State of Connecticut
Department of Social Services

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

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

August 9, 2021

MEDICAID SECTION 1115 DEMONSTRATION PROPOSAL FOR SUBSTANCE USE DISORDER TREATMENT

I. SUMMARY

The State of Connecticut (Connecticut or State) Department of Social Services (DSS), Connecticut's single State Medicaid and Children's Health Insurance Program (CHIP) agency[1], requests a Demonstration Waiver pursuant to section 1115 of the Social Security Act from the U.S. Centers for Medicare and Medicaid Services (CMS) for substance use disorder (SUD) inpatient and residential treatment for adults and children under a fee-for-service (FFS) structure (Demonstration). Except as otherwise specified below, references to Medicaid in this Demonstration document also include CHIP. Connecticut also requests that this Demonstration cover a complete array of American Society of Addiction Medicine (ASAM) levels of care (LOCs) as a component of an essential continuum of care for Medicaid-enrolled individuals with opioid addiction or other SUDs. Connecticut requests that the Demonstration be effective immediately upon approval to use Institutions for Mental Diseases (IMDs) as a Medicaid-covered setting.

The proposed Demonstration will adopt the most recent edition of ASAM, cover residential treatment in a non-hospital setting, and highlight the availability of MAT.

This Demonstration builds upon an extensive, existing array of Connecticut Medicaid covered behavioral health (BH) services, including evidence-based services and will improve upon and enhance services that are currently covered only under non-Medicaid sources, including state funding and other federal funding.

Connecticut Medicaid covers all ambulatory ASAM LOCs 0.5 through 2.5, as well as medication-assisted treatment (MAT) and inpatient withdrawal management (ASAM level 4-WM). Connecticut will be submitting a Medicaid State Plan Amendment (SPA) in conjunction with this Demonstration to cover residential and inpatient treatment, as well as all levels of withdrawal management (ASAM levels 1-WM, 2-WM, 3.1, 3.2-WM, 3.3, 3.5, 3.7, 3.7-WM, 4). The Demonstration will permit DSS to provide critical access to medically necessary SUD treatment services in the most appropriate setting for the member as part of a comprehensive continuum of SUD treatment services.

[1] As noted in the text, throughout this Demonstration, references to Medicaid also include CHIP, unless otherwise specified below.

The Demonstration would permit DSS, through the FFS delivery system, to provide medically necessary medical and BH care (including co-occurring mental health [MH] and SUD treatment services) in the most appropriate setting for individuals receiving residential and inpatient SUD treatment services. This approach is designed address the demonstration goals detailed below under Hypothesis and Evaluation, including improving health care outcomes for individuals with SUD (reducing hospital emergency department use and inpatient admissions, reducing hospital readmissions, and improving the rates of initiation, engagement and retention in treatment).

II. BACKGROUND

Modernizing Connecticut's Medicaid system of delivering SUD treatment services has been an ongoing and sequential process beginning with the contracting for a BH administrative services organization (ASO) in 2006 to better manage the continuum of BH services. In keeping with the goal of modernization, DSS, in collaboration with its sister State agencies, the Connecticut Department of Mental Health and Addiction Services (DMHAS) and the Connecticut Department of Children and Families (DCF), has implemented a comprehensive SUD benefit package of services provided by a statewide network of SUD treatment service providers that will be financed by Medicaid for Medicaid beneficiaries. DSS intends to implement the Medicaid SUD residential and inpatient services on October 1, 2021 or effective upon CMS approval, whichever is later.

The existing, well-coalesced tri-agency Medicaid BH oversight structure uses a behavioral health ASO and BH plan of care.

This Demonstration will address Connecticut's opioid crisis and support the State's effort to implement an enhanced comprehensive and lasting response to this epidemic as well as similar challenges with use of substances other than opioids. Connecticut is experiencing one of the most significant public health crises in its history. The striking escalation of opioid use and misuse over the last five years is impacting individuals, families and communities throughout the State.

From calendar year 2012 through 2018, the rate of unintentional drug-related overdose deaths in Connecticut grew from 12.2 per 100,000 to 29.9 per 100,000.[2] Connecticut's

[2] Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2018 on CDC WONDER Online Database, released in 2020.Data are from the Multiple Cause of Death Files, 1999-2018, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html on May 13, 2020.

overdose deaths continue to climb with no sign of relenting. In calendar years 2019 and 2020, fatal drug overdose deaths in Connecticut rose 16.7% and 14.3% respectively from the previous year. The majority (82%) of overdose deaths in 2019 were related to fentanyl or fentanyl analogs.[3] This Demonstration is necessary to address critical unmet needs for residential SUD treatment that continue to exist despite significant improvements to the publicly-funded treatment delivery system outside of Medicaid. Under DMHAS and DCF, State-only funds and federal Substance Abuse and Mental Health Services Administration (SAMHSA) block grant funds are used to support residential services for the uninsured and for individuals enrolled in Medicaid.

A new benefit service package that includes residential SUD services will be included under the Medicaid State Plan with an effective date on or after October 1, 2021. This comprehensive restructuring of the SUD benefit package and the transition to Medicaid reimbursement of residential and inpatient IMD services will ensure access to a comprehensive, coordinated system of SUD care for children and adults in Medicaid. Prior to this Demonstration, Connecticut Medicaid had not adopted a complete array of SUD treatment services using a national placement criteria system (e.g., ASAM) or national provider standards. Most importantly, for some Medicaid-covered individuals in need of SUD treatment, there were limited options for residential community-based SUD treatment services.

Under this Demonstration and a corresponding Medicaid SPA, Connecticut will expand services to provide a complete array of services, including residential SUD services, using placement criteria and program standards consistent with the latest edition of ASAM.

The new SUD benefit package will include support for evidence-based practices already implemented in the State, such as multi-systemic therapy (MST) and Multidimensional Family Therapy (MDFT) for children with SUD conditions. It also modernizes the SUD treatment benefit to align with the most current edition of ASAM criteria for outpatient and residential treatment. Providers will be trained using the most current edition of ASAM criteria to provide multi-dimensional assessments that inform placement and individualized treatment plans that will increase the use of community-based and non-hospital residential programs, and assure that inpatient hospitalizations are utilized appropriately for situations in which there is a need for safety, stabilization, or acute withdrawal management (ASAM LOC 4).

[3] Connecticut Office of the Chief Medical Examiner, per CDC-SUDORS grant guidelines (April 19, 2021) as published in the CT Department of Public Health Drug Overdose Monthly Report, March 2021.

Recent Historical Context for Connecticut's Medicaid Program

In 2006, DCF, which oversees BH for children in the State and DSS, in conjunction with a legislatively mandated oversight council, formed the Connecticut Behavioral Health Partnership (CT BHP), authorized pursuant to state statute (section 17a-22h of the Connecticut General Statutes), with ValueOptions[4] serving as the ASO. CT BHP is a reform initiative designed to help children and parents with serious behavioral challenges remain in their homes and communities through the use of targeted, individualized clinical and support services. The ultimate goal under the initiative was to allow children and parents to function independently, restore or maintain family integrity, improve family functioning, achieve a better quality of life and avoid unnecessary hospital and institutional care.

In 2010, DMHAS joined the CT BHP (and the authorizing statute was amended accordingly) and, collectively, a request for proposal for an ASO vendor for the expanded CT BHP was issued. ValueOptions bid on, and was awarded, the contract to be the ASO for the expanded CT BHP. The new contract went live on April 1, 2011, when more than 200,000 additional Medicaid members, primarily adults, but also a small number of youth, were added. That change brought the total membership included under the CT BHP to more than 600,000 members at that time.

While the goals of the original CT BHP described above remained in place, ValueOptions as the ASO was described in the new contract as being "the primary vehicle for organizing and integrating clinical management processes across the payer streams, supporting access to community-based services, assuring the delivery of quality services and preventing unnecessary institutional care." Additionally, ValueOptions was expected to enhance communication and collaboration within the BH delivery system, assess network adequacy on an ongoing basis, improve the overall delivery system and provide integrated services supporting health and recovery by working with the Departments (DSS, DCF, and DMHAS) to recruit and retain both traditional and non-traditional providers.

Effective January 1, 2012, DSS transitioned from three managed care organizations (MCOs) managing the physical health care of a large portion of the State's Medicaid population to a managed FFS structure with a single ASO for physical health, similar to the model in place for BH with ValueOptions. ValueOptions partnered with the MCO

[4] As a result of the 2014 merger between ValueOptions, Inc. and Beacon Health Strategies, LLC, ValueOptions, Inc. officially changed its name to Beacon Health Options on December 9, 2015.

that ultimately won the bid for this contract, Community Health Network of Connecticut (CHNCT). While this contract did not increase membership, it did result in increased responsibility for ValueOptions to coordinate care provided to Medicaid members. The new contract, which went live in 2012, embedded ValueOptions clinical care managers in the CHNCT office and leveraged McKesson technology to identify the most at-risk members to ultimately impact health outcomes.

As of September 2020, Connecticut Medicaid and CHIP had approximately 895,000 enrollees, including almost 20,000 CHIP enrollees (HUSKY B) and approximately 289,000 Medicaid adult expansion enrollees (HUSKY D) who receive the Alternative Benefit Plan (ABP) covered services as required under federal law. HUSKY A enrollees include approximately 500,000 low-income Medicaid members parents/caregiver relatives and children. HUSKY C enrollees include over 86,000 older adults and people with disabilities.

The HUSKY D benefits under the ABP are aligned with the underlying Medicaid State Plan benefits. Although Connecticut Medicaid does not currently reimburse for residential SUD services, there is a State-funded benefit for HUSKY D Medicaid beneficiaries using a former edition of ASAM. See the following table for a summary of the State-funded SUD residential benefits roughly aligned with the second edition of the ASAM criteria.

HUSKY D SUD Residential Benefits in State Fiscal Year 2019 (SFY 2019)

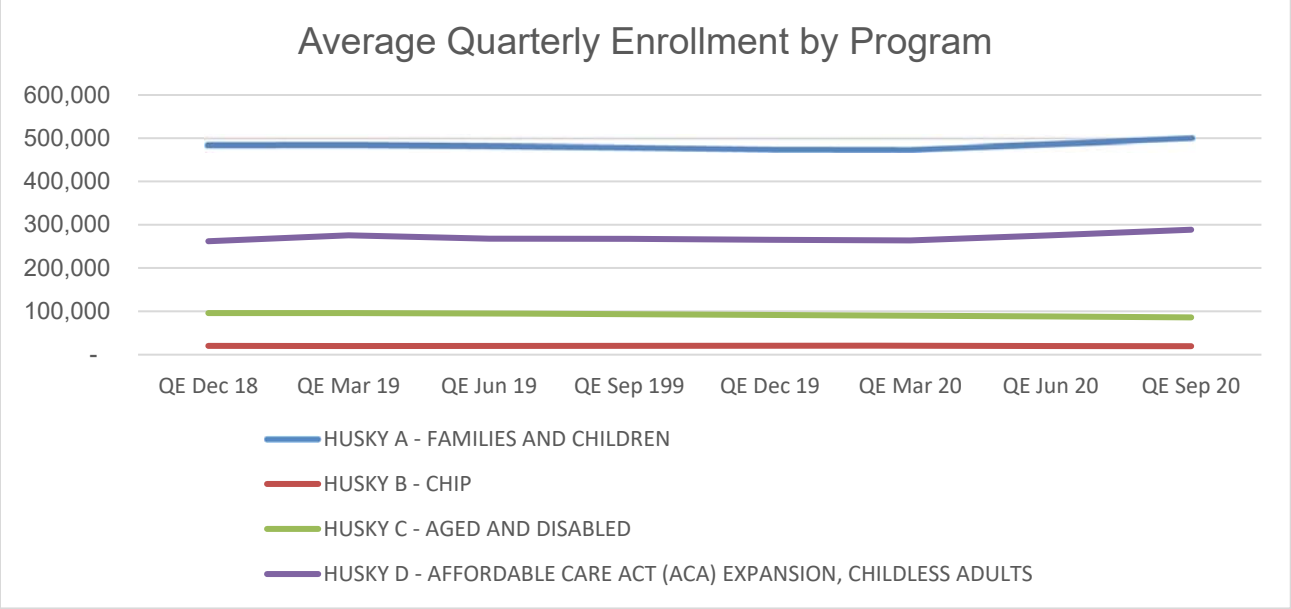
	Admissions	Total Days	Average Length of Stay in Days
ASAM 3.1 Residential halfway house	350	25,081	71.7
ASAM 3.3 Long-term care	111	17,963	161.8
ASAM 3.5 Intermediate residential treatment	1,187	57,056	67.8
ASAM 3.5 Pregnant and parenting women	59	3,846	79.4
ASAM 3.7RE Enhanced co-occurring	624	12,095	29.1
ASAM 3.7 Intensive residential treatment	2,180	29,618	22.4
ASAM 3.7R State-operated facilities	773	24,284	30.5
ASAM 4.2D Medically-Managed	16	89	5

	Admissions	Total Days	Average Length of Stay in Days
Withdrawal Management at Natchaug Hospital			
Observation/Flex Bed	8	8	1

Source: SFY 2019 BHRP Annual report

Today, the CT BHP is composed of DSS, DMHAS and DCF. CT BHP contracted with Beacon Health Options, the BH ASO, to authorize and coordinate Medicaid BH services (mental health and SUD services) for HUSKY Health members in Connecticut. Covered benefits and services administered by the CT BHP are available to members who are enrolled in HUSKY A, HUSKY B, HUSKY C, and HUSKY D. (Separate from its HUSKY Health/Medicaid responsibilities, the BH ASO also provides administrative support to a small set of services for the non-Medicaid DCF limited benefit group.) See below for a chart reflecting the relative size of each HUSKY population.

Relative Size of Each Medicaid Population



Source: DSS January 8, 2021 presentation to MAPOC, Financial Trends in the Connecticut HUSKY Health Program Transparency, Sustainability and COVID Impacts, posted here: https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&%20Presentations/20210108/HUSKY%20Financial%20Trends%20January%202021%20.pdf

The following are currently covered Medicaid SUD behavioral benefits and services:

- Screening, Brief Intervention and Referral to Treatment (SBIRT) Services

- Outpatient Services
- Methadone Maintenance
- MAT
- Intensive Outpatient Services (IOP)
- Partial Hospitalization Program (PHP)
- Ambulatory Withdrawal Management
- Inpatient Hospital Substance Use Withdrawal Management
- Residential Treatment Center for Children through DCF
- Targeted Case Management (TCM) for Ages 19 and under
- TCM for Adults with Serious Mental Illness and Co-Occurring SUD.

Connecticut is requesting this Demonstration in order to enable Federal Financial Participation (FFP) under Medicaid and CHIP for SUD residential treatment and other health care services provided in accordance with the latest edition of ASAM criteria for people residing in IMDs. The Demonstration builds upon the state's successful implementation of the CT BHP and leverages this strong foundation to ensure Connecticut's Medicaid beneficiaries have access to the entire continuum of SUD services as defined by ASAM LOCs.

III. DEMONSTRATION OBJECTIVES

The objective of this Demonstration is to provide critical access to a full array of SUD treatment services for Connecticut Medicaid enrollees and improve the delivery system for these services to provide more coordinated and comprehensive SUD treatment for these individuals.

This Demonstration seeks to improve outcomes for Medicaid members diagnosed with SUD by providing critical access to SUD treatment services, including inpatient and residential SUD treatment in IMDs, as part of a full continuum of treatment services that follow ASAM LOCs. Under a new SUD SPA, which will be associated with this Demonstration, Connecticut will implement a comprehensive, integrated SUD benefit that includes residential treatment settings. However, existing IMD limitations in FFS create barriers to ensuring members are able to access SUD treatment at a LOC appropriate to their needs using the ASAM criteria. Connecticut seeks Demonstration authority to remove Federal Medicaid restrictions on IMDs as SUD treatment settings in FFS. The new Medicaid SUD treatment continuum will enhance critical access to the full ASAM SUD treatment continuum.

Connecticut's SUD residential treatment provider network is primarily comprised of programs with more than 16 beds, for which Medicaid payment is prohibited by the federal IMD exclusion. There are only three SUD residential treatment programs in Connecticut with 16 treatment beds or fewer, which are therefore not subject to the IMD exclusion. Although that capacity is limited, the Medicaid eligibility expansion and the opioid crisis have concurrently increased the need for residential SUD treatment beds. Without IMD facilities, which have greater than 16 beds, there is insufficient capacity of SUD residential treatment services in the State to address the extent of the opioid epidemic in the State under Medicaid. This is particularly true since the State expanded Medicaid eligibility (as an early adopter effective April 2010 and full expansion effective January 2014) and such services are, as of September 2020, available to more than 289,000 expansion-eligible individuals. Therefore, enhancing Medicaid funding at this juncture – by enabling payment of SUD residential treatment services in IMDs through this waiver and making the other changes to improve the quality of the SUD treatment system described herein – is critical to help address the surge of SUD treatment needs for Medicaid enrollees associated with the opioid crisis.

