STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

55 FARMINGTON AVENUE • HARTFORD, CONNECTICUT 06105

April 28, 2021

Re: Responses to Public Comments Regarding Connecticut's Substance Use Disorder Demonstration Waiver Pursuant to Section 1115 of the Social Security Act

Dear Commenter:

Thank you for submitting comments regarding Connecticut's Substance Use Disorder (SUD) Demonstration Waiver Pursuant to Section 1115 of the Social Security Act. The Department of Social Services (DSS), Connecticut's Medicaid and Children's Health Insurance Program agency, appreciates your input. Below are summaries of the comments that DSS received during the public comment period (including both written comments and verbal comments from the public hearings on February 10 and 18, 2021) and DSS's responses.

Rate Setting

1. What will the State do about costs that will not be covered by Medicaid (e.g., room and board)?

   Response: Room and board in non-institutional settings remain not coverable under federal Medicaid rules and will remain State-funded. Rate-setting will include both a therapeutic component paid by Medicaid and a room and board component paid with State-only funds for each level of care, except inpatient hospital, which is fully covered by Medicaid.

2. Will providers be included in the rate setting process either through the state's Behavioral Health Partnership Oversight Council (BHPOC) Operations Committee or in some other way? There are a lot of factors that go into determining an adequate rate that supports the service delivery.

   Response: The Departments of Social Services (DSS), Children and Families (DCF), and Mental Health and Addiction Services (DMHAS) are committed to developing a standards and rate methodology document that will be shared with providers for feedback. DSS, DCF, and DMHAS plan to submit the proposed rates to BHPOC for review pursuant to Conn. Gen. Stat. § 17a-22o, including, to the extent applicable for the specific services that are currently grant-funded and being converted to a fee-for-service system, documentation that the applicable proposed rates seek to cover the reasonable cost of providing services, in accordance with Conn. Gen. Stat. § 17a-22h(b).

3. Will providers be reimbursed for expenses related to transforming from current service delivery to meet new American Society of Addiction Medicine (ASAM) third edition criteria?

Response: While providers will not be directly reimbursed for these expenses, the State plans to increase reimbursement rates for many of the involved services effective from the start date identified in the Medicaid State Plan Amendment (SPA) that will implement Medicaid coverage for the services described in the SUD 1115 demonstration waiver. This will authorize rate increases in the near term that will support providers during the 24-month period following which they are expected to meet the ASAM standards. Mercer Government Consulting is supporting the State is establishing these new rates, which will take into account components including, but not limited to, the staffing necessary to comply with the standards.

4. Where and how will the additional federal matching funds be allocated, who will be allocating, and how will it be overseen?

Response: Implementation of SUD waiver activities will be funded by braiding Medicaid state funding, Medicaid federal matching funds, and identified state-only funds. This funding will support: (1) higher rates to enable residential providers to meet the current edition of ASAM standards and other applicable requirements; (2) a value-based payment model for outpatient services; (3) improved credentialing, monitoring, and evaluation; and (4) administrative activities, including those necessary for authorization and oversight. All Medicaid funds spent as part of the section 1115 demonstration, including both state share and federal matching funds will be allocated, accounted for and monitored by DSS as the state's Medicaid agency. State-only dollars will continue to support the room and board for residential services other than inpatient hospital; Medicaid will pay for the therapeutic component.

Value-Based Payment

5. How do value-based payment (VBP) plans for outpatient (OP) fit in with the substance use disorder (SUD) service system that currently pays fee-for-service and does not include enough funding?

Response: As noted above, the State plans to increase reimbursement rates for many services, effective with the implementation of the SUD waiver. While the VBP plan for OP providers remains under development, overall, the State intends to ensure that providers have the tools and incentives to improve outcomes for Members. This will include selection of high-value measures, which may include one or more of the following: connect-to-care (i.e., individuals successfully transitioning to lower levels of care), hospital emergency department (ED) utilization, care provided at the appropriate level of care as the individual advances through the continuum of care, or other measures to be determined. The VBP will evaluate and pay providers a higher rate if they meet a certain performance threshold for measures of success.

