STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 23-0005-A: Rate Increases and Coverage Additions for Community First Choice (CFC) Under Section 1915(k) of the Social Security Act and State Plan Home and Community-Based Services (HCBS) Options Under Section 1915(i) of the Social Security Act for HCBS Services for Older Adults and Connecticut Housing Engagement and Support Services (CHESS)

The State of Connecticut Department of Social Services (DSS) proposes to submit the following Medicaid State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS).

Changes to Medicaid State Plan

Effective May 12, 2023, which is the first day after the scheduled end of the federal Coronavirus Disease 2019 (COVID-19) public health emergency (PHE), this SPA will amend Attachments 3.1-i, 3-1-K, and 4.19-B of the Medicaid State Plan to add the provisions detailed below.

This SPA is necessary to continue provisions under various approved disaster relief SPAs (including approved SPAs 22-0003 and 22-0003-A) and proposed SPA 23-0005, which are all disaster relief SPA governed by the flexibility in standard federal requirements implemented by CMS and pursuant to the state's approved waiver from CMS pursuant to section 1135 of the Social Security Act during the federally declared national emergency and PHE to help assist with the state's response to the COVID-19 pandemic and its effects. In accordance with federal requirements, all COVID-19 disaster relief SPAs will sunset no later than the last day of the federal PHE, which, as communicated by the federal government, will be May 11, 2023.

The purpose of this SPA is to continue implementing, with respect to the Medicaid benefits referenced above, relevant provisions of the state's Spending Plan for Implementation of the American Rescue Plan Act (ARPA) of 2021, Section 9817, as updated (ARPA HCBS Spending Plan). Each of those is summarized below.

To the extent applicable based on approved SPAs 22-0003 and 22-0003-A and proposed SPA 23-0005, each of the service expansions and rate increases continue those in effect in the disaster relief section of the Medicaid State Plan through the end of the federal PHE. 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 for 1915(i) HCBS for Older Adults are: Assistive Technology; Environmental Accessibility Modifications, Personal Response Systems, Skilled Chore, Specialized Medical Equipment, Individual Goods and Services, and all Self-Directed Services. The only CFC providers

eligible to receive these rate increases are providers of 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. Rate Modifications

i. This SPA continues the 3.5% rate increase for 1915(i) HCBS for Older Adults, 1915(i) CHESS care plan development and monitoring, pre-tenancy supports, and tenancy sustaining supports, and 1915(k) CFC agency-based support and planning coach services.

ii. For Section 1915(i) HCBS for Older Adults – Additional Rate: Continuation of new rate of $52.89 for emergency back-up personal care attendant services.

B. Value-Based Payment Supplemental Payments for 1915(i) HCBS for Older Adults, 1915(i) CHESS, and CFC Agency-Based Support and Planning Coach Services

There will be payments for July 2023 and November 2023 for applicable CHESS, 1915(i) HCBS for Older Adults, and CFC providers, who will be eligible for receive payments calculated based on 2% of expenditures for the prior four months, so long as the provider meets the benchmarks set forth in the SPA pages, which include, as applicable, standards related to training, surveys, and health information exchange participation.

Beginning in March 2024, for applicable CHESS, 1915(i) HCBS for Older Adults, and CFC providers, the value-based payment will change from the progressive benchmark payments to outcome-based payments with outcome measures set forth in the SPA pages related to decreasing avoidable hospitalization, increasing percent of people who need ongoing services discharged from hospital to community in lieu of nursing home, and increase in probability of return to community within 90 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.

C. Provider Quality Infrastructure Supplemental Payments for 1915(i) HCBS for Older Adults, 1915(i) CHESS, and CFC Agency-Based Support and Planning Coach Services

Eligible 1915(i) HCBS for Older Adults, 1915(i) CHESS, and CFC providers will receive benchmark payments in July and November 2023 based on the greater of 5% of expenditures from the four months prior to the payment or $5,000 based on the provider meeting phase 1, phase 2, and phase 3 benchmarks, respectively, of delivery system quality infrastructure improvements detailed in the SPA pages.