As detailed above, the Demonstration will remove Medicaid payment barriers in FFS for SUD residential treatment. By ensuring critical access to residential treatment capacity, Connecticut will be able to provide an effective SUD treatment continuum of care with interventions capable of meeting individuals' changing needs for various ASAM LOCs.

IV. COMPREHENSIVE DESCRIPTION OF STRATEGIES FOR ADDRESSING GOALS AND MILESTONES

The State's initial approach to key system reform milestones will be addressed in the comprehensive Implementation Plan submitted concurrently with this Demonstration request. The Implementation Plan addresses system reforms required in the Centers for Medicare & Medicaid Services (CMS) State Medicaid Director Letter (SMDL) # 17-003, dated November 1, 2017, and outlines a path toward an IMD exception using the 1115 Demonstration authority. A brief summary of the State's current environment and planned interventions for each milestone is listed below.

Milestone 1: Access to Critical LOCs for SUDs

Connecticut's current SUD Medicaid treatment system includes coverage of the following:

- Outpatient;
- Intensive Outpatient;
- Partial Hospitalization;
- MAT (medications, as well as counseling and other services, with sufficient provider capacity to meet the needs of Medicaid beneficiaries in the State);
- Intensive LOCs in inpatient hospital settings; and
- Medically-supervised withdrawal management in limited settings.

Under the Demonstration, the State will submit a SPA to provide a more complete continuum of care using ASAM criteria and standards including intensive LOCs in residential settings and withdrawal management.

Milestone 2: Use of ASAM Placement Criteria

Currently, Connecticut contracts with two entities for review of SUD admissions and placements using prior authorization and utilization management standards in the FFS Medicaid, block grant and State-funded SUD delivery systems. The State requires both the DSS-contracted Medicaid BH ASO (currently Beacon Health Options) and DMHAS' contractor for utilization management (UM) (currently Advanced Behavioral Health, Inc.) that is funded with State general funds and federal SAMHSA block grant dollars to utilize ASAM principles for utilization review. The BH ASO utilizes the ASAM placement criteria third edition and the DMHAS UM contractor utilizes the ASAM placement criteria second edition. In addition, at this time, Connecticut has not trained nor required treatment providers to create individualized treatment plans for individuals using multi-dimensional assessments based on the six dimensions of care as outlined in ASAM.

Connecticut's SUD treatment services provided to State-funded and federal SAMHSA block grant-funded recipients is consistent with ASAM second edition. The DMHAS UM contractor certifies that residential providers, under the State-funded and federal SAMHSA block grant-funded system are providing interventions consistent with the ASAM second edition as outlined in code and policy guidance. However, there are currently no similar Medicaid standards and no similar processes to certify Medicaid providers are providing interventions consistent with the diagnosis and ASAM LOC needed by individuals as documented through the BH ASO's prior authorization and UM process.

On and after the effective date of the Demonstration, SUD treatment services provided in the Medicaid FFS delivery system will comply with the current ASAM criteria for all prior authorization and utilization review decisions resulting in continuity across the Medicaid delivery systems. Connecticut will train all providers to utilize multi-dimensional assessments based on the six dimensions of care as outlined in ASAM to create individualized treatment plans. DSS, or its designee, will ensure appropriate UM is in place for SUD services for all LOCs, including prior authorization for SUD residential treatment services for individuals enrolled in the FFS delivery system. DSS will ensure Medicaid members have access to interventions at the SUD LOC appropriate for each person's diagnosis and individual circumstances. DSS will update any provider agreements necessary to emphasize the required use of the most current edition of ASAM placement criteria for providers of SUD treatment services. The State also intends to implement provider training on this requirement for ASAM placement criteria and its application to all SUD treatment services.

Milestone 3: Use of ASAM Program Standards for Residential Provider Qualifications

Connecticut Medicaid does not currently cover adult SUD residential services. Under the Demonstration, Connecticut will submit a SPA to cover residential treatment delivered by providers whose qualifications are consistent with the most current version of ASAM. Currently, Connecticut requirements for State-funded and federal SAMHSA block grant-funded residential SUD treatment, residential withdrawal management and inpatient SUD treatment services require general compliance with ASAM second edition standards.

In the future, under the Demonstration and SPA, Medicaid policy manuals will be modified to reflect the current ASAM criteria for residential programs, including requirements for the particular types of services, hours of clinical care and credentials of staff for residential treatment. The amended policies will include a requirement that residential treatment providers offer MAT onsite or facilitate access offsite with a MAT provider not associated with the residential treatment owner. Connecticut will also implement a process for initial certification and ongoing monitoring of residential treatment providers to ensure compliance with the ASAM requirements under the Demonstration.

Milestone 4: Provider Capacity of SUD Treatment including MAT

To ensure there is necessary information regarding access to residential providers, DMHAS maintains a website that is updated regularly. This report, which can be found at the following link www.ctaddictionservices.com, includes the number of withdrawal management, residential treatment, recovery house and sober house service beds available as of a specific date and time.

Connecticut currently contracts for 948 adult SUD residential treatment beds across 19 providers using non-Medicaid funds. All but three of these certified SUD residential, withdrawal management and inpatient SUD treatment service providers have more than 17 beds and meet the definition of an IMD. See the table below for the number of beds and providers providing each non-Medicaid residential level of care in Connecticut.

Number of Beds and Providers by LOC

LOC	Number of Beds	Number of Providers Providing that LOC
ASAM 3.1	76	7
ASAM 3.3	50	1
ASAM 3.5	362	17
ASAM 3.7	318	11
ASAM 3.7-WM	142	6
Total	**948**	**19***

* Total number of providers is less than the sum of the number of providers shown above for each LOC because some providers serve multiple LOCs

Based on utilization in SFY 2019, DSS estimates the number of residential days for each residential LOC is as follows:

	SFY 2019 Utilization in Bed Days by Medicaid Population			
ASAM LOC	HUSKY A	HUSKY B	HUSKY C	HUSKY D
ASAM 3.1	1,704	213	2,342	24,036
ASAM 3.2-WM	-	-	-	-
ASAM 3.3	-	-	135	17,434
ASAM 3.5	5,493	716	7,123	89,344
ASAM 3.7	8,495	708	5,595	65,495
ASAM 3.7-WM	4,505	-	2,459	41,567

	SFY 2019 Utilization in Bed Days by Medicaid Population			
ASAM LOC	**HUSKY A**	**HUSKY B**	**HUSKY C**	**HUSKY D**
ASAM 4	-	-	-	-
ASAM 4-WM	3,013	222	1,659	25,790

The State also expects to develop an assessment of the availability of the ambulatory providers enrolled in Medicaid and whether they are accepting new patients for each of the SUD ambulatory ASAM LOCs. This assessment will indicate whether facilities are currently accepting Medicaid members.

DSS will work with its partner agencies in the State to ensure the SUD provider network is adequate and distributed geographically to meet the demands for these services. If services are unavailable within a specific geographic region, DSS will recruit qualified providers within the region or seek expansion from existing providers, including those that may be outside the defined geographical boundaries in need.

Milestone 5: Implementation of Opioid Use Disorder (OUD) Comprehensive Treatment and Prevention Strategies – Opioid Prescribing Guidelines and Other Interventions to Prevent Opioid Misuse

To address the opioid and prescription medication crisis, the Connecticut Department of Public Health (DPH) has implemented prescribing guidelines to prevent opioid over-use through a number of updates to Connecticut policy and law affecting the prescribing of controlled substances and opioid medications.[5] The relevant State agencies have also collaborated with legislators and various professional groups to enhance the Connecticut Prescription Monitoring and Reporting System (CPMRS), sometimes known as the Prescription Drug Monitoring Program (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

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

include: 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.

A more complete listing of the prescribing guidelines and updates to State policies stemming from the SUPPORT Act are included in the State's SUD Implementation Plan.

Connecticut's Expanded Coverage of, and Access to, Naloxone for Overdose Reversal

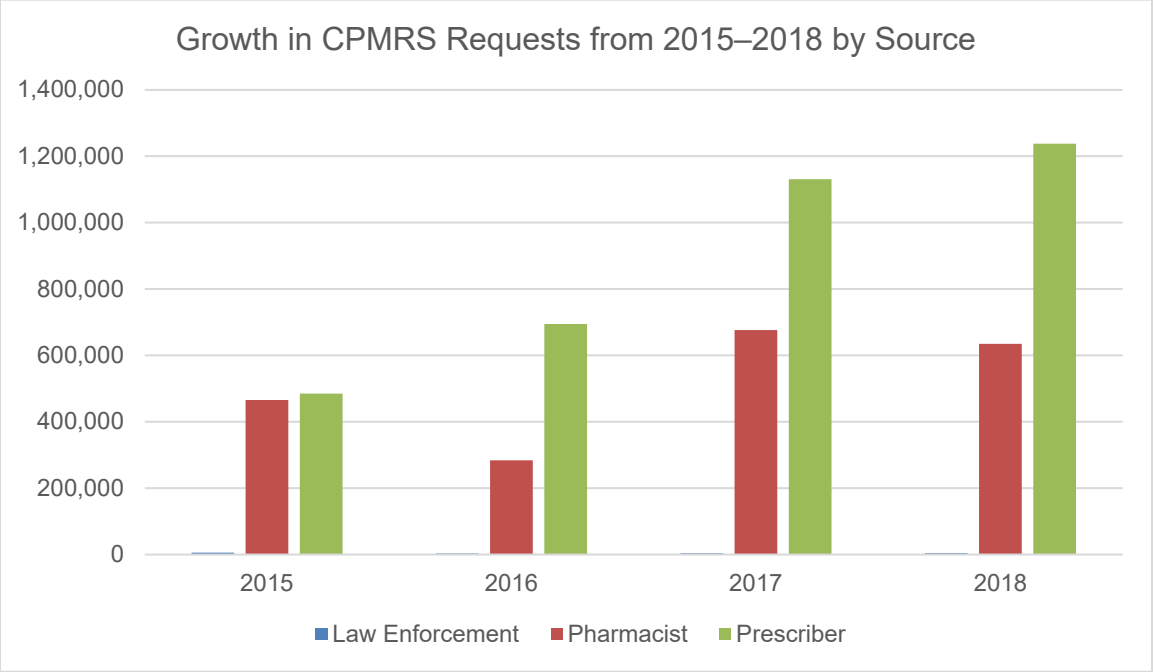
Connecticut has taken a number of steps over the past decade to make naloxone more widely available. Legislation was first introduced in 2011 in the Connecticut General Assembly and subsequent legislative sessions have included new pieces of legislation that have made naloxone more accessible over the years. A "Good Samaritan" law passed in 2011 that protects people who call 911 seeking emergency medical services for an overdose from arrest for possession of drugs/paraphernalia. State legislation enacted in 2012, which allowed prescribers (physicians, surgeons, physicians' assistants, 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. The 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, Public Act (PA) 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 these changes have made naloxone more readily available.

In addition, as outlined in the State's Implementation Plan, Connecticut has established other initiatives addressing OUD, including expanding availability of naloxone through the use of federal grant funds, such as the federal State Opioid Response grant. A total of 12,000 naloxone kits were made available for distribution in SFY 2019 through DMHAS, the Department of Correction, DPH, the Connecticut Hospital Association and the Regional Behavioral Health Action Organizations.

Increasing Utilization and Improving Functionality of PDMPs

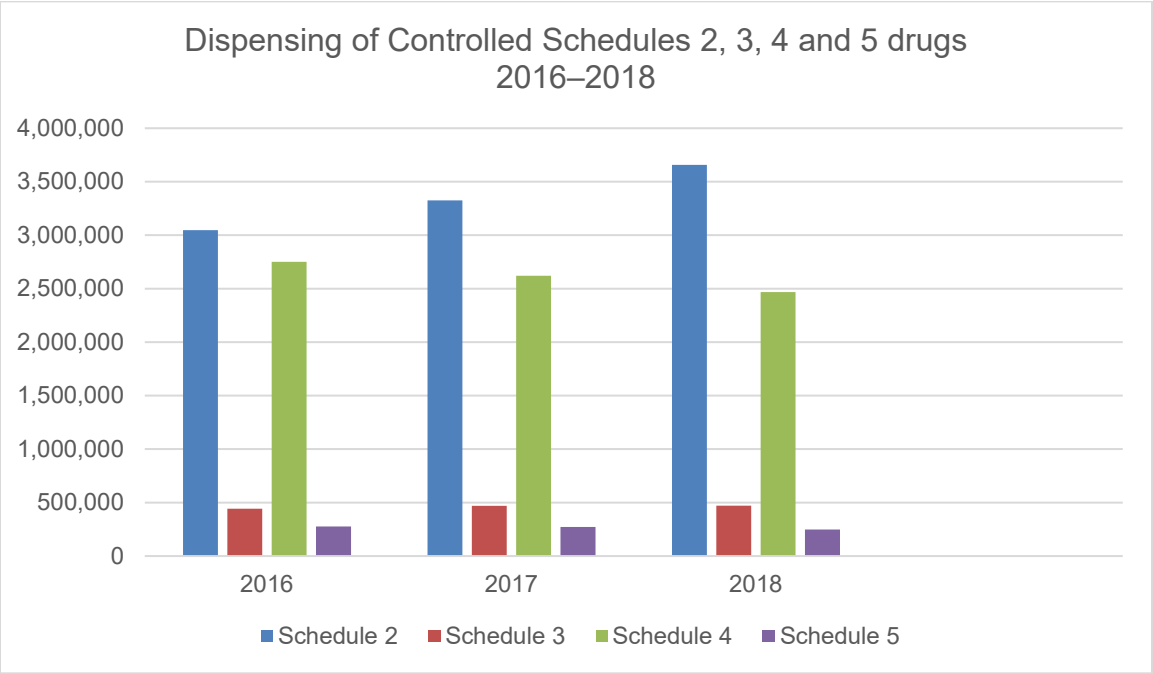
Connecticut first mandated prescriber use of the CPMRS, the State's PDMP, in 2015, with additional provisions added in 2016. CPMRS is a tool to track the dispensing of controlled prescription drugs to patients. CPMRS is designed to monitor this information for suspected misuse or diversion (i.e., channeling drugs into illegal use), and can give a prescriber or pharmacist critical information regarding a patient's controlled substance prescription history. This information has helped prescribers and pharmacists identify high-risk 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 four years earlier when there were approximately one million requests.

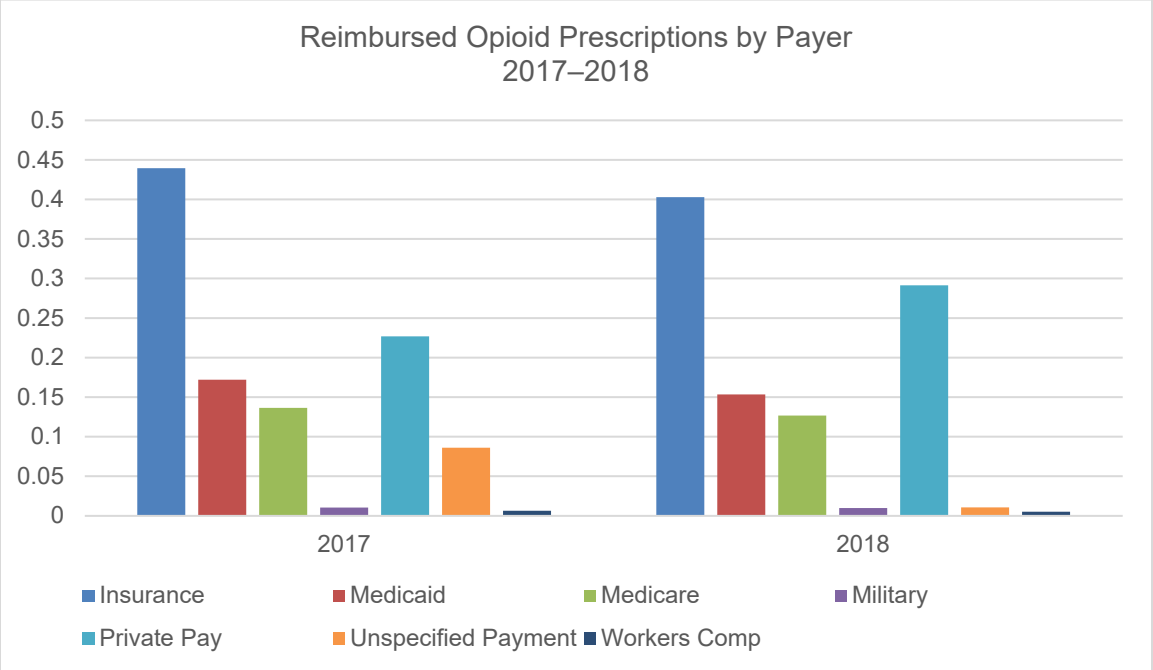


Note: The number of law enforcement requests are very small compared to pharmacist and prescriber inquiries and does not show on the graph. Law enforcement inquiries in 2015: 5,574; 2016: 3,475; 2017: 3,924; and 2018: 4,206.

