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

August 9, 2021

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.

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: • 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 Medicine (ASAM).	The Department of Social Services (DSS) will submit a SPA in the rehabilitative services benefit category to update the State's

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.		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 October 1, 2021).

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	3.1-A, currently Att. 3.1-A Page 3 and Add. Pages 4c and 14 to Att. 3.1-A) • 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	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 October 1, 2021).

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	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)		
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

Milestone Criteria	Current State	Future State	Summary of Actions Needed
			October 1, 2021).
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 October 1, 2021).
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.	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	DSS will submit a Rehabilitative SPA to update the State's standards to be consistent with the latest edition of ASAM and to include

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	3.1-A, currently Att. 3.1-A Page 1 and Add. Page 1a to Att. 3.1-A) 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)	setting. Connecticut reimburses providers outside of the Medicaid program using SAPT block grant and State funds for detoxification programs.	coverage of Medically supervised withdrawal management in a non-hospital setting no later than 12 months following CMS approval of the Demonstration (by October 1, 2021).

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	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

		receipt of services 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 October 1, 2022. 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 October 1, 2021) and related Medicaid provider manuals (completed by October 1, 2022) 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 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.	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 October 1, 2022). The DSS BH ASO will provide a website with a provider search function for Medicaid beneficiaries and providers at all LOCs (by October 1, 2022). 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 January 1, 2022).
Implementation of a utilization	Today, the State BH ASO utilizes the ASAM third edition (which is the latest edition) to review	Connecticut will develop program standards to ensure	DMHAS/DCF have statutory authority for SUD service

management approach such that (b) **interventions are appropriate for the diagnosis and level of care**	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.	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.	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 October 1, 2022). 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 October 1, 2023). 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 October 1, 2021. 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 October 1, 2023.
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-	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	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 October 1, 2023.

	_clinical/ABH_Clinical_Level_of_Care_Guidelines_2015.pdf	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.	

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**	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 April 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

residential treatment settings			later than 24 months after Demonstration approval or by October 1, 2023).
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 October 1, 2023).

Implementation of requirement that residential treatment facilities offer MAT onsite or facilitate access off-site	Connecticut already has in place a requirement that residential treatment facilities offer multiple versions of MAT on-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.	None needed – Connecticut currently meets criteria.	None needed – Connecticut currently meets criteria.

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 services);	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	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 October 1, 2022). 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 October 1, 2023).

Intensive Care in Residential and Inpatient Settings; Medically Supervised Withdrawal Management.	providers), inpatient services (1,560 providers), and prescription drugs (1,091 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		