D. Service Expansions

This SPA will make the following service expansions, all of which were previously added or proposed to be added by one or more disaster relief SPAs and all of which are described in more detail in the SPA pages:

i. For Section 1915(i) HCBS for Older Adults – Training and Counseling Services for Unpaid Caregivers Supporting Participants: This SPA continues Training and Counseling Services for Unpaid Caregivers Supporting Participants as a new service in the section 1915(i) HCBS for Older Adults benefit. This service is an inter-professional model delivered through a structured number of visits by a team comprised of a 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.

ii. For Section 1915(i) HCBS for Older Adults – Participant Training and Engagement to Support Goal Attainment and Independence: This SPA continues Participant Training and Engagement to Support Goal Attainment and Independence as a new service in the section 1915(i) HCBS for Older Adults benefit. 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 waiver 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.

iii. For Section 1915(i) HCBS for Older Adults – Environmental Adaptations: This SPA continues Environmental Adaptations as a new service in the section 1915(i) HCBS for Older Adults benefit. 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.

iv. For Section 1915(i) HCBS for Older Adults – Remote Live Supports: This SPA continues Remote Live Support as a new service in the section 1915(i) HCBS for Older Adults benefit. This service is defined in more detail in the SPA pages and includes the provision of supports by staff at a remote location who are engaged with the individual through technology/devices with the capability for live two-way communication. Individual interaction with the staff person may be scheduled, on-demand, or in response to an alert from a device in the remote support equipment system. Note that the equipment is already covered under the assistive technology

service portion of this benefit. In order to provide remote live supports, the provider entity must be certified by DSS as a community hub.

v. For 1915(i) HCBS for Older Adults, 1915(i) CHESS, and 1915(k) CFC – Updated Definition of Assistive Technology: The definition of assistive technology is modified to specifically reference remote equipment and the associated requirements for internet access.

Fiscal Impact

DSS estimates that this SPA will increase annual aggregate expenditures by approximately $0 in State Fiscal Year (SFY) 2023 (due to routine delay in claims submission and processing), $1.4 million in SFY 2024, and $2.2 million in SFY 2025.

Obtaining SPA Language and Submitting Comments

The proposed SPA is posted on the DSS website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-State-Plan-Amendments. To the extent that the SPA pages include tracked changes, those illustrate proposed revisions to the existing approved Medicaid State Plan. The proposed SPA may also be obtained at any DSS field office, at the Town of Vernon Social Services Department, or upon request from DSS (see below).

To request a copy of the SPA from DSS or to send comments about the SPA, please email: Public.Comment.DSS@ct.gov or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. Please reference "SPA 23-0005-A: Rate Increases and Coverage Additions for Community First Choice (CFC) Under Section 1915(k) of the Social Security Act and State Plan Home and Community-Based Services (HCBS) Options Under Section 1915(i) of the Social Security Act for HCBS Services for Older Adults and Connecticut Housing Engagement and Support Services (CHESS)".

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than **April 12, 2023**.

Agency	MMIS contractor and DSS Quality Assurance Staff	Initially 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: Assistive Technology

Service Definition (Scope)*:*

An item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, monitor or improve functional capabilities of client to perform ADLs or IADLs. Assistive technology service means a service that directly assists a client in the selection, acquisition, or use of an assistive technology device.

A. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices.

B. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.

C. Training or technical assistance for the client or for the direct benefit of the client receiving the service, and where appropriate, the family members, guardians, advocates or authorized representatives of the client.

D. Equipment used for remote support such as motion sensing system, radio frequency identification, live video feed, live audio feed, or web-based monitoring. Assistive technology equipment does not include non-technical, non-electronic equipment (e.g., grab bars or wheelchair ramps) or items otherwise available as environmental accessibility adaptations or specialized medical equipment and supplies. Internet service may be provided through assistive technology equipment only when the remote support vendor indicates internet service is required for the equipment used for remote support to function and the vendor to secure the connection to ensure appropriate use of the internet service solely for the function of equipment used for remote support.

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

Care plans will be developed based on the needs identified in the comprehensive assessment. The cost of the assistive technology cannot exceed the yearly cost of the service it replaces. When an assistive technology device is identified that will support the client's independent functioning, the services will be reduced commensurate with the cost of the service it replaces. This reduction will be made with consideration of the client's health and safety needs.

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):*
	The service is capped at an annual cost of $1,000.
☐	Medically needy *(specify limits):*

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

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 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 includes 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 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. The services are limited to additional services not otherwise covered under the state plan (outside 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. 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. 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 waiver 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 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. The qualifications for

OTs and RNs to participate as providers of this service are different from the qualifications required under OT and RN 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. The qualifications for

OTs and RNs to participate as providers of this service are different from the qualifications required under 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 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 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 shall 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 shall 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 (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: Remote Supports

Service Definition (Scope)*:*

Remote Supports is the provision of supports by staff at a remote location who are engaged with the individual through technology/devices with the capability for live two-way communication. Equipment used to meet this requirement must include one or more of the following systems: motion sensing system, radio frequency identification, live video feed, live audio feed, GPS tracking, web-based monitoring system, or a device that otherwise meets the requirement for two-way communication. Individual interaction with the staff person may be scheduled, on-demand, or in response to an alert from a device in the remote support equipment system.

