DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 20-K: Connecticut Housing Engagement and Support Services (CHESS) Initiative
State Plan Home and Community-Based Services (HCBS)
Pursuant to Section 1915(i) of the Social Security Act

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 on or after June 1, 2020, SPA 20-K will amend Attachments 2.2-A, 3.1-i, and 4.19-B of the Medicaid State Plan to implement CHESS through Medicaid State Plan HCBS services pursuant to section 1915(i) of the Social Security Act. The purpose of the CHESS Initiative is to improve housing stability and health outcomes for a targeted set of Medicaid members who have complex health conditions, have experienced homelessness, and have been determined to be likely to benefit from targeted tenancy sustaining services.

Service Categories: This SPA would establish four service categories: care plan development and monitoring, pre-tenancy and transition assistance, housing and tenancy sustaining services, and transportation.

Targeting Criteria: This benefit would be available only to Medicaid members who meet all of the following targeting criteria: age 18 and over, documentation of homelessness in accordance with federal Department of Housing and Urban Development regulations, have relevant diagnoses and Medicaid claims to have a risk score as defined by the Healthcare Effectiveness Data and Information Set (HEDIS) Plan All-Cause Readmissions measure, and be determined based on the methodology described in the SPA pages that the individual is experiencing more significant inpatient services than would be predicted based on the individual's risk score.

Payment Methodology: Care plan development will be paid as a fixed fee of $200. Pre-tenancy and transition assistance, and housing and tenancy sustaining services will each be paid as a per-member per-month payment calculated based on the average salary and related costs for relevant provider staff, with a withhold of 25% from the rate that will be paid based on the provider's performance on specified outcome measures.

Provider Qualifications: The provider entity and individual staff qualifications are described in more detail in the SPA pages. Provider entities are limited to those who meet all CHESS requirements and also have been selected through the Department of Mental Health and Addiction Services (DMHAS) supportive housing provider competitive procurement process. DSS also plans to submit a Selective Provider Contracting Waiver pursuant to section 1915(b)(4) of the Social Security Act in order to enable the incorporation of the DHMAS competitive procurement.

More details on all aspects of the SPA are detailed in the SPA pages. In additional, more information regarding the CHESS Initiative is posted on the DSS website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/Connecticut-Housing-Engagement-and-Support/Connecticut-Housing-Engagement-and-Support.

Fiscal Impact

Based on the information that is available at this time, DSS anticipates that this SPA will increase annual aggregate expenditures by approximately $1.7 million in State Fiscal Year (SFY) 2021 and $5.4 million in SFY 2022.

Obtaining SPA Language and Submitting Comments

The proposed SPA is posted on the DSS website at this link: http://portal.ct.gov/dss. Scroll down to the bottom of the webpage and click on "Publications" and then click on "Updates." Then click on "Medicaid State Plan Amendments". 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 (Phone: 860-424-5067). Please reference "SPA 20-K: CHESS Initiative – Section 1915(i) State Plan HCBS".

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than January 30, 2020.

"**SPECIAL NOTICE**: The public comment deadline has been extended until February 7, 2020".

1915(i) State plan Home and Community-Based Services Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled Participants as set forth below.*

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

The state's 1915(i) State plan optional HCBS benefit is named Connecticut Housing Engagement and Support Services Initiative (CHESS), which includes the following service components, each of which is described in detail below:

1. Care Plan Development and Monitoring
2. Pre-Tenancy and Transition Supports
3. Housing and Tenancy Sustaining Supports
4. Transportation

2. Concurrent Operation with Other Programs. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

◉	**Not applicable**
○	**Applicable**

Check the applicable authority or authorities:

☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
☐	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)

	☐	§1915(b)(2) (central broker)	× x	§1915(b)(4) (selective contracting/limit number of providers)
☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*			
☐	**A program authorized under §1115 of the Act.** *Specify the program*:			

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

☒	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	x	The Medical Assistance Unit *(name of unit)*:	Department of Social Services (DSS), Division of Health Services (DHS)
	○	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	
○	The State plan HCBS benefit is operated by *(name of agency)*		
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

4. Distribution of State plan HCBS Operational and Administrative Functions.

☐ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Participant State plan HCBS enrollment	☑	☐	☐	☐
2 Eligibility evaluation	☑	☐	☒	☐
3 Review of Participant service plans	☑	☐	☒	☐
4 Prior authorization of State plan HCBS	☑	☐	☒	☐
5 Utilization management	☑	☐	☒	☐
6 Qualified provider enrollment	☑	☐	☐	☐
7 Execution of Medicaid provider agreement	☑	☐	☐	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
10 Quality assurance and quality improvement activities	☑	☐	☒	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

The Medicaid program's behavioral health (BH) administrative services organization (ASO) will serve as the contracted entity to perform the functions listed above. DSS currently contracts with Beacon Health Options to serve as the department's BH-ASO.

(By checking the following boxes the State assures that):

5. ☒ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the Participant, or any paid caregiver of the Participant
- financially responsible for the Participant
- empowered to make financial or health-related decisions on behalf of the Participant
- providers of State plan HCBS for the Participant, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such Participants are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

6. ☒ **Fair Hearings and Appeals.** The state assures that Participants have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☒ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☒**Non-duplication of services.** State plan HCBS will not be provided to a Participant at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each Participant an explanation that these services do not include special education and related services defined in the Participants with Disabilities Education Improvement Act of 2004 that otherwise are available to the Participant through a local education agency, or vocational rehabilitation services that otherwise are available to the Participant through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Participants to be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	6/1/2020	5/31/2021	100[1]
Year 2	6/1/2021	5/31/2022	300[2]
Year 3	6/1/2022	5/31/2023	850
Year 4			
Year 5			

2. ☒ **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated Participants served and the estimated number of Participants for the following year.

[1] Estimate based on anticipated delays in locating individuals choosing to enroll in CHESS.
[2] Estimate based on anticipated delays in location individuals choosing to enroll in CHESS.