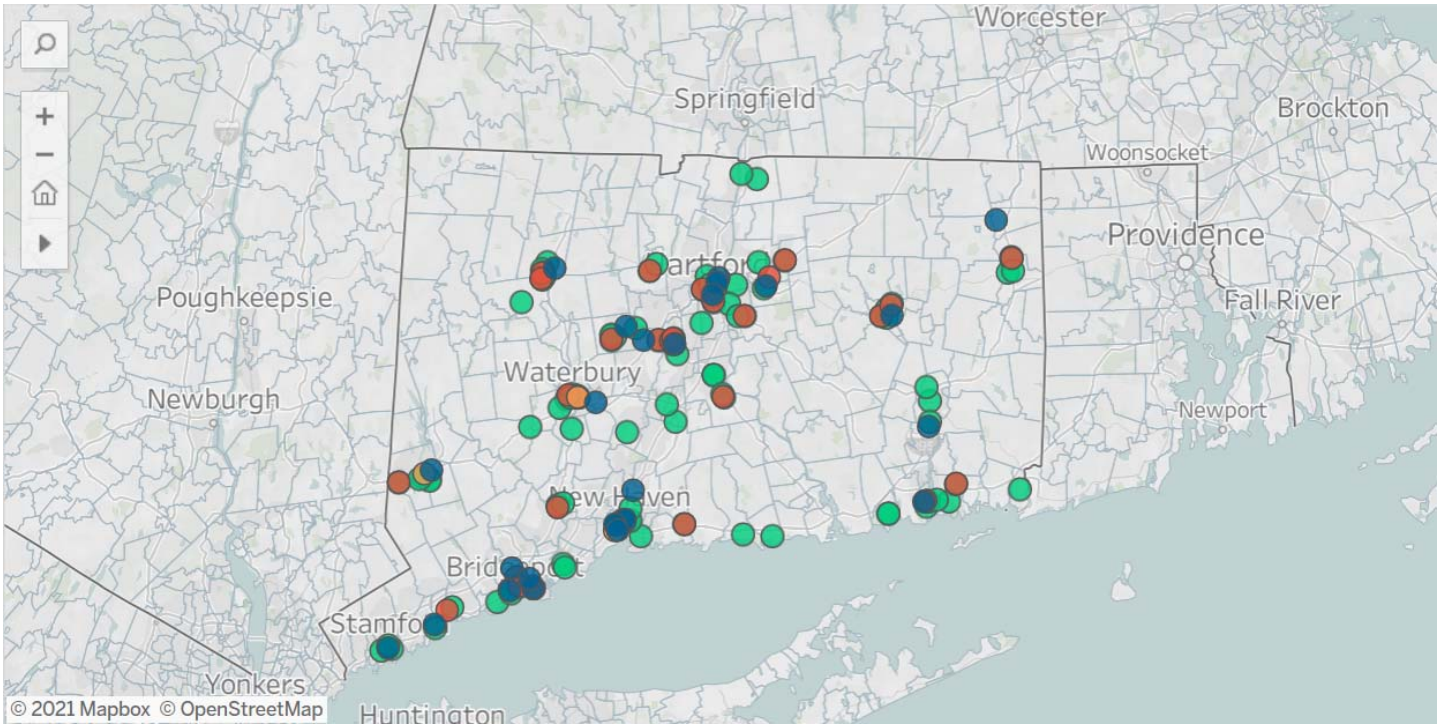
	health services (129). Overall, 42,322 members with SUD received care in at least one of the service categories outlined in the guidelines. The largest number of members with SUD (23,058) received care at a clinic, which includes FQHCs and methadone clinics. Many members also