6. Is there any consideration for developing VBP for SUD OP and the rest of behavioral health at the same time in an integrated fashion or does the waiver prohibit this?

Response: The State understands the value of implementing a VBP approach across the behavioral health service system. While there is no prohibition on developing VBP for SUD OP and mental health OP at the same time, the State is prioritizing development of the VBP for SUD OP to ensure timely compliance with federal rules for the waiver. As has recently been proposed by Governor Lamont pursuant to Special Act 21-1, however, federal American Recovery Plan Act (ARPA) funds allocated to the state may be used to support further VBP approaches for mental health services.

7. It is complicated to implement a behavioral health-wide value-based payment system all at once; there is some value in moving forward in SUD first and then later in mental health, particularly as we implement major system changes at a time when providers are hanging on by their fingernails during a pandemic.

   Response: See response to Question 6 above. The State is initially prioritizing the SUD VBP and will continue to engage with the provider community on successive steps related to VBP approaches for mental health.

8. Are there specific strategies outlined for what some of those high-value impact measures are, such as goals of increased rates of engagement, reducing death, reducing ED utilization, reducing recidivism, and improving long term recovery?

   Response: The State will assist providers in obtaining the tools necessary to meet the treatment standards outlined by the most recent edition of ASAM, which are designed to improve clinical outcomes across all levels of care, thereby reducing ED utilization, recidivism and assisting Members in achieving long-term recovery. The State also recognizes that (1) peer recovery support services are instrumental to treatment retention rates and (2)integration of these services within residential programs may, in conjunction with other supports, help providers to meet performance measures that will be adopted.

Implementation

9. What is the start-date? Is July 2021 still viable?

   Response: Although July 1, 2021 remains the target start date, that is subject to various factors, including CMS approval of the waiver and other authority documents. The State will keep providers updated on a rolling basis should this timeframe need to be shifted forward.

10. We would like to see the State include Provider Dashboards to ensure key available tools are accessible to SUD providers, to fulfill the goals and objectives of this major initiative. Data and

insights will be needed to ensure the highest quality of care and move towards Value Based Payment (VBP) and Pay for Performance (P4P).

Response: Provider dashboards containing key performance and outcome metrics are under consideration.

11. Are there any data summaries that can be publicly shared, especially to help the providers prepare for what work will need to be taking place?

    Response: Providers are encouraged to look at the Waiver Application and Implementation Plan as well as the ASAM Criteria, 3rd Edition, as are the primary reference sources that will assist providers in preparing for compliance. Additionally, the State will assess which data it may be able to release publicly.

12. The state needs to address social determinants of health in implementing this waiver.

    Response: The State agrees. The current edition of ASAM also acknowledges that factors such as an individual's recovery environment, relationships, housing stability and financial stability have an influence on the person's progress in treatment. For this reason, providers will be expected both to screen members for social determinants of health and to incorporate goals as well as means of addressing identified barriers to achieving those goals, within treatment plans.

13. Prior learning collaboratives on trauma-informed assessment and care were very helpful, which may be a useful model to consider to help providers transition to ASAM 3rd edition.

    Response: The State supports the suggestion to create learning collaboratives for this purpose.

14. At what point in the process does either DSS, DMHAS or providers bring in people in long term recovery to hear what helped keep them engaged?

    Response: The State agrees that it is important for people in long-term recovery to have a voice in helping to inform the development and improvement of the SUD service system. Residential SUD providers that employ individuals in long-term recovery, who have lived experience that can helpfully inform strategies to keep people engaged, have throughout the planning process been conveying feedback on their behalf. The State will also seek feedback through various advisory bodies, including member advisory groups convened by the medical and behavioral health ASOs and the Alcohol and Drug Policy Council's Recovery Subcommittee. The State welcomes other suggestions about how to continue learning from people in long-term recovery.