Financial Eligibility

1. ☒ **Medicaid Eligible.** *(By checking this box the state assures that):* Participants receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☒ The State does not provide State plan HCBS to the medically needy.
☐ The State provides State plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, Participants who qualify as medically needy on the basis of this election receive only 1915(i) services. ☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. Responsibility for Performing Evaluations / Reevaluations. Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each Participant). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

○	Directly by the Medicaid agency
☒	By Other (*specify State agency or entity under contract with the State Medicaid agency*):
	An Independent Assessment (IA) will be conducted by qualified staff at the BH-ASO. The BH-ASO is under contract with the State Medicaid agency and is independent of those entities providing services. For those Participants who are institutionalized, the IA will be conducted by qualified staff under contract with the State Medicaid agency to complete assessments within institutions. Qualified staff will conduct an independent evaluation of each Participant in order to: (1) verify threshold eligibility, (2) determine the Participant's level of care and need for services and (3) authorize services and budget for the Participant's Person-Centered Recovery Plan (PCRP). The PCRP will be person-centered and the goals established as part of this process will be identified in the PCRP and revised annually or more frequently as needed. IA will be conducted in the location(s) where potential participants are staying such as in homeless shelters, in hospitals, on the streets, and other locations where people experiencing homelessness may be staying.

2. Qualifications of Participants Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the Participant responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

Qualified staff (Assessors) who complete the IA shall be one or more of the following: (1) a licensed behavioral health clinician (defined below), (2) a peer specialist who meets additional qualifications set forth below and who is working under the supervision of a licensed behavioral health clinician, (3) a registered nurse licensed in the State who meets the additional qualifications set forth below, or (4) a social services worker who is a graduate of an accredited four-year college or university who meets the additional qualifications set forth below. The term "licensed behavioral health clinician" or "licensed BH clinician" means a psychiatrist, licensed psychologist, licensed clinical social worker, licensed marital and family therapist, licensed alcohol and drug counselor, licensed professional counselor, or an advanced practice registered nurse or physician assistant with at least one year of specific experience conducting behavioral health assessments.

Each registered nurse or social services worker shall have a minimum of two years of experience in health care or human services. A bachelor's degree in nursing, health, social work, gerontology or a related field may be substituted for one year of experience.

Independent assessment staff, (*i.e.*, all assessors other than peer specialists), shall have the following additional qualifications:

- demonstrated interviewing skills which include the professional judgment to probe as necessary to uncover underlying concerns of the applicant;
- demonstrated ability to establish and maintain empathetic relationships;
- experience in conducting social and health assessments;
- knowledge of human behavior, family/caregiver dynamics, human development and disabilities;
- awareness of community resources and services;
- the ability to understand and apply complex service reimbursement issues; and
- the ability to evaluate, negotiate and plan for the costs of care options.

Peer specialists must have lived experience and a minimum of one-year experience in a community-based self-help or behavioral health setting. Each assessment completed by a peer specialist must be reviewed and approved by a licensed BH clinician.

Assessor supervisors shall meet all the qualifications of Assessors, plus have demonstrated supervisory ability, at least one year of specific experience in conducting behavioral health assessments, with a preference for experience working with individuals who experience homelessness, and shall complete training requirements as established by DSS. Assessor supervisors are responsible for ensuring timely completion of assessments, ensuring that assessors properly code responses to clinical assessment questions, and ensuring appropriate identification of the Participant's unmet needs. Initial training requirements include completion of no less than 30 hours of classroom instruction on the following topics: motivational interviewing, supportive housing orientation, supervision, substance use disorder, and person-centered planning. Training requirements must be met within the first twelve months of assuming supervisory responsibilities.

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether Participants meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Evaluation Process: The process for evaluating whether Participants meet the needs-based State plan HCBS eligibility will be based on the determination of homelessness, including homelessness not more than 12 months prior to institutionalization and the determination of medical necessity. Participants are first assessed to determine if they meet category 1 or category 4 of the Department of Housing and Urban Development's (HUD) definition of homelessness as defined in 24 C.F.R. § 583.5. Entities within the State's Coordinated Access Network (CAN) are responsible for the completion of the homelessness assessment. CANs are required to document homelessness utilizing the HUD recordkeeping requirements in 24 C.F.R. § 583.301(b). Documentation related to homelessness will be sent to the BH-ASO. The BH-ASO will verify compliance with the HUD requirement in order to determine eligibility based on homelessness. For Participants who are institutionalized, determination of homelessness not more than 12 months prior to institutionalization will be based on one or more of the following, to the extent applicable to each individual: (1) to the extent available, the preference is to obtain applicable documentation provided under the HUD recordkeeping requirements in 24 C.F.R. § 583.301(b), (2) documentation within the State's Homeless Management Information System; or (3) evidence of homelessness through self-certification. If a Participant has been determined eligible based on homelessness, the BH-ASO, or other Assessor meeting the State's qualifications as defined under section 2, will determine medical necessity for the service utilizing the State's Universal Assessment (UA):

- The UA is a web-based tool located on the State's server;
- The UA is linked to the Participant's Medicaid coverage group identification number within the State's eligibility system;
- The UA is applicable to all participants in all of the state's 1915(c) waiver and 1915(i) state plan HCBS programs;
- Institutional level of care needs-based criteria and 'at-risk' of institutional level of care criteria (including hospitalization) is linked to clinical questions within the UA; and
- When assessors finalize the UA in the web-based system, clinical information entered into the tool is electronically analyzed against the State's institutional and 'at-risk' clinical criteria and the UA system generates a result.

The result predicts level of care and 'at-risk' to inform determination of eligibility. The Assessor's independent judgment may be used to support the predicted result generated by the UA or to justify a different determination. If the Assessor justifies a determination which is not consistent with the UA, a supervisor reviews the result and the justification and makes a final determination based on the clinical justification of need. If the UA is completed by a qualified Assessor other than the BH-ASO, the assessment will be reviewed by the BH-ASO supervisor for final determination of medical necessity.

Re-evaluation Process: The re-evaluation process will be limited to the process related to ongoing medical necessity for the services.

4. ☒ **Reevaluation Schedule**. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☒ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether a Participant is eligible for State plan HCBS.