received physician services (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)

Select to Highlight (dots may be overlaid)

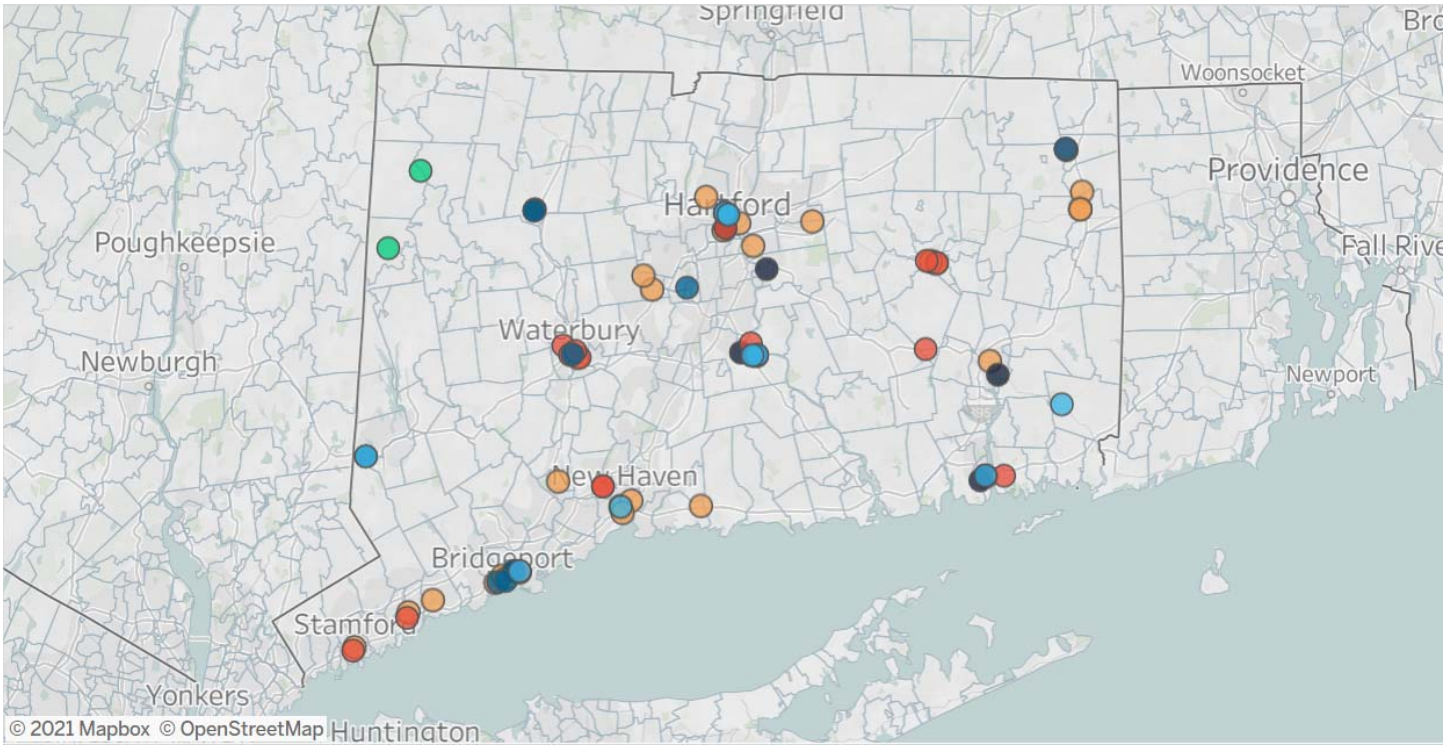
- Methadone Clinic
- Partial Hospital/IOP with Housing
- Intensive Outpatient (IOP)
- Behavioral Health Outpatient
- Partial Hospitalization (PHP)