The use of an intrusive device that signals the whereabouts or movements of an individual to ensure the safety of the individual or safety of the community, or a restriction that prevents an individual from having access to specific experiences, must always be reviewed and approved by the DSS. Remote supports includes an monthly equipment monthly cost covered under assistive technology and a virtual support fee- for- service cost. Note that the equipment is already covered under the assistive technology service portion of this benefit. In order to provide remote live supports, the provider entity must be certified by DSS as a community hub. The services are limited to additional services not otherwise covered under the state plan (outside 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):*
Remote Support Provider		Certified as Community Hub	The agency ensures that virtual support staff meet the following qualifications: Prior to Employment: ·18 yrs of age ·criminal background check ·have ability to communicate effectively with the individual/family ·have ability to complete record keeping as required by the employer Prior to being alone with the Individual: ·demonstrate competence in knowledge of DSS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques ·demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan ·demonstrate competence, skills, abilities, education and/or experience

			necessary to achieve the specific training outcomes as described in the Individual Plan ·ability to participate as a member of the team if requested by the individual ·demonstrate understanding of Person Centered Planning Understand administration of medication
Homemaker Companion Plus Agency		Registered with the Department of Consumer Protection Certified as Community Hub	Homemaker companion agency is vendor of remote supports or subcontracts with a remote supports provider. The agency ensures that virtual support staff meet the following qualifications: Prior to Employment: ·18 yrs of age ·criminal background check ·have ability to communicate effectively with the individual/family ·have ability to complete record keeping as required by the employer Prior to being alone with the Individual: ·demonstrate competence in knowledge of DSS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques ·demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan ·demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan

			·ability to participate as a member of the team if requested by the individual ·demonstrate understanding of Person Centered Planning Understand administration of medication
Adult Day Plus Provider		Certification required by the Adult Day Care Association of CT. Certification is for 3 years. Certified as Community Hub	Adult Day provider is vendor of remote supports or subcontracts with a remote supports provider. The agency ensures that virtual support staff meet the following qualifications: Prior to Employment: ·18 yrs of age ·criminal background check ·have ability to communicate effectively with the individual/family ·have ability to complete record keeping as required by the employer Prior to being alone with the Individual: ·demonstrate competence in knowledge of DSS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques ·demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan ·demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan ·ability to participate as a member of the team if requested by the individual ·demonstrate understanding of Person Centered Planning

			Understand administration of medication

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):*
Remote Supports Provider	State's fiscal intermediary	Upon enrollment and every two years thereafter
Homemaker Companion Agency	State's fiscal intermediary	Upon enrollment and every two years thereafter
Adult Day Plus Provider	State's fiscal intermediary	Upon enrollment and every two years thereafter

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

☐	Participant-directed	☒	Provider managed

1. ☒ **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. (S*elect one):*

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

equipment and supplies that are necessary for the welfare of the individual. 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 individual. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

Limit on amount and scope: The maximum benefit per individual over a 5 year period is $15,000. This benefit is in addition to the individual budget calculated by the need grouping.

Assistive Technology (AT)

Service Definition: Any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants to perform or seek assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs). Assistive Technology meets the requirement under 42 C.F.R. § 441.520(b)(2), which provides for "expenditures relating to a need identified in an individual's person-centered service plan that increases an individual's independence or substitutes for human assistance, to the extent that expenditures would otherwise be made for the human assistance." Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device, including:

- services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices;
- services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; and/or
- training or technical assistance for the participant, Attendant, or where appropriate, the participant's family members, guardian, advocate or authorized representative.
- Equipment used for remote support such as motion sensing system, radio frequency identification, live video feed, live audio feed, or web-based monitoring. Assistive technology equipment does not include non-technical, non-electronic equipment (e.g., grab bars or wheelchair ramps) or items otherwise available as environmental accessibility adaptations or specialized medical equipment and supplies. Internet service may be provided through assistive technology equipment only when the remote support vendor indicates internet service is required for the equipment used for remote support to function and the vendor to secure the connection to ensure appropriate use of the internet service solely for the function of equipment used for remote support.