The criteria take into account the Participant's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The needs-based criteria are that a Participant must: (1) meet the definition of homelessness described below or met the definition of homelessness not more than 12 months prior to institutionalization, (2) have at least 1 critical need which is a manifestation of the Participant's homelessness or institutionalization and (3) have at least 1 additional critical need that may or may not be a manifestation of homelessness or institutionalization.

Homelessness is defined as category 1 or category 4 of the HUD definition of homelessness in 24 C.F.R. § 583.5. Entities within the CAN are responsible for the completion of the homelessness assessment. CANs are required to document homelessness utilizing the HUD recordkeeping requirements in 24 C.F.R. § 583.301(b). For Participants who are institutionalized, determination of homelessness not more than 12 months prior to institutionalization will be based on one or more of the following, to the extent applicable to each individual: (1) to the extent available, the preference is to obtain applicable documentation provided under the HUD recordkeeping requirements in 24 C.F.R. § 583.301(b), (2) documentation within the State's Homeless Management Information System; or (3) evidence of homelessness through self-certification.

Critical needs are defined as need for cueing with activities of daily living or instrumental activities of daily living, including, but not limited to:

- Bathing
- Dressing
- Eating
- Toileting
- Transferring
- Meal Preparation
- Shopping
- Medication Management
- Healthcare Coordination
- Transportation
- Housework
- Managing Finances
- Maintaining housing stability
- Behavioral Health Management

6. ☒ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional

level of care to reflect more stringent needs-based criteria, Participants receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
Needs based eligibility criteria are defined as meeting the definition of homelessness described above, including meeting the definition of homelessness not more than 12 months prior to institutionalization, and having at least 1 critical need which is a manifestation of the Participant's homelessness or institutionalization plus at least 1 additional critical need that may or may not be a manifestation of homelessness or institutionalization. Critical needs are defined as need for hands-on assistance or cueing with activities of daily living or instrumental activities of daily living including, but not limited to: • Bathing • Dressing • Eating • Toileting • Transferring • Meal Preparation • Shopping • Medication Management	The NF level of care criteria utilized are as follows: 1. Supervision or cueing ≥ 3 ADLs + need factor 2. Hands-on ≥ 3 ADLs 3. Hands-on ≥ 2 ADLs + need factor 4. A cognitive impairment which requires daily supervision to prevent harm *Need factors are: 1. Rehabilitative Services PT, OT, ST. The Participant has restorative potential. 2. Behavioral Need: Requires daily supervision to prevent harm. 3. Medication Supports: Requires assistance for administration of physician-ordered medications; includes supports beyond setup. **Only these ADL items are considered:	There is reasonable indication that the person, but for the provision of waiver services, would require placement in an ICF/IID. The person requires assistance due to one or more of the following: 1. Has a physical or medical disability requiring substantial and/or routine assistance as well as habilitative support in performing self-care and daily activities. 2. Has a deficit in self-care and daily living skills requiring habilitative training. 3. Has a maladaptive social and/or interpersonal pattern to the extent that he/she is incapable of conducting self-care or activities of daily living without habilitative training. This determination is made through a planning and support team process	Chronic Disease Hospital 1. Clients who have an ongoing, unstable medical condition requiring intense medical supervision and nursing intervention continually throughout the day and the need for ancillary or technological services (i.e., laboratory, pharmacy, nutrition, diagnostic, DME); and 2. Clients who are chronically unstable, medically fragile and require frequent physician intervention and monitoring.

• Healthcare Coordination • Transportation • Housework • Managing Finances • Maintaining housing stability • Behavioral Health Management	bathing, dressing upper OR lower body, toilet use, transferring, eating.	utilizing the Level of Need Assessment and Screening Tool (LON). Development of the LON was funded through a CMS Systems Change Grant. The LON is a comprehensive assessment of a Participant's level of support needs and identification of risk areas in the following domains: Health/Medical, PICA, Behavior, Psychiatric, Criminal/Sexual, Seizure, Mobility, Safety, Comprehension and Understanding, Social Life, Communication, Personal Care, and Daily Living. The Composite Score on the CT LON is be used to validate the Participant's Level of Care. A Composite score of 1 or greater on this tool is required in order to show that the Participant requires an ICF/IID Level of Care. The scoring algorithm used to calculate the Composite score incorporates the scores from the domains listed above	

		and results in an overall score ranging from 1 to 8.	

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☒ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

The target group consists of Medicaid-enrolled individuals who meet all of the following criteria:

- Age 18 and over;
- Disability and/or disabling condition, including homelessness;
- Diagnosis of homelessness defined as category 1 or category 4 of HUD's definition of homelessness as defined in 24 C.F.R. § 583.5, including diagnosis of homelessness not more than 12 months prior to institutionalization.. Entities within the State's CAN are responsible for the completion of the homelessness assessment. CANs are required to document homelessness utilizing the HUD recordkeeping requirements in 24 C.F.R. § 583.301(b). For Participants who are institutionalized, determination of homelessness not more than 12 months prior to institutionalization will be based on one or more of the following, to the extent applicable to each individual: (1) to the extent available, the preference is to obtain applicable documentation provided under the HUD recordkeeping requirements in 24 C.F.R. § 583.301(b), (2) documentation within the State's Homeless Management Information System; or (3) evidence of homelessness through self-certification;
- Has a risk score as defined by Healthcare Effectiveness Data and Information Set (HEDIS) Plan All-Cause Readmissions measure, which is a combination of diagnoses for individuals with inpatient hospital utilization, which is a method of measuring disability; and
- Has been determined to be most likely to benefit from the services included in this section 1915(i) state plan HCBS based on the following methodology, which uses a combination of measures of diagnoses and disability as described below. The methodology for determining the risk ratings of homeless individuals who are Medicaid eligible is based on the National Committee for Quality Assurance (NCQA) HEDIS Plan All-Cause Readmissions measure. The HEDIS measure calculates the predicted probability of a hospital readmission within 30 days based on the diagnoses associated with the index admission as well as diagnoses for that individual in the year prior to the index admission. NCQA has developed weighted risks specific to the Medicaid population associated with distinct as well as combinations of medical and behavioral health diagnoses. The NCQA weighted risk scores for the Medicaid population were based on nationwide sampling data.