CPMRS has also documented a drop in Schedules 4 and 5 controlled substances over time, as depicted in the graph below.



Consistent with the overall data, the number of Medicaid-reimbursed opioid prescriptions have dropped, as well as Medicaid's percentage of payments for opioids dispensed.



PA 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 plans to continue to leverage opportunities described in 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 electronic health records and pharmacy management systems.

All hospitals and pharmacies now have the ability to integrate CPMRS into their EHRs and pharmacy management systems. As of the submission of Connecticut's Medicaid Implementation Advanced Planning Document (IAPD) in 2019, 31,124 practitioners have controlled substance registrations, with some practitioners having more than one registration. CPMRS data have been integrated with 6,868 EHRs, including the three major health systems in Connecticut. This initiative has allowed 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.
- Assist providers in achieving the medication reconciliation meaningful use objective and measure.[6]

An additional goal of this integration is to provide as many avenues as possible for an authorized health care provider to access the CPMRS, including integrated access through Health Information Exchanges (HIEs).

Milestone 6: Improved Care Coordination and Transitions between LOCs

Connecticut has multiple interventions for coordinating the care of individuals with SUD and transitioning between LOCs including, but not limited to, facility credentialing, discharge, referral and transition requirements, and care management initiatives at DSS, DCF and DMHAS.

[6] Stage 3 of the meaningful use requirements for providers participating in the Medicaid Promoting Interoperability Program 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.

Under the Demonstration, Connecticut will examine all of the service definitions and existing care management models and strengthen the transition management component for SUD populations between LOCs. DSS, DCF and DMHAS will create a clear delineation of responsibility for improved coordination and transitions between LOCs to ensure individuals receive appropriate follow-up care following residential treatment.

In addition, under the Demonstration, in order to ensure improved care coordination and transitions between LOCs, Connecticut will also monitor access and healthcare outcome measures by demographic information, including race and ethnicity. In addition, Connecticut intends to implement coverage of enhanced individualized care coordination for individuals with SUD that is designed to identify, prevent, and address health inequities and challenges related to social determinants of health.

V. COMPREHENSIVE PLAN TO ADDRESS OPIOID MISUSE AND ASSESSMENT OF HOW THE DEMONSTRATION COMPLEMENTS AND DOES NOT SUPPLANT OTHER STATE ACTIVITIES

In Connecticut, state activities for addressing opioid use disorder and other substance use disorders fall under the state statutory mandate for multiple state agencies. As the single State Medicaid and CHIP agency, DSS oversees SUD treatment services for Medicaid and CHIP beneficiaries, while DMHAS oversees SUD services for all adults, and DCF oversees SUD services for all youth. The Demonstration increases covered SUD services and expands access to these services for Medicaid and CHIP members. Under current state law, DMHAS and DCF broadly oversee the overall SUD service system, with the purpose of facilitating access to and ensuring the quality of SUD services for everyone in the state. Leveraging the work of the Connecticut Alcohol and Drug Policy Council (ADPC), and in collaboration with DCF, DSS, and other partners, DMHAS prepares every three years a comprehensive statewide Triennial State Substance Use Plan, which establishes the state's overall plan for addressing SUD. The plan outlines the state's overall activities to address SUD, including opioid use disorder. This Demonstration will complement and not supplant the state's various activities to address SUD, including OUD.

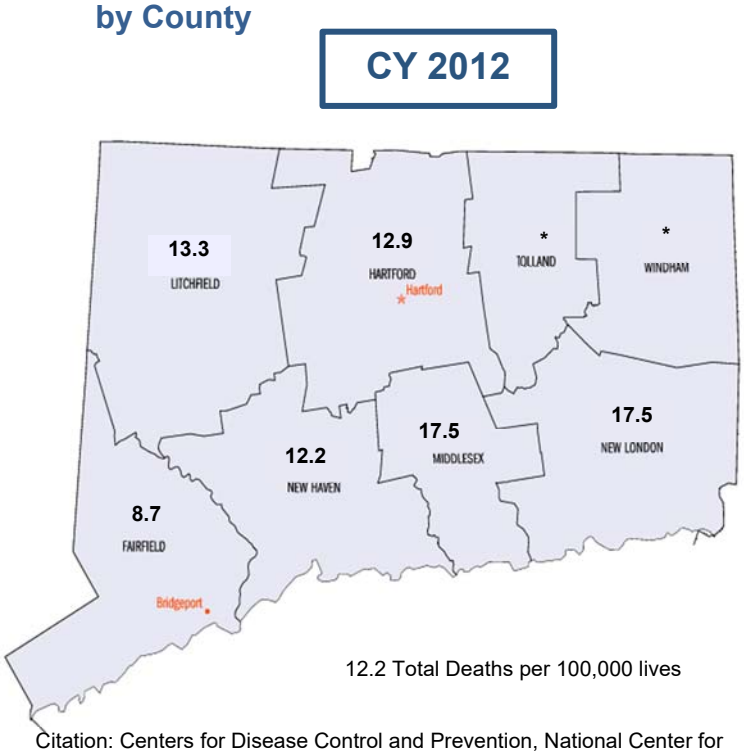
Connecticut's collaborative policy council, the ADPC, is charged under state statute with reviewing policies and practices of the state regarding SUD programs and services and developing and coordinating a statewide plan for SUD programs and services. The ADPC was established in 1997 pursuant to state law (section 17a-667 of the

Connecticut General Statutes) and is comprised of representatives from all three branches of State government (including DSS, DCF, and DMHAS from the state's executive branch), legislators, advocacy groups for individuals with SUD, private service providers, individuals in recovery from SUDs and other stakeholders. It is tasked with developing a coordinated statewide response to SUD in Connecticut. In 2015, the ADPC's governing state statute was amended to reconstitute the council composition with the key purpose to focus its efforts on identifying programs and policies that would help stem the state's opioid crisis. This Demonstration is being coordinated with that larger effort and will complement and not supplant State activities called for or supported by other Federal authorities and funding streams.

Historically, and particularly over the last several years, Medicaid has played a crucial role in the ADPC. DSS has a permanent appointment to the ADPC and, as part of that membership, shares Medicaid data and systems improvement efforts with the ADPC and its various subcommittees to inform their ongoing work.

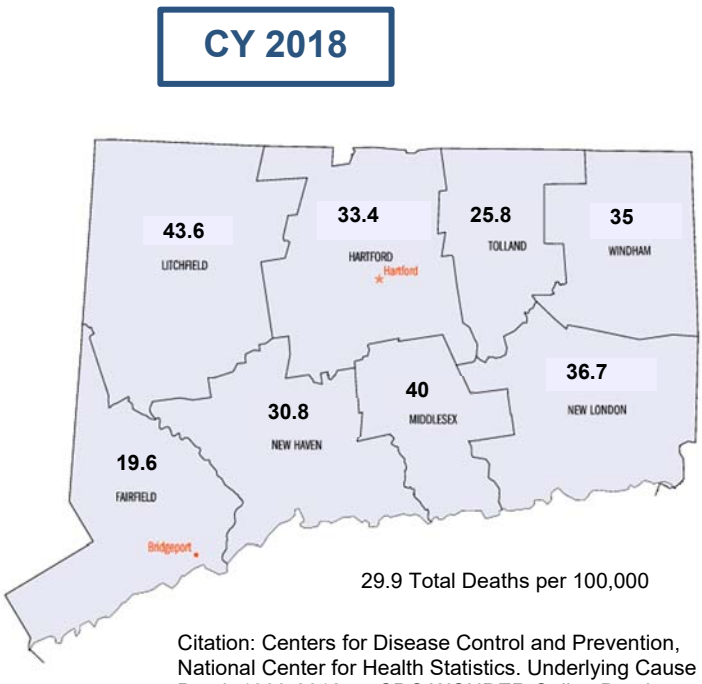
The ADPC's interventions increased as opioid deaths rose from 12.2 to 29.9 deaths per 100,000 lives. See Figure 1 for maps outlining the growth in drug-related deaths in Connecticut counties between calendar year (CY) 2012 and CY 2018.

Figure 1: Rate of Unintentional Drug-Related Overdose Deaths per 100,000 People by County



12.2 Total Deaths per 100,000 lives

Citation: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2018 on CDC WONDER Online Database, released in 2020.Data are from the Multiple Cause of Death Files, 1999-2018, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html on May 13, 2020.
*Indeterminate because the applicable numbers reported were not listed in the CDC data, likely due to CDC standards confidentiality for small sample sizes.



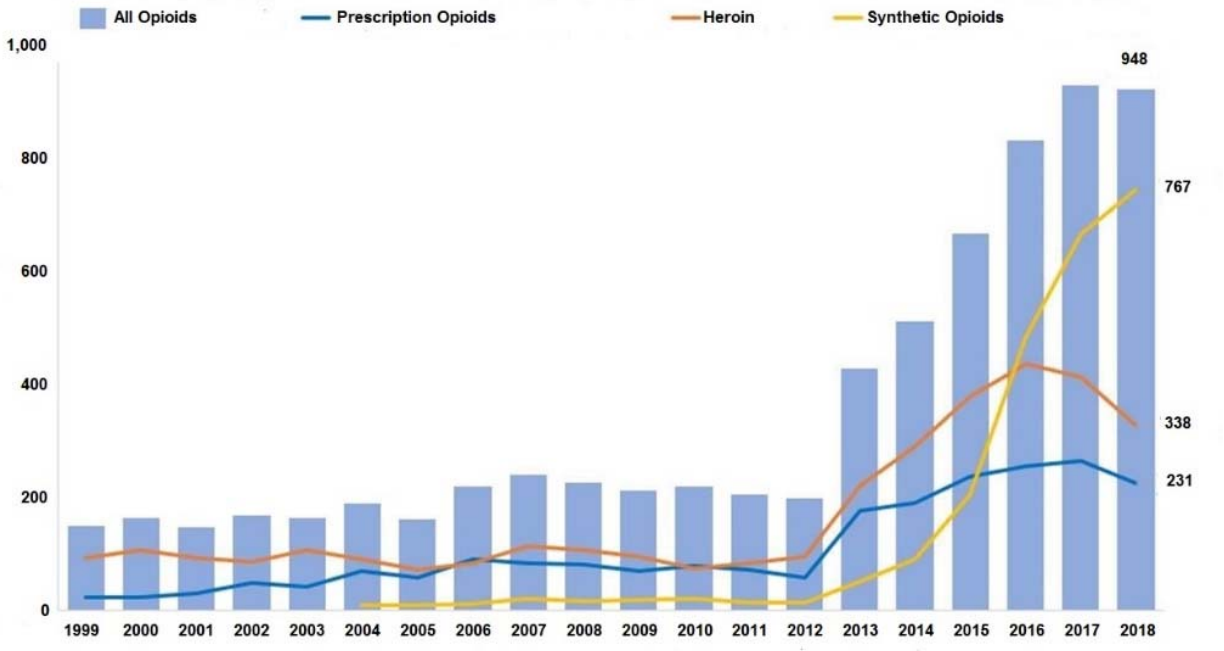
29.9 Total Deaths per 100,000

Citation: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2018 on CDC WONDER Online Database, released in 2020. Data are from the Multiple Cause of Death Files, 1999-2018, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html on May 13, 2020.

In 2018, there were 948 overdose deaths involving opioids in Connecticut — a rate of 29.9 deaths per 100,000 persons, which was double the national rate of 14.6 deaths per 100,000 persons.[7]

In Connecticut, opioid-involved overdose deaths remained steady from 2017 to 2018. Of the 948 opioid-involved deaths reported in 2018, those involving prescription opioids declined to 231 deaths while those involving heroin declined to 338 deaths. The greatest increase in opioid deaths since 2016 was seen in cases involving synthetic opioids (mainly fentanyl and fentanyl analogs), which is reflected in a rise from 79 deaths in 2016 to 767 in 2018. Deaths involving heroin also increased from 98 deaths in 2012 to 450 in 2016 but saw a decrease in 2017 and 2018 with 338 deaths in 2018. Prescription opioids were involved in 273 deaths in 2017 and while deaths decreased to 231 in 2018, this represents an almost fourfold increase from the 60 deaths recorded in 2012. (Figure 1).

Drug Overdose Deaths by Type of Drug

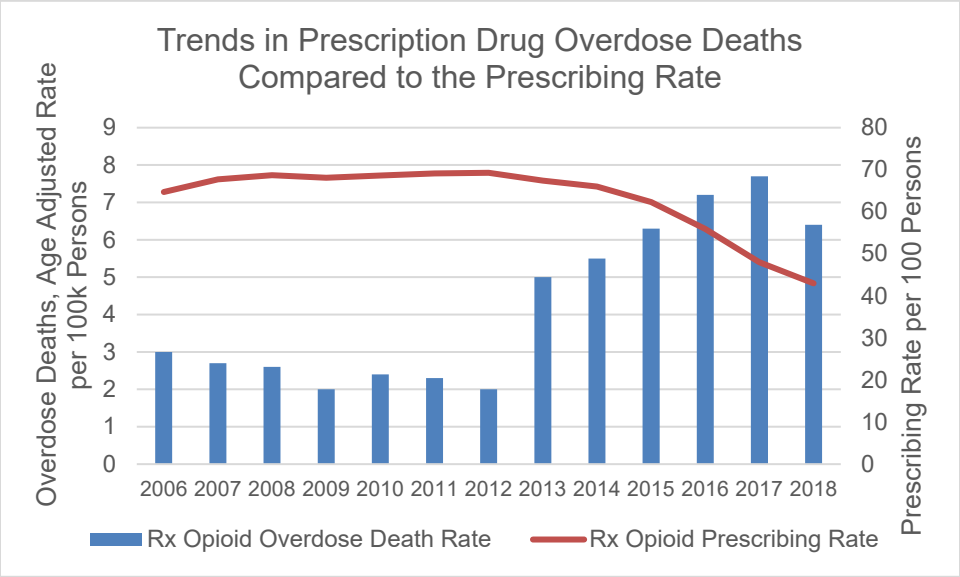


Source: CDC WONDER
https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/connecticut-opioid-summary
In 2018, Connecticut providers wrote 43.0 opioid prescriptions for every 100 persons compared to the national average rate of 51.4 opioid prescriptions. Since 2012, this represents a 66% decline.

[7] Mortality data can be found at the following website: https://wonder.cdc.gov/

DSS has been particularly assertive in promoting changes designed to reduce unnecessary opioid prescribing for Medicaid members due to reporting from the U.S. Centers for Disease Control and Prevention (CDC) that Medicaid members were being prescribed opioids at more than twice the rate of those with commercial insurance and were at greater risk for opioid misuse and death.[8] However, the rate of overdose deaths involving opioid prescriptions steadily rose from 1.6 deaths in 2012 to 7.7 deaths per 100,000 persons in 2017, even though the overall rate of opioid prescribing declined over that time period. See the chart below.

Trends in Prescription Drug Overdose Deaths Compared to the Prescribing Rate



Source: CDC and CDC WONDER
www.cdc.gov/drugoverdose/data/prescribing/overdose-death-maps.html
www.cdc.gov/drugoverdose/maps/rxstate2018.html
www.cdc.gov/drugoverdose/data/prescribing/prescribing-practices.html
www.drugabuse.gov

VI. DELIVERY SYSTEMS

This Demonstration will not change the current delivery system structure. All Medicaid services will continue to be delivered through a FFS delivery system. However, as

[8] CDC. Overdose deaths involving prescription opioids among Medicaid enrollees. *Morbidity and Mortality Weekly Report.* 2009; 58:1171-1175, and CDC. Patient review and restriction programs: Lessons learned from state Medicaid programs. *CDC Expert Panel Meeting Report*. Aug 27-28, 2012; Atlanta, GA.

described elsewhere in this Demonstration waiver application, through this Demonstration, the State will make various improvements to the SUD service system statewide, including aligning with ASAM third edition criteria, analyzing care management initiatives that are available and improving coordination of care, and improving transitions of care. Overall, while continuing to use a FFS delivery system structure, the Demonstration will streamline, clarify, and improve the content of each LOC and improve transitions in the care management system.

VII. ELIGIBILITY

Medicaid eligibility requirements will not differ from the approved Medicaid State Plan.

VIII. BENEFITS

Connecticut will submit a Medicaid SPA for a complete continuum of SUD treatment services consistent with ASAM standards, including residential treatment and withdrawal management. After CMS approval of the SPA, the State will begin reimbursing for a full array of services using the current ASAM criteria effective on the effective date of the SPA, which is anticipated to be on or after July 1, 2021. The Demonstration is expected to be implemented on or after October 1, 2021, or with CMS approval, whichever is later.

