DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

April 14, 2022

Deidre S. Gifford, MD, MPH
Commissioner
Office of the Commissioner
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Dear Commissioner Gifford:

The Centers for Medicare & Medicaid Services (CMS) is approving Connecticut's application for a section 1115(a) demonstration, titled "Connecticut Substance Use Disorder Demonstration" (Project Number 11-W-00372/1 and 21-W-00069/1) effective April 14, 2022, through March 31, 2027. Approval of this demonstration, with concurrent approval of the required Substance Use Disorder (SUD) Implementation Plan and SUD Health Information Technology (HIT) Plan described below, will enable the state to receive federal financial participation (FFP) for state plan services provided to otherwise-eligible Medicaid beneficiaries who are primarily receiving treatment and withdrawal management services for SUD while residing in institutions for mental diseases (IMD). Additionally, this demonstration provides expenditure authority for services for enrollees in the Children's Health Insurance Program (CHIP) who are primarily receiving treatment and withdrawal management services for SUD and who move into an IMD while enrolled, or individuals who otherwise would be eligible for CHIP but who are residing in an IMD at the time of application or renewal.

CMS's approval of this section 1115(a) demonstration is subject to the limitations specified in the attached expenditure authority, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this demonstration project. The state may deviate from Medicaid and CHIP state plan requirements only to the extent that those requirements have been specifically listed as not applicable under the demonstration.

The goal of this demonstration is for the state to maintain and enhance access to SUD services, and continue delivery system improvements to provide more coordinated and comprehensive treatment for beneficiaries with SUD. With this approval, beneficiaries will have access to a continuum of services at new settings that, absent this approval, would be ineligible for payment for most Medicaid enrollees. Specifically, the demonstration—in alignment with the demonstration goals outlined in the State Medicaid Director Letter (SMDL) #17-003, "Strategies to Address the Opioid Epidemic,"[1] published on November 1, 2017—is expected to:

[1] https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd17003.pdf.

- Increase identification, initiation, and engagement of Medicaid beneficiaries diagnosed with SUD;
- Increase beneficiary adherence to, and retention in, SUD treatment programs;
- Reduce overdose deaths, particularly those due to opioids;
- Reduce inappropriate or preventable utilization of emergency departments and inpatient hospital settings through improved access to a continuum of care services;
- Reduce readmissions to the same or higher level of care; and
- Provide a continuum of care to increase the chances of Medicaid beneficiaries having a successful recovery process, and improve access to care for physical health conditions among beneficiaries.

In addition to covering SUD services in IMDs for Medicaid beneficiaries ages 21-64, this demonstration also will assure that CHIP beneficiaries diagnosed with an SUD are able to access SUD services furnished in IMDs. The inclusion of this Title XXI expenditure authority will ensure that children who otherwise would have been ineligible for CHIP because they reside in IMDs will be able to gain CHIP coverage and receive SUD treatment.

We have determined that this demonstration is likely to assist in promoting the objectives of Medicaid and CHIP because it will expand Medicaid and CHIP coverage.

Connecticut submitted its SUD Implementation Plan and SUD HIT Plan as required by the STCs. The SUD Implementation Plan describes the strategic approach and detailed project implementation plan, with timetables, programmatic content, and the key goals and objectives of the SUD demonstration. The SUD Implementation Plan also includes a HIT Plan that details the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. CMS has completed its review of the SUD Implementation Plan and SUD HIT Plan, and has determined that both the SUD Implementation Plan and SUD HIT Plan are consistent with the applicable requirements set forth in the STCs. The agency, therefore, concurrently is approving the SUD Implementation Plan and SUD HIT Plan. These documents will be incorporated as Attachment C of the STCs.

Consideration of Public Comments

To increase the transparency of demonstration projects, sections 1115(d)(l) and (2) of the Social Security Act (the Act) direct the Secretary of Health & Human Services to issue regulations providing for two periods of public comment on a state's application for a section 1115 demonstration that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing. The first comment period occurs at the state level before submission of the section 1115 application, and the second comment period occurs at the federal level after the application is received by the Secretary.

Section 1115(d)(2)(A) & (C) of the Act further specifies that comment periods should be "sufficient to ensure a meaningful level of public input," but the statute imposed no additional requirement on the states or the Secretary to provide an individualized response to address those comments, as might otherwise be required under a general rulemaking. Accordingly, the

implementing regulations issued in 2012 provide that CMS will review and consider all comments received by the deadline, but will not provide individualized written responses to public comments. 42 CFR 431.416(d)(2).

During the federal comment period, which took place from August 20, 2021, to September 19, 2021, CMS received five comments, three of which were out of scope. The other two comments came from individuals, both of whom indicated support for the demonstration. One writer noted the importance of cooperation between multiple aspects of care. The other writer noted that access to SUD treatment and medication-assisted treatment has led to a decline in overall medical costs.

After carefully reviewing the demonstration proposal and the public comments submitted during the federal comment period, CMS has concluded that the demonstration is likely to assist in promoting the objectives of Medicaid and CHIP.

Other Information

Consistent with the STCs, the state is required to conduct systematic monitoring and an independent mid-point assessment of the demonstration in alignment with CMS-identified metrics and applicable guidance, which will support tracking the state's progress towards its demonstration milestones and goals, as well as identifying any necessary mitigation strategies. Furthermore, the state will develop a robust evaluation design to support a comprehensive independent evaluation of the demonstration. This will help assess whether the demonstration initiatives are effective in producing the desired outcomes for its beneficiaries and the state's Medicaid program overall.

CMS's approval of this demonstration project is contingent upon compliance with the enclosed expenditure authority and the STCs defining the nature, character, and extent of anticipated federal involvement in the demonstration. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

The project officer for this demonstration is Ms. Julia Buschmann. Ms. Buschmann is available to answer any questions concerning your section 1115 demonstration. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Julia.Buschmann@cms.hhs.gov

We appreciate your state's commitment to improving the health of people in Connecticut, and we look forward to partnering with you on the Connecticut Substance Use Disorder Demonstration. If you have questions regarding this approval, please contact Ms. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

[redacted]

Chiquita Brooks-LaSure

Enclosures

cc: Marie DiMartino, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: 11-W-00372/1 and 21-W-00069/1

TITLE: Connecticut Substance Use Disorder Demonstration

AWARDEE: Connecticut Department of Social Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Connecticut for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from April 14, 2022, through March 31, 2027, unless otherwise specified, be regarded as expenditures under the state's title XIX plan.

The Secretary of Health and Human Services (HHS) has determined that the Connecticut Substance Use Disorder Demonstration, including the granting of the expenditure authorities described below, is likely to assist in promoting the objectives of title XIX of the Act.

The following expenditure authorities may only be implemented consistent with the approved special terms and conditions (STC), and shall enable Connecticut to operate this section 1115(a) demonstration.

1. **Residential and Inpatient Treatment for Individuals with Substance Use Disorder.** Expenditures for otherwise covered Medicaid services that are furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) as short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

Title XXI Expenditure Authority:

1. **Residential and Inpatient Treatment for Individuals with Substance Use Disorder.** Expenditures for otherwise covered services that are furnished to otherwise eligible individuals of the Children's Health Insurance Program (CHIP) who are primarily receiving treatment and withdrawal management services for SUD as short-term residents in facilities that meet the definition of an IMD.

   Under the authority of section 1115(a)(2) of the Act as incorporated into Title XXI by section 2107(e)(2)(A), state expenditures described below, shall, for the period of this demonstration (April 14, 2022 through March 31, 2027) and based on state's available allotment under section 2104 of the Act, be regarded as match-able expenditures under the state's Title XXI plan. All requirements of Title XXI will be applicable to such expenditures for children who are residing in an IMD at the time of application or at the time of renewal and would be ineligible for coverage under CHIP pursuant to 2110(b)(2)(A).

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00372/1 and 21-W-00069/1

TITLE: Connecticut Substance Use Disorder Demonstration

AWARDEE: Connecticut Department of Social Services

I. PREFACE

The following are the special terms and conditions (STCs) for the "Connecticut Substance Use Disorder" section 1115(a) Medicaid demonstration (hereinafter, "demonstration"), to enable the Connecticut Department of Social Services (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authorities authorizing federal matching of demonstration costs not otherwise match-able, which are separately enumerated. These STCs set forth conditions and limitations on those expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration, and the state's obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted. The demonstration will be statewide and is approved for a five-year period, from April 14, 2022 through March 31, 2027, unless otherwise specified.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility and Enrollment
V. Demonstration Programs and Benefits
VI. Cost Sharing
VII. Delivery System
VIII. General Reporting Requirements
IX. Evaluation of the Demonstration
X. General Financial Requirements Under Title XIX
XI. Monitoring Budget Neutrality for the Demonstration
XII. Monitoring Allotment Neutrality
XIII. Schedule of Deliverables for the Demonstration Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A: Developing the Evaluation Design

Attachment B: Preparing the Interim and Summative Evaluation Reports
Attachment C: SUD Implementation Plan and SUD Health IT Plan
Attachment D: Reserved for SUD Monitoring Protocol
Attachment E: Reserved for SUD Evaluation Design

II. PROGRAM DESCRIPTION AND OBJECTIVES

This demonstration will provide the state with authority to provide clinically appropriate treatment to individuals diagnosed with a SUD while they are short-term residents in treatment facilities that qualify as IMDs. This demonstration will address currently unmet needs, support a continuum of treatment options, and provide access to a comprehensive and coordinated system of evidence-based SUD services at varied levels of intensity for Medicaid and Children's Health Insurance Program (CHIP) enrollees. Through coverage for CHIP enrollees, this demonstration will provide access to essential healthcare for children who are diagnosed with a SUD and require treatment in an IMD, and who would otherwise be ineligible for services under Medicaid or for enrollment in CHIP.

The demonstration—in alignment with the demonstration goals outlined in the State Medicaid Director Letter (SMDL) #17-003, entitled "Strategies to Address the Opioid Epidemic"[1] and published on November 1, 2017—is expected to:

- Increase identification, initiation, and engagement of Medicaid beneficiaries diagnosed with SUD;
- Increase beneficiary adherence to, and retention in, SUD treatment programs;
- Reduce overdose deaths, particularly those due to opioids;
- Reduce inappropriate or preventable utilization of emergency departments and inpatient hospital settings through improved access to a continuum of care services;
- Reduce readmissions to the same or higher level of care; and
- Provide a continuum of care to increase the chances of Medicaid beneficiaries having a successful recovery process, and improve access to care for physical health conditions among beneficiaries.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

2. **Compliance with Medicaid and CHIP Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement,

[1] https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd17003.pdf.

not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state thirty (30) business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.

    b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

5. **State Plan Amendments**. The state will not be required to submit title XIX or XXI state plan amendments (SPA) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary of Health & Human Services (HHS) in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance

expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than one hundred twenty (120) calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny (or delay approval of) a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

    a. An explanation of the public process used by the state, consistent with the requirements of STC 12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

    b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

    c. A data analysis that identifies the specific "with-waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with-waiver" and "without-waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with-waiver" expenditure total as a result of the proposed amendment, which isolates (by eligibility group) the impact of the amendment;

    d. An up-to-date CHIP allotment worksheet, if necessary;

    e. Updates provided by the state to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring, and measurement of the provisions.

8. **Extension of the Demonstration.** If the state intends to request an extension of the demonstration, it must apply to CMS from the Governor or Chief Executive Officer of the state in accordance with the requirements of 42 CFR §431.412(c). If the state does not intend to request an extension of a demonstration beyond the period authorized in these STCs, it must submit a phase-out plan consistent with the requirements of STC 9.

9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than fourteen (14) calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures: The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210 and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination, 42 CFR 435.916. For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six (6) months of the demonstration, enrollment of new individuals into the demonstration must be suspended.

The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation. If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

10. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

11. **Adequacy of Infrastructure.** The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to applying to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

    The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

13. **Federal Financial Participation.** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the single state Medicaid agency must maintain authority, accountability, and oversight of the program. The state Medicaid agency must exercise

oversight of all delegated functions to operating agencies, managed care organizations (MCOs), and any other contracted entities. The single state Medicaid agency is responsible for the content and oversight of the quality strategies for the demonstration.

15. **Common Rule Exemption.** The state must ensure the only involvement of human subjects in research activities authorized and/or required by this demonstration is for projects conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program—including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration, as represented in these approved STCs, meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

IV. ELIGIBILITY AND ENROLLMENT

16. **Eligibility Groups Affected by the Demonstration.** Under the demonstration, there is no change to Medicaid eligibility. Standards and methodologies for eligibility remain as set forth under the state plan. This demonstration will apply to otherwise-eligible Medicaid beneficiaries who are short-term residents in IMDs for a SUD diagnosis.

    Under the demonstration, an individual eligible for CHIP, except for if the individual is residing in an IMD for diagnoses of SUD at the time of application or renewal, will continue to be eligible for CHIP. All other standards and methodologies for eligibility remain as set forth under the state plan.

17. **Applicability of title XXI Maintenance of Effort to Demonstration Populations.** The maintenance of effort provision at section 2105(d)(3)(A) of the Act applies to title XXI eligible children enrolled in this demonstration. This provision requires that, with certain exceptions, as a condition of receiving FFP for Medicaid, states must maintain CHIP "eligibility standards, methodologies, and procedures" for children that are no more restrictive than those in effect on March 23, 2010. See STCs 72 and 73 related to the title XXI funding limits and shortfalls.

V. SUBSTANCE USE DISORDER PROGRAMS AND BENEFITS

18. **SUD Program Benefits.** Effective upon CMS' approval of the SUD Implementation Plan, the demonstration benefit package for Medicaid beneficiaries will include SUD treatment services, such as services provided in residential and inpatient treatment settings that meet the definition of an IMD, which are not otherwise match-able expenditures under section 1903 of the Act. The state must achieve a statewide average length of stay of no more than thirty (30) days in residential and inpatient treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in STC 27 below.

Under this demonstration, beneficiaries will have access to high-quality, evidence-based treatment services for opioid use disorder (OUD) and SUD across a comprehensive continuum of care, ranging from residential and inpatient treatment to ongoing chronic care for these conditions in cost-effective community-based settings.

19. SUD Implementation Plan and Health IT Plan.

a. The state must submit the SUD Implementation Plan within ninety (90) calendar days after approval of this demonstration for CMS review and comment. The state must submit the revised SUD Implementation Plan within sixty (60) calendar days after receipt of CMS' comments. The state may not claim FFP for services provided in IMDs to beneficiaries who are primarily receiving SUD treatment and withdrawal management services until CMS has approved the SUD Implementation Plan. Once approved, the SUD Implementation Plan will be incorporated into the STCs as Attachment C and, once incorporated, may be altered only with CMS approval. After approval of the applicable implementation plans required by these STCs, FFP will be available prospectively, not retrospectively.

b. Failure to submit a SUD Implementation Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SUD program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 24.

c. At a minimum, the SUD Implementation Plan must describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:

    i. **Access to Critical Levels of Care for OUD and other SUDs:** Coverage of SUD/OUD treatment services across a comprehensive continuum of care, within 12-24 months of SUD demonstration approval, including: outpatient; intensive outpatient; medication-assisted treatment (medication as well as counseling and other services, with sufficient provider capacity to meet the needs of Medicaid beneficiaries); intensive levels of care in residential and inpatient settings; and medically supervised withdrawal management;

    ii. **Use of Evidence-based SUD-specific Patient Placement Criteria:** Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines, within 12-24 months of demonstration approval;

iii. **Patient Placement:** Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings, within 12-24 months of demonstration approval;

iv. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities:** Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in the provider manual at: http://www.abhct.com/Customer-Content/WWW/CMS/files/BHRP_Provider_Manual_2013.pdf. The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

v. **Standards of Care:** Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

vi. **Standards of Care:** Establishment of a requirement that residential treatment providers offer medication assisted treatment (MAT) on-site or facilitate access to MAT off-site within 12-24 months of demonstration approval;

vii. **Sufficient Provider Capacity at Each Level of Care Including MAT for SUD/OUD:** An assessment of the availability of providers in the critical levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT, within twelve (12) months of demonstration approval;

viii. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OUD:** Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

ix. **Improved Care Coordination and Transitions Between Levels of Care:** Establishment and implementation of policies to ensure residential and inpatient

facilities link beneficiaries with community-based services and supports following stays in these facilities within twenty-four (24) months of demonstration approval.

x. **SUD Health IT Plan:** Implementation of the milestones and metrics as detailed in STC 19(d).

d. **SUD Health Information Technology Plan.** The SUD Health Information Technology (Health IT) Plan applies to all states where the health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #17-003, states must submit to CMS the applicable Health IT Plan(s), to be included as a section(s) of the associated Implementation Plan(s) (see STC 19.a. and 19.c), to develop infrastructure and capabilities consistent with the requirements outlined in each demonstration-type.