15. A provider offered the State an opportunity to participate in a virtual visit to one of the residential programs or for one or more staff members in long-term recovery to speak with the State.

Response: Thank you.

16. How does this waiver address people with co-occurring mental illness and substance use disorder?

Response: SUD residential providers have expressed that most people whom they serve have co-occurring mental health and substance use diagnoses. The State believes that transitioning to ASAM 3rd edition, which among other provisions includes detailed guidelines around incorporating consideration of mental health conditions within SUD placement and treatment, will improve quality and outcomes, including for individuals with co-occurring disorders. Residential providers will be expected to demonstrate competency in addressing the needs of individuals with co-occurring SUD and mental illness. Currently, there are three intensive residential treatment facilities that are "co-occurring enhanced", meaning that they have licensure to provide both SUD and mental health services. Specific additional standards apply to those facilities.

17. Is there any recommendation for trauma-competent services as part of the service array or service models being delivered in inpatient, residential, and outpatient settings under this waiver for both adolescents and adults? Pervasive exposure to very complicated, highly impactful trauma was often so debilitating that even with effective programing and supports, the ability to maintain sobriety and successful, rewarding life really rested on how effective the support could be on overcoming both the unconscious and conscious trauma impact.

Response: We recognize the high prevalence of trauma history for people with SUD and that residential providers have also reported that a large proportion of the individuals whom they serve have experienced trauma. The State welcomes more in-depth dialogue on this topic, especially as it relates to services for children, to ensure that screenings and treatment are timely provided, with the intent to prevent adult onset SUD. The State acknowledges that complex trauma impacts substance use disorders and the potential to initiate and sustain recovery. In addition, the ASAM 3rd edition criteria, which will be implemented as a condition of participation under this waiver, include guidelines for providers around assessment for trauma-related conditions.

18. How in this waiver are families of those affected by SUD being taken into consideration? For those who have died from SUD, are the families who have been left behind being considered?

Response: ASAM criteria, third edition, require a comprehensive view of each person and the circumstances, including family and circles of support, that can either support or inhibit that person's recovery. Treatment, including family therapy where indicated, will include the individual's support system (e.g. family, significant others, friends) to the extent possible and appropriate for that individual's treatment, through direction of the individual and with the individual's consent.

19. Will there be considerations for investing in community resources for families outside of the treatment agency?

    Response: While the SUD Waiver will focus on Medicaid-covered services performed by enrolled providers, there may be opportunities through the proposed provider collaborative to surface successful strategies around access to and pairing of community services.

20. When will providers know exactly what the requirements will be for each level of care?

    Response: The residential standards and requirements are still under development. The State has met with providers representing every residential ASAM level of care and is in the process of finalizing proposed standards for providers, with the goal of making them publicly available in May 2021. Providers can safely assume that the 3rd edition of ASAM reflects the minimum requirement for each level of care.

21. Will the requirements be provided before the rates?

    Response: The State's goal is to provide the standards and the rates together.

22. Is anything changing for services and language in each of the levels of care under ASAM 3rd edition, including, but not limited to, LOCs 3.1, 3.5, 3.7?

    Response: Yes, there are a number of changes for these levels of care under ASAM 3rd edition compared to the current requirements. The State strongly encourages providers to become familiar with the ASAM 3rd edition.

23. It seems that this waiver is moving the focus away from residential and more into medication-assisted treatment (MAT) and community-based treatment. Short-term programs and systems where an individual has to fail three times in a 30-day program before a 90-day program will be approved by insurance may make the situation worse. Residential offers many facets that helps heal the addicted brain and MAT needs to be provided in conjunction with intensive and long-term residential treatment in order to ensure that someone does not end up homeless or in a much worse situation. If the funds are being matched, why is this being driven away from long-term residential and also why is Vivitrol not as discussed? There are multiple paths to recovery.