Connecticut's Medicaid State Plan currently covers a range of community-based ambulatory care services designed to prevent institutionalization. The benefit package, developed over the past several years in close coordination and consultation with CMS and SAMHSA best practice guidelines, includes:

- Outpatient SUD treatment, including MAT, consistent with ASAM LOCs
- Community-based SUD services for children, such as MST and MDFT.

The Demonstration will permit Medicaid recipients in Connecticut with SUD to receive high-quality, clinically-appropriate Medicaid State Plan-approved SUD treatment services in outpatient and community-based settings, as well as in residential and inpatient treatment settings that qualify as an IMD.

IX. COST-SHARING

Cost sharing requirements under the Demonstration will not differ from the approved Medicaid State Plan.

X. HYPOTHESIS AND EVALUATION

The Demonstration will evaluate whether the Connecticut Medicaid SUD treatment system is more effective through a provision of a complete coordinated continuum of care using ASAM placement criteria and standards, including SUD residential treatment services. The delivery system reforms are particularly important to address the needs of the Medicaid expansion population, which has historically been underserved.

Through a contract with an independent contractor, Connecticut will conduct an independent evaluation to measure and monitor the outcomes of the SUD Demonstration. The evaluation will focus on the key goals and milestones of the Demonstration. The researchers will assess the impact of providing the full continuum of SUD treatment services, particularly residential treatment, on hospital emergency department (ED) utilization, inpatient hospital utilization and readmission rates. Both a midpoint evaluation and an evaluation at the end of the five-year waiver period will be completed. The evaluation will be designed to demonstrate achievement of the Demonstration's goals, objectives and metrics. As required by CMS, the evaluation design will include the following elements:

- General background information
- Evaluation questions and hypotheses
- Methodology
- Methodological limitations
- Attachments

The details of the evaluation design will be developed in concert with CMS during the Demonstration negotiation process with an evaluation design submitted no later than 180 days after the effective date of the Demonstration. The State will also submit a monitoring protocol no later than 150 days after approval of the Demonstration, outlining the State's intent and ability to report on various metrics, including the required performance metrics outlined in the CMS SUD performance metric technical specifications.

DSS proposes to evaluate the Demonstration's success and will include an evaluation of the following goals, research questions and hypotheses:

- Demonstration Goal 1: Improve quality of care and population health outcomes for Medicaid enrollees with SUD.

  - Research Question 1.1: What is the impact of the Demonstration on ED utilization by Medicaid enrollees with SUD?
    - Evaluation Hypothesis 1.1.1: The Demonstration will decrease the rate of ED use among Medicaid enrollees with SUD.
      Primary Driver: Reduce hospital ED and inpatient hospital use

  - Research Question 1.2: What is the impact of the Demonstration on inpatient hospital use by Medicaid enrollees with SUD?
    - Evaluation Hypothesis 1.2.1: The Demonstration will decrease hospital admissions among Medicaid enrollees with SUD.
      Primary Driver: Reduce hospital ED and inpatient hospital use
    - Evaluation Hypothesis 1.2.2: Enrollees with SUD will have lower hospital readmission rates.
      Primary Driver: Reduce readmissions to hospitals

  - Research Question 1.3: What is the impact of the Demonstration on population health outcomes among Medicaid enrollees?
    - Evaluation Hypothesis 1.3.1: Enrollees with SUD will have improved rates of initiation and engagement of alcohol and other drug use treatment (IET).
      Primary Driver: Improve the rates of initiation, engagement and retention in treatment

  - Research Question 1.4: Will more adolescents be treated for SUD using early identification and ambulatory ASAM LOCs including early access to treatment?
    - Evaluation Hypothesis 1.4.1: More adolescent SUD treatment services will be provided at the ambulatory ASAM LOCs.
      Primary Driver: Improve access for youth through early intervention and SUD treatment in ambulatory ASAM LOC

  - Research Question 1.5: What is the impact of the Demonstration on opioid-related overdose deaths?
    - Evaluation Hypothesis 1.5.1: Enrollees will have fewer opioid-related overdose deaths.

Primary Driver: Improve the rates of initiation, engagement and retention in treatment.

- Demonstration Goal 2: Increase enrollee access to and use of appropriate SUD treatment services based on ASAM criteria.

  - Research question 2.1: Has access to critical LOCs improved in Medicaid?
    - Evaluation Hypothesis 2.1.1: The Demonstration will increase the supply of the critical LOCs for Medicaid enrollees.
      Primary Driver: Access to care
      Secondary Driver: Access to critical LOCs for OUD and other SUDs

  - Research question 2.2: Since the development of the 1115 SUD waiver, are more individuals receiving services at critical LOCs when compared to the numbers prior to the waiver?
    - Evaluation Hypothesis 2.2.1: The Demonstration will increase the use of residential, MAT, withdrawal management, early intervention and ambulatory care available by Medicaid enrollees.
      Primary Driver: Access to a full continuum of SUD treatment services

  - Research question 2.3: Has the use of evidence-based SUD-specific patient placement criteria (ASAM criteria) been implemented across all LOCs for all patient populations?
    - Evaluation Hypothesis 2.3.1: The Demonstration will lead to use of the most recent version of the ASAM placement criteria by all providers.
      Primary Driver: Access to care
      Secondary Driver: Use of evidence-based placement criteria

  - Research question 2.4: Has the availability of providers in Medicaid accepting new patients, including MAT providers, improved under the Demonstration?
    - Evaluation Hypothesis 2.4.1: The Demonstration will increase provider capacity for SUD treatment at critical LOCs for individuals in the State.
      Primary Driver: Access to care
      Secondary Driver: Sufficient provider capacity

    - Evaluation Hypothesis 2.4.2: The Demonstration will improve access and develop capacity for adolescent girls needing SUD residential treatment.
      Primary Driver: Access to care
      Secondary Driver: Sufficient provider capacity

- Demonstration Goal 3: Improve care coordination and care transitions for Medicaid enrollees with SUD.

  - Research Question 3.1: What is the impact of the Demonstration on the integration of physical and BH care among Medicaid enrollees with SUD and co-morbid conditions?

    - Evaluation Hypothesis 3.1.1: The Demonstration will increase the rate of Medicaid enrollees with SUD-related conditions who are also receiving primary/ambulatory care.
      Primary Driver: Improve discharge planning and continuity of care between providers

  - Research Question 3.2: Has the Demonstration impacted access to care for individuals with SUD by linking beneficiaries with community-based services and supports following ED visits and reducing readmission rates for hospital stays?

    - Evaluation Hypothesis 3.2.1: The Demonstration will improve follow-up after discharge from EDs and decrease readmissions for individuals with SUD.
      Primary Driver: Care coordination
      Secondary Driver: Improved coordination and transitions between LOCs

    - Evaluation Hypothesis 3.2.2: Enrollees with SUD will have increased treatment engagement as measured by treatment duration (Medicaid utilization over time).
      Primary Driver: Care coordination
      Secondary Driver: Improved coordination and transitions between LOCs

    - Evaluation Hypothesis 3.2.3: Medicaid IMD providers will demonstrate consistency in program design and discharge planning policies.
      Primary Driver: Improved discharge planning and connect to care metrics between providers

- Demonstration Goal 4: Maintain or reduce Medicaid cost of individuals with SUD.
  - Research Question 4.1: Will Medicaid maintain or decrease overall Medicaid costs after accounting for the newly added residential and withdrawal management services? The spending will be compared to spending prior to the implementation of the waiver, but will be adjusted by the cost of the services new to Medicaid.

- Evaluation Hypothesis 4.1.1: The Demonstration will be budget neutral to the Federal government.
  Primary Driver: Maintain or reduce cost

- Evaluation Hypothesis 4.1.2: Total Medicaid SUD spending during the measurement period will remain constant after adjustment for the new residential services and any other new SUD treatment services including care coordination developed under this Demonstration.
  Primary Driver: Maintain or reduce cost

- Evaluation Hypothesis 4.1.3: Total Medicaid SUD spending on residential treatment within IMDs during the measurement period will remain constant after adjustment for the new residential services and any other new SUD treatment services including care coordination developed under this Demonstration.
  Primary Driver: Maintain or reduce cost

- Evaluation Hypothesis 4.1.4: Costs by source of care for individuals with SUD incurring high Medicaid expenses during the measurement period will remain constant after adjustment for the new residential services and any other new SUD treatment services including care coordination developed under this Demonstration.
  Primary Driver: Maintain or reduce cost

XI. LIST OF WAIVER AND EXPENDITURE AUTHORITIES

Waiver Authority

None.

Expenditure Authority

Connecticut is requesting expenditure authority under Section 1115 to claim as medical assistance the following services that are not otherwise coverable under Medicaid:

- **Residential and Inpatient Treatment for Individuals with SUD**
  Expenditures for otherwise covered services furnished to otherwise eligible individuals who are receiving treatment and withdrawal management services for SUD in an IMD.

XII. ESTIMATE OF EXPECTED INCREASE/DECREASE IN ANNUAL ENROLLMENT AND ANNUAL AGGREGATE EXPENDITURES

Enrollment is not expected to change as a result of this Demonstration. A separate SPA for a complete continuum of SUD treatment services consistent with ASAM placement criteria and standards including residential services will be submitted with a fiscal impact. This Demonstration will permit Connecticut to reimburse SUD treatment services, including services for individuals who receive services in an IMD, which is generally a cost-effective alternative setting to hospitalization.

Consistent with the federal guidance regarding the calculation of federal budget neutrality (BN) in SUD 1115 demonstration waivers, this Demonstration has been designed in a manner to maintain federal BN consistent with federal requirements based on monthly per capita expenditures per Medicaid eligibility group.

Utilization of Medicaid State Plan-covered services for individuals who receive SUD treatment services in an IMD will be authorized only if DSS, or its designee, determines the admission to a residential setting is consistent with the current ASAM placement criteria and generally complies with all other applicable requirements, including medical necessity. This will be cost effective compared to inpatient hospital admissions.

Budget Neutrality

Mercer was engaged by the State of Connecticut and DSS to develop the response to the BN Form section for the Section 1115 Medicaid Demonstration Waiver Application for SUD residential services. BN is a comparison of without waiver expenditures to with waiver expenditures. CMS recommends two potential methodologies of demonstrating BN:

1. Per Capita Method: Assessment of the per member per month (PMPM) cost of the Demonstration
2. Aggregate Method: Assessment of both the number of members and PMPM cost of the Demonstration

BN for the 1115 waiver will be demonstrated through the per capita method. The BN projections were developed using CMS BN requirements. The SUD residential BN worksheets prepared by Mercer are attached as Attachment A.

Mercer has relied upon certain data and information provided by DSS, DMHAS, and DCF in the development of the estimates contained in the BN Worksheet. Mercer has relied upon DSS, DMHAS, and DCF for the accuracy of the data and accepted them without audit. To the extent the data provided are not accurate, the results of this analysis may need to be modified to reflect revised information.

Differences between Mercer's projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the finite assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience. It should be emphasized that the values in the BN Form are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this analysis.

Background

Mercer assisted DSS in developing BN estimates to include in the state's SUD 1115 waiver application, which is anticipated to be effective October 1, 2021 or upon CMS approval, whichever is later.

This document provides a summary to the State of the 1115 BN modeling methodology for SUD services in IMDs for which federal law would prohibit Medicaid FFP absent a section 1115 demonstration waiver. This includes a summary of one year of historical data and modeling assumptions to develop projected SUD services over the five-year 1115 demonstration period. These estimates were included within the overall BN documentation delivered to the State on December 18, 2020 and updated on August 6, 2021, which includes BN estimates as required by the SUD 1115 BN template provided by CMS.

This document includes appendices summarizing the base data and SUD BN projection outcomes, which will be shared with CMS as part of the formal 1115 waiver application.

Overview

The State, through its 1115 waiver application, seeks to provide the full continuum of SUD treatment to children and adults including, when necessary, treatment in residential settings that may exceed 16 beds. The State intends to provide these services under the FFS delivery system, which is consistent with the FFS delivery model of the Connecticut Medicaid program. As such, the State seeks 1115 waiver

authority to allow the State to claim FFP for services provided to Medicaid eligible individuals that utilize SUD services provided in an IMD.

Currently, individuals eligible for Medicaid receive SUD residential services through state-only and non-Medicaid federal block grant funded programs. Current State expenses for SUD IMD users do not reflect current ASAM standards or Medicaid documentation requirements because of the limited funding available. In addition, the state agencies administering the current non-Medicaid SUD residential programs had utilization data because the programs are contract-funded. Because the programs are not funded through the FFS delivery system, Mercer relied on the SFY 2019 utilization in Connecticut state-only and non-Medicaid federal block grant funded SUD programs priced at the state's newly set Medicaid ASAM fees as the basis for developing the BN baseline, as further detailed below. Connecticut will be submitting a Medicaid SPA adding SUD residential services to the Medicaid State Plan, which is anticipated to be for an effective date of on or after October 1, 2021.

These PMPM costs, along with an estimated caseload, were relied upon to establish Without Waiver (WoW) and With Waiver (WW) projections utilizing the draft SUD Toolkit provided by CMS.

Historical Base Data

To develop the SUD projections for BN, Mercer evaluated available utilization data related to historical SUD state-only and block grant funded residential services. Mercer discussed the available data sources with the State and determined that state-specific utilization data was available for developing projections, but that utilizing the State's proposed newly set Medicaid fee schedule for specific ASAM levels would be the most expedient manner to establish a baseline. The state informally submitted a draft Medicaid State Plan Amendment to CMS on July 30, 2021, to support these proposed Medicaid fees. Mercer compiled historic data that consists of FFS information from the non-Medicaid funded programs priced at the State's proposed newly set Medicaid ASAM rates. Mercer expects that the SFY 2019 historic experience is sufficient in understanding historic State expense.

In accordance with CMS guidance for SUD 1115 demonstration waivers, the State is demonstrating BN to the federal government using the PMPM expenditures for SUD IMD services for each of the Medicaid Eligibility Groups (MEGs) within the Connecticut beneficiary population. The methodology for developing the MEGs is illustrated below.

Medicaid Eligibility Groups (MEGs)

Historically, Connecticut reimbursed SUD IMD residential services for Medicaid-eligible individuals using non-Medicaid funding sources. Mercer utilized SFY 2019 state-specific utilization data priced at the State's proposed newly set Medicaid ASAM residential fee schedule and known hospital provider rates to determine historic PMPM costs for all Medicaid members. Using a listing of State facilities identified as IMDs, as well as procedure codes for SUD residential services, Mercer filtered the SUD data to identify SUD IMD users by month of service in SFY 2019. Due to the variation in PMPM levels and caseload growth, the State and Mercer are developing BN projections under four FFS MEGs for all ages combined, including those who are dually-eligible: HUSKY A (TANF-related, generally children and caretaker adult coverage groups), HUSKY B (CHIP), HUSKY C (Aged, Blind and Disabled coverage groups), and HUSKY D (Adult expansion population coverage groups). This MEG structure is consistent with the current Connecticut eligibility structure.

The State provided identification numbers for Medicaid members receiving state-funded and block grant funded residential services. Mercer acknowledges the complexities of the various State datasets but, where possible, identified other concurrent non-SUD expenditures during an IMD stay in historic data available from SFY 2019. Mercer utilized the available non-SUD IMD residential services experience combined with the proxy-priced IMD utilization data that suggests a PMPM for SUD IMD of $4,715 for HUSKY A, $7,260 for HUSKY B, $11,850 for HUSKY C and $7,839 for HUSKY D is appropriate.

Modeling Assumptions

From the historical base data, Mercer developed projected per capita costs for the four MEGs: HUSKY A, HUSKY B, HUSKY C and HUSKY D.

The SFY 2019 (base year) per capita costs as outlined above were projected forward 39 months from the midpoint of SFY 2019 to the midpoint of federal fiscal year (FFY) 2022, which is represented as demonstration year (DY) 01. Note that the State is requesting an effective date for its 1115 waiver of October 1, 2021 or upon CMS approval, whichever is later, for FFY 2022 (DY 01). Beyond DY 01, PMPMs are trended forward on an annual basis.

Mercer analyzed and summarized trend rates from the Medicaid expenditure projections from the CMS Office of the Actuary's (OACT) report titled "2018 Actuarial Report on the

Financial Outlook for Medicaid"[9]. Mercer recognizes that this trend rate is subject to change based on CMS review.

Mercer filtered the SUD data to identify SUD IMD users by month of service in SFY 2019 and used this as the basis for the caseload estimates for the four MEGs. Mercer estimated caseload growth rates using available Medicaid enrollment growth rates illustrated in the "2018 Actuarial Report on the Financial Outlook for Medicaid," by MEG. The caseload projections by DY are illustrated in Appendix B.