The Health IT Plan must detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan will also be used to identify areas of health IT ecosystem improvement. The plan must include implementation milestones and projected dates for achieving them (see Attachment C), and must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) IT Health Plan.

i. The state must include in its Monitoring Protocol (see STC 27) an approach to monitoring its SUD Health IT Plan which will include performance metrics to be approved in advance by CMS.

ii. The state must monitor progress, each demonstration year (DY), on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Report (see STC 28).

iii. As applicable, the state should advance the standards identified in the "Interoperability Standards Advisory—Best Available Standards and Implementation Specifications" (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

iv. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or accountable care organization participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.

v. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.

A. Components of the Health IT Plan include:

1. The Health IT Plan must describe the state's goals, each DY, to enhance the state's prescription drug monitoring program (PDMP).[1]

2. The Health IT Plan must address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[1 above] This must also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan must describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.

3. The Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the Health IT Plan must describe current and future capabilities regarding PDMP queries—and the *state's* ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

4. The Health IT Plan will describe how the activities described in (*i), (ii*) and (*iii*) above will support broader *state* and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.[2]

5. The Health IT Plan will describe the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: (1) Referrals, (2) Electronic care plans and medical records, (3) Consent, (4) Interoperability, (5) Telehealth, (6) Alerting/analytics, and (7) Identity management.

6. In developing the Health IT Plan, states should use the following resources.

    - States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and

[1] PDMPs are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.

[2] Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

"Section 34: Opioid Epidemic and Health IT." (https://www.healthit.gov/playbook/health-information-exchange/).

- States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

7. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP interoperability, electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

20. Unallowable Expenditures Under the SUD Expenditure Authority. In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

VI. COST SHARING

21. Cost Sharing. Cost sharing imposed upon individuals enrolled in the demonstration is consistent with the provisions of the approved state plan.

VII. DELIVERY SYSTEM

22. Delivery System. All demonstration beneficiaries will continue to receive services through the same delivery system arrangements as currently authorized in the state.

VIII. GENERAL REPORTING REQUIREMENTS

23. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: (1) thirty (30) calendar days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or (2) thirty calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.

c. If CMS agrees to an interim corrective plan in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement with respect to required deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the requirements specified in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

24. Deferral of FFP from IMD Claiming for Insufficient Progress Toward Milestones. Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Plan and the required performance measures in the monitoring plan agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

25. Submission of Post-approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

26. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
c. Submit deliverables to the appropriate system as directed by CMS.

27. SUD Monitoring Protocol(s). The state must submit a draft Monitoring Protocol for the SUD programs authorized by this demonstration no later than one hundred fifty (150) calendar days after the effective date of the demonstration. The SUD Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. The state must submit a revised Monitoring Protocol within sixty (60) calendar days after receipt of CMS' comments. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment D. Progress on the performance measures identified in the Monitoring Protocol must be reported via the Quarterly and Annual Monitoring Reports. Components of the Monitoring Protocol include:

a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in STC 19(c) and reporting relevant information to the state's Health IT plan described in STC 19(d);
b. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section VIII (General Reporting Requirements) of the demonstration; and
c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

28. Monitoring Reports. The state must submit three (3) quarterly monitoring reports and one (1) annual monitoring report each DY. The fourth quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the annual monitoring report. The quarterly monitoring reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The annual monitoring report is due no later than ninety (90) calendar days following the end of the DY. The state must submit a revised monitoring report within sixty (60) calendar days after receipt of CMS' comments, if any. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The monitoring reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates. The operational updates will focus on progress toward meeting the demonstration's milestones. Additionally, per 42 CFR 431.428, the monitoring reports must document any policy or administrative difficulties in operating the demonstration.

The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, monitoring reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the demonstration's milestones and/or goals and must cover all key policies under this demonstration. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration on beneficiaries' outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, and if conducted, grievances and appeals. The required monitoring and performance metrics must be included in the monitoring reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the monitoring reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every monitoring report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the monitoring reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished as well as challenges encountered and how they were addressed.

e. SUD Health IT. The state will include a summary of progress made in regards to SUD Health IT requirements outlined in STC 19.d.

29. SUD Mid-Point Assessment. The state must contract with an independent entity to conduct a mid-point assessment by March 31, 2025. This timeline will allow for the mid-point assessment report to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In the design, planning and conduction of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of MCOs, if applicable, SUD treatment providers, beneficiaries, and other key partners.

The state must require that the assessor provide a mid-point assessment report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS no later than sixty (60) calendar days after March 31, 2025. The state must brief CMS on the report, if requested. The state must submit a revised mid-point assessment report within sixty (60) calendar days after receipt of CMS' comments, if any.

For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS modifications to the SUD Implementation Plan and the SUD Monitoring Protocol for ameliorating these risks. Modifications to the applicable Implementation Plan and Monitoring Protocol are subject to CMS approval.

Elements of the mid-point assessment report include:

a. An examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Plans, and toward meeting the targets for performance measures as approved in the SUD monitoring protocol;

b. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;

c. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's SUD Implementation Plan to pertinent factors that the state can influence that will support improvement; and

e. An assessment of whether the state is on track to meet the budget neutrality requirements.

30. Corrective Action Plan Related to Monitoring. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS will withdraw an authority, as described in STC 10, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

31. Close-Out Report. Within one hundred twenty (120) calendar days after the expiration of the demonstration, the state must submit a draft close-out report to CMS for comments.

a. The draft close-out report must comply with the most current guidance from CMS.

b. The state will present to and participate in a discussion with CMS on the close-out report.

c. The state must take into consideration CMS' comments for incorporation into the final close-out report.

d. The final close-out report is due to CMS no later than thirty (30) calendar days after receipt of CMS' comments.

e. A delay in submitting the draft or final version of the close-out report may subject the state to penalties described in STC 23.

32. Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

33. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Monitoring Report.

IX. EVALUATION OF THE DEMONSTRATION

34. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents; providing data and analytic files to CMS; entering into a data use agreement that explains how the data and data files will

be exchanged; and providing a technical point of contact to support specification of the data and files to be disclosed as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they make data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 23.

35. **Independent Evaluator.** Upon approval of the demonstration, the state must arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The state must require the independent party to sign an agreement that the independent party will conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved draft evaluation design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

36. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft evaluation design with implementation timeline no later than one hundred eighty (180) calendar days after the approval of the demonstration.

    The draft evaluation design must be developed in accordance with:

    a. Attachment A (Developing the Evaluation Design) of these STCs;

    b. CMS' evaluation design guidance for SUD, including guidance for approaches to analyzing associated costs; and

    c. All applicable CMS guidance on applying robust evaluation approaches, including establishing valid comparison groups and assuring causal inferences in demonstration evaluations.

    The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 39 and 40.

37. **Evaluation Design Approval and Updates.** The state must submit to CMS a revised draft evaluation design within sixty (60) calendar days after receipt of CMS' comments. Upon CMS approval of the evaluation design, the document will be included as Attachment E to these STCs. Per 42 CFR 431.424(c), the state will publish the approved evaluation design to the state's website within thirty (30) calendar days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the quarterly and annual monitoring reports, including any required rapid cycle assessments specified in these STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for

approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the evaluation design in monitoring reports.

38. Evaluation Questions and Hypotheses. Consistent with Attachments A and B (Developing the Evaluation Design; Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation design must include a discussion of the evaluation questions and hypotheses that the state intends to test. The evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and also its effectiveness in achieving the goals. Each demonstration component should have at least one evaluation question and hypothesis. The state must also conduct a demonstration cost assessment. Additionally, the state should accommodate data collection and analyses stratified by key subpopulations of interest to inform a fuller understanding of existing disparities in access and health outcomes, and how the demonstration's policies might support bridging any such inequities.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS' Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, and/or measures endorsed by National Quality Forum (NQF).

The findings from each evaluation component must be integrated to help inform whether the state met the overall demonstration goals, with recommendations for future efforts regarding all components.

39. Evaluation Budget. A budget for the evaluations must be provided with the draft Evaluation Design. It will include the total estimated cost as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

40. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When applying for extension, the Interim Evaluation Report should be posted to the state's website with the application for public comment.

a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.

b. For demonstration authority that expires prior to the overall demonstration's expiration date, the interim evaluation report must include an evaluation of the authority as approved by CMS.

c. If the state is seeking to extend the demonstration, the draft interim evaluation report is due when the application for extension is submitted. If the state made changes to the demonstration in its application for extension, the research questions and hypotheses and a description of how the design was adapted should be included. If the state is not requesting a renewal for the demonstration, the interim evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft interim evaluation report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit a revised interim evaluation report within sixty (60) calendar days of receiving CMS comments on the draft interim evaluation report.

e. Once approved by CMS, the state must post the final interim evaluation report to the state's Medicaid website within thirty (30) calendar days of approval by CMS.

f. The interim evaluation report must comply with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs.

41. Summative Evaluation Report. The state must submit a draft summative evaluation report for the demonstration's current approval period within eighteen (18) months of the end of the approval period represented by these STCs. The summative evaluation report must include the information in the approved evaluation design.

a. Unless otherwise agreed upon in writing by CMS, the state must submit a revised summative evaluation report within sixty (60) calendar days of receiving comments from CMS on the draft.
b. Once approved by CMS, the final summative evaluation report must be posted to the state's Medicaid website within thirty (30) calendar days of approval by CMS.
c. The summative evaluation report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs.

42. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's interim evaluation report, or as part of the review of the summative evaluation report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC

10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

43. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the evaluation design, the interim evaluation report, and/or the summative evaluation report.

44. Public Access. The state shall post the final documents (e.g., monitoring reports, close-out report, the approved evaluation design, interim evaluation report, and summative evaluation report) on the state's Medicaid website within thirty (30) calendar days of approval by CMS.

45. Additional Publications and Presentations. For a period of twelve (12) months following CMS' approval of deliverables, CMS will be notified prior to presentation of these reports or their findings, including in related publications (e.g., journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment on or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

46. Allowable Expenditures. This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.[3]

47. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate match-able demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the

[3] For a description of CMS' current policies related to budget neutrality for Medicaid demonstration projects authorized under section 1115(a) of the Act, see State Medicaid Director Letter #18-009.

state, and include the reconciling adjustment in the finalization of the grant award to the state.

48. Extent of FFP for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality expenditure limits described in section XI:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration approval period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

49. Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that the non-federal share is obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that such funds must not be used to match any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, CMS reserves the right to prohibit the use of any sources of non-federal share funding that it determines impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to fund the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal regulations, the state must address CMS' concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

50. State Certification of Funding Conditions. As a condition of demonstration approval, the state certifies that the following conditions for non-federal share funding of demonstration expenditures have been met:

a. Units of state or local government, including health care providers that are units of state or local government, certify that state or local monies have been expended as the non-federal share of funds under the demonstration.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the state share of title XIX payments, including expenditures authorized under a section 1115 demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies that are allowable under 42 CFR 433.51 to satisfy demonstration expenditures. If the CPE is claimed under a Medicaid authority, the federal matching funds received cannot be used as the non-federal share needed to receive other federal matching funds under 42 CFR 433.51(c). The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d. The state may use intergovernmental transfers (IGT) to the extent that such funds are derived from state or local revenues and are transferred by units of government within the state. Any transfers from units of government must be made in an amount not to exceed the non-federal share of title XIX payments.

e. Under all circumstances, health care providers must retain 100 percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 CFR 447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

51. Financial Integrity for Managed Care and Other Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based MCO, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR §438.6(b)(2), 438.6(c), 438.6(d), 438.60 and/or 438.74.

b. For non-risk-based PIHPs and PAHPs, arrangements comply with the upper payment limits specified in 42 CFR §447.362, and if payments exceed the cost of services, the state will recoup the excess and return the federal share of the excess to CMS.

52. Requirements for health care related taxes and provider donations. As a condition of demonstration approval, the state attests to the following, as applicable:

a. All health care-related taxes as defined by Section 1903 (w)(3)(A) of the Social Security Act and 42 CFR § 433.55 are broad-based as defined by Section 1903 (w)(3)(B) of the Social Security Act and 42 CFR § 433.68 (c).

b. All health care-related taxes are uniform as defined by Section 1903 (w)(3)(C) of the Social Security Act and 42 CFR § 433.68 (d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903 (w)(3)(E)(i) of the Social Security Act and 42 CFR § 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903 (w)(4) of the Social Security Act and 42 CFR § 433.68 (f).

e. All provider related-donations as defined by 42 CFR § 433.52 are bona fide as defined by Section 1903 (w)(2)(B) of the Social Security Act, 42 CFR § 433.66, and 42 CFR § 433.54.

53. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

54. Medicaid Expenditure Groups. Medicaid expenditure groups (MEGs) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The master MEG Chart table provides a master list of MEGs defined for this demonstration. The column titled *MEG* in the below table reflects the state's terminology for their distinct eligibility groups. The table does not include Husky B, which is the eligibility group for children enrolled in CHIP.

Table 2: Master MEG Chart

MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description
Husky A	Hypo 1	X		X	Low-income Medicaid enrollees, parents/caregiver relatives, and children
Husky C	Hypo 1	X		X	Aged, Blind, and Disabled
Husky D	Hypo 1	X		X	Medicaid expansion enrollees

55. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00372/1). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. Pharmacy Rebates. Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

d. Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the Master MEG Chart table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. Member Months. As part of the Quarterly and Annual Monitoring Reports described in section VIII, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG

Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three (3) months contributes three (3) eligible member months to the total. Two individuals who are eligible for two (2) months, each contribute two (2) eligible member months, for a total of four (4) eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 3: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
Husky A	Children and Caretaker adults (Non-Expansion Adult Medicaid beneficiaries) diagnosed with a SUD	*See STC # 19*	Follow CMS 64.9 Base Category of Service Definitions	Date of service	MAP	Y	April 14, 2022	March 31, 2027
Husky C	Aged, Blind, and Disabled Medicaid beneficiaries diagnosed with a SUD	*See STC # 19*	Follow CMS 64.9 Base Category of Service Definitions	Date of service	MAP	Y	April 14, 2022	March 31, 2027
Husky D	Medicaid Expansion adult beneficiaries diagnosed with a SUD	*See STC # 19*	Follow CMS 64.9 Base Category of Service Definitions	Date of service	MAP	Y	April 14, 2022	March 31, 2027

56. Demonstration Years. Demonstration years for this demonstration are defined in the Demonstration Years table below.

Table 4: Demonstration Years

Demonstration Year 1	April 14, 2022 to March 31, 2023	12 months
Demonstration Year 2	April 14, 2023 to March 31, 2024	12 months
Demonstration Year 3	April 14, 2024 to March 31, 2025	12 months
Demonstration Year 4	April 14, 2025 to March 31, 2026	12 months
Demonstration Year 5	April 14, 2026 to March 31, 2027	12 months

57. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in section XI. CMS will provide technical assistance, upon request.[4]

58. Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

59. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if

[4] 42 CFR §431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and §431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS' current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and in states agree to use the tool as a condition of demonstration approval.

any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

60. Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit may consist of a Main Budget Neutrality Test, and one or more Hypothetical Budget Neutrality Tests, as described below. CMS' assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

61. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

62. Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost multiplied by the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

63. Main Budget Neutrality Test. This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of Hypothetical Budget Neutrality Tests. Any excess spending under the Hypothetical Budget Neutrality Tests must be returned to CMS.

64. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), CMS considers these expenditures to be "hypothetical;" that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable services. This approach reflects CMS' current view that states should not have to "pay for," with demonstration savings, costs that could have been otherwise eligible for FFP under a Medicaid state plan or other title XIX authority; however, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures. That is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent Hypothetical Budget Neutrality Test, which subjects hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending by savings elsewhere in the demonstration or to refund the FFP to CMS.

