive payment also includes reimbursement for the cost of such training, separate from the outcome payment. Trainings noted are not a requirement to become a qualified waiver provider under CT DDS.

Explanation of payment: A qualified provider that successfully submits the training expectations for each job coach or developer that completes the training expectations consistent with professional standards from accepted accreditation or certification after 2/1/2023 and before 3/31/2025 and is verified by DDS will be eligible for an incentive payment. A provider that completes the training expectations will receive a one-time outcome payment of \$3,000 per employee up to a total of \$30,000 per provider agency. The incentive payment also includes reimbursement for the cost of such training, separate from the outcome payment. The maximum total amount of \$1,250,000 is to be paid out over the ARPA period across the relevant services as long as the criteria outlined above is met. This is the DDS portion of the total state funding as referenced on page 4 of the Initial HCBS Spending Plan Projection section of the approved CT ARPA spending plan. Payments are expected to be made to providers within 90 days of when the above criteria is met.

Services impacted: This impacts all qualified providers that meet the criteria outlined above

6. **An incentive payment for any DDS qualified provider that has one or more of their staff complete training certification expectations consistent with Technology First SHIFT LLC, Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) Assistive Technology professional, or other similarly recognized organizations that focus on utilization of assistive technology.** This does NOT need to be a component of an approved plan. Payment for completion will be a flat outcome payment of \$3,000 per employee and up to a total of \$30,000 per qualified provider agency, once verification of completion is received by the department. The incentive payment also includes reimbursement for the cost of such training, separate from the outcome payment. Trainings noted are not a requirement to become a qualified waiver provider under CT DDS.

Explanation of payment: A qualified provider that submits the successful assistive technology training for one or more staff after 2/1/2023 and before 3/31/2025 and is verified by DDS will be eligible for an incentive payment. A provider that completes the training expectations will receive a one-time outcome payment of \$3,000 per employee up to a total of \$30,000 per qualified provider agency. The incentive payment also includes reimbursement for the cost of such training, separate from the outcome payment. The maximum total amount of \$1,250,000 is to be paid out over the ARPA period across the relevant services as long as the criteria outlined above is met. This is the DDS portion of the total state funding as referenced on page 4 of the Initial HCBS Spending Plan Projection section of the approved CT ARPA spending plan. Payments are expected to be made to providers within 90 days of when the above criteria are met.

Services impacted: This impacts all qualified providers that meet the criteria outlined above.

7. **Temporary enhanced rate/ rate increases for specific employment and residential waiver service authorizations covered under this waiver.** All enhanced rate/rate

increases will promote the independence of the individual and will result in at least one of the following outcomes:

1. Moving out of a congregate residential setting into a more independent setting that meets the final settings rule or are solely independent, in that they no longer require DDS funds.
2. Moving into a non-congregate residential setting that meets their needs.
3. Adding remote supports or increasing the hours of residential service in a non-congregate residential setting to focus on skill-based training to ensure continued independence and avoid movement to a more restrictive congregate setting.
4. Moving out of a non-employment day setting into a setting that works toward competitive integrated community employment.
5. Moving into a setting that works towards employment.
6. Moving out of a group employment setting toward a more independent competitive integrated community employment-based setting.
7. Increasing the support hours of a day setting that works towards competitive integrated community employment to ensure continued independence.
8. Transitioning support hours from a non-employment day setting with the intent of moving such hours toward a setting that works toward competitive integrated community employment.

Explanation of increase: : A qualified provider that transitions individuals in accordance with their approved transition plan will receive a temporary enhanced rate above the service rate. This enhanced rate is based on either an individual's current or previous service rate specific to the outcomes identified above. Generally, the average percentage increase will be 100 percent. Increased will be evaluated based on the effectiveness of this initiative. A single transition may qualify for more than one of the enhanced rates associated with the outcomes identified above. The maximum total amount of \$17,700,000 is to be paid out over the ARPA period. This is the DDS portion of the total state funding as of 2/2023 referenced on page 4 of the Initial HCBS Spending Plan Projection section of the approved CT ARPA spending plan.

Services impacted: This impacts all residential and employment and day program service rates as applicable that meet the criteria outlined above.

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

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

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

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

[Specify the services.]

j. _ Temporarily include retainer payments to address emergency related issues.

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

k. ___ Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards]

l. ___ Increase Factor C.

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

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

Contact Person(s)

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

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

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

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

8. Authorizing Signature

Signature: /S/

Date: 5/3/2023

State Medicaid Director or Designee

First Name: William
Last Name Halsey
Title: Interim Director of Medicaid and Division of Health Services
Agency: Department of Social Services
Address 1: 55 Farmington Avenue
Address 2: 9th Floor
City Hartford
State CT
Zip Code 06105
Telephone: 860-424-5077
E-mail William.Halsey@ct.gov
Fax Number 860-424-4963

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

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

Service Specification					
Service Title:					
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>					
Service Definition (Scope):					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
Provider Specifications					
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:		<input type="checkbox"/>	Agency. List the types of agencies:
Specify whether the service may be provided by (check each that applies):		<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):					
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)		
Verification of Provider Qualifications					
Provider Type:	Entity Responsible for Verification:			Frequency of Verification	
Service Delivery Method					
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E		<input type="checkbox"/>	Provider managed



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