  For the purposes of this section 1915(i) state plan HCBS initiative, the following steps are

followed to target individuals who are most likely to benefit from the services included in this benefit and for whom the services are most likely to result in the reduction of preventable Medicaid expenditures:

1) Risk scores and costs associated with inpatient stays are calculated for each of the adults who have been identified as homeless at any time during the measurement period, which includes any method of identifying the individual as meeting the target criteria of homelessness described above.
2) Risk scores and costs associated with inpatient stays are calculated for Medicaid adults without any evidence of homelessness during the measurement period. Evidence of homelessness is identified utilizing the HUD definition and documented using any of the following: the Homeless Management Information System, any use of shelter, DSS address or literal use of the term "homeless" in the address field in Medicaid eligibility data, or the use of the ICD codes for homelessness on any claim submitted by any Medicaid provider during the measurement period.
3) The average inpatient cost by risk score is then calculated for the non-homeless population.
4) The inpatient costs of homeless individuals by risk score ("observed") are then compared to the average inpatient cost of non-homeless individuals ("expected") with the same risk score.
5) The difference in cost for each of the homeless individuals is the estimate of possible savings that could be achieved by providing stable housing as well as supportive services to the homeless population.
6) CHESS will target those people where the "observed" inpatient cost over a 12 month period is greater than the "expected" inpatient cost.
7) Identification methodology is further adjusted to account for and thereby prevent any racial and ethnic disparity.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of Participants or the provision of services to enrolled Participants in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible Participants within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box the State assures that):

8. ☒ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an Participant to be determined to need the 1915(i) State plan HCBS benefit, an Participant must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the Participant requires regular monthly

monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an Participant must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* One	
ii.	**Frequency of services**. The state requires (select one):	
	○	**The provision of 1915(i) services at least monthly**
	☒	**Monthly monitoring of the Participant when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☒ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to Participants who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where Participants will reside and where Participants will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

Services are provided to recipients living in their own home (residence owned or leased by the Participant/Participant's family for personal use other than a home owned or leased by a provider) where the recipient controls the services they receive and who provides them.

Services may also be provided in community-based settings such as health care provider offices or other locations of the Participant's choosing including community-based settings in order to coach Participants on the utilization and navigation of these services. Services may also be provided in institutional settings such as a hospital, if a person experiences institutionalization while receiving services.

Pre-tenancy and housing transition services may be provided while a recipient is still homeless and/or residing on the street, in a shelter or in an institutional or licensed setting if the person is expected to be discharged and moved into a community setting.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☒ There is an independent assessment of Participants determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☒ Based on the independent assessment, there is a person-centered service plan for each Participant determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☒ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the Participant's circumstances or needs change significantly, and at the request of the Participant.

4. Responsibility for Face-to-Face Assessment of a Participant's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the Participants who will be responsible for conducting the independent assessment, including specific training in assessment of Participants with need for HCBS. *(Specify qualifications):*

Qualifications are the same as detailed above in the Evaluation and Revaluation section, #2 'Qualifications of Participants Performing Evaluation / Reevaluation'

5. Responsibility for Development of Person-Centered Service Plan. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

CHESS Qualified Providers are responsible for supporting the Participant in the development of the PCRP. The qualifications of staff who support the Participant in the development of the PCRP are as follows:

- Master's degree in social work, rehabilitation counseling, psychology, counseling, or other behavioral health, counseling program or other helping profession such as human services or criminal justice;
- Bachelor's degree in social work, rehabilitation counseling, psychology, counseling or other behavioral health counseling program and a minimum of one-year experience working in a health care or behavioral health care or related community-based setting;
- Graduation from an accredited college or university with an Associate's degree in one of the helping professions such as social work, human services, counseling, psychiatric rehabilitation, psychology, criminal justice and a minimum of two years working in a community-based behavioral health or related setting;
- High school diploma/equivalent and minimum of three years working in a community-based setting; or
- Peer specialist with one-year experience in a community-based self-help or behavioral health setting. Years of lived experience can be used in lieu of education.

In addition, all staff must meet training requirements as defined by DSS. Initial training requirements include completion of no less than 30 hours of classroom instruction on the following topics: motivational interviewing, supportive housing orientation, supervision, substance use disorder, and person-centered planning. Training requirements must be met within the first twelve months of providing services to Participants.

After the Participant's PCRP is completed, the plan is submitted to the BH-ASO for review and approval. Upon approval from the BH-ASO, services are authorized to begin.

6. Supporting the Participant in Development of Person-Centered Service Plan. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

Person-Centered Planning principles are used in the development of the service plan. This includes engaging Participants and their representatives, as appropriate, in the community living supports planning process and supporting Participants in directing the process to the extent that they choose. This also includes conducting assessments in the location of the Participants' choice, including in the shelter or other community-based setting.

The tool used to help support the development of the PCRP is the Supportive Housing Assessment. The Supportive Housing Assessment is the tool used within the State's existing Supportive Housing program. The Supportive Housing Assessment guides the

discussion to focus on service needs related to maintenance of housing.

The development of the plan is a team process that includes the Participant, the Conservator or other legal representative such as a guardian (if applicable) and any other person at the direction of the Participant. Each Participant has a Person-Centered Recovery Plan (PCRP). A PCRP is intended to meet the needs of the Participant. This planning process, and the resulting PCRP, provides the framework for the participant to achieve personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare. Services are aligned with the Participant's goals and address the Participant's need for assistance with housing pre-tenancy and housing sustaining supports in Connecticut. It uses a person-centered approach to ensure services meet each Participant's strengths, goals, preferences and assessed needs.

Providers and Assessors are responsible for informing Participants about the care planning process, the various services available and the assessment summary. Additionally, the DSS website offers a considerable amount of information related to CHESS and offers training for case managers, Participants and families regarding person-centered service delivery and Participant choice. It also offers links to applicable resources.