65. Hypothetical Budget Neutrality Test 1: SUD Services. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality

expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

MEG	PC or Agg *	WOW Only, WW Only, or Both	BASE YEAR SFY2019	TREND	DY 1	DY 2	DY 3	DY 4	DY 5
Husky A	PC	Both	$4,821.33	4.5%	$5,562.82	$5,813.15	$6,074.74	$6,348.10	$6,633.76
Husky C	PC	Both	$11,950.54	3.9%	$13,532.81	$14,060.59	$14,608.95	$15,178.70	$15,770.67
Husky D	PC	Both	$8,019.71	5.7%	$9,602.90	$10,150.27	$10,728.84	$11,340.38	$11,986.78

66. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Main or Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

67. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from April 14, 2022 to March 31, 2027. If at the end of the demonstration approval period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

68. **Mid-Course Correction.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 9: Hypothetical Budget Neutrality Test Mid-Course Correction Calculations		
Demonstration Year	**Cumulative Target Definition**	**Percentage**

DY1	Cumulative budget neutrality limit plus:	2.0 percent
DY1 through DY2	Cumulative budget neutrality limit plus:	1.5 percent
DY1 through DY3	Cumulative budget neutrality limit plus:	1.0 percent
DY1 through DY4	Cumulative budget neutrality limit plus:	0.5 percent
DY1 through DY5	Cumulative budget neutrality limit plus:	0.0 percent

XII. MONITORING ALLOTMENT NEUTRALITY

69. Reporting Expenditures Subject to the Title XXI Allotment Neutrality Agreement. The following describes the reporting of expenditures subject to the allotment neutrality agreement for this demonstration:

a. Tracking Expenditures: In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outlined in section 2115 of the State Medicaid Manual.

b. Use of Waiver Forms: Title XXI demonstration expenditures will continue to be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made).

c. Claiming Period: All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately, on the Form CMS-21 Waiver, net expenditures related to dates of service during the operation of the demonstration.

70. Standard CHIP Funding Process. The standard CHIP funding process will continue to be used during the demonstration. The state will continue to estimate match-able CHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the state shall provide updated estimates of expenditures for the demonstration populations. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) calendar days after the end of each quarter, the state must submit the Form CMS-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

71. **Title XXI Administrative Costs.** Administrative costs will not be included in the allotment neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. Total expenditures for outreach and other reasonable costs to administer the CHIP state plan and this demonstration that are applied against the state's title XXI allotment may not exceed ten percent of total title XXI net expenditures.

72. **Limit on Title XXI Funding.** The state will be subject to a limit on the amount of federal title XXI funding that the state may receive on allowable demonstration expenditures during the demonstration period. Federal title XXI funds for the state's CHIP program (i.e., the approved title XXI state plan and this demonstration) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., that allotment or reallocated funds) must first be used to fully fund costs associated with CHIP state plan populations. Demonstration expenditures are limited to remaining funds.

73. **Exhaustion of Title XXI Funds.** The state is eligible to receive title XXI funds for the demonstration population as described in STC 16, up to the amount of its title XXI allotment.

XIII. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Table 6: Schedule of Deliverables for the Demonstration Period

Date	Deliverable	STC
30 calendar days after approval date	State acceptance of demonstration STCs, and Expenditure Authorities	Approval letter
90 calendar days after approval date	SUD Implementation Plan (including Health IT Plan)	STC 19
60 calendar days after approval date	Revised SUD Implementation Plan (including Health IT Plan)	STC 19
150 calendar days after demonstration effective date	Monitoring Protocol	STC 32
60 calendar days after receipt of CMS comments	Revised Monitoring Protocol	STC 32
180 calendar days after approval date	Draft Evaluation Design	STC 36
60 calendar days after receipt of CMS comments	Revised Draft Evaluation Design	STC 36
No later than 60 calendar days after March 31, 2025	SUD Mid-Point Assessment	STC 29
60 calendar days after receipt of CMS comments	Revised SUD Mid-Point Assessment	STC 29
March 31, 2026 or with extension application	Draft Interim Evaluation Report	STC 40

60 calendar days after receipt of CMS comments	Revised Interim Evaluation Report	STC 40(d)
Within 18 months after March 31, 2027	Draft Summative Evaluation Report	STC 41
60 calendar days after receipt of CMS comments	Revised Summative Evaluation Report	STC 41(a)
Monthly Deliverables	Monitoring Calls	STC 32
Quarterly monitoring reports due 60 calendar days after end of each quarter, except 4th quarter	Quarterly Monitoring Reports, including implementation updates	STC 28
	Quarterly Expenditure Reports	STC 28
Annual monitoring reports due 90 calendar days after end of each 4th quarter	Annual Monitoring Reports	STC 28

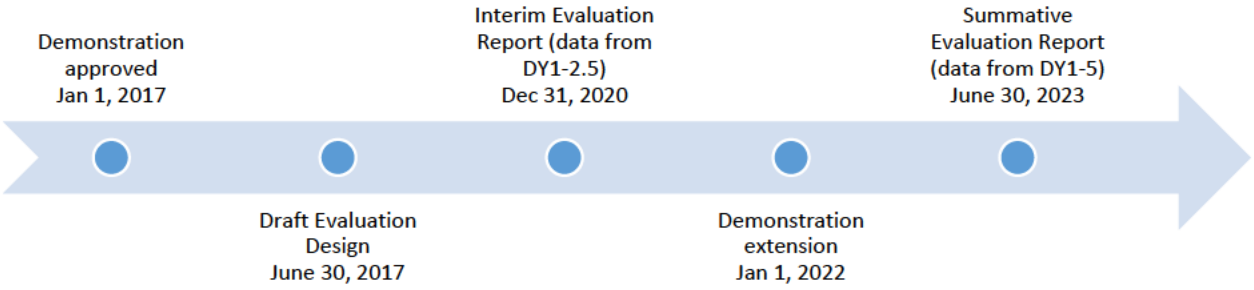
ATTACHMENT A
Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations.

The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- **A.** General Background Information;
- **B.** Evaluation Questions and Hypotheses;
- **C.** Methodology;
- **D.** Methodological Limitations;
- **E.** Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.
2. Address how the hypotheses and research questions promote the objectives of Titles XIX and/or XXI.
3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured.
4. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve

health and health care through specific interventions. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure. Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre-test or post-test only assessments. If qualitative analysis methods will be used, they must be described in detail.
2. *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
3. *Evaluation Period* – Describe the time periods for which data will be included.
4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate. The state also should include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating, securing, and submitting for endorsement, etc.) Proposed health measures could include CMS' Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.
6. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:
    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression).
    b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
    c. Include a discussion of how propensity score matching and difference-in-differences designs may be used to adjust for differences in comparison populations over time, if applicable.
    d. Consider the application of sensitivity analyses, as appropriate.
7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long-standing, it may be difficult for the state to include baseline data because any pre-test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
    a. Non-complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
    b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).
2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes;
    b. No or minimal appeals and grievances;

c. No state issues with CMS-64 reporting or budget neutrality; and
d. No Corrective Action Plans for the demonstration.

E. Attachments

1. **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.

2. **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.

3. **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

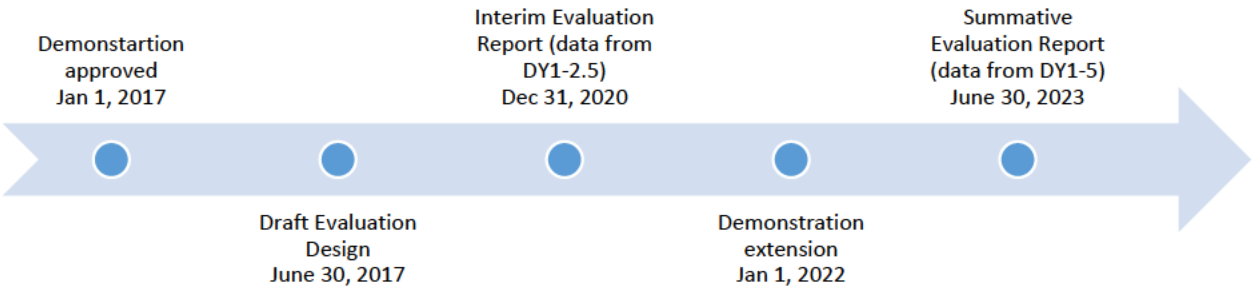
ATTACHMENT B
Preparing the Interim and Summative Evaluation Reports

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverable's timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already-approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow

the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When applying for renewal, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

Intent of this Attachment
Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports
The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and,
J. Attachment(s).

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

C. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
2. Address how the research questions / hypotheses of this demonstration promote the objectives of titles XIX and XXI.
3. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
4. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Methodological Design* – Whether the evaluation included an assessment of pre/post or post-only data, with or without comparison groups, etc.
2. *Target and Comparison Populations* – Describe the target and comparison populations, describing inclusion and exclusion criteria.
3. *Evaluation Period* – Describe the time periods for which data will be collected.
4. *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.
5. *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.
6. *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
2. If the state did not fully achieve its intended goals, why not?

3. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long-range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

Connecticut Department of Social Services

Implementation Plan

for

Substance Use Disorder Demonstration Waiver Pursuant to Section 1115 of the Social Security Act

Submitted to the U.S. Centers for Medicare and Medicaid Services

Updated March 7, 2022

OVERVIEW

This Implementation Plan is submitted in conjunction with the Connecticut Department of Social Services (DSS) submission of a substance use disorder (SUD) demonstration waiver pursuant to Section 1115 of the Social Security Act. Connecticut is committed to providing a full continuum of care for people with opioid use disorder (OUD) and other SUDs and expanding access and improving outcomes in the most cost-effective manner possible. Consistent with the state's waiver application, except as otherwise specifically provided below or as required by federal law, all references in this Implementation Plan to Medicaid also apply to the state's Children's Health Insurance Program (CHIP).

Goals:

1. Increased rates of identification, initiation and engagement in treatment for OUD and other SUDs;
2. Increased adherence to and retention in treatment for OUD and other SUDs;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where readmissions is preventable or medically inappropriate for OUD and other SUDs; and
6. Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

Milestones:

1. Access to critical levels of care for OUD and other SUDs;
2. Widespread use of evidence-based, SUD-specific patient placement criteria;
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
4. Sufficient provider capacity at each level of care, including medication assisted treatment (MAT);
5. Implementation of comprehensive treatment and prevention strategies to address opioid misuse and

OUD; and
6. Improved care coordination and transitions between levels of care.

Section I – Implementation Plan Milestone Completion

This section contains information detailing Connecticut's strategies for meeting the six milestones over the course of the Demonstration. Specifically, this section:

1. Includes a summary of how, to the extent applicable, Connecticut already meets each milestone, in whole or in part, and any actions needed to meet each milestone, including the persons or entities responsible for completing actions;
2. Describes the timelines and activities that Connecticut will undertake to achieve the milestones; and
3. Provides an overview of future plans to improve beneficiary access to SUD services and promote quality and safety standards

Milestones

1. Access to Critical Levels of Care for OUD and Other SUDs

Connecticut will improve access to OUD and SUD treatment services for Medicaid beneficiaries by offering a range of services at varying levels of intensity across a continuum of care because each type of treatment or level of care may be more or less effective depending on each beneficiary's individual clinical needs. To meet this milestone, Connecticut will provide coverage of the following services:

- Outpatient services;
- Intensive outpatient services;
- Medication-Assisted Treatment (MAT) (medications, as well as counseling and other services, with sufficient provider capacity to meet the needs of the Medicaid beneficiaries in the state);
- Intensive levels of care in residential and inpatient settings; and

- Medically supervised withdrawal management.

Below is a table that describes Connecticut's plans to meet Milestone 1, to improve access to SUD treatment services for Medicaid beneficiaries, including a variety of services at different levels of intensity across a continuum of care. This milestone will be met within 12 to 24 months of Demonstration approval.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	**Provide an overview of current SUD treatment services covered by the state in each level of care. For services currently covered in the state plan, list the benefit category and page location; for services currently covered in a Demonstration, include the program name and Special Term and Condition number.**	**Provide an overview of planned SUD treatment services to be covered by the state in each level of care: indicate whether planned services will be added to the state plan or authorized through the 1115.**	**Provide a list of action items needed to be completed to meet milestone requirements, if any. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item.**
Coverage of outpatient services	Connecticut Medicaid covers SUD outpatient treatment services under the following sections of the Medicaid State Plan[5]: • Outpatient hospital (Section 2.a of Attachment [Att.] 3.1-A, currently Att. 3.1-A Page 1 and Addendum [Add.] Page 1c to Att. 3.1-A)	Connecticut plans to submit a SUD Medicaid State Plan Amendment (SPA) updating the State's standards to be consistent with the latest edition of the American Society of Addiction	The Department of Social Services (DSS) will submit a SPA in the rehabilitative services benefit category to update the State's

[5] The CHIP State Plan substantively covers the same services listed here as covered by Medicaid, although they are reflected differently in the CHIP State Plan and EPSDT is a concept unique to federal Medicaid law that does not apply to CHIP.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	• FQHC (Section 2.c of Att. 3.1-A, currently Att. 3.1-A Page 1 and Add. Page 1d to Att. 3.1-A) • Physician services (Sec. 5 of Att. 3.1-A, currently Att. 3.1-A Page 2 and Add. Pages 2g and 3 to Att. 3.1-A) • Other licensed practitioner (OLP) Licensed Psychologist services (Sec. 6 of Att. 3.1-A, currently Att. 3.1-A Page 3 and Add. Page 4b to Att. 3.1-A) • OLP Licensed Clinical Social Worker services (Sec. 6 of Att. 3.1-A, currently Att. 3.1-A Page 3 and Add. Page 4d to Att. 3.1-A) • OLP Licensed Marital and Family Therapists services (Sec. 6 of Att. 3.1-A, currently Att. 3.1-A Page 3 and Add. Pages 4d and 4d(i) to Att. 3.1-A) • OLP Licensed Professional Counselor Services (Sec. 6 of Att. 3.1-A, currently Att. 3.1-A Page 3 and Add. Page 4e to Att. 3.1-A) • OLP Licensed Alcohol and Drug Counselor Services (Sec. 6 of Att. 3.1-A, currently Att. 3.1-A Page 3 and Add. Page 4e to Att. 3.1-A) • OLP Nurse Practitioner Services, Certified Pediatric Nurse Practitioner Services, and Family Nurse Practitioner Services (Secs. 6 and 23 of Att. 3.1-A, currently Att. 3.1-A Page 3 and Add. Pages 4c and 14 to Att. 3.1-A)	Medicine (ASAM).	standards to be consistent with the latest edition of ASAM no later than 12 months following Centers for Medicare and Medicaid Services (CMS) approval of the Demonstration (by April 1, 2023).

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	• OLP Physician Assistants (Sec. 6 of Att. 3.1-A, currently Att. 3.1-A Page 3 and Add Page 4f to Att. 3.1-A) • Clinic Free-standing clinic services (non-FQHC) Methadone Clinics or Chemical Maintenance Clinics (Sec. 9 of Att. 3.1-A, currently Att. 3.1-A Page 4 and Add. Page 7 to Att. 3.1-A) • Rehabilitation Services Pursuant to EPSDT – Office-based off-site rehabilitation services (Sec. 13.d of Att. 3.1-A, currently Att. 3.1-A Page 6 and Supplement Page 2b to Add. Page 12 to Att. 3.1-A)		
Coverage of intensive outpatient services	Connecticut Medicaid covers SUD intensive outpatient treatment services, including partial hospitalization, under the following sections of the State Plan: • Outpatient hospital (Section 2.a of Attachment [Att.] 3.1-A, currently Att. 3.1-A Page 1 and Add. Page 1c to Att. 3.1-A • FQHC (Section 2.c of Att. 3.1-A, currently Att. 3.1-A Page 1 and Add. Page 1d to Att. 3.1-A) • Clinic Free-standing clinic services (non-FQHC) Behavioral Health Clinics/Mental Health and Substance Abuse Clinics (Sec. 9 of Att. 3.1-A, currently Att. 3.1-A Page 4 and Add. Page 7 to Att. 3.1-A)	Connecticut plans to submit a SUD SPA updating the State's standards to be consistent with the latest edition of ASAM.	DSS will submit a Rehabilitative SPA to update the State's standards to be consistent with the latest edition of ASAM no later than 12 months following CMS approval of the Demonstration (by April 1, 2023).