In accordance with CMS guidance for SUD 1115 demonstration waivers, the WoW and WW projections have identical assumptions, which results in the projected per capita and total spending being equivalent (i.e., no assumed waiver savings exist within this 1115 projection), consistent with CMS guidance for treatment of hypothetical MEGs.

Results

Across the five-year waiver period, the per capita State cost projections range from $5,525 to $16,879 resulting in total cost estimates combined for all MEGs of $1,316,728,207. This includes the estimated costs for acute care, MH and SUD services as well as SUD IMD expenditures for members who utilize SUD IMD services. The caseload and per capita estimates by DY for both the WoW and WW projections are provided in Appendix C, and are broken out separately into the projections for each MEG (and, in total, result in the total cost estimate listed immediately above).

Caveats and Limitations

In preparing these projection estimates, Mercer relied on readily available State-specific information and guidance from the State. Mercer reviewed the data and information for internal consistency and reasonableness but did not audit them. These projection estimates are being provided to CMS to facilitate review in advance of the State's 1115 waiver effective date. Through ongoing discussions with the State and CMS, additional information may become known that would necessitate modification of these projections. If changes become necessary, Mercer will revise these projections and update the enclosed appendices, accordingly.

The suppliers of data are solely responsible for its validity and completeness. Mercer reviewed the data and information for internal consistency and reasonableness, but Mercer did not audit it. All estimates are based upon the information and data available

[9] https://www.cms.gov/files/document/2018-report.pdf

at a point in time and are subject to unforeseen and random events, and actual experience will vary from estimates.

The assumptions outlined throughout this narrative are based upon Mercer's understanding of the services and provisions to be included in the State's waiver. To the extent changes to the planned residential services continuum or to the program design are made, these projections may be impacted and need to be updated accordingly. Further, Mercer acknowledges that CMS review may necessitate changes to the proposed projections. As such, the information included in this report should be considered draft and subject to change.

This methodology document assumes the reader is familiar with the State's 1115 waiver application and actuarial projection techniques. It is intended for the State and should not be relied upon by third parties. Other readers should seek advice of qualified professionals to understand the technical nature of these results. This document should only be reviewed in its entirety. **This document is not intended for broad distribution beyond Mercer, the State of Connecticut, its stakeholders (including the public notice and comment processes and related stakeholder engagement) and CMS.** Mercer expressly disclaims responsibility, liability or both for any reliance on this communication by third parties or the consequences of any unauthorized use.

These projections have been prepared by the actuary noted below who is a member of the American Academy of Actuaries and meets its qualification standards to issue statements of actuarial opinion.

To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.

Brad Diaz, FSA, MAAA

Note: This certification by Mercer and the above explanation applies only to Section XII of this waiver application.

XIII. PUBLIC NOTICE AND TRIBAL CONSULTATION

Summary of Public Comments and the State's Responses

A summary of comments received during the public comment period, the State's responses to the comments, and a description of how the State has incorporated the comments into the waiver application are all included in the attached State responses to comments.

Public Notice Process

The State published public notice in the Connecticut Law Journal, which is the state's administrative record, on February 2, 2021 and also posted the public notice on the DSS website for a 30-day public comment period that ran from February 2, 2021 through March 4, 2021. The public notice, both as published in the Connecticut Law Journal and as posted on the DSS website, contained all information required by 42 C.F.R. § 431.408(a) and was posted on the following dedicated demonstration webpage within the DSS website: https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project and also posted a link to that dedicated webpage on the DSS main page under the "News and Press" section, entitled "Substance Use Disorder Demonstration Waiver—Public Comment & Hearings." That content remained posted throughout the state's public comment and review period.

The State utilized additional mechanisms to notify interested parties of the Demonstration, including distributing a link to the public notice on the email lists for the state's legislatively established Behavioral Health Partnership Oversight Council (BHPOC), the Medical Assistance Program Oversight Council (MAPOC), and the Connecticut Alcohol and Drug Policy Council (ADPC). Informally, the State has also been engaging in stakeholder engagement throughout the process of developing this Demonstration, including presenting on and seeking feedback from various groups of consumers, providers and other stakeholders.

DSS held two electronic public hearings, both of which had electronic and telephone access. Due to public health protocols related to the Coronavirus Disease 2019 (COVID-19) public health emergency, these public hearings were held electronically and were open to anyone who wished to participate. The first public hearing was hosted by the BHPOC on February 10, 2021, which is a legislative process that would afford an interested party the opportunity to learn about the Demonstration and to comment on its contents. The second public hearing was hosted by DSS on February

18, 2021 and provided interested parties the opportunity to learn about the contents of the Demonstration and to comment on its contents.

Tribal Consultation

There are two federally-recognized Indian tribes in Connecticut, the Mashantucket Pequot Tribal Nation and the Mohegan Tribe. In accordance with the State's approved tribal consultation process in the Medicaid State Plan, the State sent an email to tribal representatives of each tribe on February 2, 2021 with a summary of the Demonstration, plus a copy of the public notice, waiver application, and implementation plan (as well as a link to the DSS Demonstration webpage referenced above). The tribal representatives did not send any comments to the State about this Demonstration. This Demonstration does not have a unique or particular impact, nor a direct effect on tribal members, tribes, or tribal health programs or organizations.

Attachment A: Budget Neutrality

The 1115 Waiver SUD residential services budget neutrality worksheets are below.

State of Connecticut | Appendix A | Draft and subject to change based on CMS review

1115 Budget Neutrality Historic Data Summary

IMD Historical

Representative Data Year:	2019
Type of State Years:	State Fiscal Year

HUSKY A	2019
TOTAL EXPENDITURES	$11,708,448
ELIGIBLE USER MONTHS	2,810
PMPM COST	$4,166.71

HUSKY B	2019
TOTAL EXPENDITURES	$767,723
ELIGIBLE USER MONTHS	111
PMPM COST	$6,916.42

HUSKY C	2019
TOTAL EXPENDITURES	$28,205,050
ELIGIBLE USER MONTHS	2,415
PMPM COST	$11,679.11

HUSKY D	2019
TOTAL EXPENDITURES	$140,723,842
ELIGIBLE USER MONTHS	19,152
PMPM COST	$7,347.74

Adjusted FY2019 Baseline

Medicaid Eligibility Group (MEG)	Estimated Total Expenditures for SUD Medical Assistance Provided in an IMD	Estimated Total Expenditures for All Other non-SUD/IMD Title XIX State Plan Medical Assistance	Estimated Eligible Member Months for All Medical Assistance Provided in an IMD	Revised Baseline PMPM Cost	PB Trend Rate(s) Used:
HUSKY A	$ 11,708,448	$ 1,540,417	2,810	$ 4,714.90	5.0%
HUSKY B	$ 767,723	$ 38,179	111	$ 7,260.38	5.0%
HUSKY C	$ 28,205,050	$ 412,410	2,415	$ 11,849.88	5.0%
HUSKY D	$ 140,723,842	$ 9,408,233	19,152	$ 7,838.98	5.0%
All MEGs	$ 181,405,062	$ 11,399,240	24,488	$ 7,873.42	

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Appendix B
1115 Budget Neutrality Caseload Projections

Draft and subject to change based on CMS review

Projected SUD IMD Member Months/Caseloads				DEMONSTRATION YEARS (DY)				
	Trend Rate	FY2019 SUD IMD User Months	Months of Trend	DY 01	DY 02	DY 03	DY 04	DY 05
HUSKY A	1.0%	2,810	39	2,902	2,931	2,960	2,990	3,020
HUSKY B	1.0%	111	39	115	116	117	118	119
HUSKY C	1.0%	2,415	39	2,494	2,519	2,544	2,569	2,595
HUSKY D	1.0%	19,152	39	19,781	19,979	20,179	20,381	20,585

State of Connecticut

Appendix C
1115 Budget Neutrality Projections

Draft and subject to change based on CMS review

Without-Waiver Projections

		BASE YEAR FY2019	TREND RATE	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WOW
HUSKY A	Eligible User Months	2,810	n.a.	2,902	2,931	2,960	2,990	3,020	
HUSKY A	PMPM Cost	$ 4,714.90	5.0%	$ 5,525.07	$ 5,801.32	$ 6,091.39	$ 6,395.96	$ 6,715.76	
HUSKY A	**Total Expenditure**			**$ 16,033,753**	**$ 17,003,669**	**$ 18,030,514**	**$ 19,123,920**	**$ 20,281,595**	**$ 90,473,452**
HUSKY B	Eligible User Months	111	n.a.	115	116	117	118	119	
HUSKY B	PMPM Cost	$ 7,260.38	5.0%	$ 8,507.94	$ 8,933.34	$ 9,380.01	$ 9,849.01	$ 10,341.46	
HUSKY B	**Total Expenditure**			**$ 978,413**	**$ 1,036,267**	**$ 1,097,461**	**$ 1,162,183**	**$ 1,230,634**	**$ 5,504,959**
HUSKY C	Eligible User Months	2,415	n.a.	2,494	2,519	2,544	2,569	2,595	
HUSKY C	PMPM Cost	$ 11,849.88	5.0%	$ 13,886.06	$ 14,580.36	$ 15,309.38	$ 16,074.85	$ 16,878.59	
HUSKY C	**Total Expenditure**			**$ 34,631,834**	**$ 36,727,927**	**$ 38,947,063**	**$ 41,296,290**	**$ 43,799,941**	**$ 195,403,054**
HUSKY D	Eligible User Months	19,152	n.a.	19,781	19,979	20,179	20,381	20,585	
HUSKY D	PMPM Cost	$ 7,838.98	5.0%	$ 9,185.96	$ 9,645.26	$ 10,127.52	$ 10,633.90	$ 11,165.60	
HUSKY D	**Total Expenditure**			**$ 181,707,475**	**$ 192,702,650**	**$ 204,363,226**	**$ 216,729,516**	**$ 229,843,876**	**$ 1,025,346,742**

With-Waiver Projections

		BASE YEAR FY2019	TREND RATE	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
HUSKY A	Eligible Member Months	2,810	n.a.	2,902	2,931	2,960	2,990	3,020	
HUSKY A	PMPM Cost	$ 4,714.90	5.0%	$ 5,525.07	$ 5,801.32	$ 6,091.39	$ 6,395.96	$ 6,715.76	
HUSKY A	**Total Expenditure**			**$ 16,033,753**	**$ 17,003,669**	**$ 18,030,514**	**$ 19,123,920**	**$ 20,281,595**	**$ 90,473,452**
HUSKY B	Eligible Member Months	111	n.a.	115	116	117	118	119	
HUSKY B	PMPM Cost	$ 7,260.38	5.0%	$ 8,507.94	$ 8,933.34	$ 9,380.01	$ 9,849.01	$ 10,341.46	
HUSKY B	**Total Expenditure**			**$ 978,413**	**$ 1,036,267**	**$ 1,097,461**	**$ 1,162,183**	**$ 1,230,634**	**$ 5,504,959**
HUSKY C	Eligible Member Months	2,415	n.a.	2,494	2,519	2,544	2,569	2,595	
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Attachment B: Public Comments and Responses

Attached are the State's responses to public comments received during the public comment period, which also include a summary of the comments themselves and how the State has incorporated the comments into this waiver application. The State has also attached the various documents demonstrating the public process, including the public notice, tribal notifications, public hearing agendas, and copies of the written comments received and the formal responses to public comments, which are the same as the responses pasted immediately below.

STATE'S RESPONSES TO COMMENTS SENT APRIL 28, 2021

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.

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid and Children's Health Insurance Program Substance Use Disorder Demonstration Waiver Pursuant to Section 1115 of the Social Security Act

The State of Connecticut Department of Social Services (DSS) proposes to submit the following Medicaid and Children's Health Insurance Program (CHIP) Substance Use Disorder (SUD) Demonstration Waiver Pursuant to Section 1115 of the Social Security Act to the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS). ***Note:*** For more information, see below and DSS website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project. **Public comment and public hearing information are at the bottom of this notice.**

Description of Demonstration Waiver

Pursuant to section 17b-8 of the Connecticut General Statutes and 42 C.F.R. § 431.408, DSS provides notice that it intends to submit to CMS a SUD Demonstration Waiver pursuant to Section 1115 of the Social Security Act for Connecticut's Medicaid Program and CHIP (Demonstration). This Demonstration is the result of a collaborative effort among various state agencies and other partners, including the three partner state agencies of the Connecticut Behavioral Health Partnership (CTBHP): DSS, Connecticut's single state agency for Medicaid and CHIP; the Department of Children and Families (DCF), the lead state agency for children's behavioral health; and the Department of Mental Health and Addiction Services (DMHAS), the single state agency for adult behavioral health. Connecticut's Medical Assistance Program (CMAP) includes the state's Medicaid program and CHIP.

The Demonstration is intended to be effective on or after July 1, 2021 upon CMS approval and is a comprehensive project to enhance the state's SUD service system in accordance with federal guidance. Once approved, the Demonstration will enable federal financial participation (FFP) Medicaid and CHIP matching funds for individuals receiving SUD services residing in Institutions for Mental Diseases (IMDs) that would ordinarily not be covered under federal law. In accordance with CMS guidance, this Demonstration will ensure a complete American Society of Addiction Medicine (ASAM) levels of care (LOCs) service array is available as part of an essential continuum of care for Medicaid enrolled individuals with opioid use disorder (OUD) and other SUDs.

This Demonstration implements CMS guidance for SUD 1115 demonstration waivers, set forth in CMS State Medicaid Director Letter (SMD) # 17-003, Strategies to Address the Opioid Epidemic, posted on the CMS website at this link: https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf. Additional information about SUD 1115 demonstrations, including a list of other states that have already established a SUD 1115 demonstration, is posted to the CMS website at this link:
https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-substance-use-disorder-demonstrations/section-1115-demonstrations-substance-use-disorders-serious-mental-illness-and-serious-emotional-disturbance/index.html.

(A) The program description, goals, and objectives to be implemented or extended under the demonstration project, including a description of the current or new beneficiaries who will be impacted by the demonstration.

Program Description, Including Affected CMAP Members

CMAP enrollment is not expected to change as a result of this Demonstration. As detailed above, the Demonstration will enable CMAP coverage for individuals with SUD who are residing in IMDs for which coverage would otherwise be prohibited under federal law. This Demonstration will also ensure enhancements in the SUD service system to provide a full continuum of care in accordance with the latest version of ASAM LOCs.

Goals/Objectives

The Demonstration includes the following goals, all of which are designed to improve services and quality of life for CMAP members with SUD.

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 hospital emergency departments (EDs) 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 the readmission 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.

(B) To the extent applicable, the proposed health care delivery system and the eligibility requirements, benefit coverage and cost sharing (premiums, copayments, and deductibles) required of individuals that will be impacted by the demonstration, and how such provisions vary from the State's current program features.

This Demonstration will not change the underlying program; in particular, it will not change the current CMAP fee-for-service delivery system, eligibility requirements, covered services, or cost-sharing. Connecticut's Medicaid program currently does not include any cost-sharing. Connecticut's CHIP includes specified cost-sharing for certain services.

The Demonstration will not change covered benefits, except that it will enable FFP to the state for individuals with SUD residing in IMDs. Separately, DSS intends to submit a Medicaid State Plan Amendment (SPA) in the future (for which public notice will be published when the draft SPA has been developed) to enable full implementation of this Demonstration to cover residential and inpatient treatment, as well as all levels of withdrawal management (ASAM levels 1 WM, 2-WM, 3.1, 3.2-WM, 3.3, 3.5, 3.7, 3.7 WM, 4).

(C) An estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures, including historic enrollment or budgetary data, if applicable. This includes a financial analysis of any changes to the demonstration requested by the State in its extension request.

This Demonstration is not anticipated to change annual CMAP enrollment because this Demonstration does not change CMAP eligibility requirements. This Demonstration is not expected to change to annual aggregate Medicaid and CHIP expenditures because it will comply with federal budget neutrality requirements for SUD 1115 demonstration waivers. Utilization of Medicaid State Plan covered services for individuals who receive SUD treatment services in an IMD will be authorized only if DSS or its designee, determines the admission to a residential setting is medically necessary, which includes consideration of consistency with ASAM placement criteria and all other applicable requirements. Changes in Medicaid State Plan covered services and reimbursement will be set forth in a separate SPA, as noted above, and any fiscal impact of those changes will be part of that SPA, not this Demonstration.

Federal law in section 1115 requires the Demonstration to be budget-neutral to the federal government. In SMD # 18-009, Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects, posted on the CMS website at this link: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf, CMS set forth budget neutrality guidance for section 1115 demonstration waivers. CMS notes in SMD # 18-009 (p. 6) that it has approved Medicaid payments for services to individuals residing in an IMD primarily to receive treatment for SUD, which would otherwise be coverable by Medicaid but for the federal law exclusion on Medicaid coverage for services in an IMD, as hypothetical expenditures. CMS applies hypothetical expenditures to a budget neutrality test in which with-waiver and without-waiver costs are treated as the same, which means that that the state is not required to account for separate savings to offset costs that would already be federally coverable under Medicaid but for the IMD exclusion.