7. Informed Choice of Providers. *(Describe how Participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

Assessors will provide each Participant with a list of qualified providers in the Participant's geographic area and will support the Participant through the provider selection process. Assessors will refer the Participant to the provider selected by the Participant for planning and ongoing receipt of service.

8. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency. *(Describe the process by which the person-centered service is made subject to the approval of the Medicaid agency):*

The Medicaid agency's contractor, the BH-ASO is authorized by the Medicaid Agency to review and approve all PCRPs. The BH-ASO reviews all plans to ensure that plans are person-centered, that goals are well defined and that the activities described in the plan are aligned with the Participant's goals. PCRPs are submitted by the CHESS Qualified Provider for review and approval prior to implementation of service. The PCRPs are submitted electronically to the BH-ASO. If approved, the BH-ASO communicates with the CHESS Qualified Provider and authorizes services associated with the PCRP in the State's MMIS. Ongoing monitoring of the plans and assurance of person-centered delivery of service is the responsibility of the BH-ASO.

9. Maintenance of Person-Centered Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency		Operating agency	☐	Case manager
☒	Other (*specify):CHESS PROVIDER*				

Services

1. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*			
Service Title:	Care Plan Development and Monitoring		
Service Definition (Scope)*:*			
This service is provided to support the Participant in the development of his or her PCRP related to CHESS services. The Participant leads the development of his or her planning process. The process includes a discussion related to the Participant's goals and how the available services will best support the Participant in achieving the goals. The role of the staff is to guide the Participant through the planning process rather than to develop a plan for the person. Service plans are updated annually or more often based on the needs of the Participant.			
Additional needs-based criteria for receiving the service, if applicable *(specify):*			
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 Participant 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):*
Agency – Agencies must meet standard qualifications for provision of pre-tenancy and transition supports			Agencies are limited to those agencies who qualify as Supportive Housing providers under the Department of Mental Health and Addiction Services (DMHAS) request for proposal (RFP) process. The most recent RFP process was in 2014. Agencies must continue to successfully compete under future DMHAS RFPs for Supportive Housing and must continue to meet provider performance requirements as

			defined by the DMHAS annually. Agencies must continue to meet Medicaid performance requirements ensuring timely access to services and ensuring services are delivered in accordance with the approved PCRP and all other DSS requirements applicable to CHESS.
Participants hired by agencies must meet qualifications for staff of provider agencies			• Master's degree in social work, rehabilitation counseling, psychology, counseling, or other behavioral health, counseling program or other helping profession; • Bachelor's degree in social work, rehabilitation counseling, psychology, counseling or other behavioral health counseling program and a minimum of one-year experience working in a health care or behavioral health care or related community-based setting; • Graduation from an accredited college or university with an Associate's degree in one of the helping professions such as social work, human services, counseling, psychiatric rehabilitation, psychology, criminal justice and a minimum of two years working in a community-based behavioral health or related setting; • High school diploma/equivalent and minimum of three years working in a community-based setting; or • Peer Specialist with one-year experience in a community-based self-help or behavioral health setting. Years of lived experience can be used in lieu of education. In addition, staff must participate in training as required by DSS.

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):*
Agency – Agencies that meet the service standard	DSS, Division of Health Services	2 years
Participants hired by agencies	DSS, Division of Health Services	2 years

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: Pre-Tenancy and Transition Supports

Service Definition (Scope)*:*

Pre-tenancy and transition services provide direct support to the target population in order to assist them in moving from homelessness or higher level of care into housing in the community. Services are aligned with the Participant's goals as documented in the PCRP and include, but are not limited to:

a. Conducting a tenant screening and housing assessment that identifies the Participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers and identification of housing retention barriers;
b. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, including short and long-term measurable goals for each issue, establishes the Participant's approach to meeting the goals, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goals;
c. Residential supports such as motivating the Participant to find and lease an apartment and assistance with tenancy issues and problems;
d. Landlord recruitment and advocacy, voucher and security deposit applications, apartment search, lease compliance education, assistance with tenant inspection, and lease signing;
e. Finding and choosing a place to live, meeting housing eligibility requirements as needed, negotiating landlord/neighbor relationships and understanding and maintaining rights of tenancy;
f. Assistance in obtaining required ID;
g. Assisting with the housing application process and housing search process;
h. Identifying resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, and other one-time expenses;
i. Ensuring that the living environment is safe and ready for move-in;

j. Assisting in arranging for and supporting the details of the move;
k. Assistance with transition from homelessness, inpatient, residential treatment, jail and/or other institutions including assistance with discharge planning and planning for returning to community life by assisting with moving, timely access to services, medication and benefits, returning to or finding a place to live, collaboration with discharge planners and other staff to develop and implement effective discharge or transition plans and other assistance as needed during the transition;
l. Accessing resources and making applications including access to utilities and essential items and resources to move into a new home;
m. Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized;
n. Therapeutic, rehabilitative and skills development;
o. Income, employment, education and vocational activities; and
p. Behavioral/medical health coordination.

Pre authorized for up to 180 days at a monthly rate. Ongoing authorization beyond the initial pre-authorization is tailored based on medical necessity.

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

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 Participant 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):*
Agency – Agencies must meet standard qualifications for provision of pre-tenancy and transition supports			Same as Care Plan Development
Participants hired by agencies must			Same as Care Plan Development

meet qualifications for staff of provider agencies			

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):*
Agency – Agencies that meet the service standard	DSS, Division of Health Services	2 years
Individuals hired by agencies	DSS, Division of Health Services	2 years

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: Housing and Tenancy Sustaining Supports

Service Definition (Scope)*:*

This service is made available to support Participants to maintain tenancy once housing is secured. The availability of ongoing housing-related services in addition to other long-term services and supports promotes housing success, fosters community integration and inclusion, and develops natural support networks. Housing and Community Living Supports include, but are not limited to:

a. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations;
b. Education and training on the roles, rights and responsibilities of the tenant and landlord;
c. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy;
d. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action;
e. Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become, jeopardized;
f. Assistance with the housing recertification process;
g. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; and
h. Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

This service also covers a wide array of supports focused on helping Participants to live with

maximum independence in the community and in their own home, including activities to improve socialization, self-advocacy, and the development of natural supports. The specific activities covered in this service area include:

1. Therapeutic rehabilitative skills development
2. Income, employment, education and vocational activities

This service area also includes support with accessing and using medical, dental, substance use disorder and/or behavioral health treatment. Additionally, this service area will focus on supporting Participants to manage their complex health needs/conditions through health coaching, wellness education, medication education, and helping Participants to overcome barriers to treatment adherence.