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Coverage of MAT (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the State)	Connecticut Medicaid covers MAT (for non-OUD and OUD) and associated counseling/services under the following sections of the State Plan: • Physician services (Sec. 5 of Att. 3.1-A, currently Att. 3.1-A Page 2 and Add. Pages 2g and 3 to Att. 3.1-A) • Clinic Free-standing clinic services (non-FQHC) Behavioral Health Clinics/Mental Health and Substance Abuse Clinics (Sec. 9 of Att. 3.1-A, currently Att. 3.1-A Page 4 and Add. Page 7e to Att. 3.1-A) • Clinic Free-standing clinic services (non-FQHC) Methadone Clinics or Chemical Maintenance Clinics (Sec. 9 of Att. 3.1-A, currently Att. 3.1-A Page 4 and Add. Page 7g to Att. 3.1-A) • Medication-Assisted Treatment (MAT) 1905(a)(29)	Connecticut plans to submit a SUD SPA updating the State's standards to be consistent with the latest edition of ASAM.	DSS will submit a SPA in the rehabilitative services benefit category ("Rehabilitative SPA") to update the State's MAT standards for Non-OUD, as well as for services provided after the end-date of the 1905(a)(29) OUD MAT SPA to be consistent with the latest edition of ASAM no later than 12 months following CMS approval of the Demonstration (by April 1, 2023).

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Coverage of intensive levels of care in residential and inpatient settings	Connecticut Medicaid does not cover residential SUD in a non-hospital setting. Connecticut Medicaid covers the following inpatient SUD treatment: • Inpatient hospital services (Sec. 1 of Att. 3.1-A, currently Att. 3.1-A Page 1 and Add. Pages 1a and 1b to Att. 3.1-A) • Inpatient hospital for individuals age 65 or older in institutions for mental diseases (Sec. 14 of Att. 3.1-A, currently Att. 3.1-A page 6) • Inpatient psychiatric facility services for individuals under 22 years of age (Sec. 16 of Att. 3.1-A, currently Att. 3.1-A page 7) Connecticut reimburses providers outside of the Medicaid program using a Substance Abuse Prevention and Treatment (SAPT) block grant and State funds for residential programs.	Connecticut plans to submit a SUD SPA updating the State's standards to be consistent with the latest edition of ASAM and including residential SUD treatment for children and adults. Connecticut will reimburse SUD residential providers for children and adults in the Medicaid program in non-IMDs with the effective date of the SPA and for IMDs with the effective date of the 1115 Demonstration and SPA	DSS will submit a Rehabilitative SPA to update the State's residential standards to be consistent with the latest edition of ASAM and to include coverage of residential SUD treatment no later than 12 months following CMS approval of the Demonstration (by April 1, 2023).
Coverage of medically supervised withdrawal management	Connecticut Medicaid does not cover medically supervised withdrawal management in a non-hospital setting. Connecticut Medicaid covers the following detoxification: • Inpatient detoxification in a general hospital setting (Inpatient hospital Services, Sec. 1 of Att. 3.1-A, currently Att. 3.1-A Page 1 and Add. Page 1a to Att. 3.1-A)	Connecticut plans to submit a SUD SPA updating the State's standards to be consistent with the latest edition of ASAM and including coverage of medically supervised withdrawal management in a non-hospital setting.	DSS will submit a Rehabilitative SPA to update the State's standards to be consistent with the latest edition of ASAM and to include coverage of Medically supervised withdrawal

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	Connecticut Medicaid covers limited ambulatory detoxification under the following authorities: • Outpatient hospital (Sec. 2 of Att. 3.1-A, currently Att. 3.1-A Page 1 and Add. Page 1c to Att. 3.1-A) • Clinic Free-standing clinic services (non-FQHC) e. Behavioral Health Clinics/Mental Health and Substance Abuse Clinics (Sec. 9 of Att. 3.1-A, currently Att. 3.1-A Page 4 and Add. Page 7 to Att. 3.1-A) • Clinic Free-standing clinic services (non-FQHC) g. Methadone Clinics or Chemical Maintenance Clinics (Sec. 9 of Att. 3.1-A, currently Att. 3.1-A Page 4 and Add. Page 47 to Att. 3.1-A)	Connecticut reimburses providers outside of the Medicaid program using SAPT block grant and State funds for detoxification programs.	management in a non-hospital setting no later than 12 months following CMS approval of the Demonstration (by April 1, 2023).

2. Use of Evidence-based, SUD-specific Patient Placement Criteria

Under this milestone, Connecticut will implement the latest edition of ASAM, which is evidence-based, SUD-specific patient placement criteria. To meet this milestone, Connecticut will ensure that:

- Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, linked to the ASAM Criteria; and
- Utilization management approaches are implemented to ensure that
  (a) beneficiaries have access to SUD services at the appropriate level of care,
  (b) interventions are appropriate for the diagnosis and level of care, and
  (c) there is an independent process for reviewing placement in residential treatment settings.

Below, Connecticut identifies its plan to increase the use of ASAM's evidence-based, SUD-specific placement criteria to provide treatment that reflects diverse patient needs and evidence-based clinical guidelines. This table includes current and intended actions and associated timelines needed to meet Milestone 2 (*Use of evidence-based, SUD-specific patient placement criteria)*. This milestone will be met within 12-24 months of Demonstration approval.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	Provide an overview of current state use of evidence-based, SUD-specific patient placement criteria and utilization management approach to ensure placement in appropriate level of care and receipt of services recommended for that level of care	Provide an overview of planned state implementation of requirement that providers use an evidence-based, SUD-specific patient placement criteria and use of utilization management to ensure placement in appropriate level of care and receipt of services	Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item

		recommended for that level of care.	
Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines	Connecticut providers are not required to utilize assessments that are directly tied to the ASAM criteria for treatment planning. DCF has cross-walked the GAIN (the current children's tool) to the ASAM placement criteria for children's assessment and treatment planning.	Connecticut will develop a universal training program for providers to assess treatment needs based on ASAM's multi-dimensional tools (or a tool cross-walked to ASAM criteria such as the GAIN for children) and to base treatment needs on those assessments. Connecticut will require all Medicaid SUD providers to sign an addendum to the Medicaid provider enrollment agreement that includes requirements for level of care (LOC) assessments using ASAM's most recent edition, consistent with provider training.	Department of Mental Health and Addiction (DMHAS)/Department of Children and Families (DCF) have statutory authority for SUD service provision. These agencies, or their designated contractor(s), will ensure that providers receive training necessary to implement the provider training portion of the Demonstration on behalf of DSS and the Medicaid program within 12 months of approval by April 1, 2023. Training would include utilization of State-approved provider assessment tools using, and/or cross-walked to the six dimensions of ASAM criteria, for treatment planning and implementation of most recent ASAM edition patient placement criteria and

			program standards. The Medicaid SPA (submitted by April 1, 2023) and related Medicaid provider manuals (completed by April 1, 2024) will establish the ASAM as requirements for providers to assess treatment needs and develop recommendations for placement in appropriate levels of care with the effective date of the Rehabilitative SPA compliant with the most recent edition of ASAM.
Implementation of a utilization management approach such that (a) **beneficiaries have access to SUD services at the appropriate level of care**	Although Connecticut Medicaid's current behavioral health (BH) administrative services organization (ASO), which performs utilization management for all Medicaid BH services, including SUD services, internally uses the latest edition of ASAM patient placement criteria, the State's website is not consistent with that criteria. The state's non-Medicaid BH ASO, which reviews residential placements, utilizes an older version of the ASAM placement criteria.	Connecticut will ensure that program standards are set for beneficiaries to have access to SUD services at the appropriate LOC based on the six ASAM dimensions of care. Connecticut will update contract language (BH ASO) to reflect requirements for utilization	DMHAS/DCF have statutory authority for SUD service provision. These agencies or their designated contractor(s), will work with providers to ensure access for the Demonstration on behalf of DSS and the Medicaid program within 12 months of Demonstration approval (by April 1, 2023). The DSS BH ASO will

		management using ASAM's most recent edition language consistent with provider training. Connecticut will use the most recent ASAM edition for utilization review. All website, provider information and internal documentation will be consistent with the latest ASAM edition.	provide a website with a provider search function for Medicaid beneficiaries and providers at all LOCs (by April 1, 2023). DSS will direct the Medicaid BH ASO to use the most recent ASAM edition for utilization review and to update the website, provider information and internal documentation (by April 1, 2023).
Implementation of a utilization management approach such that (b) **interventions are appropriate for the diagnosis and level of care**	Today, the State BH ASO utilizes the ASAM third edition (which is the latest edition) to review utilization for ambulatory care and inpatient hospital care. However, the ASO for residential care, which is outside of the Medicaid system, utilizes an earlier version of ASAM for utilization review. State websites do not consistently refer to the latest versions of ASAM for determining that interventions are appropriate for the diagnosis and level of care.	Connecticut will develop program standards to ensure that providers' interventions are appropriate for the diagnosis and each ASAM LOC. All Medicaid websites, criteria, manuals, and provider standards will consistently refer to the latest ASAM edition.	DMHAS/DCF have statutory authority for SUD service provision. These agencies, or their designated contractor(s), will work with providers to develop the program standards consistent with ASAM for the Demonstration on behalf of DSS and the Medicaid program within 12 months of Demonstration approval (by April 1, 2023). DMHAS/DCF have statutory authority for SUD service

			provision. These agencies, or their designated contractor(s), will ensure that providers are monitored and certified to provide the ASAM LOC for which the provider is enrolled in the Medicaid program within 24 months of Demonstration approval (by April 1, 2024). With the effective date of the new SPA, DSS Provider enrollment standards will require certification by DMHAS/DCF (or their designated contractor(s)) with an agreement also from DSS (or its designated contractor) to provide the ASAM LOC for which they are enrolled by April 1, 2023. Provisional certification for no more than 24 months will be granted to providers if they meet milestones for implementing the new requirements under the Demonstration by April 1, 2024.

Implementation of a utilization management approach such that (c) **there is an independent process for reviewing placement in residential treatment settings**	The current Medicaid BH ASO already uses the most recent ASAM edition for inpatient utilization review. DMHAS' ASO for the non-Medicaid Behavioral Health Recovery Program (BHRP) uses an older edition of ASAM to review placements in non-hospital residential treatment settings. The residential placement criteria currently in use can be found at the following link: http://www.abhct.com/Customer-Content/WWW/CMS/files/BHRP-_clinical/ABH_Clinical_Level_of_Care_Guidelines_2015.pdf	Connecticut will use the most recent ASAM edition for utilization review of Medicaid inpatient and residential placements. All website, provider information and internal documentation will be consistent with the latest ASAM edition. Connecticut will update contract language (BH ASO and addendum to the Medicaid provider enrollment agreement) to reflect requirements for utilization management and LOC assessments using the language in the most recent ASAM edition, consistent with provider training.	DSS will direct the Medicaid BH ASO to use the most recent ASAM edition for utilization review, prior authorization, and to update the website, provider information and internal documentation within 24 months of Demonstration approval by April 1, 2024.

3. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Through this Demonstration, Connecticut will receive federal financial participation (FFP) for a continuum of SUD services, including services provided to Medicaid enrollees residing in residential treatment facilities that qualify as institutions for mental diseases (IMDs). To meet this milestone, Connecticut will ensure that the following criteria are met:

- Implementation of residential treatment provider qualifications (in licensure requirements, policy manuals, managed care contracts (in Connecticut, this reference refers to the Administrative Services Organization contracts), or other guidance) that meet the ASAM criteria or other nationally recognized, SUD-specific program standards regarding the types of services, hours of clinical care and credentials of staff for residential treatment settings;
- Implementation of a State process for reviewing residential treatment providers to assure compliance with these standards; and
- Implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off site.

Below, Connecticut has outlined how it will incorporate nationally recognized, SUD-specific ASAM program standards into their provider qualifications for residential treatment facilities through their policy manuals and other guidance to meet Milestone 3 (*Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities)*. This milestone will be met within 24 months of Demonstration approval.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	Provide an overview of current provider qualifications for residential treatment facilities and how these compare to nationally recognized SUD-specific program standards, e.g., the ASAM Criteria	Provide an overview of planned use of nationally recognized SUD-specific program standards in improving provider qualifications for residential treatment facilities.	Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action

			item
Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, contracts, or other guidance. Qualification should meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding, in particular, **the types of services, hours of clinical care, and credentials of staff for residential treatment**	Connecticut Medicaid does not currently reimburse for SUD residential treatment for adults. Residential treatment is reimbursed by non-Medicaid SAPT block grant and State funds and includes ASAM 3.1, ASAM 3.5, ASAM 3.7 and ASAM 3.7D using the second edition of ASAM. The current standards can be found in Section 3 of the manual at the following linked website: http://www.abhct.com/Customer-Content/WWW/CMS/files/BHRP_Provider_Manual_2013.pdf Medicaid SUD treatment for children is reimbursed under EPSDT and roughly corresponds to an ASAM 3.5 LOC.	Connecticut plans to submit a SUD SPA updating the State's standards to be consistent with the latest edition of ASAM and including residential SUD treatment. Connecticut is currently conducting a public process for stakeholders to provide feedback on the types of services, hours of clinical care, and credentials of staff for residential treatment settings that will be Implemented under the Medicaid State Plan.	With the effective date of the SPA, DSS will update the Medicaid MMIS coding, rates, and billing guidance to support provider enrollment and billing under the new Medicaid Rehabilitative SPA (effective date of SPA). DSS, in conjunction with DMHAS and DCF, will update provider standards and certification developed by both State agencies within 18 months of Demonstration approval (by October 1, 2023). Other operational guidance will be updated by each State agency to support the latest edition of ASAM standards as needed to provide timely provider training in Milestone 2 (no later than 24 months after Demonstration approval

settings			or by April 1, 2024).
Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards	Currently SUD residential treatment providers are not enrolled in the Connecticut Medicaid program. All SUD residential providers are licensed by the Connecticut Department of Public Health (DPH). In addition: (1) SUD residential providers for children must also be licensed by DCF; and (2) SUD residential providers for adults that participate in BHRP must also be reviewed by DMHAS non-Medicaid BHRP ASO using criteria from the second edition of ASAM.	DMHAS/DCF have statutory authority for SUD service provision. These agencies, or their designated contractor(s), will ensure that providers are monitored and certified to provide the ASAM LOC for which the provider is enrolled in the Medicaid program.	Within 24 months of Demonstration approval, DSS provider enrollment standards will require certification by DMHAS/DCF (or their designated contractor(s)) with an agreement also from DSS (or its designated contractor) to provide the ASAM LOC for which they are enrolled: The monitoring of the providers will include both a review of the facility's infrastructure, as well as how the infrastructure is applied to ensure compliance with the new state standards consistent with the latest edition of ASAM. The monitoring will include initial certification, monitoring and recertification (by April 1, 2024).
Implementation of requirement that residential	Connecticut already has in place a requirement that residential treatment facilities offer multiple versions of MAT on-	None needed – Connecticut currently meets criteria.	None needed – Connecticut currently meets criteria.

treatment facilities offer MAT onsite or facilitate access off-site	site or facilitate access off-site. All but one residential treatment provider already offers multiple versions of MAT on-site or facilitates access off-site. The one facility in question does not accept residents receiving methadone, but accepts placement of residents using Buprenorphine. The State has provided education to this facility and it will be accepting methadone residents in the future consistent with ASAM criteria and the Demonstration requirements.		