DSS anticipates that federal budget neutrality for this Demonstration will be determined using per-member per-month (PMPM) CMAP expenditures for SUD IMD services for the following Medicaid Eligibility Groups (MEGs) within CMAP: HUSKY A (children and caretaker adult coverage groups), HUSKY B (CHIP), HUSKY C (aged, blind and disabled coverage groups), and HUSKY D (low-income adult Medicaid expansion coverage groups).

(D) The hypothesis and evaluation parameters of the demonstration.

The Demonstration will evaluate whether the CMAP SUD treatment system is more effective through a provision of a complete coordinated continuum of care using ASAM placement criteria and standards, including SUD residential treatment services. Through a contract with an independent contractor, the state will conduct an independent evaluation to measure and monitor the outcomes of the Demonstration in accordance with CMS guidance, focusing on the key goals and milestones of the Demonstration. The researchers will assess the impact of providing the full continuum of SUD treatment services, particularly residential treatment, on hospital ED utilization, inpatient hospital utilization and readmission rates.

(E) The specific waiver and expenditure authorities that the State believes to be necessary to authorize the demonstration.

The specific waiver and expenditure authorities necessary to implement this demonstration are those that allow for the state to receive Medicaid and CHIP FFP for otherwise covered services furnished to otherwise eligible individuals, who are receiving treatment and withdrawal management services for SUDs in an IMD, which, absent this waiver, are not coverable in accordance with federal law.

Where the Demonstration is Posted

The Demonstration and related materials, including the Demonstration Waiver Application, Implementation Plan, and Budget Neutrality Summary are posted on the DSS

website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project. The proposed Demonstration and related materials may also be obtained upon request from DSS (see below), at any DSS field office, or the Town of Vernon Social Services Department.

Where and When to Submit Written Comments

To send comments about the Demonstration, please email: Public.Comment.DSS@ct.gov or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. In any correspondence, please reference "SUD 1115 Demonstration Waiver". Please also send any other questions about the Demonstration to this contact information, including requests for a copy of the Demonstration (and/or related materials).

Anyone may send DSS written comments about the Demonstration. Written comments must be received by DSS at the above contact information no later than March 5, 2021 (which is more than 30 days after the date of the publication of this notice in the Connecticut Law Journal). Please note that comments received will also be posted to the same website referenced above.

Public Hearings

In addition to the opportunity for submitting written comments (see above), DSS will also seek input from the public on the Demonstration at the following public hearings, both of which will include opportunities for members of the public to have an opportunity to provide comments:

1. Public Hearing at a meeting of the Behavioral Health Partnership Oversight Council on Wednesday, February 10, 2021, from 2:00 to 4:00 p.m., with electronic link and call-in information to be posted on the DSS website at the link below.
2. Public Hearing before DSS, on Thursday, February 18, 2021, from 10:00 a.m. to 12:00 p.m., with electronic link and call-in information to be posted on the DSS website at the link below.

For the latest information on the public hearing date, time, and the link/call-in information for each public hearing, please go to the DSS website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project and **please check that website regularly for updates before logging onto the public hearing**.

As a result of restrictions and guidelines to protect public health due to the Coronavirus Disease 2019 (COVID-19) pandemic and ongoing state and federal public health emergency declarations, the public hearings referenced above are being convened only using electronic means, with opportunity for individuals to participate by electronic device, telephone, or both.

Norwood, Joel C.

From: Norwood, Joel C.
Sent: Tuesday, February 2, 2021 4:49 PM
To: 'Connie Hilbert'; 'Carrie Janus'; 'sjacobs@moheganmail.com'
Cc: Halsey, William (William.Halsey@ct.gov); Mahoney, Ginny L.; Robinson-Rush, Dana (Dana.Robinson-Rush@ct.gov)
Subject: CT SUD 1115 Demonstration - Tribal Consultation [not-secure]
Attachments: CT SUD 1115 - Public Notice - Final - 02-01-21.pdf; CT SUD 1115 - Waiver Application - Draft for Public Comment - 02-01-21.pdf; CT SUD 1115 - Implementation Plan - Draft for Public Comment - 02-01-21.pdf

Connie and Carrie,

The Department of Social Services (DSS), in collaboration with the Department of Children and Families (DCF) and the Department of Mental Health and Addiction Services (DMHAS), proposes a Substance Use Disorder (SUD) demonstration waiver under section 1115 of the Social Security Act (Demonstration). The Demonstration is a comprehensive project to enhance Connecticut's SUD services by ensuring a complete array of American Society of Addiction Medicine (ASAM) levels of care and enabling federal Medicaid and Children's Health Insurance Program (CHIP) matching funds for residential SUD services.

The Demonstration is described in more detail in the attached public notice (which was published today, 2/2/21, in the Connecticut Law Journal). Also attached are the draft waiver application and draft implementation plan. These documents are also posted to the DSS website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project

Please let me know if you have any questions and feel free to send me comments on the Demonstration. In addition, please also let me know if you would like to discuss the Demonstration with DSS. In addition, as described in the public notice, there is also a written public comment period and two public hearings. Thank you.

Thanks,
Joel

Joel C. Norwood
Staff Attorney
Connecticut Department of Social Services
Office of Legal Counsel, Regulations and Administrative Hearings
55 Farmington Avenue
Hartford, CT 06105-3725
Phone: (860) 424-5124
Email: joel.norwood@ct.gov

Norwood, Joel C.

From: Norwood, Joel C.
Sent: Tuesday, February 2, 2021 4:49 PM
To: Reels, Shanna; sreels@mptn.org; jvital@mptn.org; jvital@mptn-nsn.gov
Cc: Halsey, William (William.Halsey@ct.gov); Mahoney, Ginny L.; Robinson-Rush, Dana (Dana.Robinson-Rush@ct.gov)
Subject: CT SUD 1115 Demonstration - Tribal Consultation [not-secure]
Attachments: CT SUD 1115 - Public Notice - Final - 02-01-21.pdf; CT SUD 1115 - Waiver Application - Draft for Public Comment - 02-01-21.pdf; CT SUD 1115 - Implementation Plan - Draft for Public Comment - 02-01-21.pdf

Shanna,

The Department of Social Services (DSS), in collaboration with the Department of Children and Families (DCF) and the Department of Mental Health and Addiction Services (DMHAS), proposes a Substance Use Disorder (SUD) demonstration waiver under section 1115 of the Social Security Act (Demonstration). The Demonstration is a comprehensive project to enhance Connecticut's SUD services by ensuring a complete array of American Society of Addiction Medicine (ASAM) levels of care and enabling federal Medicaid and Children's Health Insurance Program (CHIP) matching funds for residential SUD services.

The Demonstration is described in more detail in the attached public notice (which was published today, 2/2/21, in the Connecticut Law Journal). Also attached are the draft waiver application and draft implementation plan. These documents are also posted to the DSS website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project

Please let me know if you have any questions and feel free to send me comments on the Demonstration. In addition, please also let me know if you would like to discuss the Demonstration with DSS. In addition, as described in the public notice, there is also a written public comment period and two public hearings. Thank you.

Thanks,
Joel

Joel C. Norwood
Staff Attorney
Connecticut Department of Social Services
Office of Legal Counsel, Regulations and Administrative Hearings
55 Farmington Avenue
Hartford, CT 06105-3725
Phone: (860) 424-5124
Email: joel.norwood@ct.gov

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid and Children's Health Insurance Program Substance Use Disorder Demonstration Waiver Pursuant to Section 1115 of the Social Security Act

The State of Connecticut Department of Social Services (DSS) proposes to submit the following Medicaid and Children's Health Insurance Program (CHIP) Substance Use Disorder (SUD) Demonstration Waiver Pursuant to Section 1115 of the Social Security Act to the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS). ***Note:*** For more information, see below and DSS website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project. **Public comment and public hearing information are at the bottom of this notice.**

Description of Demonstration Waiver

Pursuant to section 17b-8 of the Connecticut General Statutes and 42 C.F.R. § 431.408, DSS provides notice that it intends to submit to CMS a SUD Demonstration Waiver pursuant to Section 1115 of the Social Security Act for Connecticut's Medicaid Program and CHIP (Demonstration). This Demonstration is the result of a collaborative effort among various state agencies and other partners, including the three partner state agencies of the Connecticut Behavioral Health Partnership (CTBHP): DSS, Connecticut's single state agency for Medicaid and CHIP; the Department of Children and Families (DCF), the lead state agency for children's behavioral health; and the Department of Mental Health and Addiction Services (DMHAS), the single state agency for adult behavioral health. Connecticut's Medical Assistance Program (CMAP) includes the state's Medicaid program and CHIP.

The Demonstration is intended to be effective on or after July 1, 2021 upon CMS approval and is a comprehensive project to enhance the state's SUD service system in accordance with federal guidance. Once approved, the Demonstration will enable federal financial participation (FFP) Medicaid and CHIP matching funds for individuals receiving SUD services residing in Institutions for Mental Diseases (IMDs) that would ordinarily not be covered under federal law. In accordance with CMS guidance, this Demonstration will ensure a complete American Society of Addiction Medicine (ASAM) levels of care (LOCs) service array is available as part of an essential continuum of care for Medicaid enrolled individuals with opioid use disorder (OUD) and other SUDs.

This Demonstration implements CMS guidance for SUD 1115 demonstration waivers, set forth in CMS State Medicaid Director Letter (SMD) # 17-003, Strategies to Address the Opioid Epidemic, posted on the CMS website at this link: https://www.medicaid.gov/federal-policy-

guidance/downloads/smd17003.pdf. Additional information about SUD 1115 demonstrations, including a list of other states that have already established a SUD 1115 demonstration, is posted to the CMS website at this link: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-substance-use-disorder-demonstrations/section-1115-demonstrations-substance-use-disorders-serious-mental-illness-and-serious-emotional-disturbance/index.html.

(A) The program description, goals, and objectives to be implemented or extended under the demonstration project, including a description of the current or new beneficiaries who will be impacted by the demonstration.

Program Description, Including Affected CMAP Members

CMAP enrollment is not expected to change as a result of this Demonstration. As detailed above, the Demonstration will enable CMAP coverage for individuals with SUD who are residing in IMDs for which coverage would otherwise be prohibited under federal law. This Demonstration will also ensure enhancements in the SUD service system to provide a full continuum of care in accordance with the latest version of ASAM LOCs.

Goals/Objectives

The Demonstration includes the following goals, all of which are designed to improve services and quality of life for CMAP members with SUD.

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 hospital emergency departments (EDs) 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 the readmission 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.

(B) To the extent applicable, the proposed health care delivery system and the eligibility requirements, benefit coverage and cost sharing (premiums, co-payments, and deductibles) required of individuals that will be impacted by the demonstration, and how such provisions vary from the State's current program features.

This Demonstration will not change the underlying program; in particular, it will not change the current CMAP fee-for-service delivery system, eligibility requirements, covered services, or cost-sharing. Connecticut's Medicaid program currently does not include any cost-sharing. Connecticut's CHIP includes specified cost-sharing for certain services.

The Demonstration will not change covered benefits, except that it will enable FFP to the state for individuals with SUD residing in IMDs. Separately, DSS intends to submit a Medicaid State Plan Amendment (SPA) in the future (for which public notice will be published when the draft SPA has been developed) to enable full implementation of this Demonstration to cover residential and inpatient treatment, as well as all levels of withdrawal management (ASAM levels 1 WM, 2-WM, 3.1, 3.2-WM, 3.3, 3.5, 3.7, 3.7 WM, 4).

(C) An estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures, including historic enrollment or budgetary data, if applicable. This includes a financial analysis of any changes to the demonstration requested by the State in its extension request.

This Demonstration is not anticipated to change annual CMAP enrollment because this Demonstration does not change CMAP eligibility requirements. This Demonstration is not expected to change to annual aggregate Medicaid and CHIP expenditures because it will comply with federal budget neutrality requirements for SUD 1115 demonstration waivers. Utilization of Medicaid State Plan covered services for individuals who receive SUD treatment services in an IMD will be authorized only if DSS or its designee, determines the admission to a residential setting is medically necessary, which includes consideration of consistency with ASAM placement criteria and all other applicable requirements. Changes in Medicaid State Plan covered services and reimbursement will be set forth in a separate SPA, as noted above, and any fiscal impact of those changes will be part of that SPA, not this Demonstration.

Federal law in section 1115 requires the Demonstration to be budget-neutral to the federal government. In SMD # 18-009, Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects, posted on the CMS website at this link: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf, CMS set forth budget neutrality guidance for section 1115 demonstration waivers. CMS notes in SMD # 18-009 (p. 6) that it has approved Medicaid payments for services to individuals residing in an IMD primarily to receive treatment for SUD, which would otherwise be coverable by Medicaid but for the federal law exclusion on Medicaid coverage for services in an IMD, as hypothetical expenditures. CMS applies hypothetical expenditures to a budget neutrality test in which with-waiver and without-waiver costs are treated as the same, which means that that the state is not required to account for separate savings to offset costs that would already be federally coverable under Medicaid but for the IMD exclusion.

DSS anticipates that federal budget neutrality for this Demonstration will be determined using per-member per-month (PMPM) CMAP expenditures for SUD IMD services for the following Medicaid Eligibility Groups (MEGs) within CMAP: HUSKY A (children and caretaker adult coverage groups), HUSKY B (CHIP), HUSKY C (aged, blind and disabled coverage groups), and HUSKY D (low-income adult Medicaid expansion coverage groups).

(D) The hypothesis and evaluation parameters of the demonstration.

The Demonstration will evaluate whether the CMAP SUD treatment system is more effective through a provision of a complete coordinated continuum of care using ASAM placement criteria and standards, including SUD residential treatment services. Through a contract with an independent contractor, the state will conduct an independent evaluation to measure and monitor the outcomes of the Demonstration in accordance with CMS guidance, focusing on the key goals and milestones of the Demonstration. The researchers will assess the impact of providing the full continuum of SUD treatment services, particularly residential treatment, on hospital ED utilization, inpatient hospital utilization and readmission rates.

(E) The specific waiver and expenditure authorities that the State believes to be necessary to authorize the demonstration.

The specific waiver and expenditure authorities necessary to implement this demonstration are those that allow for the state to receive Medicaid and CHIP FFP for otherwise covered services furnished to otherwise eligible individuals, who are receiving treatment and withdrawal management services for SUDs in an IMD, which, absent this waiver, are not coverable in accordance with federal law.

Where the Demonstration is Posted

The Demonstration and related materials, including the Demonstration Waiver Application, Implementation Plan, and Budget Neutrality Summary are posted on the DSS website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project. The proposed Demonstration and related materials may also be obtained upon request from DSS (see below), at any DSS field office, or the Town of Vernon Social Services Department.

Where and When to Submit Written Comments

To send comments about the Demonstration, please email: Public.Comment.DSS@ct.gov or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. In any correspondence, please reference "SUD 1115 Demonstration

Waiver". Please also send any other questions about the Demonstration to this contact information, including requests for a copy of the Demonstration (and/or related materials).

Anyone may send DSS written comments about the Demonstration. Written comments must be received by DSS at the above contact information no later than March 5, 2021 (which is more than 30 days after the date of the publication of this notice in the Connecticut Law Journal). Please note that comments received will also be posted to the same website referenced above.

Public Hearings

In addition to the opportunity for submitting written comments (see above), DSS will also seek input from the public on the Demonstration at the following public hearings, both of which will include opportunities for members of the public to have an opportunity to provide comments:

1. Public Hearing at a meeting of the Behavioral Health Partnership Oversight Council on Wednesday, February 10, 2021, from 2:00 to 4:00 p.m., link and call-in as follows:

   Zoom Meeting:
   https://beaconhealthoptions.zoom.us/j/94763921094?pwd=OTlGNmtiaXBQZUU1SUN0Z05RcE42QT09 Meeting ID: 947 6392 1094; Passcode: 339399

   One tap mobile: +13017158592,,94763921094#,,,,*339399# US (Washington D.C)

   Dial by your location:
   +1 646 876 9923 US (New York);
   +1 669 900 6833 US (San Jose)
   Meeting ID: 947 6392 1094; Passcode: 339399

   Join by SIP: 94763921094@zoomcrc.com

   Join by H.323: 162.255.37.11 (US West); 162.255.36.11 (US East)
   Meeting ID: 947 6392 1094; Passcode: 339399

2. Public Hearing before DSS, on Thursday, February 18, 2021, from 10:00 a.m. to 12:00 p.m., link and call-in as follows:

   Zoom Meeting:
   https://zoom.us/j/99666874256?pwd=K2NKZEkycEdmR2dMRGkvakEwL2c3QT09
   Meeting ID: 996 6687 4256; Passcode: 457gYU

One tap mobile: +13126266799,,99666874256#,,,,*058267# US (Chicago)
+19292056099,,99666874256#,,,,*058267# US (New York)

Dial by your location:
+1 312 626 6799 US (Chicago);
+1 929 205 6099 US (New York);
+1 301 715 8592 US (Washington DC)
+1 346 248 7799 US (Houston)
+1 669 900 6833 US (San Jose)
+1 253 215 8782 US (Tacoma)
Meeting ID: 996 6687 4256
Passcode: 058267

For the latest information on the public hearing date, time, and the link/call-in information for each public hearing, please go to the DSS website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project and **please check that website regularly for updates before logging onto the public hearing**.