    Response: To the extent that the comment relates to proposed state legislation, that is beyond the scope of this waiver. To the extent that the comment was addressing this waiver, please note that it does include both residential programs and outpatient levels of care, for a full continuum of SUD treatment services. The primary structural change that the waiver will make is to enable Medicaid payment for coverable services at SUD residential providers for which Medicaid payment would otherwise not be allowed by the federal Institutions for Mental Diseases (IMD) coverage exclusion.

As noted above and in the waiver, the waiver includes various steps to improve the quality of SUD residential services, including mandating the adoption of ASAM standards. Further, as noted in response to Question 3 above, the waiver will enable rate increases designed to enable SUD residential providers to comply with the ASAM standards. Both the entity authorizing payment and the residential treatment provider will be utilizing ASAM placement criteria. If an individual continues to meet criteria for a level of care (LOC), that person will be permitted to remain in that LOC. Although the State may identify guidelines for length of stay in certain levels of care and generally endorses serving people to be in the least restrictive, lowest acuity setting that is appropriate for them based on their individual clinical needs, the State will not establish specific lengths of stay. Both ASAM standards and the state statutory definition of medical necessity for the Connecticut Medicaid program, section 17b-259b(a) of the Connecticut General Statutes, require development of individualized lengths of stay based on each person's clinical needs All MAT types (including buprenorphine, naltrexone/Vivitrol, methadone) are currently covered under Medicaid and are available within residential LOCs and individuals can continue with MAT with OP providers following discharge from residential care.

24. Are people also able to use residential levels of care to come off of Medication Assisted Treatment if that is their goal?

Response: Although medication titration alone is not a qualifying reason for admission into a residential level of care, if an individual otherwise meets applicable level of care for a residential treatment setting, based on the person's individual clinical needs and consistent with ASAM 3rd edition criteria and the Connecticut Medicaid program's statutory definition of medical necessity in section 17b-259b(a) of the Connecticut General Statutes, the provider would appropriately work with the person to develop an appropriate plan of care that includes assistance with ceasing medication-assisted treatment.

25. The waiver should focus on individualized care based on each person's needs, the commenter disagrees with the utility of a cookie-cutter standard approach for all individuals.

Response: The State agrees. The ASAM 3rd edition endorses this approach in requiring treatment plans to be individualized based on each person's needs and generally requiring that the services that are provided meet the person's medical needs in alignment with the treatment plan.

26. Will this additional funding make more beds available? When COVID is under control (and bed availability is more normalized), will bed availability be increased? Or will it be more focused on community-based services? Will organizations be able to create bed availability?

Response: The federal guidelines for a SUD section 1115 demonstration waiver require the State to analyze and assess network availability and capacity at all levels of care during the implementation of the waiver. Implementation of the SUD waiver in Connecticut will give providers the tools to

serve individuals in the level of care most appropriate to their condition. This may mean that the number of individuals who need higher levels of care, including but not limited to acute withdrawal management, decreases at the same time that readmission rates decrease. That said, it is premature to predict how demand for beds may shift over time.

27. There are concerns of an individual being discharged from a facility before the person is able to understand the treatment options and individuals/families may not be able to advocate for what they are able to receive. Unsure if the services are steered more towards MAT or regular engagement with a clinic or doctor, someone may slip through the process, concerned about whether the system will encourage SUD to recur after recovery. Also concerned that members may not understand how they fit within a level of care and how it relates to their insurance coverage. How is it possible to keep people in the level of care as long as possible, as appropriate? Recommends warm hand-offs to encourage smoother and faster transitions to MAT and lower levels of care because people may be discharged from a facility or incarceration too suddenly and not immediately transitioned to the next level of care and may die of an overdose due to the delay.

    Response: Providers will be expected to develop and perform on care plans for each individual served that include attention to supporting people as then move through various levels of care. Providers must ensure careful coordination and warm hand-offs between levels of care.