4. Sufficient Provider Capacity at Critical Levels of Care Including for Medication Assisted Treatment for OUD

To meet this milestone, Connecticut will complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care listed in Milestone 1. This assessment will determine the availability of treatment for Medicaid beneficiaries in each of these LOCs, as well as availability of MAT and medically supervised withdrawal management, throughout the State. This assessment will identify gaps in availability of services for beneficiaries in the critical LOCs and develop plans for enhancement of capacity based on assessments of provider availability

The table below summarizes the current and future actions, including associated timelines, to meet Milestone 4 (*Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment)*. This milestone will be met within 24 months of Demonstration approval. *Note: It is necessary to ensure the complete implementation of the new service array in Medicaid prior to the capacity assessment being conducted.*

The anticipated penetration rate and geographic distributions of providers at each LOC is noted where available.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	Provide an overview of current provider capacities throughout the state to provide SUD treatment at each of the critical levels of care listed in Milestone 1.	Provide an overview of planned improvements to provider availability and capacity intended to improve Medicaid beneficiary access to treatment throughout the State at each of the critical levels of care listed in Milestone 1.	Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item

Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the state including those that offer MAT: Outpatient Services; Intensive Outpatient Services; Medication Assisted Treatment (medications as well as counseling and other	For non-residential levels of care, the state's behavioral health ASO currently tracks ambulatory/outpatient providers level of care and capacity. Except for situations such as fixed prescribing limits, the ASO does not otherwise track specific slots for open-access ambulatory levels of care. In the report entitled "*Connecticut Opioid and Other Substance Use Disorder Treatment and Recovery Service Capacity and Infrastructure Planning Support Act Semiannual Report*," dated September 30, 2020, Connecticut reported on the capacity of the Medicaid SUD system. As a fee-for-service system, Connecticut Medicaid's provider network consists of direct service Medicaid providers who are each enrolled with DSS. Based on data from the State's September 2020 capacity report, in total, 7,824 providers delivered services to members with SUD during dates of service from October 1, 2019 through December 31, 2019. The majority (4,014) were providing physician services, while significant numbers were also providing outpatient hospital services including ED services (2,528 providers), inpatient services (1,560 providers), and prescription drugs (1,091	Connecticut will examine the potential to enhance access monitoring reporting under the Demonstration. This initiative will leverage the DMHAS bed monitoring and the BH ASO bed monitoring for ongoing access monitoring and recruitment and enrollment of new facilities.	The Medicaid BH ASO in conjunction with DMHAS, or its designee, will complete an assessment of the availability of Medicaid SUD providers accepting new patients at ambulatory ASAM levels of care including MAT within 12 months of Demonstration approval (by April 1, 2023). The Medicaid BH ASO in conjunction with DMHAS, or its designee, will complete an assessment of the availability of Medicaid SUD providers accepting new patients at residential ASAM levels of care within 24 months of Demonstration approval once all residential providers are enrolled in Medicaid and fully meet the latest edition of ASAM criteria (by April 1, 2024).

services); Intensive Care in Residential and Inpatient Settings; Medically Supervised Withdrawal Management.	prescribers of medications related to SUD, including MAT for OUD and AUD). MAT Providers Since different data sources were used to determine providers for prescription drugs (pharmacy claims) and all other service categories (medical and behavioral health claims), there is substantial overlap between the providers listed in the “prescription drugs” category and the “other” service categories. The total number of State MAT providers during dates of service from October 1, 2019 through December 31, 2019 was 711; of which, 704 appeared as prescribers of MAT in the pharmacy claims data. For other service categories, providers appeared on medical and behavioral health claims largely for distributing methadone and, to a smaller extent, non-pharmaceutical buprenorphine (i.e. injectable). The service categories with the most MAT providers, other than prescription drugs, were physician services (162), outpatient hospital services including ED services (157), clinic services (146), and home health services (129).		

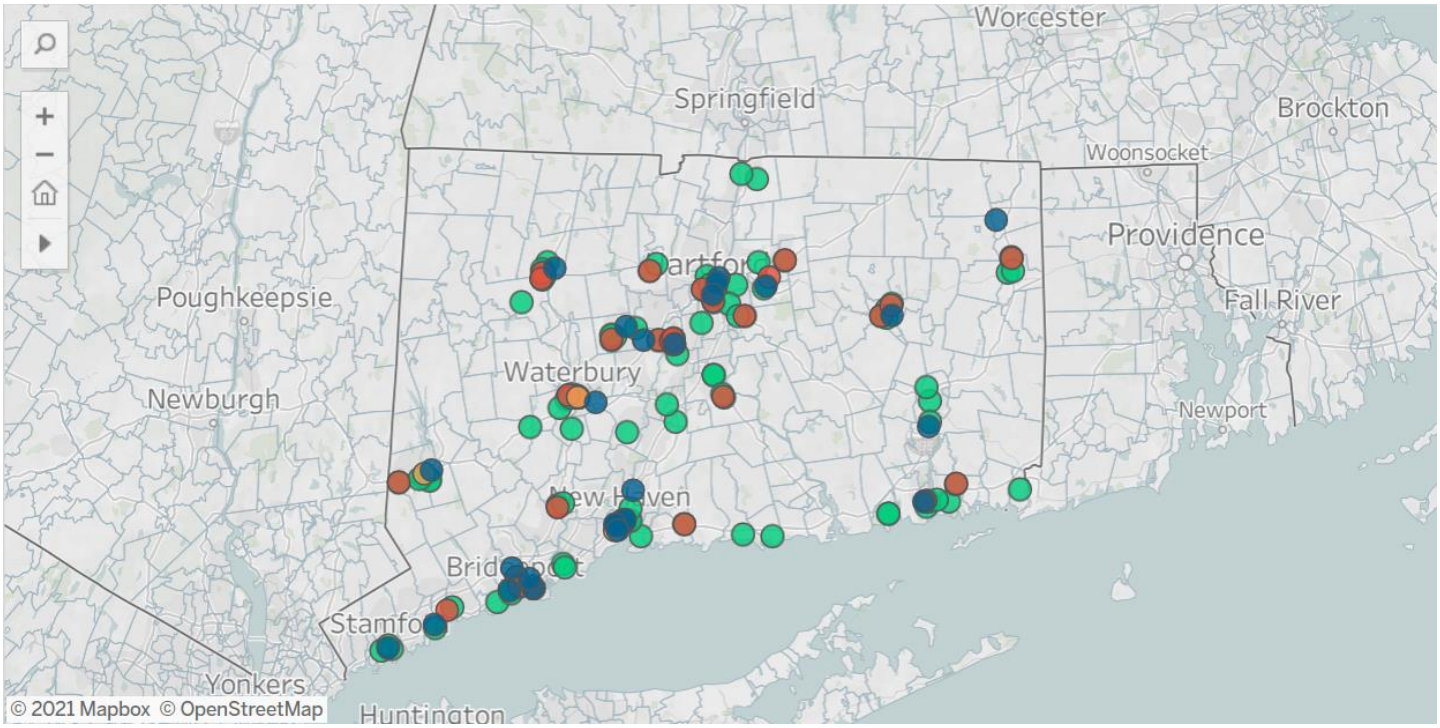
	Overall, 42,322 members with SUD received care in at least one of the service categories outlined in the guidelines. The largest number of members with SUD (23,058) received care at a clinic, which includes FQHCs and methadone clinics. Many members also received physician services (14,525) and outpatient hospital services, including ED services (10,718). DMHAS maintains a real-time website listing the open residential and inpatient SUD treatment beds for the public and providers at https://www.ctaddictionservices.com/. This current online capacity system is working with real-time access. DMHAS' BHRP ASO also maintains residential data that tracks utilization and sends weekly updates (by provider by LOC by site) – on average capacity and bed count. This information calculates the rolling average capacity by fiscal year and is provided to DMHAS weekly.		

	DDaP is the DMHAS data warehouse and is used to analyze actual utilization data. The DMHAS Evaluation Quality Metrics Improvement Division manages DDaP data. The Medicaid BH ASO maintains a search capacity for outpatient SUD treatment availability including an accessibility map for MAT. That search capacity and map can be found at the following link: https://public.tableau.com/views/CTBHPMedicaidMATProviderMap/TreatmentProviders?:embed=y&:display_count=yes&:showVizHome=no The Medicaid BH ASO SUD accessibility maps (current as of 6/16/2021) can be found below this chart. At this time, the search capacity and maps do not include an indicator of which providers are accepting new patients and must be used in combination with the DMHAS website.		

Sample Connecticut Medicaid BH ASO accessibility maps and search function (current as of June 16, 2021) – Search for a Behavioral Health Medicaid provider offering MAT services by name, city, or medication ([http://www.ctbhp.com/medication-assisted-treatment.html)](http://www.ctbhp.com/medication-assisted-treatment.html)

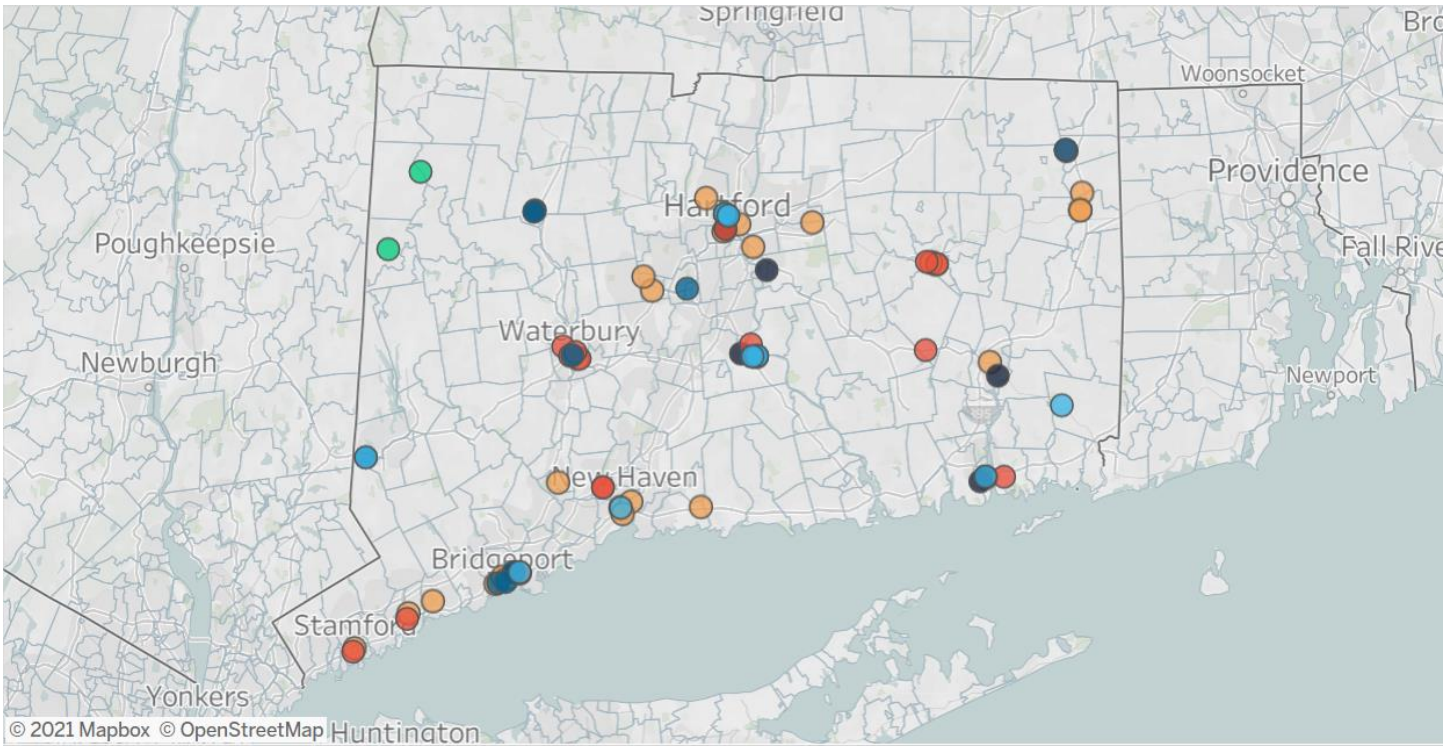
Select to Highlight (dots may be overlaid)

- Methadone Clinic
- Partial Hospital/IOP with Housing
- Intensive Outpatient (IOP)
- Behavioral Health Outpatient
- Partial Hospitalization (PHP)



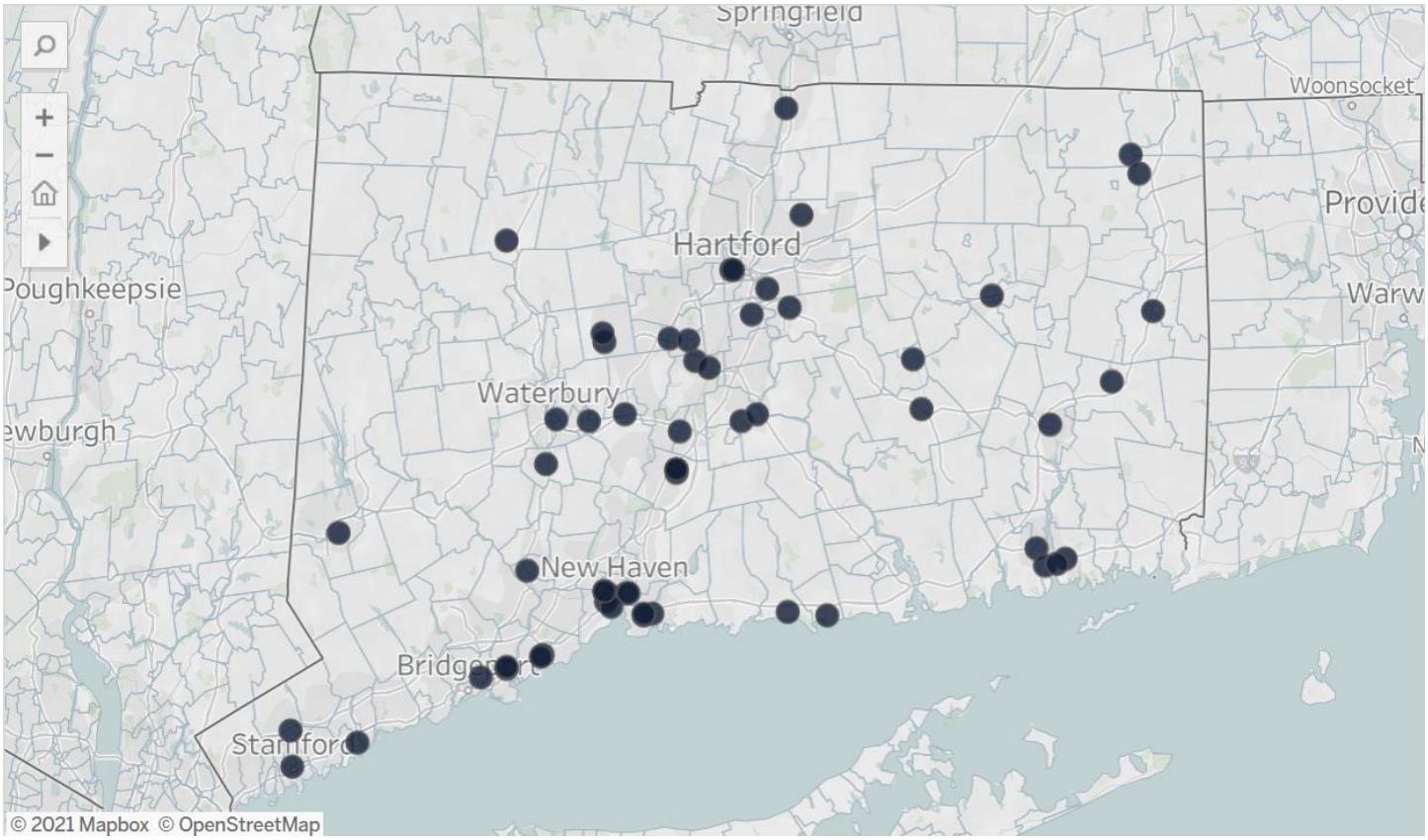
Search for other treatment services that support substance use recovery
Select to Highlight

- Freestanding or State Hospital Detoxification
- SA 3.7 - Intensive Residential Co-Occurring (30 to 45 days)
- SA 3.7 - Intensive Residential (14 to 28 days)
- SA 3.5 - Women's & Children's Programs (3 to 6 Months)
- SA 3.5 - Intermediate Treatment (1 to 3 Months)
- SA 3.3 - Long-Term Care (4 to 6 Months)
- SA 3.1R - Halfway House (3 to 4 months)
- Walk-In Access Center



Medical data is provided and maintained with accuracy/integrity under the responsibility of the Medical ASO

Search for a MEDICAL Medicaid provider offering MAT services.