As a result of restrictions and guidelines to protect public health due to the Coronavirus Disease 2019 (COVID-19) pandemic and ongoing state and federal public health emergency declarations, the public hearings referenced above are being convened only using electronic means, with opportunity for individuals to participate by electronic device, telephone, or both.

Connecticut State Department of Social Services (DSS)

- Health & Home Care (/DSS/Services/Health-and-Home-Care)
- Food and Nutrition (/DSS/Services/Food-and-Nutrition)
- Children, Family, and Older Adults (/DSS/Services/Children-Family-and-Older-Adults)
- Community and Social Work (/DSS/Services/Community-and-Social-Work)
- Financial and Employment (/DSS/Services/Financial-and-Employment)
- Programs and Services (/DSS/Lists/Programs-and-Services)

Search Department of Social Services

Most Popular Resources

- ConneCT to DSS - Apply Online, Open 'MyAccount' and more! (https://connect.ct.gov/access/jsp/access/Home.jsp)
- DSS Response to COVID-19 (/DSS/Communications/DSS-Response-to-COVID-19)
- Free Online Tax Preparation Help (VITA); New COVID-19 Aid May be Available (/DSS/Communications/Free-Online-Tax-Preparation-Help-VITA-New-COVID-19-Aid-May-be-Available)
- Personal Protection Equipment PPE for Home Care Participants Self-Directed (/DSS/Health-And-Home-Care/PPE-Request-Form)
- DSS Field Offices (/DSS/About-the-Department-of-Social-Services/Contact)
- 2-1-1 Connecticut Human Service Information - search online or dial 2-1-1 (https://www.211ct.org/)

SNAP – Supplemental Nutrition Assistance Program (/DSS/SNAP/Supplemental-Nutrition-Assistance-Program---SNAP) >

CT Pathways - for SNAP Enrollees at Colleges & Educational Partners (/DSS/SNAP/SNAP-Employment-and-Training) >

HUSKY Health (http://www.ct.gov/hh) >

Child Support Services (/DSS/Child-Support/Child-Support) >

More Services (/DSS/Most-Popular-Services) >

For Clients & Applicants

Special menu for DSS customers. How to apply, renew & report changes, other key information.

(/DSS/Common-Elements/Clients-and-Applicants)

DSS Response to COVID-19

Information, guidance and resources from DSS in response to COVID-19

(/DSS/Communications/DSS-Response-to-COVID-19)

Partners & Vendors

Special section for contracts, procurement and related information.

(/DSS/Services/Partners-and-Vendors)

News and Press

4/8/2021
Notice of Intent to Amend the Medicaid Waivers for Individual and Family Support and Comprehensive Supports
(/DSS/Health-And-Home-Care/Medicaid-Waiver-Applications/Medicaid-Waiver-Applications)

4/13/2021
Working Group on Diabetes and High Deductible Health Plans to meet on Thursday, April 15th from 11:00am – 12:30pm
(/DSS/Press-Room/Press-Releases/Working-Group-on-Diabetes)

2/23/2021
Notice for Public Review and Comment – Proposed Revision to FFY 2021 LIHEAP Block Grant Allocation Plan
(/DSS/Press-Room/Press-Releases/Notice-for-Public-Review-and-Comment-Proposed-Revision-to-FFY-2021)

2/1/2021
Substance Use Disorder Demonstration Waiver—Public Comment & Hearings
(/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project)

1/11/2021
The Department of Social Services will convene the first meeting of the Advisory Board for Transparency on Medicaid Cost and Quality on Tuesday, January 12, 2021, from 11 a.m. to 12:30 p.m.
(/DSS/Press-Room/Press-Releases/Advisory-Board-for-Transparency)

More News and Press Results (/DSS/Press-Room/Press-Releases) ›

Highlights

UPDATED! - Advisory Board for Transparency on Medicaid Cost and Quality (/DSS/Common-Elements/Advisory-Board-for-Transparency-on-Medicaid-Cost-and-Quality) ›

Personal Protection Equipment (PPE) for Home Care Participants (Self-Directed) (https://dss-pperequest.ct.gov/) ›

Business Intelligence and Big Data (/DSS/ITS/DSS-HealthIT/Business-Intelligence-and-DSS-HealthIT/Business-Intelligence-and-Big-Data) ›

- Census 2020: Special Information for DSS Enrollees about Working for the Census (/DSS/Highlights/Census-2020--Special-Information)
- Connecticut Housing Engagement and Support Services - CHESS (/DSS/Health-And-Home-Care/Connecticut-Housing-Engagement-and-Support/Connecticut-Housing-Engagement-and-Support-Services---CHESS)
- Data and Program Reports (/DSS/ITS/DSS-HealthIT/Business-Intelligence-and-DSS-HealthIT/Data-and-Program-Reports)
- CT Fatherhood Initiative (https://www.ct.gov/fatherhood)
- HUSKY Health and IRS Form 1095-B (/DSS/Common-Elements/1095B)
- Integrated Care for Kids (/DSS/Health-And-Home-Care/InCK/Integrated-Care-for-Kids)
- Medicaid Long-Term Care Demand Projections (/DSS/Health-And-Home-Care/Medicaid-Long-Term-Care-Demand-Projections/Medicaid-Long-Term-Care-Demand-Projections)
- Public Charge: About Federal Rule Change (/DSS/Common-Elements/Public-Charge--Special-Information-about-Federal-Rule-Change)
- Special Notices for Electronic Asset Verification (/DSS/Highlights/Special-Notices-for-Electronic-Asset-Verification)
- Job Opportunities (/DSS/About-the-Department-of-Social-Services/Job-Opportunities)
- Internship Opportunities (/DSS/Human-Resources/Internship-at-the-Connecticut-Department-of-Social-Services)
- MyPlaceCT.org (http://www.myplacect.org)
- Non-Emergency Medical Transportation (/DSS/Health-And-Home-Care/Non-Emergency-Medical-Transportation)
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- CaringCareers.org (http://www.CaringCareers.org)
- Report Fraud/Abuse (/DSS/Quality-Assurance/To-Report-Fraud-or-Abuse-of-Programs)
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It's National Infant Immunization Week! This week is dedicated to recognizing the importance of protecting infants and young children from vaccine-preventable diseases. #ImmunizeCT

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Commissioner Deidre S. Gifford, MD, MPH

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- Uniform Policy Manual - UPM (/DSS/Lists/Uniform-Policy-Manual) >

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- Toll-Free Numbers (/DSS/Common-Elements/Toll-free-Numbers) >
- Media Room and Press Releases (/DSS/Common-Elements/Media-Room-and-Press-Releases) >
- Agency E-Mail Directory (/DSS/Common-Elements/Agency-Email-Directory) >

Section 1115 Demonstration Waiver for Substance Use Disorder (SUD) Treatment

Overview (/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project)

Goals and Milestones (/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project/Goals-and-Milestones)

Meeting Schedule (/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project/Meeting-Schedule)

Provided by:
Department of Social Services (/DSS)

Overview

Public Comment & Public Hearings – Substance Use Disorder (SUD) Section 1115 Demonstration Waiver

The Department of Social Services (DSS), in collaboration with the Department of Children and Families (DCF) and the Department of Mental Health and Addiction Services (DMHAS), proposes a SUD demonstration waiver under section 1115 of the Social Security Act (Demonstration), described below. For public review and comment, please see the following documents:

- **Public Notice (posted 02/02/2021)**
- **Waiver Application – Draft for Public Comment (posted 02/02/2021)**
- **Implementation Plan – Draft for Public Comment (posted 02/02/2021)**

Public Comments: Written comments are accepted from February 2, 2021 through March 4, 2021. Please send comments to: **Public.Comment.DSS@ct.gov (mailto:Public.Comment.DSS@ct.gov)**

Public Hearings: There will be two electronic public hearings (accessible by electronic device and telephone). Links and call-in information below. Please check this webpage regularly for updates before logging onto the public hearing.

1. Public Hearing at a meeting of the Behavioral Health Partnership Oversight Council (BHPOC) on Wednesday, February 10, 2021 from 2:00 to 4:00 p.m.

Zoom Meeting: **https://beaconhealthoptions.zoom.us/j/94763921094?pwd=OTlGNmtiaXBQZUU1SUN0Z05RcE42QT09 (https://beaconhealthoptions.zoom.us/j/94763921094?pwd=OTlGNmtiaXBQZUU1SUN0Z05RcE42QT09)** Meeting ID: 947 6392 1094; Passcode: 339399

One tap mobile: +13017158592,,94763921094#,,,,*339399# US (Washington D.C)

Dial by your location:

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+1 669 900 6833 US (San Jose)

Meeting ID: 947 6392 1094; Passcode: 339399

Join by SIP: **94763921094@zoomcrc.com (mailto:94763921094@zoomcrc.com)**

Join by H.323: 162.255.37.11 (US West); 162.255.36.11 (US East)

Meeting ID: 947 6392 1094; Passcode: 339399

1. DSS Public Hearing on Thursday, February 18, 2021, from 10:00 a.m. to 12:00 p.m.

Zoom Meeting: **https://zoom.us/j/99666874256?pwd=K2NKZEkycEdmR2dMRGkvakEwL2c3QT09 (https://zoom.us/j/99666874256?pwd=K2NKZEkycEdmR2dMRGkvakEwL2c3QT09)**

Meeting ID: 996 6687 4256; Passcode: 457gYU

One tap mobile: +13126266799,,99666874256#,,,,*058267# US (Chicago)

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Meeting ID: 996 6687 4256

Passcode: 058267

Section 1115 Demonstration Waiver for Substance Use Disorder Treatment

As part of the U.S. Department of Health and Human Services' effort to combat the ongoing opioid crisis, the Centers for Medicare & Medicaid Services (CMS) created an opportunity under the authority of section 1115(a) of the Social Security Act for states to demonstrate and test flexibilities to improve the continuum of care for beneficiaries with substance use disorders (SUD) including Opioid Use Disorder (OUD).

The Connecticut Department of Social Services (DSS) is requesting an 1115 Demonstration Waiver for SUD inpatient and residential treatment for adults and children under fee-for-service (FFS). Connecticut also requests this Demonstration to ensure a complete American Society of Addiction Medicine (ASAM) levels of care (LOCs) service array is available as part of an essential continuum of care for Medicaid-enrolled individuals with OUD and other SUDs. Connecticut requests the Demonstration amendment be effective immediately upon approval to use Institutions for Mental Diseases (IMDs) as a Medicaid-covered setting.

Connecticut Medicaid covers all ambulatory ASAM LOCs 0.5 through 2.5, as well as inpatient withdrawal management (ASAM level 4-WM). Connecticut will be submitting a Medicaid State Plan Amendment (SPA) in conjunction with this Demonstration to cover residential and inpatient treatment, as well as all levels of withdrawal management (ASAM levels 1-WM, 2-WM, 3.1, 3.2-WM, 3.3, 3.5, 3.7, 3.7-WM, 4). The Demonstration will permit DSS to provide critical access to medically necessary SUD treatment services in the most appropriate setting for the member as part of a comprehensive continuum of SUD treatment services.

Additional information about SUD 1115 demonstrations, including a list of other states that have already established a SUD 1115 demonstration, is posted to the CMS website at this link: **https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-substance-use-disorder-demonstrations/section-1115-demonstrations-substance-use-disorders-serious-mental-illness-and-serious-emotional-disturbance/index.html (https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-substance-use-disorder-demonstrations/section-1115-demonstrations-substance-use-disorders-serious-mental-illness-and-serious-emotional-disturbance/index.html)**. In addition, after it has been formally submitted to CMS (which will not occur until after the state's public comment process and any additional analysis has been completed), Connecticut's SUD 1115 application will be accessible from this webpage: **https://www.medicaid.gov/medicaid/section-1115-**

demo/demonstration-and-waiver-list/index.html (https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html) (select the appropriate filters within the webpage to find the relevant waiver application).

Norwood, Joel C.

From: Kaplan, David <David.Kaplan@cga.ct.gov>
Sent: Tuesday, February 2, 2021 3:42 PM
To: Rep. Abercrombie, Catherine; Sen. Abrams, Mary; Rehmer, Patricia; Wilson, Beresford; Rep. Demicco, Mike
Subject: FW: Medicaid SUD Demonstration Waiver - Public Notice [not-secure]
Attachments: CT SUD 1115 - Public Notice - Final - 02-01-21.pdf

Dear Members of BHPOC, MAPOC, and Affiliates:

Please see below. This Public hearing will take place in lieu of the regular BHPOC meeting on Wednesday, February 10, 2021 at 2:00 PM. Thank you.

Substance Use Disorder (SUD) – Section 1115 Demonstration Waiver – Public Comment Opportunity

The Department of Social Services (DSS), in collaboration with the Department of Children and Families (DCF) and the Department of Mental Health and Addiction Services (DMHAS), proposes a SUD demonstration waiver under section 1115 of the Social Security Act (Demonstration). The Demonstration is a comprehensive project to enhance Connecticut's SUD services by ensuring a complete array of American Society of Addiction Medicine (ASAM) levels of care and enabling federal Medicaid and Children's Health Insurance Program (CHIP) matching funds for residential SUD services.

Public notice attached. More details, including draft waiver application and implementation plan, are posted to the DSS website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project **Please check that website regularly for updates before logging onto the public hearing.**

Public Comments: Written comments are accepted from February 2, 2021 through March 4, 2021. Please send comments to: Public.Comment.DSS@ct.gov

Public Hearings: There will be two electronic public hearings (accessible by electronic device and telephone). Links and call-in information pasted below and posted on the DSS website above.

1. Public Hearing at a meeting of the Behavioral Health Partnership Oversight Council (BHPOC) on Wednesday, February 10, 2021 from 2:00 to 4:00 p.m.

   Zoom Meeting:
   https://beaconhealthoptions.zoom.us/j/94763921094?pwd=OTlGNmtiaXBQZUU1SUN0Z05RcE42QT09 Meeting ID: 947 6392 1094; Passcode: 339399

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2. DSS Public Hearing on Thursday, February 18, 2021, from 10:00 a.m. to 12:00 p.m.