Search for other treatment services that support substance use recovery

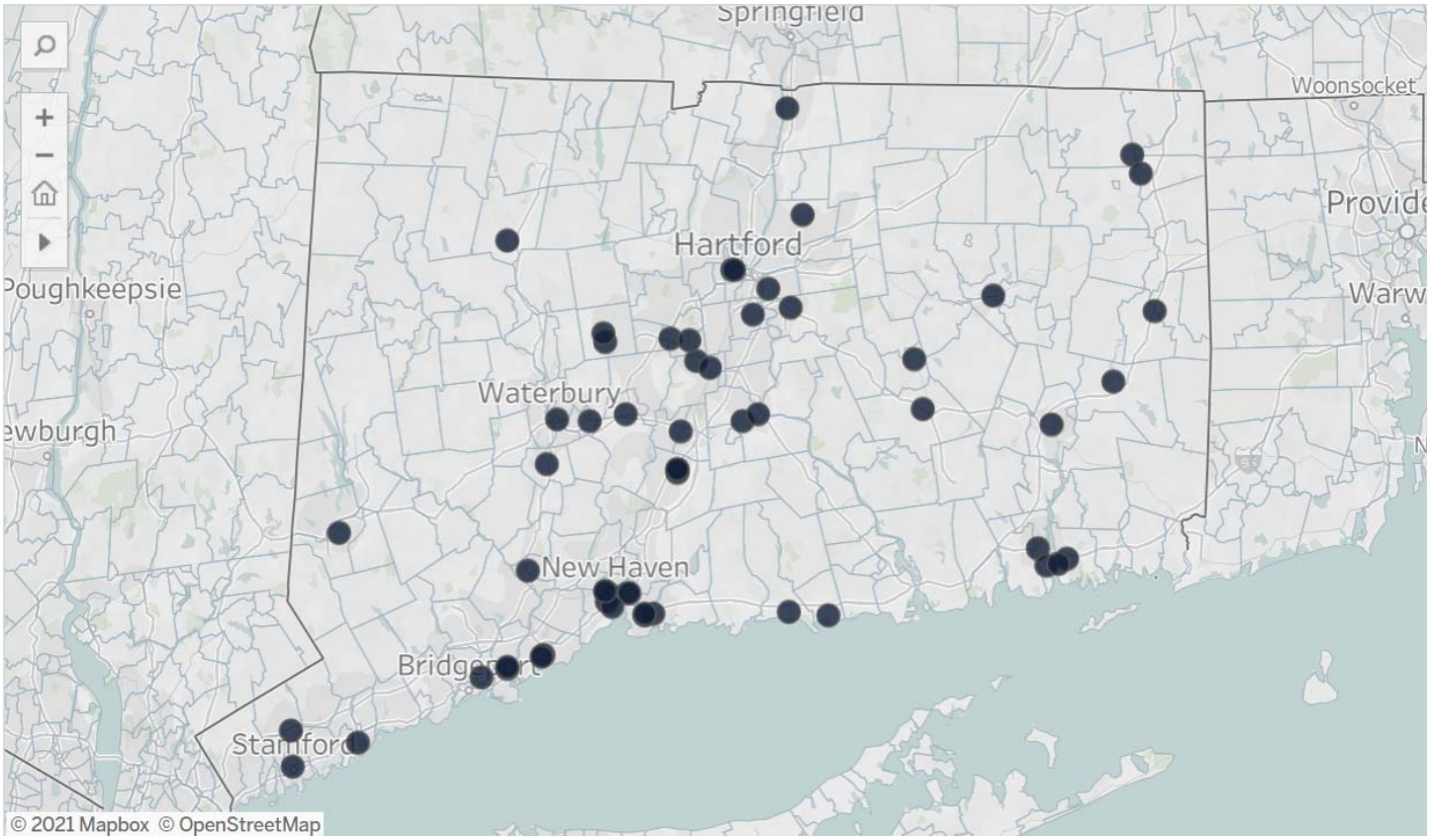
Select to Highlight

- 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.[1] 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		

[1] 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,	None needed – Connecticut currently meets criteria.	None needed – Connecticut currently meets criteria.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	advanced practice registered nurses, dentists, and podiatrists) to prescribe, 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		

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	changes have supported efforts to make naloxone widely available. In addition, Connecticut has established other initiatives addressing OUD, 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	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	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	See Attachment A

Milestone Criteria	Current State	Future State	Summary of Actions Needed
programs	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 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	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: • 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.[2]	

[2] 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
	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 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	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 access through Health Information Exchanges (HIEs).	

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	management systems.		

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 October 1, 2021. 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		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 October 1, 2021. 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 SUD versus SUD-only) by

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	care, and promoting linkages to community supports, services and natural support 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		October 1, 2021.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	including 75 care coordinators) – wraparound process (staff ratio 1:10-12), provided by DCF and its contractor. 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:	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

• Enhance the State's health IT functionality to support its PDMP. • Enhance and/or support clinicians in their usage of the State's PDMP.			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. 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	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, and will assess use of RxCheck hub to support interstate exchanges. Connecticut is seeking approval to participate in a multi-state planning effort to determine a qualified PDMP in each state to maximize regional efficiencies with Maine, New York, and Rhode Island. Connecticut would like to continue to increase the number and value of the interstate data sharing agreements with other states. The proposed contract	As data sharing is dependent on other states (including necessary changes to state law), there are no specific actions that can be listed here.

	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.	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, 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	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 and pharmacies may request to have CPMRS integrated into their EHRs and pharmacy management systems.	The Connecticut Department of Consumer Protection (DCP), the PDMP vendor (Appriss Health), and DSS, as the administrator of the EHR Incentive Program, will continue to onboard new EHR and pharmacy dispensing vendors.

	systems. Connecticut is also working on the integration of the PDMP into the HIE, which is seen as a more sustainable option.		
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, *Medicaid Management Information System Support Act*, to request 100% federal	DCP has been working with Connecticut's Office of Health Strategy (OHS) for the purpose of integrating the CPMRS into the HIE once the infrastructure is built. 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	DCP, in collaboration with OHS and DSS, will continue to link the CPRMS with the HIE consistent with the IAPD.

	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.	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 [3]	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	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	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.