5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Misuse and OUD

To meet this milestone, Connecticut will ensure that the following criteria are met:

- Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug misuse;
- Expanded coverage of and access to naloxone for overdose reversal; and
- Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs.

Connecticut has detailed the strategies it has in place currently to address prescription drug misuse and opioid use disorders as well as plans to implement additional strategies. Attachment A describes the State's plans for improving its SUD health IT infrastructure to improve its prescription drug monitoring program (PDMP).

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	Provide an overview of current treatment and prevention strategies to reduce opioid abuse and OUD in the state.	Provide an overview of planned strategies to prevent and treat opioid abuse and OUD.	Specify a list of action items needed to be completed to meet milestone requirements as detailed above. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item
Implementation of opioid prescribing guidelines along	To address the opioid and prescription medication crisis, DPH has implemented prescribing guidelines to prevent opioid	None needed – Connecticut currently meets criteria.	None needed – Connecticut currently meets criteria.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
with other interventions to prevent opioid abuse	over-use through a number of updates to Connecticut policy and law regulating the prescribing of controlled substances and opioid medications.[6] Connecticut has also collaborated with other State agencies, legislators, and various professional groups to improve the Connecticut Prescription Monitoring and Reporting System (CPMRS) – the State's PDMP. Effective October 1, 2019, Connecticut amended the Medicaid State Plan to reflect new drug utilization review provisions required in federal law (Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act [SUPPORT Act; P.L. 115-271]). These provisions are designed to reduce opioid-related overprescribing and abuse. The required provisions include		

[6] Rodrick Marriott, PharmD, Director, Department of Consumer Protection Drug Control Division, Connecticut Laws Impacting Prescribing and Practice, 2019, https://portal.ct.gov/-/media/DCP/drug_control/PMP/Educational-Materials/Prescribing-Laws-2019-CM.pdf

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	the following: 136 separate opioid prescription claim reviews at the point of sale as well as retrospective reviews, monitoring and management of antipsychotic medication in children, and identification of processes to detect fraud and abuse. See a more complete listing below this chart.		
Expanded coverage of, and access to, naloxone for overdose reversal	Connecticut has taken a number of steps over the past eight years to make naloxone more widely available. State legislation was first introduced in 2011 in the State's General Assembly and some of the subsequent legislative sessions included new state legislation that has made naloxone more accessible over the years. A "Good Samaritan" law passed in 2011 protects people, who call 911 seeking emergency medical services for an overdose, from arrest for possession of drugs/paraphernalia. Legislation enacted in 2012, which allowed prescribers (physicians, surgeons, physician assistants, advanced practice registered nurses, dentists, and podiatrists) to prescribe,	None needed – Connecticut currently meets criteria.	None needed – Connecticut currently meets criteria.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	dispense, or administer naloxone to any person to prevent or treat a drug overdose, protects the prescriber from civil liability and criminal prosecution. Protection from civil liability and criminal prosecution was extended to the person administering the naloxone in response to an overdose in 2014. Legislation enacted in 2015 allows pharmacists, who have been trained and certified, to prescribe and dispense naloxone directly to customers requesting it. Most recently, another State law (Public Act 18-166) allows prescribers to develop agreements with organizations wishing to train and distribute naloxone. This legislation established new reporting requirements, established a framework for expanding distribution and availability of naloxone, enacted limitations on prescribing controlled substances, and commissioned a feasibility study for opioid intervention courts. All of these changes have supported efforts to make naloxone widely available. In addition, Connecticut has established other initiatives addressing OUD,		

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	including expanding availability of naloxone as outlined in the State's Implementation Plan due to receipt of federal grant funds. Additional opportunities to expand naloxone availability to the public have been met through the federal State Opioid Response grant. A total of 12,000 naloxone kits were made available for distribution in FY 2019 through DMHAS, the Department of Correction, DPH, the Connecticut Hospital Association, and the Regional Behavioral Health Action Organizations.		
Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs	Connecticut first mandated use of the CPMRS, the State's PDMP, by prescribers in 2015, with additional provisions added in 2016. CPMRS is a tool to track the dispensing of controlled prescription drugs to patients. CPMRS is designed to monitor information for suspected misuse or diversion (i.e., channeling drugs into illegal use), and can give a prescriber or pharmacist critical information regarding a patient's controlled substance prescription history. This information has helped prescribers and pharmacists identify high-risk	As of the submission of the Medicaid Implementation Advanced Planning Document (IAPD) in 2019, 31,124 practitioners have controlled substance registrations, with some practitioners having more than one registration. CPMRS data have been integrated with 6,868 EHRs, including three major health systems. This initiative will allow the State to meet the following objectives:	See Attachment A

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	patients who would benefit from early interventions. Since implementation, the use of CPMRS has grown. In 2018, CPMRS reported 1.9 million annual requests from law enforcement, pharmacists, and prescribers. This is nearly double the annual law enforcement, pharmacist, and prescriber requests from 2015 when there were one million requests. CPMRS has also documented a drop in Schedules IV and V controlled substances over time. Consistent with the overall data, the number of Medicaid-reimbursed opioid prescriptions have dropped, as well as Medicaid's percentage of payments for opioids dispensed. Public Act 15-198 mandated that practitioners review a patient's controlled substance prescription history prior to prescribing controlled substances. The	• Further reduce the number of individuals who "doctor shop;" • Provide health care providers critical information regarding a patient's controlled substance prescription history and expand the availability of other data sources to support clinical decision making; • Support clinician interventions for patients exhibiting high-risk behaviors; and • Assist providers in achieving the medication reconciliation meaningful use objective and measure.[7] An additional goal of this integration initiative is to explore providing as many avenues as possible for an authorized health care provider to access the CPMRS, including integrated	

[7] Stage 3 of meaningful use consolidates medication reconciliation into the HIE objective. The objective requires that eligible professionals provide a summary of the care record when transitioning or referring a patient to another setting of care, receive or retrieve a summary of care record upon the receipt of a transition or referral or upon the first encounter with a new patient, and incorporate summary of care information from other providers into their EHR using the functions of Certified EHR Technology. Providers must attest to all three measures and must meet the threshold for at least two measures to meet the objective.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	law also mandated that pharmacists report controlled substance dispensing on a daily basis. Connecticut also plans to continue to leverage opportunities described in State Medicaid Director Letter (SMDL) 16-003 to help professionals and hospitals eligible for the Medicaid Promoting Interoperability Program, formerly known as the Medicaid Electronic Health Record (EHR) Incentive Program connect to other Medicaid providers through the integration of CPMRS into EHRs and pharmacy dispensing systems. All hospitals and pharmacies now have the ability to have CPMRS integrated into their EHRs and pharmacy management systems.	access through Health Information Exchanges (HIEs).	

Connecticut Laws Impacting Prescribing and Practice

RODRICK MARRIOTT, PharmD, Director, Department of Consumer Protection, Drug Control Division

There have been a number of updates to Connecticut law in past years that have an impact on the prescribing community, especially in regards to controlled substances and opioid medications. All of the changes have been small steps to help combat the opioid and prescription medication crisis. The changes for practitioners were made keeping in mind the effect they may have on their day to day work.

We have worked with sister agencies, legislators, and different professional groups to ensure we're taking thoughtful steps forward, and improving the Connecticut Prescription Monitoring and Reporting System (CPMRS), sometimes known as the Prescription Drug Monitoring Program (PDMP). Here are some of the changes:

2015

- Physicians are required to take continuing education courses in risk management, in controlled substance prescribing, and pain management.
- Prescribers are required to review a patient's record on the CPMRS before prescribing any schedule II-V controlled substance meant to last more than 72 hours.
- Physicians must review patient records once every 90 days for a controlled substance prescription meant for on-going treatment.

2016

- In a major change, the law mandates a 7-day supply limit on opioid prescriptions for first time outpatient use. The law maintains professional judgment of the prescribing practitioner to prescribe more than a 7-day supply for on-going use when needed.

- The law requires education for patients under 18 and their guardian regarding the risks of addiction and overdose associated with opioids, and the dangers of combining them with alcohol, benzodiazepines, and other depressants. Patients should also understand the reason for the prescription.
- Also in 2016, practitioners were allowed to delegate an authorized agent to search the CPMRS.
- Under this law, patient records now only need to be reviewed once per year for on-going prescriptions that are Schedule V controlled substances. All other schedules remain at the 90-day level.

2017

- The number of days an opioid can be prescribed on a first visit is limited to five (5) days for patients who are minors.

- The law expands the educational requirement in the 2016 law update to include adults.

- Patients are now allowed to opt-out of being prescribed opioids by filling out a voluntary nonopioid directive form.

2018

- Prescribers are no longer allowed to prescribe controlled substances to themselves or their family members, except in cases of emergency.
- This law expands the ability of telehealth professionals (practitioners who may not see you in person) to prescribe Schedule II and III controlled substances in certain circumstances.

- The law requires that prescribers begin to use electronic prescribing for controlled substance prescriptions if they haven't already, unless there is an emergency, or the proper technology is not available.

We look forward to making more improvements and updates to the systems we use to ensure public health and safety in conjunction with all of our great partners. We know that we always have more work to do, but numbers in recent years are encouraging. Opioid prescriptions are on a steady decline, more pharmacists are able to prescribe naloxone, and residents are using drug drop boxes in record numbers.

At the Drug Control Division, we always welcome questions, concerns, or ideas from the practitioners we work with. You can get in touch with us most easily by emailing dcp.drugcontrol@ct.gov.

https://portal.ct.gov/-/media/DCP/drug_control/PMP/Educational-Materials/Prescribing-Laws-2019-CM.pdf?la=en

6. Improved Care Coordination and Transitions between Levels of Care

Connecticut will implement policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD and other SUDs, with community-based services and supports following stays in these facilities. The table below outlines Connecticut's current procedures for care coordination and transitions between LOCs to ensure seamless transitions of care and collaboration between services, including:

- Current content of specific policies to ensure these procedures;
- Specific plans to help beneficiaries attain or maintain a sufficient level of functioning outside of residential or inpatient facilities; and
- Current policies or plans to improve care coordination for co-occurring physical and mental health conditions.

This milestone will be met within 12 to 24 months of Demonstration approval.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities.	Provide an overview of current care coordination services and transition services across levels of care.	Provide an overview of planned improvements to care coordination services and transition services across levels of care	Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Additional policies to ensure coordination of care for co-occurring physical and mental health conditions	Connecticut has multiple interventions for coordinating the care of individuals with SUD and transitioning them between LOCs, including, but not limited to, facility credentialing, discharge planning requirements, and care management initiatives at DSS, DCF and DMHAS. These include, but are not limited to: • Discharge planning; • Referral and transition requirements; and • Cross-departmental care management initiatives. Current care coordination/case management interventions include: 1. Medicaid targeted case management (TCM) for individuals with serious and chronic mental illness inclusive of individuals with SUD and co-occurring mental illness. 2. Medicaid behavioral health homes pursuant to section 1945 of the Social Security Act. 3. Non-Medicaid DMHAS intensive case management (regions 1, 2, 4 and 5) for HUSKY D Medicaid beneficiaries. Case management support priority is given to	Under the Demonstration, DSS, DCF and DMHAS will create a clear delineation of responsibility for improved coordination and transitions between LOCs to ensure that individuals receive services and supports following stays in facilities and are retained in care; this includes efforts to align activities between DSS, DCF and DMHAS.	DSS will work with DMHAS and DCF to incorporate strong discharge planning and transition planning into the residential and ambulatory LOC at the provider level using new ASAM standards within 12 months of Demonstration approval by April 1, 2023. Service coordination in all ASAM LOCs will be required. Service coordination, includes, but is not limited to, provider-specific and LOC-specific activities that enhance and improve linking members between Medicaid treatment services and enhance and improve the likelihood of engagement in treatment.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	those with a recent inpatient treatment for BH disorders with a focus on SUD diagnoses. Specific care management initiatives include an opioid antagonist treatment protocol. The model also utilizes a recovery specialist who works with the individual in the community to assist them in moving through the recovery continuum. 4. Non-Medicaid DMHAS Region 3 intensive case management under the Eastern Region Service Center (ERSC). This collaborative effort between MH and SUD agencies offers person-centered care and develops recovery plans with the consumer to facilitate employment, independent living, housing, and use of social, 12 step and other community supports. 5. Medicaid Person-Centered Medical Home Plus (PCMH+) benefit. This Medicaid State Plan benefit is an integrated care program under section 1905(a)(30) of the Social Security Act that includes primary care case management services (PCCM) as defined in section 1905(t) and offers enhanced care coordination activities in several key areas, including integrating primary care and BH care, and promoting linkages to community supports, services and natural support		Within 12 months of Demonstration approval, DSS, DMHAS, and DCF will review all of the existing care management models reimbursed via State dollars, Medicaid administrative dollars and Medicaid fee-for-service payments across the State and ensure care management for the SUD population includes a strong transition management component between LOCs by April 1, 2023. Within 12 months, DSS will, based on the budget analysis, determine if the target population in the TCM SPA can be expanded to include SUD-only (i.e., TCM co-occurring

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	systems. PCMH+ provider performance is measured using various quality measures and providers are encouraged to facilitate improvement in transitions of care. 6. Connecticut Behavioral Health Partnership Intensive Care Management (ICM) by the Medicaid program's BH ASO, which is a Medicaid administrative service. 7. Intensive Care Coordination (ICC) for children in Child Welfare (CW) and non-system-involved children by DCF's contractor. This Integrated Family Care and Support (IFCS) model engages families and connects them to traditional and non-traditional resources and services in their community. The model also includes a peer specialist and service delivery is coordinated through family team meetings (eight care coordinators who can serve CW families and psychiatric residential treatment facility transitions directly [staff ratio 1:8-10]). 8. State-funded, non-Medicaid routine care coordination for children (10 providers including 75 care coordinators) – wraparound process (staff ratio 1:10-12), provided by DCF and its contractor.		SUD versus SUD-only) by April 1, 2023.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	9. Intensive family care including case management by DCF and its contractor (unsubstantiated families at risk [staff ratio 1:20-25}) 10. Intensive Care Management (ICM) by the Medicaid program's medical ASO, which is a Medicaid administrative service. This program includes outreach to providers as well as direct member engagement. Primary care providers are notified when patients are filling high-dose opioid prescriptions and are provided an opioid utilization report. The ICM team conducts monthly outreach to members attributed to non-PCMH practices who have filled high-dose opioid prescriptions. Members are offered MAT or other SUD treatment. The model also uses community health workers if community resource needs are identified.		

Section II – Implementation Plan Administration

Please provide the contact information for the state's point of contact for the Implementation plan.

Name and Title: William Halsey, Director of Integrated Care, Division of Health Services, Department of Social Services
Telephone Number: 860-424-5077
Email Address: William.Halsey@ct.gov

Section III – Implementation Plan Relevant Documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.

Attachment A: Template for Substance Use Disorder Health Information Technology Plan

Attachment A Section I.

As a component of Milestone 5, Implementation of Strategies to Increase Utilization and Improve Functionality of PDMPs, in SMDL 17-003, states with approved Section 1115 Substance Use Disorder (SUD) demonstrations are generally required to submit a SUD Health Information Technology (IT) Plan as described in the Special Terms and Conditions (STCs) for these demonstrations within 90 days of demonstration approval. The SUD Health IT Plan will be a section within the state's SUD Implementation Plan Protocol and, as such, the state may not claim federal financial participation for services provided in Institute for Mental Disease until the SUD Health IT Plan has been approved by CMS.

In the event that the state believes it has already made sufficient progress with regards to the health IT programmatic goals described in the STCs (i.e., PDMP functionalities, PDMP query capabilities, supporting prescribing clinicians with using and checking the PDMPs, and master patient index and identity management), it must provide an assurance to that effect via the assessment and plan below (see Table 1, "Current State").

SUD Demonstration Milestone 5.0, Specification 3: Implementation of Strategies to Increase Utilization and Improve Functionality of PDMP.

The specific milestones to be achieved by developing and implementing a SUD Health IT Plan include:

- Enhancing the health IT functionality to support PDMP interoperability.
- Enhancing and/or supporting clinicians in their usage of the State's PDMP.