28. Shame and embarrassment are common elements of a person with SUD. Even if the person is asked if they understand, they will often say they do only because they do not want to be embarrassed. Need to ensure there is sufficient explanation and do not assume that people will understand their options and potential resources.

    Response: The State agrees.

29. Supports the mention in the proposal of the frequency of co-occurring mental health disorders in this population.

    Response: The State appreciates the support.

30. Supports the plan to use Institutions for Mental Disease (IMDs) as a Medicaid covered setting, in recognition of the crucial role played by Merritt Hall in the menu of treatment options available to people with substance use disorders (PWSUDs) and the fact that they may often have co-occurring mental health disorders.

    Response: The State appreciates the support.

31. Strongly urges that this waiver not inhibit the current efforts to provide substance use disorder treatment in the most appropriate location, recognizing "where the person is at" at the time of engagement, whether that is in a person's home, in a faith-based location or any other non-traditional setting.

    Response: Standards of practice, medical necessity, and least restrictive environment rules all require that each person receives the type of covered services that are appropriate for that person's needs, including services in the most appropriate and least restrictive possible setting. As part of a person-centered approach, providers are expected to work with the individual to determine the most appropriate setting and services for each person.

32. The commenter strongly urges that this waiver recognize the already severe health disparities for persons of color and assure that neither the waiver's structure nor provisions have any negative impact on services for that population.

    Response: The State agrees. The State intends to track healthcare outcome measures by demographic information, including race and ethnicity, and to use this data to help inform development of the value-based payment model. The State will amend the care management requirements in Milestone 6 of the waiver application to address health equity concerns through enhanced individualized care coordination that addresses health inequities and social determinants of health.

33. Strongly urges that this waiver assure that the already limited workforce of persons of color not be further reduced by any ripple effect of this process. It is so important that people with SUD seeking treatment see "people who look like me."

    Response: The State agrees. Through this waiver, the State intends to train, fund, and recruit more individuals and professionals to provide SUD treatment, including persons of color and members of other under-represented groups.

Medicaid State Plan Amendment

34. When will work begin on the outpatient Medicaid State Plan Amendment (SPA)?

    Response: The State is developing the standards and related elements that will be incorporated into the SPA. The State plans to publish notice for the SPA prior to the proposed effective date of the waiver, to observe all requirements around a written public comment period, and to submit the SPA to the U.S. Centers for Medicare and Medicaid Services (CMS) no later than the end of the calendar quarter in which the waiver takes effect.

Staffing

35. What will be the process for grandfathering long-standing staff that may be excluded under the new standards if they do not meet the new certification or licensure requirements? For example, an individual with 30 years' experience as a Certified Addiction Counselor (CAC) and certified supervisors through the CT Certification Board (CCB).

    Response: Because the number of staff needed to provide treatment under the new ASAM 3rd edition is expected to increase, the State expects both to train existing staff to meet the new requirements and to recruit additional staff into the workforce. In order to comply with ASAM 3rd edition requirements, provider qualifications must be enhanced. Because the requirements will limit capacity to grandfather current staff, providers should develop: (1) plans to assist their staff in meeting the new requirements within the initial implementation period (i.e., the initial 24 months of the waiver implementation, which is the transition period before the ASAM 3rd edition requirements take effect); and (2) contingency plans, including such features as reassigning staff who may not be able to meet the new requirements to other tasks.

36. Are recovery specialists/recovery coaches part of the waiver package, including within residential providers?

    Response: The State is considering including recovery specialists/recovery coaches as part of this waiver.

37. There is a need for social workers and peer specialists ensuring that transitions happen between levels of care.

    Response: As noted in the response to Question 27, the State agrees transitions between levels of care must be improved. The State is considering enhancements to staffing requirements, such as use of social workers or peer specialists, to support transitions between levels of care.