Limit on amount and scope: The maximum allowance per individual is $5,000 per calendar year

A. Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks.

Service Definition: Services to support the acquisition, maintenance, and enhancement of skill in order for the individual to accomplish ADLs, IADLs and health-related tasks. Providers for

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 ~~July 1, 2022~~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
	HCBS Remote Supports: 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 HCBS Spending Implementation Plan Pursuant to Section 9817 of the American Rescue Plan Act (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, Skilled Chore, Specialized Medical Equipment, Individual Goods and Services, and all Self-Directed 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 participation in related learning collaboratives; (b) Accessing data within the HIE and viewing baseline 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 data within the HIE and viewing baseline 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). The higher limit of 4% will be based on availability of funds as approved within the ARP 9817 Spending Plan. Providers who meet all three performance measures will receive a full

	payment. Providers who meet fewer performance measures will receive a partial payment based on the number of performance measures that they meet. (b) Quality Infrastructure Supplemental Payments Payments will be made on or before July 31, 2023 and November 30, 2023 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 delivery system modifications complete; (b) Benchmark for November 2023 payment – Providers have delivery system implemented and integrated into member service planning; member satisfaction survey complete.

PRA Disclosure Statement

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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

The payment methodology described below applies to all services and supports provided under Connecticut's Community First Choice (CFC) State Plan Option pursuant to section 1915(k) of the Social Security Act, as described in and provided in accordance with Attachment 3.1-K of the Medicaid State Plan.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of CFC services pursuant to section 1915(k) of the Social Security Act. Except as otherwise provided below, CFC services are paid pursuant to the current fee schedule for CFC. The agency's fee schedule rates were set as of ~~January 1, 2023~~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: www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule. Medicaid payment under CFC does not include payment for room and board.

Payments are made by the Medicaid agency directly to the providers of State Plan services or to the fiscal intermediary to disperse payments. Payments for all State Plan services are made through the state's Medicaid Management Information System (MMIS).

As set forth on the fee schedule referenced above, the following CFC services are reimbursed as described below:

Attendant Care: Attendant care rates are billed under five distinct payment methodologies, each of which is based on the plan of care and the specific circumstances of the services provided, as follows:
1. Hourly Rate: When care is provided over a period of time which is neither live-in care for a continuous 24-hour period, nor a 12-hour overnight shift, a quarter-hour rate is used.
2. Per Diem Rate: When care is provided for a continuous 24-hour period by a live-in attendant, a per diem rate is billed, which assumes that the attendant receives at least eight hours of sleep, at least five of which is uninterrupted.
3. Pro-Rated Per Diem Rate: When the 24 hour shift is not completed; services are billed at a pro-rated per-diem rate.
4. Overnight Rate: When care is provided overnight for a 12-hour period, services are billed under an overnight rate, which assumes that the attendant sleeps for half of the hours.

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 HCBS Spending Implementation Plan Pursuant to Section 9817 of the American Rescue Plan Act (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, Skilled Chore, Specialized Medical Equipment, Individual Goods and Services, and all Self-Directed 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 data within the HIE and viewing baseline 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 data within the HIE and viewing baseline 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). The higher limit of 4% will be based on availability of funds as approved within the ARP 9817 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 three performance measures will receive a full payment. Providers who meet fewer performance measures will receive a partial payment based on the number of performance measures that they meet.

(b) Quality Infrastructure Supplemental Payments

Payments will be made on or before July 31, 2023 and November 30, 2023 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 delivery system modifications complete; (b) Benchmark for November 2023 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: $~~200.00~~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 $~~200~~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 ~~August 16, 2021~~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 ~~August 16, 2021~~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 rate that is charged to the general public.

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

	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 HCBS Spending Implementation Plan Pursuant to Section 9817 of the American Rescue Plan Act (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.

(a) Performance Supplemental Payments:

i. 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 data within the HIE and viewing baseline participation in data use learning collaboratives and training.

ii. 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 data within the HIE and viewing baseline 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) 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 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). The higher limit of 4% will be based on availability of funds as approved within the ARP 9817 Spending Plan. Providers who meet all three performance measures will receive a full payment. Providers who meet fewer performance measures will receive a partial payment based on the number of performance measures that they meet.

(b) Quality Infrastructure Supplemental Payments

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

	Payments will be made on or before July 31, 2023 and November 30, 2023 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 delivery system modifications complete; (b) Benchmark for November 2023 payment – Providers have delivery system implemented and integrated into member service planning; member satisfaction survey complete.

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