The State should provide CMS with an analysis of the current status of its health IT infrastructure/"ecosystem" to assess its readiness to support PDMP interoperability. Once completed, the analysis will serve as the basis for the health IT functionalities to be addressed over the course of the demonstration — or the assurance described above.

The SUD Health IT Plan should detail the current and planned future state for each functionality/capability/support — and specific actions and a timeline to be completed over the course of the demonstration — to address needed enhancements. In addition to completing the summary table below, the State may provide additional information for each Health IT/PDMP milestone criteria to further describe its plan.

Table 1. State Health IT/PDMP Assessment and Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
5. Implementation of comprehensive treatment and prevention strategies to address Opioid Abuse and Opioid Use Disorder, that is: • Enhance the State's health IT functionality to support its PDMP. • Enhance and/or support clinicians in their usage of the State's PDMP.	Provide an overview of current PDMP capabilities, health IT functionalities to support the PDMP and supports to enhance clinicians' use of the state's health IT functionality to achieve the goals of the PDMP.	Provide an overview of plans for enhancing the State's PDMP, related enhancements to its health IT functionalities and related enhancements to support clinicians' use of the health IT functionality to achieve the goals of the PDMP.	Specify a list of action items needed to be completed to meet the Health Information Technology (HIT)/PDMP milestones identified in the first column. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item
PDMP Functionalities			
Enhanced interstate data sharing in order to better track patient specific prescription data	Connecticut's PDMP, the Connecticut Prescription Monitoring and Reporting System (CPMRS), participates in Prescription Monitoring Program Interconnect (PMPI). The system allows a user to search PDMPs in other states.	Connecticut will continue to grant access to PDMP users from other states via the PMPi platform. This will depend on each state's ability to share data. Connecticut will continue to explore expanding connectivity to states not currently exchanging with CPMRS, will participate in NESCSO SUPPORT Act planning process. Connecticut has begun	As data sharing is dependent on other states (including necessary changes to state law), there are no specific actions that can be listed here.

	Currently there are 45 active and pending participants. Figure 1 illustrates that Connecticut has activated interstate data sharing with 40 states, in addition to Puerto Rico and Washington D.C., and includes all states bordering Connecticut and the northeast region. The CPMRS has not connected with all participants due to several factors, with the most common barrier being: • A state is focusing on connecting with their border states first. • A state is currently transitioning to a new PDMP system. • A state has prioritized other PDMP projects over interstate connectivity.	to use RxCheck hub to support interstate exchanges. Connecticut would like to continue to increase the number and value of the interstate data sharing agreements with other states. The proposed contract resources and existing administrative technician will work to improve the interstate data sharing relationships, as well as seek out additional state agreements to expand the value of the PDMP for Connecticut-covered providers. This activity will improve the comprehensiveness and accuracy of every PDMP query made by covered providers by ensuring that medication history located in other state PDMPs can be considered when consulting Connecticut's PDMP.	
Enhanced "ease of use" for prescribers and other State and federal stakeholders	Connecticut has been working diligently to encourage and facilitate integration of the CPMRS into EHRs. This integration puts the CPMRS data directly into the workflow of health care professionals,	Connecticut plans to continue to leverage opportunities described in SMDL 16-003 to help professionals and hospitals eligible for Medicaid EHR Incentive Payments connect to other Medicaid providers through the integration of CPMRS into EHRs and pharmacy dispensing systems. Hospitals	The Connecticut Department of Consumer Protection (DCP), the PDMP vendor (Appriss Health), and DSS, as the administrator of the EHR Incentive Program, will

	bypassing multiple password requirements and the need to exit their EHR to access the CPMRS from a separate web portal. As noted in the SUPPORT Act IAPD, CPMRS data have been integrated with some EHRs, including three major health systems. Connecticut is also working on the integration of the PDMP into the HIE, which is seen as a more sustainable option.	and pharmacies may request to have CPMRS integrated into their EHRs and pharmacy management systems. **Effective January 1, 2021, dispensation information for insulin drugs, glucagon drugs, diabetes devices, diabetic ketoacidosis devices, gabapentin, and naloxone are required to be uploaded into the CPMRS. All listed prescriptions will be available on patient reports except for naloxone. Only CPMRS admin will have access to naloxone data for the purpose of aggregate population analytics that will help to inform public policy.** The Connecticut Prescription Monitoring Program (PMP) announced a statewide initiative to integrate the CPMRS into approved EHR/PMS using Appriss Health's PMP Gateway service in 2021. The integration will eliminate the need for providers to navigate to the CPMRS website, log in, and enter their patient's information. Instead, the EHR/PMS will automatically initiate a patient query, which will return the patient's controlled substance prescription records directly	continue to onboard new EHR and pharmacy dispensing vendors.

		within the clinical workflow inside the EHR/PMS. • Access PMP data at the point-of-care • Streamline searches • Increase utilization of the CPMRS • Access to PMP data and NarxCare analytics within the workflow	
Enhanced connectivity between the State's PDMP and any statewide, regional or local HIE	Leveraging the HIE infrastructure would potentially allow for the most efficient pathway for practitioners and dispensers to access a complete patient profile that includes their controlled substance history. **PDMP Activities** In 2018, Congress passed the SUPPORT Act, which includes important health reforms to combat the opioid crisis by advancing treatment and recovery initiatives, improving prevention, protecting communities and more. In December 2019, DSS submitted a new IAPD to CMS,	DCP has been working with Connecticut's Office of Health Strategy (OHS) for the purpose of integrating the CPMRS into the HIE. The Health Information Exchange (HIE) is working with our software vendor to integrate the Connecticut Prescription Monitoring and Reporting System (CPMRS) data. The HIE is still in its infancy in Connecticut and they are working through the technical specifications to ensure that the data shared is appropriate and auditable to ensure compliance with regulations. **The CPMRS can now be accessed through approved electronic health records (EHR) and pharmacy management systems (PMS) where PDMP data and NarxCare analytics will be delivered directly into practitioner workflow. The Connecticut Prescription**	DCP, in collaboration with OHS and DSS, will continue to link the CPMRS with the HIE consistent with the IAPD.

	Medicaid Management Information System Support Act, to request 100% federal funds available under Section 5042 of the *SUPPORT Act*. The IAPD application was subsequently approved in February of 2020. In July 2020, DSS submitted an updated HIT IAPD that included activities related to PDMP HIE connectivity.	**Monitoring Program (PMP) announced a statewide initiative to integrate the CPMRS into approved EHR/PMS using Appriss Health's PMP Gateway service in 2021. For updated accessibility statistics, see Table 1 and Table 2.** The SUPPORT Act and the HIT IAPDs include activities intended to expand the capacity of the CPMRS by continuing to connect health systems and providers and by integrating CPMRS into EHRs. The work proposed within the IAPDs will continue the existing work of adding connections and integrating into additional EHRs and initiate some implementation activities as well as planning for areas where there are gaps between the current PDMP and the definition of a "qualified" PDMP, pursuant to the SUPPORT Act. Connectivity and integration to the statewide HIE ("Connie") is strategically seen as a preferred solution for provider workflow integration. For EHR integrations, the HIE will connect to Appriss Health's PDMP gateway product, to the RxCheck hub or both. The HIE connection will facilitate a bi-directional data feed between the HIE and PDMP. The trigger for the	

		query will occur during the prescribing workflow and can be automated. The diagram after this chart (Figure 2) illustrates the basic connectivity architecture with the HIE available for connections to the PDMP through the Appriss Health hub.	
Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns [8]	CPMRS data informs planning and decision making such as identification of geographical hot spots for prescribed opioids and other controlled substances, prescriber outreach and relationships between reported prescription drug use and overdose deaths. In 2016, the CPMRS introduced automated clinical notifications for prescribers and dispensers to assist them with timely information about patients they are treating. In 2018, the CPMRS added the "prescriber report," which provides prescribers with individual controlled substance prescribing	Connecticut will develop additional analytical tools to address limitations in the current system and correlate long-term opioid use directly to clinician prescribing patterns. Connecticut has recently purchased the "NarxCare Enterprise"™ platform via a federal grant. NarxCare provides a comprehensive tool to assess narcotic overdose and diversion risk. NarxCare aggregates and analyzes controlled substance prescription information from providers and pharmacies, and presents interactive, visual representations of that information as well as advanced analytic insights, complex risk scores and more features to aid physicians, pharmacists and care teams to increase patient safety	Connecticut is considering purchasing another new analytical tool from Appriss Health to: • improve the ability to monitor all pharmacy and dispensing practitioners for uploading compliance. • identify those practitioners and prescribers who are not compliant with the lookup mandate or other aspects of the law. DCP and/or DSS will evaluate the feasibility of

[8] Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: http://dx.doi.org/10.15585/mmwr.mm6610a1. (See also "Use of PDMP" #2 below.)

	data to assist them in understanding how their prescribing compares against their peers. In 2016, the PDMP transitioned to a new, more robust CPMRS platform that provides a better range of analytical tools for all users and allows reports to aid with the enforcement of the mandatory registration of all Community Support Program (CSP) registrants in CPMRS. Connecticut's PDMP does not have the tools to determine compliance with uploading for dispensing practitioners and non-resident pharmacies. Connecticut is currently attempting to purchase a module from Appriss Health to improve the ability to monitor all pharmacy and dispensing practitioners for uploading compliance.	and outcomes. The platform can also accommodate additional information sources to create more holistic risk models, assessments and alerts. NarxCare helps practitioners assess narcotic overdose and diversion risk. DCP is currently working with the vendor to implement this tool in the CPMRS.	utilizing predictive analytics to forecast increased risk of long-term prescription misuse based on initial prescribing characteristics.
Current and Future PDMP Query Capabilities			
Facilitate the State's ability to properly match	**Integrated Eligibility System**	**OHS and Connie**	DCP, OHS and DSS will work to identify

patients receiving opioid prescriptions with patients in the PDMP (i.e., the State's Master Patient Index [MPI] strategy with regard to PDMP query)	Implemented in August 2017, the integrated eligibility system uses a NextGate solution for patient-matching across programs. The DSS Enterprise Master Person Index (EMPI) is funded through a shared services APD and will be retained by DSS for continued use by the integrated eligibility system. **EMPI** DSS implemented the NextGate EMPI solution in January 2016 with a goal of creating a consolidated view of patient/person information across disparate source systems as well as workflow and basic reporting tools for ongoing maintenance of the system. Today, the EMPI is used by the State's eligibility and enrollment system (DSS-ImpaCT) and the State's HIE system, Access Health CT. EMPI is hosted by the State's Department of	The State is developing a federated model of HIE (aka "network-of-networks"). This structure will allow both individual EHRs and existing HIE initiatives to connect and share data through secure interfaces connecting public and private HIE nodes to the statewide HIE network using national standards for point-to-point exchange or participating in a national network. In this federated HIE data model, EHR patient data will remain within the individual systems of record and be pulled or pushed from HIE services as required. Queried data will be organized and contextualized through HIE services to support identified use cases. The roadmap has three major lanes: (i) governance, (ii) enterprise data governance, and (iii) HIE. See Figure 3. Statewide HIE Roadmap The HIE will be implemented in multiple stages to deliver functionality to the stakeholders/users in a timely and efficient manner, following an incremental delivery methodology and procurement process. The initial focus is on core foundational components: HIE services as shown in	management across systems for better integration. As a benefit of the IAPD, we are offering a simplified system to provide enhanced data sharing within the state known as the gateway. We have onboarded a significant number of providers via integration into the electronic health record (EHR) and pharmacy dispensing software that leverage the data from those systems to provide searches and return PDMP data. **The CPMRS can now be accessed through approved electronic health records (EHR) and pharmacy management systems (PMS) where PDMP data and NarxCare analytics will be**

	Administrative Services, Bureau of Enterprise Systems and Technology.	Figure 3 Statewide HIE Roadmap. These core services will focus on the installation and configuration of HIE componentry, including enhancement, transformation and alignment of data, management and auditing, technical assistance, and deploying to existing EHRs via standard protocols. Each stage will focus on the release of solution components as required to deliver the functionality captured in the prioritized use cases. The HIE services will interface with the Core Data Analytic Solution (CDAS) shared core system components, including the Informatica Master Data Management (MDM) multi-domain system Identity as a Service (IDaaS) The MDM component implemented includes a master person index (MPI). The HIE services will interface with the UConn CDAS MDM solution for identity and consent management. Optimizing access to Medicaid patient data and recognizing a statutory obligation for hospitals to be connected within one year of operations, the initial implementation of use cases will focus on one or two FQHCs and a large hospital. The HIE will utilize	**delivered directly into practitioner workflow. The Connecticut Prescription Monitoring Program (PMP) announced a statewide initiative to integrate the CPMRS into approved EHR/PMS using Appriss Health's PMP Gateway service in 2021. For updated accessibility statistics, see Table 1 and Table 2.**

		industry standard interfaces to obtain data from the FQHCs and a hospital in the format of Continuity of Care Documents and/or Quality Reporting Document Architecture Category I to the HIE. The initial implementation will focus efforts on building to match patients and providers and establish care relationships. The result is proven capability to patient matching that will ensure the success of future connections and value proposition to stakeholders. Once stable service is verified, the intention is to deploy to the remaining FQHCs, hospitals and small independent provider groups to include additional EHRs, CDAS and lab information. The HIT Project Management Office (PMO) will develop and recommend a sequence of connections as the HIE scales based on readiness at care settings and priorities that will be reviewed with the HIT Advisory Council for evaluation. The State will provide a single, combined view of data regardless of the data origination point through IDaaS. This will capture a unified view of person, provider and relationship data in a manner to deliver	

		a best instance of identity, as a service. For example, the architectural approach that we wish to achieve would allow the interface of these identity services with other master person index and provider registry systems, such as, Medicaid EMPI, and other related tools used to support their specific needs. Stakeholder outreach and feedback and the movement to interface foundational services via published web services and application programming interface architectures, identifies a clear objective to provide an IDaaS for use by other stakeholders. A key component of the architecture is access controls to ensure appropriate and permitted use of data through identity management. An additional shared service will perform the transformation of data to align and normalize the data for interoperability across EHR systems. These services will provide data parsing and standardization to classify, de-duplicate and enrich clinical data and enable improved patient care and clinical informatics. Quality control and assurance capability will be used for alerts	

		and scorecards to enable providers to better understand and improve the quality of data in their EHRs. **Master prescription history database** Statewide databases like the CPMRS and networks like Surescripts have established feasible methods of maintaining and accessing prescription medication fill data and have largely addressed issues of privacy, data security, data storage and data access. The State is researching to determine if, with appropriate resources and legal empowerment, these databases might form the basis of a centralized master list of active prescription medications and medication history.	
Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes			
Develop enhanced provider workflow/business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow	Leveraging the HIE infrastructure would potentially allow for the most efficient pathway for practitioners and dispensers to access a complete patient profile that includes their controlled substance history.	PDMP has been working with OHS for the purpose of integrating the CPMRS into the HIE once the infrastructure is built. The new approved SUPPORT Act IAPD includes activities intended to expand the capacity of the CPMRS by connecting health systems and providers and integrating CPMRS into EHRs. The work proposed within this IAPD and the HIT IAPD will continue the existing work of adding connections and integrating into	Connecticut will continue to integrate the CPMRS into the HIE as the infrastructure is built consistent with the newly approved IAPDs. The CPMRS is a highly integrate tool in the EHR and pharmacy dispensing software today and looking

		additional EHRs, begin some implementation activities, and begin the planning for areas where there are gaps between the current PDMP and the definition of a qualified PDMP pursuant to the SUPPORT Act. Planning for use cases dependent on PDMP participation and utilization is also included and Connecticut's statewide HIE will be connected to the PDMP. *Connie* is strategically seen as a preferred solution for provider workflow integration. For EHR integrations, the HIE will connect to Appriss Health's PDMP Gateway product, to the RxCheck hub, or both. The HIE connection will facilitate a bi-directional data feed between the HIE and PDMP. The trigger for the query will occur during the prescribing workflow and can be automated. The diagram (Figure 2) after this chart illustrates the basic connectivity architecture with the HIE available for connections to the PDMP, through the Appriss Health hub. The Medicaid enterprise can query the PDMP through an HIE connection. In the future, if statutory and data sharing issues are resolved to remove current restrictions, Medicaid could	to add the HIE. The software team at the EHR and pharmacy dispensing software get to determine where the information is displayed based on their internal development. In 2020, the CPMRS received over 19 million requests via integrated search which was a new record for the state without connection to the HIE. The technical work of integration is being managed by the staff at the HIE and our software vendor. Our software vendor has an Active Programming Interface (API) developed but will also build a custom interface if the EHR or pharmacy dispensing software requires it. **The CPMRS can now be accessed through approved electronic health records (EHR) and**