Home Health

38. What role will Home Health have within the implementation plan? Behavioral home care providers are uniquely capable of serving as the coordinative focal point of effective treatment partnerships for patients with an SUD/OUD diagnosis. When community-based SUD treatment is discussed, it clearly identifies and recognizes the contributions made by Outpatient Providers, Residential Treatment, and IOP. However, it does not so clearly recognize the collaborative work done within the BH Home Care arena. If we are truly invested in the full Continuity of Care for SUD treatment, as this Demonstration Waiver Application and Implementation Plan seem to demonstrate, and a

comprehensive approach that involves ALL levels of care, I am asking that Home Care not be overlooked in that model. Understanding the implementation plan appears tailored to providers who meet ASAM level of care guidelines and criteria, we hope that you will acknowledge that while home health care may not be traditionally contemplated by ASAM, Home Care in Connecticut has been a partner with the state in previous efforts to work within level of care guidelines developed collaboratively with the Behavioral Health Partnership. We hope the role home care can play in the SUD treatment community will be taken into account as part of the implementation plan.

Relatedly, a SUD/OUD diagnosis alone does not qualify for reimbursement currently for home care. We understand new reimbursement categories may not be considered at this time, but as you work to assess the future of SUD treatment and evaluate the existing provider infrastructure, we believe allowing a SUD/OUD diagnosis alone to be a reimbursable Home Care service would enhance care collaboration, improve outcomes, and enhance quality of life to the many individuals with SUDs who may benefit from a new approach to community based treatment**.**

Response: The federal Medicaid home health services benefit category, as defined in federal regulations at 42 C.F.R. § 440.70, is limited in scope to nursing services (including medication administration), home health aide services, and physical therapy, occupational therapy, speech pathology, and audiology services. Due to that limited federal scope and also because home health services are not recognized as an evidence-based SUD treatment modality, it is not feasible for home health services to be a specific component of the SUD waiver services, nor is it feasible for a SUD/OUD diagnosis to be the sole basis for coverage of home health services under Medicaid. However, home health agencies and other provider categories should review the State's ASAM provider qualifications for outpatient SUD services once they have been developed and posted to determine if the provider can meet qualifications (i.e., licensure, certification, staffing) to provide coverable outpatient SUD services (not as home health services). In addition, providers may explore various types of collaborative arrangements with other providers.

Recovery Health Home

39. Is there a plan for a recovery health home? Recovery Health Home model, that includes use of Recovery Coaching across the continuum would be an importance advance in care. Need to make sure that there is a focus on the whole person as the heart and focus of the SUD waiver. There need to be flexible "beds" in IP Residential from higher acuity 3.7 to 3.5 levels of care, and also allowing for extended stays as needed and connection to OP/community-based care, wraparound support for housing and care coordination.

Response: Although the State is not explicitly considering the development of a Recovery Home model at this time, the State is broadly reviewing current care management models to determine how to best address and utilize its workforce, including peers in recovery. The State is considering

the Addiction Recovery Care Value-based Care model in its design discussions. The state is also analyzing the impact that flexible beds from 3.7 to 3.5 to 3.1 acuity could have on retaining individuals in care.

Miscellaneous

40. The commenter is in favor of the proposal and believes it will benefit the treatment community and will bring standardization and improve the quality of care.

    Response: The State appreciates the support.

41. Is the information regarding other legislative bills connected to SUD services, including those mentioned at the Alcohol and Drug Policy Council being considered/tracked?

    Response: Those legislative bills are outside the scope of this waiver.

42. The proposal refers to Value Options. It would more accurately now be referred to as Beacon Health Options.

    Response: Reference to Value Options was made as part of the historical reference to the state's behavioral health system. Beacon Health Options is the present behavioral health ASO.

Thank you again for your comments and for your shared interest in improving the SUD service system in Connecticut.

Best regards,
/s/
Kate McEvoy, Esq.
Director, Division of Health Services