Providers must provide services monthly and must provide the service through direct face-to-face contact with the Participant at least one time every 3 months.

Pre authorized for up to 365 days at a monthly rate. Ongoing authorization beyond the initial pre-authorization is tailored based on medical necessity.

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

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 Participant 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):*
Agency – Agencies must meet standard qualifications for provision of pre-tenancy and transition supports			Same as Care Plan Development
Individual hired by agencies must meet			Same as Care Plan Development

qualifications for staff of provider agencies			

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):*
Agency – Agencies that meet the service standard	DSS, Division of Health Services	2 years
Participants hired by agencies	DSS, Division of Health Services	2 years

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:	Transportation

Service Definition (Scope)*:*

Mileage is payable under this service when the provider utilizes their own vehicle. Transportation includes mileage reimbursement and/or bus passes for transportation related to goals defined in the PCRP including:

a. Travel to appointments with a Participant and/or transportation to access community services, activities and supports;
b. Assistance with transition, including transportation as needed, to move back to the community if hospitalized or in residential treatment, including gaining access to waiver or personal care services;
c. Transporting a Participant or providing bus passes to support the Participant to be self-employed, work from home or perform work in a community-based setting.

Goals associated with transportation must be clearly defined in the PCRP. Authorization for transportation service must be defined in the Plan.

Monthly bus passes may also be provided, but may not duplicate a bus pass provided for non-emergency medical transportation (NEMT).

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

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 Participant 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):*
	Service limited to $1000 per year, which may be exceeded based on medical necessity.
☐	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):*
Agency – Agencies must meet standard qualifications for provision of pre-tenancy and transition supports			Same as care plan development and monitoring
Individuals hired by agencies	Driver's license		Individuals meet the standard qualifications for care plan development and monitoring and also have a valid driver's license. Motor vehicle violations are considered during the enrollment process.

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):*
Agency – Agencies that meet the service standard	DSS, Division of Health Services	2 years
Individuals hired by agencies	DSS, Division of Health Services	2 years

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

☐	Participant-directed	☒	Provider managed

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

Payments to relatives, legally responsible individuals, and legal guardians of the Participant for the provision of services under CHESS is not permitted.

Participant-Direction of Services

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

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

☒	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. Description of Participant-Direction. (Provide an overview of the opportunities for participant-*direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

5. Financial Management. (*Select one)* :

☒	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. ***(****Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

N/A

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

☒	The state does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

☒	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.

	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

Requirement	**Service plans address assessed needs of 1915(i) participant**
Discovery	
Discovery Evidence *(Performance Measure)*	1. The number and percent of new CHESS enrollees whose level of care determination has been reviewed by the BH-ASO supervisory level staff. Numerator= number of LOC determinations reviewed and denominator= number of new enrollees. 2. Number and percent of records that have a completed Supportive Housing Assessment. 3. The number and percent of annual reassessments completed timely. The numerator is the number of reassessments done timely and the denominator is the total number of reassessments done. 4. The number and percent of service plans that document activities aligned with the UA and Supportive Housing Assessment needs and Participant goals.
Discovery Activity *(Source of Data & sample size)*	Data source: UA system reports and Supportive Housing Assessments stored in case management system. Sample size: 8[3] housing providers per year which will be randomly selected from a pool that has a minimum of 5 members enrolled. Two audits conducted per quarter. Total 40 member records audited annually.

[3] 8/30 file review methodology is used by the National Committee for Quality Assurance (NCQA) of health plans in evaluating health plan accreditation. Through this methodology a random sample of 30 files are selected. Eight files are reviewed for the particular standard. If all 8 files meet the standard, then the standard has passed. If less than 8 meet the standard, an additional 22 files are reviewed to evaluate the standard.
The Department is seeking to increase the sample size and divide the auditing function into a quarterly process in order to continuously monitor program adherence and enable provider feedback and shaping as necessary.

		Performance Standard: 80% per provider audit.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The BH-ASO with quarterly reports submitted to DSS DMHAS is responsible for ongoing monitoring of the provider's performance requirements as they relate to the provider's contract issued under the competitive procurement process.
	Frequency	Ongoing: Two provider audits per quarter
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The BH-ASO will be responsible for monitoring service plans. For those service plans that do not comply with the performance indicators, the Department will work with providers to ensure remediation compliance takes place within 30 days of notice of the finding. Performance issues that require mediation will result in corrective action plans developed by the provider within 30 days of being informed of the finding. The BH-ASO will review and approve all corrective action plans and will continuously monitor providers' performance until the issue is resolved. The BH-ASO will notify DSS and DMHAS at the conclusion of the review cycle.
	Frequency *(of Analysis and Aggregation)*	Bi-annually