		establish a direct connection to the PDMP if needed by a use case. Among its various funding opportunities, the *SUPPORT Act* provides resources to better integrate and utilize state PDMPs or PDMP in Connecticut (CPMRS). DSS, DCP and OHS recently submitted a request to CMS to fund a planning and design process to identify specific, tangible, value-added initiatives related to CPMRS. Current collaborations include a successful three-agency workgroup focused on the SUPPORT Act. This group, composed of DSS, DCP, and OHS were successful in receiving CMS approval for SUPPORT Act funding. The three agencies are now developing plans for PDMP improvements to make sure that the PDMP will meet the qualified standard for a qualified PDMP. Other initiatives that are in the joint DSS-OHS portfolio include e-consults and e-referrals. Through the SUPPORT Act IAPD and other SUPPORT Act-funded initiatives, opportunities related to the stated purpose	**pharmacy management systems (PMS) where PDMP data and NarxCare analytics will be delivered directly into practitioner workflow. The Connecticut Prescription Monitoring Program (PMP) announced a statewide initiative to integrate the CPMRS into approved EHR/PMS using Appriss Health's PMP Gateway service in 2021. For updated accessibility statistics, see Table 1 and Table 2.**

		and goals of the Medication Reconciliation and Polypharmacy Committee are actively monitored.	
Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP — prior to the issuance of an opioid prescription	Connecticut will continue to implement Appriss Health's NarxCare program.	Connecticut hopes to add to the CPMRS the NarxCare platform via a federal grant. NarxCare provides a comprehensive tool to assess narcotic overdose and diversion risk. NarxCare aggregates and analyzes controlled substance prescription information from providers and pharmacies, and presents interactive, visual representations of that information as well as advanced analytic insights, complex risk scores and more features to aid physicians, pharmacists and care teams to increase patient safety and outcomes. The platform can also accommodate additional information sources to create more holistic risk models, assessments and alerts. DCP is currently working with Appriss Health to implement this tool in the CPMRS. One large healthcare system and one national pharmacy chain have already purchased this enhanced analytic tool on their own.	The PDMP administrator, along with the PDMP vendor (Appriss Health), are responsible for the development of processes and system testing for the inclusion of NarxCare. Integration into the CPMRS continues grow and as stated earlier we had over 19 million integrated searches in 2020. There are mandatory look-up requirements for prescribers of controlled substances in the law in Connecticut. The EHR vendor and operator as well as the pharmacy dispensing software operate are permitted flexibility regarding the timing of the information being presented.

			Currently, the state is providing NarxCare, which is an enhanced analytical tool to identify overdose risk, free as part of grants with other partners like the Department of Public Health, the Department of Mental Health and Addiction Services, the Center for Disease Control and Prevention, the Department of Justice, and the Substance Abuse and Mental Health Services Administration. The program is operational at this point.
Master Patient Index / Identity Management			
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	• The PDMP system already uses an algorithm that automatically links patient records (coming from pharmacies) based on name, date of birth, zip code and street address. • Appriss Health uses the prescription drug monitoring	DCP and DSS will develop an approach for the CPMRS and HIE to identify management functions across both systems with a goal to improve efforts to integrate care and have better outcomes.	DCP, OHS and DSS will work to identify management across systems for better integration.

	interface, AWARxE, which provides Project Management Professional staff the following capabilities to: – Authorize practitioners, their delegates and pharmacists registering for CPMRS access – Manage CPMRS accounts – Maintain a list of data submitters, from pharmacies and licensed practitioners, who dispense Schedule II, III, IV or V controlled substances – Approve data submissions from pharmacies and licensed practitioners who dispense Schedule II, III, IV or V controlled substances under federal and state law – Conduct analysis of pharmacies that have not reported or are delayed in reporting		

	— Create dashboard announcements accessible to registered users — Consolidate patient information for patients reported to the database with differences in name, date of birth or gender — Generate patient prescription history reports — Generate dispensary activity reports — Generate alerts for practitioners and pharmacists based on thresholds for high doses, high-risk drug combinations, and potentially risky patient behavior.		
Overall Objective for Enhancing PDMP Functionality & Interoperability			
Leverage the above functionalities/capabilities/supports (in concert with any other state health IT, technical assistance or workflow	Prior to 2017, there was no consistent way to track whether or not CSP/CPMRS registrants who wrote a controlled substance prescription were reviewing a patient's record	The PDMP administrator refers issues to Drug Control Agents, who enforce the mandated lookup requirements. DSS receives reports from its medical and dental ASOs of Medicaid patients filling opioid prescriptions in amounts exceeding	Connecticut will explore additional analytical tools to assist with enforcement to minimize the risk of inappropriate overprescribing.

effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing — and to ensure that Medicaid does not inappropriately pay for opioids	when prescribing more than a three-day supply. In 2017, through a collaborative effort supported by a federal grant with DPH, DCP was able to hire a durational employee with technical expertise in data analytics to run additional reports that aggregate the number of prescribers who have never reviewed any patient's controlled substance prescription records. Appriss Health has a new analytical tool that will enable the PDMP to identify those who are not compliant with the lookup mandate. The PDMP cannot generate automated, comprehensive reports to flag prescribers who fail to follow the three-day supply mandated lookup. Because of the lack of analytical tools, enforcement has been based on individual complaints to the Drug Control Division. **e-Prescribing Support**	100 morphine milligram equivalents (MME) per day for a minimum of 90 consecutive days. That information is utilized for outreach to providers.	The compliance module, which we hope to turn on by the end of the year, includes automated reports that will identify non-compliance with our law. Currently, we can do these manually and do so as required during investigations. We recently turned on an enhance tool to identify prescribers who were utilizing the CMPRS via integration without being compliant with the registration requirement and credential. These steps are dramatically improving our data and will allow us to activate this module efficiently and reduce false positives.

	The interChange system includes e-Prescribing functionality, which allows providers to check eligibility and medication history, access program formulary information and obtain potential drug interactions for the Medicaid program participants. Surescripts is utilized as a subcontractor to provide connectivity between the provider and the pharmacy and between the provider and the payer and to build the Medicaid portal into the State's e-Prescribing network. Transaction volume for e-Prescribing has increased steadily since implementation in 2010 as more prescribers have begun utilizing the functionality. Approximately 777,500 eligibility and 424,000 medication history transactions are processed monthly.		

Attachment A Section II – Implementation HIT Administration

Please provide the contact information for the State's point of contact for the SUD Health IT Plan.

Name and Title: William Halsey, Director of Integrated Care, Division of Health Services, Department of Social Services

Telephone Number: 860-424-5077

Email Address: William.halsey@ct.gov

Attachment A Section III – Relevant Documents

Please provide any additional documentation or information that the State deems relevant to successful execution of the implementation plan

Figure 1. Interstate PDMP Data Sharing

Authorized roles in the CPMRS currently have access to prescription data from 39 states, Washington DC, Puerto Rico, and the Military Health System. This includes all border states. Connecticut allow other states to connect via the PMP Interconnect (PMPi) or RxCheck, which are data sharing hubs that use end-to-end encryption to facilitate data sharing across state borders.

Source: https://portal.ct.gov/DCP/Prescription-Monitoring-Program/Prescription-Monitoring-Program, accessed on 10/25/2021.

Figure 2: PDMP Diagram with HIE

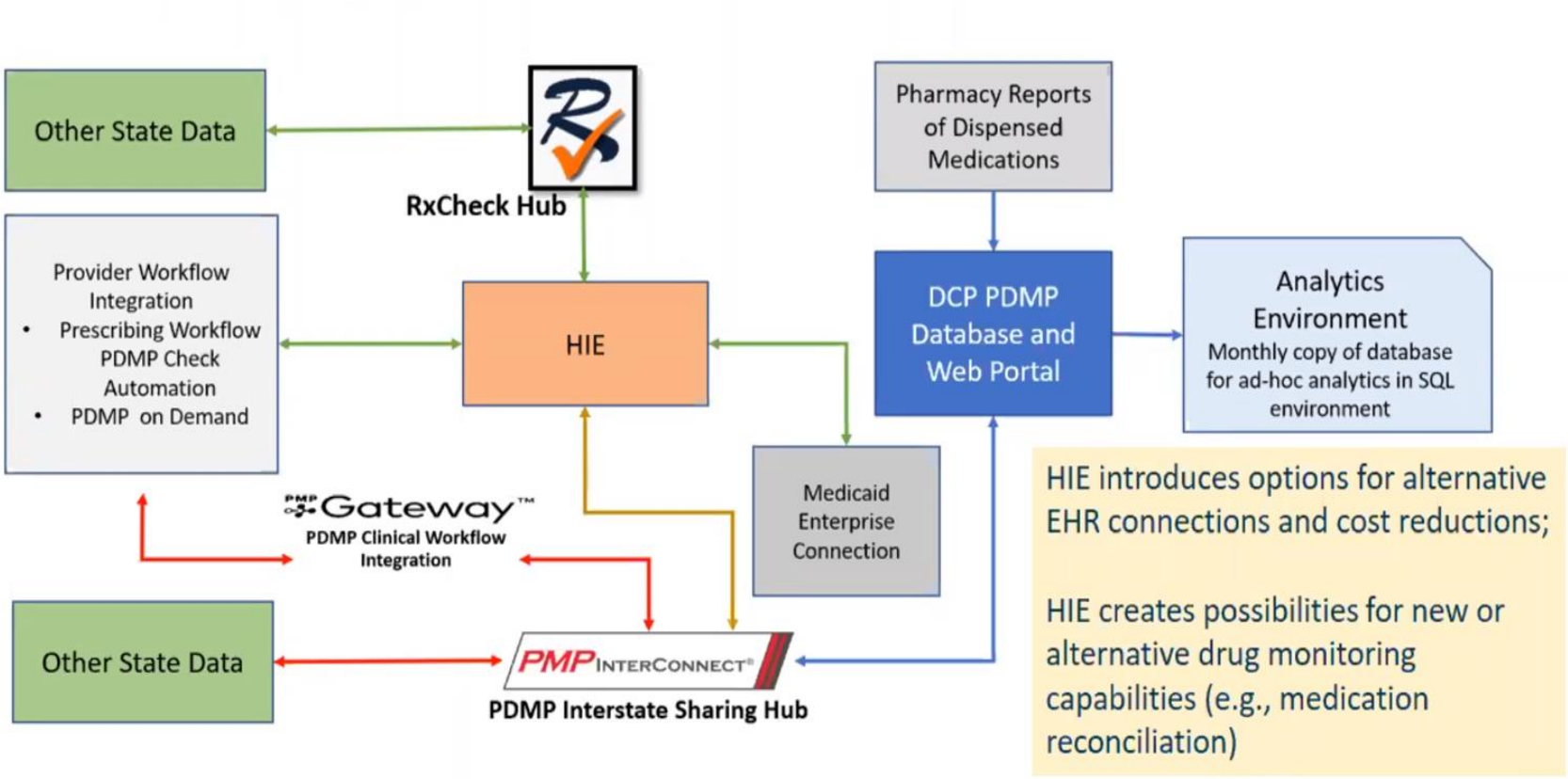


Figure 3: Statewide HIE Roadmap

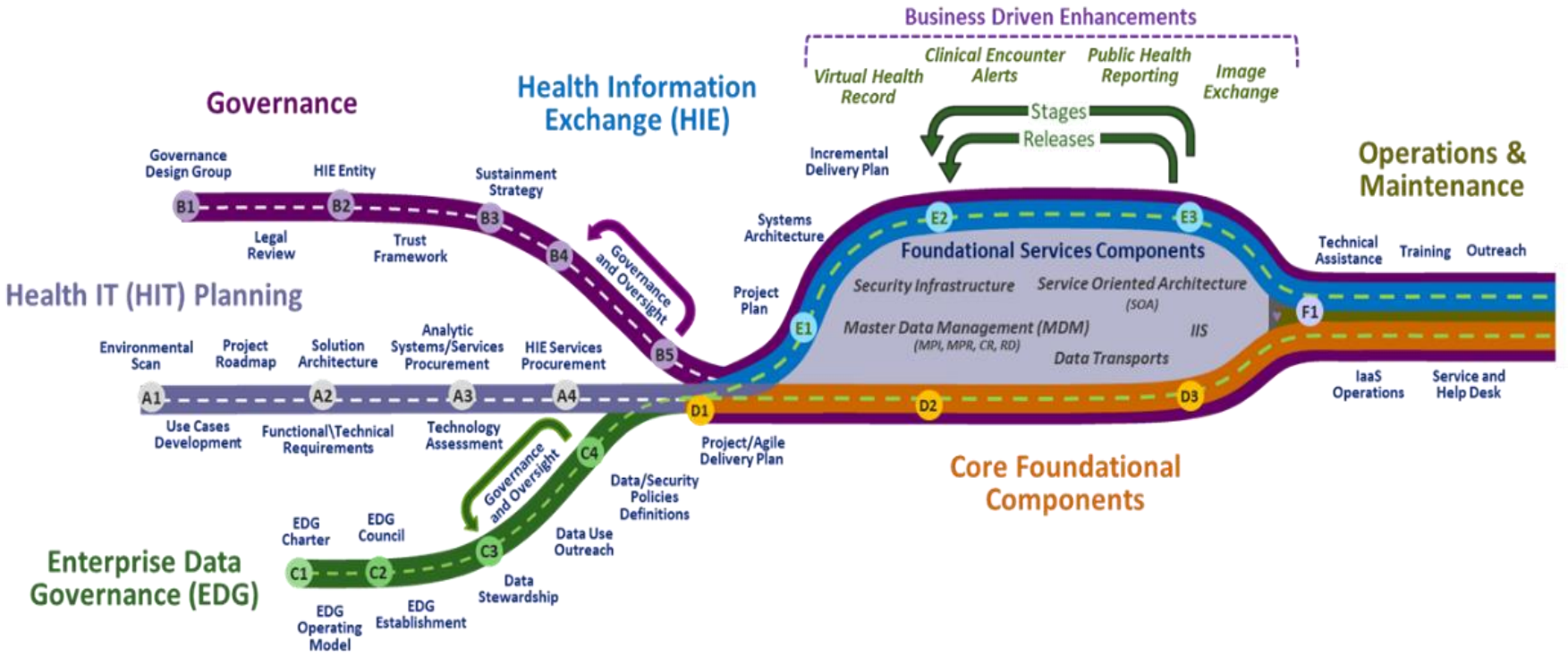


Table 1: CPMRS User Growth

	Prescribers	Prescriber Delegates	Pharmacists	Pharmacist's Delegate	Total
2016	24,068	362	2,255		26,685
2017	26,015	741	2,515		29,271
2018	28,791	1,157	2,730		32,678
2019	26,943	1,521	2,937	43	31,444
2020	29,351	1,767	3,026	68	34,212

Source: https://data.ct.gov/Health-and-Human-Services/Bar-Chart-CPMRS-Registered-Users/cx8y-d3r6

Table 2: CPMRS User Search Growth

	Law Enforcement	Pharmacist	Pharmacist's Delegate	Prescriber	Prescriber Delegate	Total
2015	5,574	465,256		484,736		955,566
2016	3,475	283,588		694,510		981,573
2017	3,924	675,926		1,130,511	142,033	1,952,394
2018	4,206	634,497		1,237,933	284,521	2,161,157
2019	3,808	611,141	3,027	1,392,390	300,580	2,310,946
2020	4,165	576,685	15,038	1,425,554	283,062	2,304,504

Source: https://data.ct.gov/Health-and-Human-Services/Bar-Chart-CPMRS-User-Searches-per-Year/i7mq-p6p2

ATTACHMENT D
Reserved for SUD Monitoring Protocol

ATTACHMENT E
Reserved for SUD Evaluation Design