[3]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.)

	controlled substance prescribing 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 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. NarxCare helps practitioners assess narcotic overdose and diversion risk. DCP is currently working with the vendor to implement this tool in the CPMRS.	DCP and/or DSS will evaluate the feasibility of 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 patients receiving opioid prescriptions with patients in the PDMP (i.e., the State's Master Patient Index [MPI] strategy with regard to PDMP query)	**Integrated Eligibility System** 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	**OHS and Connie** 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.	DCP, OHS and DSS will work to identify management across systems for better integration.

	the State's Department of Administrative Services, Bureau of Enterprise Systems and Technology.	The initial focus is on core foundational components: HIE services as shown in 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 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	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	Connecticut will continue to integrate the CPMRS into the HIE as the infrastructure is built consistent with the newly approved IAPDs.

address the issues which follow		IAPD will continue the existing work of adding connections and integrating into 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 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 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	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.

		purchased this enhanced analytic tool on their own.	
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 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,	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.

	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 effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing — and to ensure that Medicaid does not inappropriately pay for opioids	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 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	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 100 morphine milligram equivalents (MME) per day for a minimum of 90 consecutive days. That information is utilized for outreach to providers.	Connecticut will explore additional analytical tools to assist with enforcement to minimize the risk of inappropriate overprescribing.

	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** 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