Requirement	**Service plans are updated annually**
Discovery	
Discovery Evidence *(Performance Measure)*	1. The number and percent of Participants who report they are satisfied with the services they receive to ensure that their assessed needs, including health and safety, are met. The Numerator is the number of Participants who are satisfied and the Denominator is the number surveyed. 2. Number and percent of service plans that are reviewed by the BH-ASO prior to approval to ensure compliance with documented needs and Medicaid eligibility. Numerator = number of service plans in compliance and the Denominator = total number of services plans reviewed by the BH-ASO. 3. Number and percent of reports generated monthly to identify outstanding reviews. Numerator = number of reports that identify outstanding reviews and the Denominator = total number of reports received. 4. The number and percent of service plans that are updated when warranted by changes in Participants' need. The Numerator is number of

		plans updated and the Denominator is the total number of plans. 5. The number and percent of reports from the case management system indicating the type, scope and frequency of services provided received on time and in accordance with contract requirements. The Numerator is the reports received in compliance with contract requirements and the Denominator is the total number of reports received.
	Discovery Activity *(Source of Data & sample size)*	Data Source: Referral and eligibility data tracked through CareConnect and DSS Case Management System. Sample Size: All cases with an annual re-evaluation.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The BH-ASO will conduct monitoring and remediation activities and will submit reports quarterly to DSS.
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The BH-ASO will be responsible for monitoring service plans. Performance issues that require remediation will result in corrective action plans developed by the provider within 30 days of being informed of the finding. The BH-ASO will review and approve all corrective action plans and will continuously monitor providers' performance until the issue is resolved.
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement	**Service plans document choice of services and providers.**
Discovery	
Discovery Evidence *(Performance Measure)*	Percentage of plans reviewed that document the Participant's choice between/among service and providers. • Numerator: Number of plans reviewed in which Participant choice was documented. • Denominator: Number of plans reviewed by the BH-ASO Health Options. Performance Standard 100%
Discovery Activity *(Source of Data & sample size)*	Case management system 100% sample size
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The BH-ASO will submit compliance reports to DSS quarterly.
Frequency	Continuously and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Department will be responsible for monitoring service plans. For those service plans that do not comply with the performance indicators, the Department will work with providers to ensure remediation compliance takes place within 30 days of notice of the finding. Performance issues that require remediation will result in corrective action plans developed by the provider within 30 days of being informed of the finding. The Department will review and approve all corrective action plans and will continuously monitor providers' performance until the issue is resolved.
Frequency *(of Analysis and Aggregation)*	Continuously and ongoing

Requirement	**Providers meet required qualifications.**
Discovery	
Discovery Evidence *(Performance Measure)*	**1.** Number and percent of new CHESS providers recruited, who will meet licensure/certification standards prior to delivery of services. Numerator = number of new CHESS providers recruited who will meet licensure/certification standards prior to delivery of services. Denominator = total number of new CHESS providers recruited. **2.** Number and percent of new CHESS providers who complete their required training prior to delivery of services. Numerator = number of new CHESS providers who received training prior to service delivery. Denominator = the total number of providers trained. **3.** Number and percent of providers with criminal background checks completed prior to employment. The Numerator = all CHESS providers who have a criminal background check completed prior to employment and the Denominator = all providers have completed a criminal background check.
Discovery Activity *(Source of Data & sample size)*	All provider agency applications are reviewed prior to approval. Data Source: Provider enrollment data tracked by Department staff through MMIS. Sample Size: All providers applying to deliver 1915(i) services.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency – contractor for MMIS.
Frequency	Every 2 years
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Department verifies that providers initially and continually meet required certification standards and adhere to other standards prior to their furnishing housing stabilization services. The Department will review provider qualifications upon initial enrollment, and every five years thereafter, to ensure providers meet compliance standards. Providers who do not meet required certification standards will not qualify to provide housing stabilization services.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	**Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**
Discovery	
Discovery Evidence *(Performance Measure)*	In order to provide housing stabilization/sustaining services, providers must submit documentation attesting that the Participant is moving to a HCBS-compliant setting. This document is submitted to the BH-ASO for approval prior to 'lease-up'. Measure #1: Percentage of Participants determined eligible in the past 12 months that have a provider attestation that recipient is moving to a HCBS-compliant setting. • Numerator: Number of Participant files with the provider attestation. • Denominator: Number of Participant files reviewed. Performance Standard: 100% Measure #2: Percentage of Participants who had a recertification in the past 12 months that have a provider attestation that meets HCBS settings requirements. • Numerator: Number of Participant files with the provider attestation. • Denominator: Number of Participant files reviewed. Performance Standard: 100%
Discovery Activity *(Source of Data & sample size)*	The BH-ASO staff will review service plans to verify the Participant is moving to a compliant setting. Data Source: Lease uploaded to the Case Management system, Request to lease up including description of apartment uploaded to the Case Management system for approval. Sample Size: All recipients of state plan HCBS
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Discovery and remediation reports will be submitted to the State Medicaid Agency
Frequency	Ongoing - continuous
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Participants residing in settings that do not meet the requirements described in this plan may not receive housing stabilization/sustaining services.

Frequency *(of Analysis and Aggregation)*	Ongoing

Requirement	**The SMA retains authority and responsibility for program operations and oversight.**
Discovery	
Discovery Evidence *(Performance Measure)*	The Department of Social Services is responsible for overseeing the contractual operations of the contracted agencies. This is done through clinical record reviews, client and provider visits and consumer satisfaction surveys. Monitoring of reporting requirements takes place 2 times per quarter. The Department's Division of Quality Assurance also conducts regular audits to ensure compliance with billing and claims submission.
Discovery Activity *(Source of Data & sample size)*	The BH-ASO on behalf of DSS will conduct two provider record reviews per quarter for a total of 8 provider audits annually. Providers with 5 or more enrolled Participants will be eligible for review. A total of 40 Participant records will be reviewed annually. If a provider does not meet the performance indicator of 80%, the provider will supply a corrective action plan to the BH-ASO within 30 days of this finding. The BH-ASO will review and approve the action plan followed by continuously monitoring the provider's performance until the 80% performance standard is reached. Monitoring reports will be submitted to DSS quarterly
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	CHESS provider will document all Participant- related activities, including but not limited to, satisfaction surveys, care coordination and support functions. The BH-ASO will audit provider records to ensure the CHESS provider is providing adequate support to pre and post-tenancy stages of care. Audit reports will be submitted to DSS quarterly.
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The BH-ASO will be responsible for monitoring provider operations. For operational reviews that do not comply with the performance indicators, the BH-ASO will work with providers to ensure remediation compliance takes place within 30 days of notice of the finding. Performance issues that require remediation will result in corrective action plans developed by the provider within 30 days of being informed of the finding. The BH-ASO will review and approve all corrective action plans and will continuously monitor providers' performance until the issue is resolved. Remediation reports will be submitted to DSS quarterly. Accordingly, DSS will be responsible for the BH-ASO. The BH-ASO will submit reports on all assurances to DSS quarterly. DSS will review each

	report to determine if all discovery evidence, activity and remediation targets are met. If targets are not met, DSS will implement a corrective action plan with the BH-ASO to improve program operational performance.
Frequency *(of Analysis and Aggregation)*	Two provider audits per quarter

Requirement	**The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**
Discovery	
Discovery Evidence *(Performance Measure)*	1. Number and percent of claims that are coded and paid for in accordance with the reimbursement methodology specified in the SPA. Numerator= number of claims paid in accordance with SPA reimbursement strategy. Denominator= total number of claims paid. 2. The number and percent of claims reviewed by the Department's Office of Quality Assurance (QA) staff that is supported in the provider agency's documentation/records. Numerator= Total number of claims reviewed by QA that are supported by documentation Denominator= total number of claims reviewed. 3. Number and percent of SPA claims that are denied due to existing system edits and audits. Numerator= total number of claims denied Denominator= total number of claims.
Discovery Activity *(Source of Data & sample size)*	Reports to State Medicaid Agency on delegated administrative functions; Data Source: State Medicaid Management Information System; Sampling:100% review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency and Office of Quality Assurance, Audit Division
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Semi-annual reports of MMIS claims and claims edit development. The Department will engage in continuous and on-going review and development of MMIS claims edits to ensure claims are properly paid.

Frequency *(of Analysis and Aggregation)*	Annually

Requirement	**The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**
Discovery	
Discovery Evidence *(Performance Measure)*	1. Number and percent of Participants and/or legal guardians who receive information about how to report abuse, neglect and exploitation. Numerator = Total number of Participants; Denominator = number of Participants and/or legal guardian with signed acknowledgement affirming receipt of information. 2. Number and percent of serious incident reports that are reported to the department unit within 48 hours as required by the state plan. Numerator = reports of serious incident reports that are reported within 48 hours as required by the state plan. Denominator= all incident reports are received. 3. The number and percent of critical incident requiring review/investigation. Numerator is critical incidents reviewed and the denominator is the total number of critical incidents reviewed.
Discovery Activity *(Source of Data & sample size)*	Case Management system.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Critical incidents will be entered by the CHESS Qualified Provider within specified required timelines. The BH-ASO will monitor reports from the Case Management system.
Frequency	
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Training and remediation. The Department will review and approve all corrective action plans and will continuously monitor providers' performance for 30 days or until the issue is resolved.

	Frequency *(of Analysis and Aggregation)*	Ongoing

System Improvement
(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

Actual results will be compared to performance targets. Continual improvement towards attainment of performance targets will be documented. Data related to performance targets will be analyzed to determine if performance gaps are specific to a qualified provider or if the performance gap is a systemic issue. Systemic issues will be documented by performance gaps across the state. Quality management reports will be submitted to DSS and shared by DSS with the CHESS workgroup for review.
The CHESS workgroup is comprised of key state agency staff and certain organizations who advocate for people who are homeless.

2. Roles and Responsibilities

The BH-ASO is responsible for implementation of the aggregated discovery and remediation activities.

DSS and the CHESS workgroup are responsible for analysis of systemic issues documented in the reports and for addressing the systemic issue through program modification, training, policy modifications, modifications to target criteria, etc.

3. Frequency

Quarterly or more frequently as required.

4. Method for Evaluating Effectiveness of System Changes

All systemic changes will be implemented with clear understanding of how success will be measured. A timeline for full attainment of success will also be documented. Quarterly reports will be submitted and reviewed by the CHESS workgroup to document measurable changes associated with the systemic change. Systemic changes which fail to achieve the measures of success will be further modified.

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 Participants 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 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 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.
	Pre-Tenancy and Transition Supports: Per-member per-month (PMPM) base payment of $747.75, with a PMPM add-on payment that will be paid based on the provider's performance on specified outcome measures in accordance with the schedule set forth below. The PMPM amount 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 Participants. Specific outcome measures for per-tenancy and transition supports and associated outcome PMPM adjusters are as follows: Lease-up in housing equal to or less than 90 days of approved PCRP: $648.05 Lease-up in housing between 91 and 120 days of approved PCRP: $448.65 Lease-up in housing between 121 and 150 days of approved PCRP: $329.01 Lease-up in housing between 151 and 180 days of approved PCRP: $249.25 Lease-up after 180 days of approved PCRP: No payment above base payment.
	Housing and Tenancy Sustaining Supports: Per-member per-month (PMPM) base payment of $523.50, with a PMPM add-on payment of up to $174.50 that will be paid based on the provider's performance on specified outcome measures in accordance with the schedule set forth below. The PMPM amount 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 Participants. Specific outcome measures for housing and tenancy sustaining supports are based on a visit to the Participant's primary care physician and/or behavioral health physician as determined medically necessary through the UA process within the first 8 weeks of moving into housing. For the first two months of the service, the full amount of the PMPM add-on payment will be made if visits are completed within 8 weeks after the Participant moves into the housing. For the third and subsequent months of the service, the PMPM add-on payment will be made based on other measures of ongoing results showing that the provider is: (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; (2) successfully meeting the following performance measures as defined under the Quality Management Assurance in Attachment 3.1-i for CHESS: Service plans address assessed needs of 1915(i) participant; (3) successfully assisting the Participant in maintaining housing; and (4) successfully assisting the Participant with maintaining access to food.
	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.

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to Participants described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of Participants described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☐ No. Does not apply. State does not cover optional categorically needy groups.

☒ Yes. State covers the following optional categorically needy groups.
(Select all that apply):

(a) ☒ Participants not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used: *(Select one):*

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

☒ OTHER (*describe*):
The state covers the expansion population with income equal to or less than 138% of the federal poverty level.

(b) ☒ Participants who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☒ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):* _____%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these Participants would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Participants eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these Participants would be eligible. *(Specify demonstration name(s) and number(s)):*

PRA Disclosure Statement