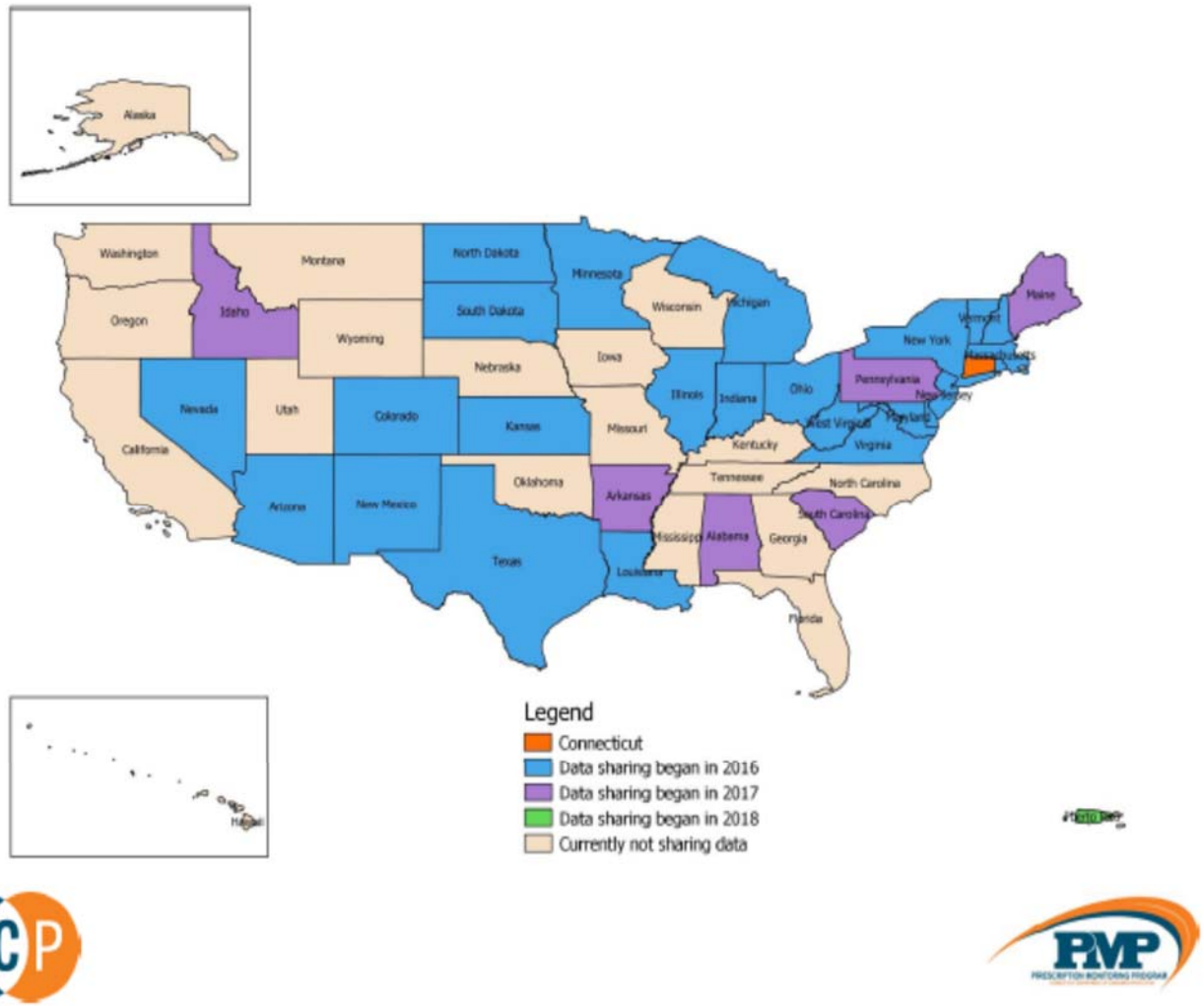


Figure 2: PDMP Diagram with HIE

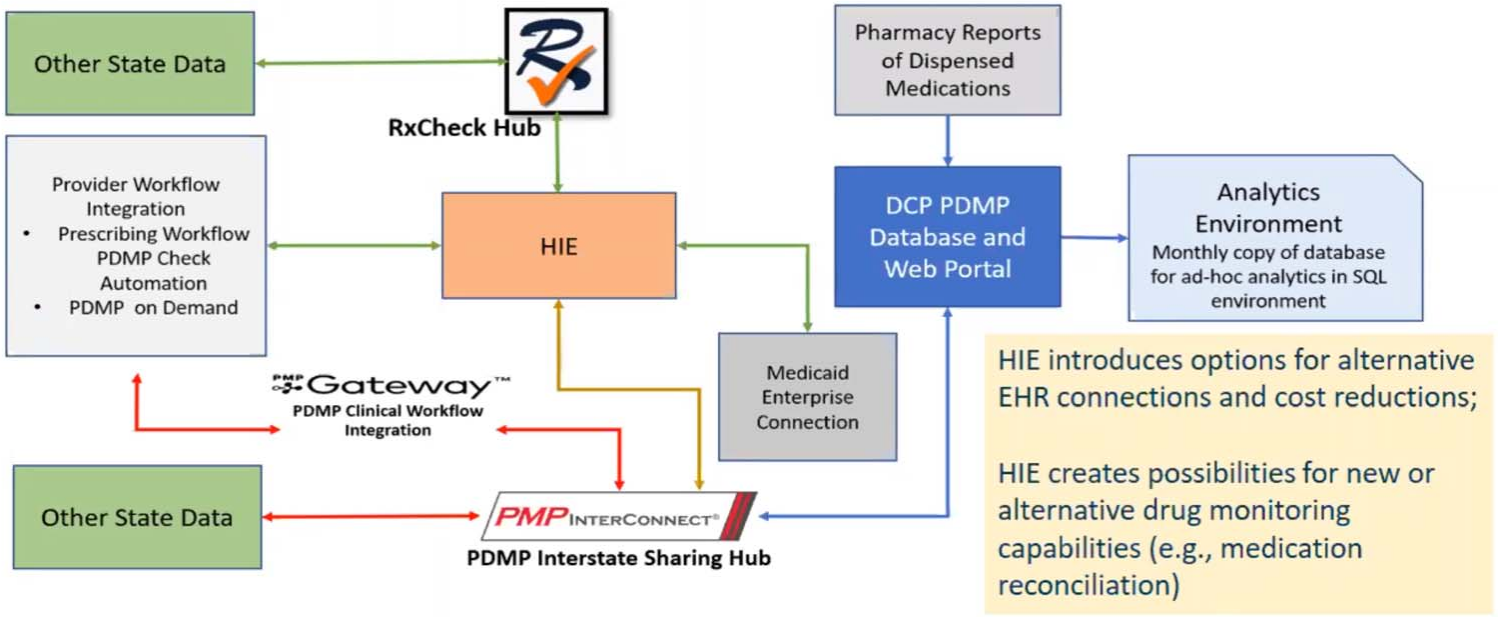


Figure 3: Statewide HIE Roadmap