   Zoom Meeting: https://zoom.us/j/99666874256?pwd=K2NKZEkycEdmR2dMRGkvakEwL2c3QT09
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   +1 253 215 8782 US (Tacoma)
   Meeting ID: 996 6687 4256
   Passcode: 058267

Sincerely,

David Kaplan
Behavioral Health Partnership Oversight Council
Legislative Office Building Room 3000
Hartford, CT 06106
860-240-0346
Info Line 860-240-8329
(F) 860-240-5306
david.kaplan@cga.ct.gov

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

55 FARMINGTON AVENUE • HARTFORD, CONNECTICUT 06105

PUBLIC HEARING AGENDA

Proposed Medicaid and Children's Health Insurance Program
Substance Use Disorder (SUD) Demonstration Waiver
Pursuant to Section 1115 of the Social Security Act

Wednesday, February 10, 2021, from 2:00 to 4:00 p.m. at a Meeting of the Behavioral Health Partnership Oversight Council (Link and Call-In Information Below)

1. Introduce State Staff (DSS, DMHAS, DCF)

2. Summary/Background for SUD Demonstration Waiver (DSS, DMHAS, DCF)
    a. Purpose
    b. Goals, Objectives, Milestones
    c. Corresponding State Plan Amendment
    d. DSS Website: https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project (including Public Notice, Waiver Application, Implementation Plan)

3. Public Comment
    a. Everyone is welcome to provide comments during this public hearing
    b. 2nd public hearing: Thursday, February 18, 2021 from 10:00 to 12:00 p.m. convened by DSS (see public notice for link and call-in information)
    c. Written comment period open through March 4, 2021: Public.Comment.DSS@ct.gov
    d. DSS will send responses to comment after the public comment period is closed

4. Closing

Link and Call-In Information

Zoom Meeting:
https://beaconhealthoptions.zoom.us/j/94763921094?pwd=OTlGNmtiaXBQZUU1SUN0Z05RcE42QT09 Meeting ID: 947 6392 1094; Passcode: 339399

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Meeting ID: 947 6392 1094; Passcode: 339399

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

55 FARMINGTON AVENUE • HARTFORD, CONNECTICUT 06105

PUBLIC HEARING AGENDA

Proposed Medicaid and Children's Health Insurance Program
Substance Use Disorder (SUD) Demonstration Waiver
Pursuant to Section 1115 of the Social Security Act

Thursday, February 18, 2021 from 10:00 a.m. to 12:00 p.m.
Convened by the Department of Social Services (Link and Call-In Information Below)

1. Introduce State Staff (DSS, DMHAS, DCF)

2. Summary/Background for SUD Demonstration Waiver (DSS, DMHAS, DCF)
    a. Purpose
    b. Goals, Objectives, Milestones
    c. Corresponding State Plan Amendment
    d. DSS Website: https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project (including Public Notice, Waiver Application, Implementation Plan)

3. Public Comment
    a. Everyone is welcome to provide comments during this public hearing
    b. Written comment period open through March 4, 2021: Public.Comment.DSS@ct.gov
    c. DSS will send responses to comment after the public comment period is closed

4. Closing

Link and Call-In Information

Zoom Meeting: https://zoom.us/j/99666874256?pwd=K2NKZEkycEdmR2dMRGkvakEwL2c3QT09
Meeting ID: 996 6687 4256; Passcode: 457gYU

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Meeting ID: 996 6687 4256
Passcode: 058267

Comment, Public

From: Sullivan-Wiley <kswiley@sbcglobal.net>
Sent: Wednesday, March 3, 2021 12:27 PM
To: Comment, Public
Subject: commentary on proposed SUD Demonstration waiver

Good morning. My name is Janine Sullivan-Wiley, and I am submitting the following commentary on the proposed Medicaid and Children's Health Insurance Program Substance Use Disorder (SUD) Demonstration Waiver, pursuant to Section 115 of the Social Security Act.
My comments are as a citizen in Connecticut, retired Director of the Northwest Regional Mental Health Board, as a family member of persons with substance use disorders, as a long-time community advocate for persons with mental health conditions as well as substance use disorders, and a member of the Behavioral Health Partnership Oversight Council.

My comments include both support for and concerns about parts of this proposal. I leave commentary on its more technical components to providers of such services.

1. Support: of the mention in the proposal of the frequency of co-occurring mental health disorders in this population.
2. Support: of the plan to use 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.
3. Concerns: ***Strongly urge that this waiver***
    a. 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 and
    b. 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 and
    c. 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 PWSUD seeking treatment see “people who look like me.”

One technical point: the proposal refers to Value Options. It would more accurately now be referred to as Beacon Health Options.

Thank you for your consideration of my comments.

Norwood, Joel C.

From: Halsey, William
Sent: Wednesday, March 3, 2021 4:11 PM
To: Norwood, Joel C.
Subject: FW: Checking in-SUD Waiver hearing and Elara
Attachments: 2-18 Elara testimony to DSS SUD Waiver_ (002).docx

Joel, here is a formal comment for the SUD demo.

Bill

From: Felton-Reid, Hilary <hfeltonreid@rc.com>
Sent: Wednesday, March 3, 2021 4:05 PM
To: Halsey, William <William.Halsey@ct.gov>
Subject: FW: Checking in-SUD Waiver hearing and Elara

Hi Bill. You may have noticed when the DSS hearing was had on the SUD waiver Gloria Merritt was on but then was unable to speak as she had a call at the same time. I wanted to make sure you saw the testimony she submitted. If you are willing, it would be great if there could be another opportunity for them to discuss the Department's work on the waiver and as we stated in our testimony, whether there is a role for home health or could be consideration for reimbursement for the to treat individuals with SUD as a primary diagnosis. You'll note in her testimony, they have been engaging more in recovery oriented work and working with other community partners, and we would love the chance for them to elaborate on that for you. Let me know if you're willing and if so when might be a good time. Of course, I know there are many competing priorities right now. Just wanted to make sure to flag the testimony. Thanks for all you do!

Hilary

From: Felton-Reid, Hilary
Sent: Wednesday, February 17, 2021 2:56 PM
To: Halsey, William <William.Halsey@ct.gov>
Subject: Checking in-SUD Waiver hearing and Elara

Hi Bill. I hope you are well. I just wanted to check in on the SUD Waiver application regarding a few things. One, logistically, do you have a sense of how the DSS hearing tomorrow will go? I assume it will be like the regulatory hearings where a person attends to speak but there isn't a lot of give and take, do you concur with that assessment? Secondly, I know there is the tie in with the ASAM criteria and ASAM level of care. We are still trying to understand the home health role within the implementation plan and I think it would be great if you would be willing to meet again with Elara to discuss some recent updates. Building on their BH expertise, they've been engaging more with recovery providers and it would be helpful if we could meet to allow them to outline some of that work for you. We will be submitting some testimony on the waiver, whether spoken or just in writing still TBD. Let me know if you're willing and able to meet anytime in the next few weeks or so. Thanks so much.

Hilary Felton-Reid
Lobbyist

Robinson & Cole LLP
280 Trumbull Street
Hartford, CT 06103
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hfeltonreid@rc.com | www.rc.com
Bio | Contact Card

Robinson+Cole
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Los Angeles | Wilmington | Philadelphia | Albany | New London

Attn: CT Department of Social Services
Medical Policy Unit
Re: SUD 1115 Demonstration Waiver
2/18/21

Good afternoon and thank you for the opportunity to testify at this very important hearing. My name is Gloria Merritt and I have been a behavioral health nurse with Elara Caring (formally New England Home Care) for 20-years. Prior to this role, I worked in the substance abuse treatment community for more than a decade. During my time in these roles, I've come to see that 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. In behavioral home health, we serve as the facilitator of the relationship between patient, physician, and often family members as we perform the healthcare treatments to best meet the patient's desired recovery and life goals. Home health is, if you will, the hands on, field based partner, that meets patients where they are, delivers healthcare treatments and connects with related community providers as required to best assist our mutual patient's progress.

We are very excited to mention that Elara Caring has developed a Home Care Recovery Program that compliments and enhances the Principles of Recovery and is used in collaboration with Outpatient Community Providers. Specifically, we are currently engaged in partnering with community providers to assist with SUD/OUD wrap around treatment when a client with a primary psychiatric diagnosis experiences co-occurring SUDs. We partner with Recovery Homes, IOP Programs, work to transition clients to the community from inpatient stays, and work in collaboration with clients in Outpatient SUD Programs. Currently, we are working very closely with A New Beginning Recovery House in New Haven which includes Recovery Houses and a Redemption House that provides stabilization when needed. In this work, we help to provide medication management, case management and client stabilization efforts to ensure the clients maintains their path to recovery. We are the Preferred Provider for Help, Inc. in Waterbury.

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.

I am proud of the work we are already doing in this much needed service arena. However, I am also aware of those lives we currently cannot touch. A SUD/OUD diagnosis alone does not qualify for reimbursement currently. 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. It seems only appropriate that behavioral home health providers be recognized as a legitimate and important community-based SUD/OUD treatment option and permitted to join the ranks of other outpatient providers, residential treatment providers and IOP, as direct service providers under Connecticut Medicaid. Availability of recovery services need not be linked to a physical address, and particularly for a patient population where many are often profoundly challenged to get to a treatment location. Indeed, if ever there was a population of patients with much to gain from a healthcare provider possessing the capabilities to meet them where they are, wherever that may be, and deliver highly personalized, maximally coordinated services, its patients with an SUD/OUD diagnosis.

Connecticut has been ahead of the curve with BH home care, as I can personally attest to, and I commend the Department for its role in that excellent work. Accordingly, I'm very proud of the work we're doing at Elara Caring to engage in recovery work and partner with others in our community; but I also know we can have a much greater impact if we work together to modernize the approach to SUD treatment.

Please know, whatever assistance we may be able to provide you in support of this request, we're happy too.

Respectfully,

Gloria Merritt, RN, MSN

VP BH Clinical Services, Elara Caring

Norwood, Joel C.

From: Halsey, William
Sent: Monday, February 15, 2021 8:09 AM
To: Norwood, Joel C.
Subject: Fwd: comments for Sec 1115 Demonstration Waiver

FYI
Get Outlook for iOS

From: Kaplan, David <David.Kaplan@cga.ct.gov>
Sent: Saturday, February 13, 2021 6:52:52 PM
To: Halsey, William <William.Halsey@ct.gov>
Subject: FW: comments for Sec 1115 Demonstration Waiver

FYI-

Sincerely,

David Kaplan
Behavioral Health Partnership Oversight Council
Legislative Office Building Room 3000
Hartford, CT 06106
860-240-0346
Info Line 860-240-8329
(F) 860-240-5306
david.kaplan@cga.ct.gov

From: Kent & Janine Sullivan-Wiley <kswiley@sbcglobal.net>
Sent: Saturday, February 13, 2021 2:49 PM
To: Kaplan, David <David.Kaplan@cga.ct.gov>; Rehmer, Patricia <Patricia.Rehmer@hhchealth.org>; Terri DiPietro Co-Chair, Operations Comm <terri.dipietro@midhosp.org>; Heather Gates <Hgates@CHRHEALTH.ORG>
Subject: comments for Sec 1115 Demonstration Waiver

Hi All (note: I didn't have the emails for all of the executive committee here in Boston with me)

I cannot be at the meeting tomorrow as I am on Grandma duty. (What a joy indeed!) But I went through the proposal…perhaps not as well as I might have – working during Alia's nap time – so hopefully none of my comments are rendered moot by content I might have missed.
But could you please convey my comments below.
Thank you!
Janine

1. Support of the mention in the proposal of the frequency of co-occurring mental health disorders in this population.
2. Support of the plan to use 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.
3. Concern: The strongest possible urging that this waiver

a. 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 and
b. Recognition of the already severe health disparities for persons of color and that there not be any negative impact on services for that population and
c. Inclusion of a process whereby the already limited workforce of persons of color not be further reduced by any ripple effect of this process. It is so important that PWSUD seeking treatment see "people who look like me."

One technical point: the proposal refers to Value Options. It would more accurately now be referred to as Beacon Health Options.

Sent from Mail for Windows 10

Comment, Public

From: Gloria Merritt <gmerritt@elara.com>
Sent: Tuesday, February 23, 2021 1:50 PM
To: Comment, Public
Subject: SUD Testimony
Attachments: HFR edits 2-18 Elara testimony to DSS SUD Waiver .docx

Gloria Merritt, RN, MSN | VP of Clinical Services/Behavioral Health
c 203.525.9299 | gmerritt@elara.com
Right Care • Right Time • Right Place

Attn: CT Department of Social Services
Medical Policy Unit
Re: SUD 1115 Demonstration Waiver
2/18/21

Good afternoon and thank you for the opportunity to testify at this very important hearing. My name is Gloria Merritt and I have been a behavioral health nurse with Elara Caring (formally New England Home Care) for 20-years. Prior to this role, I worked in the substance abuse treatment community for more than a decade. During my time in these roles, I've come to see that 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. In behavioral home health, we serve as the facilitator of the relationship between patient, physician, and often family members as we perform the healthcare treatments to best meet the patient's desired recovery and life goals. Home health is, if you will, the hands on, field based partner, that meets patients where they are, delivers healthcare treatments and connects with related community providers as required to best assist our mutual patient's progress.

We are very excited to mention that Elara Caring has developed a Home Care Recovery Program that compliments and enhances the Principles of Recovery and is used in collaboration with Outpatient Community Providers. Specifically, we are currently engaged in partnering with community providers to assist with SUD/OUD wrap around treatment when a client with a primary psychiatric diagnosis experiences co-occurring SUDs. We partner with Recovery Homes, IOP Programs, work to transition clients to the community from inpatient stays, and work in collaboration with clients in Outpatient SUD Programs. Currently, we are working very closely with A New Beginning Recovery House in New Haven which includes Recovery Houses and a Redemption House that provides stabilization when needed. In this work, we help to provide medication management, case management and client stabilization efforts to ensure the clients maintains their path to recovery. We are the Preferred Provider for Help, Inc. in Waterbury.

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.

I am proud of the work we are already doing in this much needed service arena. However, I am also aware of those lives we currently cannot touch. A SUD/OUD diagnosis alone does not qualify for reimbursement currently. 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. It seems only appropriate that behavioral home health providers be recognized as a legitimate and important community-based SUD/OUD treatment option and permitted to join the ranks of other outpatient providers, residential treatment providers and IOP, as direct service providers under Connecticut Medicaid. Availability of recovery services need not be linked to a physical address, and particularly for a patient population where many are often profoundly challenged to get to a treatment location. Indeed, if ever there was a population of patients with much to gain from a healthcare provider possessing the capabilities to meet them where they are, wherever that may be, and deliver highly personalized, maximally coordinated services, its patients with an SUD/OUD diagnosis.

Connecticut has been ahead of the curve with BH home care, as I can personally attest to, and I commend the Department for its role in that excellent work. Accordingly, I'm very proud of the work we're doing at Elara Caring to engage in recovery work and partner with others in our community; but I also know we can have a much greater impact if we work together to modernize the approach to SUD treatment.

Please know, whatever assistance we may be able to provide you in support of this request, we're happy too.

Respectfully,

Gloria Merritt, RN, MSN

VP BH Clinical Services, Elara Caring

Comment, Public

From: Bonni Hopkins <bonni.hopkins@liberationprograms.org>
Sent: Tuesday, March 2, 2021 5:18 PM
To: Comment, Public
Cc: John Hamilton; Joanne Montgomery; Maggie Young
Subject: Written Comments: Substance Use Disorder Medicaid Waiver Demonstration

Importance: High

PUBLIC COMMENTS SUBMITTED BY LIBERATION PROGRAMS:

JOHN HAMILTON, LMFT LADC, CEO/President
BONNI HOPKINS, PhD, Chief Operating & Innovation Officer
JOANNE MONTGOMERY, LCSW, Chief Clinical & Outreach Officer
MAGGIE YOUNG, LADC LMSW, Chief Recovery Officer

Please note, Maggie and Joanne are also in long term recovery, with over 50 years of combined recovery. Maggie is Chief Recovery Officer of Liberation programs, and has been with Liberation Programs for over 25 years. Maggie also began her recovery journey at Liberation Programs, and recently celebrated her 29th anniversary. Maggie Young is also the new CCAR Board president, a Spirit of Hope Honoree, and a Lifetime Achievement Awardee by the CT Certification Board.

WRITTEN COMMENTS BELOW SUBMITTED FOR CONSIDERATION, AS NOTED AT PUBLIC HEARING BHPOC MEETING ON 2/10/2021

- **Grandfather longstanding dedicated Residential IP clinicians through the CT Certification Board (CCB),** specifically for certified counselors with ten years' experience and certified supervisors through the CCB. As an example, this would have included Don Johnson who had a CAC and retired from Liberation Programs recently, after decades as a Counselor in our Men's Residential Program. Every program would be fortunate to have clinicians of his caliber and experience— despite not having a formal license. There is a dedicated experienced workforce in place at many IP Residential programs, that needs to be included in the SUD Waiver.

- **Include Provider Dashboards** to ensure key available tools are accessible to SUD providers, to fulfill the goals and objectives of this major initiative. Similar to dashboards already available to some Medicaid providers, SUD providers need an integrated lens into available behavioral health authorizations, system-wide Medicaid claims, DMHAS, Admission/Discharge Real-time data, and demographic data. This would be feasible by leveraging investments into existing available CT provider dashboards, such as the interactive Tableau dashboards available to the Behavioral Health Homes and PAR Providers of Inpatient Psychiatric programs. Data and insights will be needed to ensure the highest quality of care, and move towards Value Based Payment (VBP) & Pay for Performance (P4P). As an example, the Behavioral Health Home Dashboard integrates status information on preventative or medical screenings needed for Medicaid members, and SUD Providers could assist with coordinating care to ensure improved health outcomes. There are also additional existing platforms that would also be helpful for key data-sharing and care coordination, including Beacon Health Options' Spectrum platform for Medicaid Providers and Members.

- **Recovery Health Home model**, that includes use of **Recovery Coaching** across the continuum would be an importance advance in care. 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.

Best wishes,
Bonni

Bonni Hopkins, Ph.D.
Chief Operating & Innovation Officer
Liberation Programs, Inc.
129 Glover Avenue
Norwalk, CT 06850
Cell Phone: 203-940-2681

Visit **www.liberationprograms.org**
Follow us on: Facebook, Instagram, Twitter & LinkedIn

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Norwood, Joel C.

From: Gloria Merritt <gmerritt@elara.com>
Sent: Tuesday, February 23, 2021 1:46 PM
To: Comment, Public
Subject: Testimony
Attachments: HFR edits 2-18 Elara testimony to DSS SUD Waiver .docx

Sent from Mail for Windows 10

Attn: CT Department of Social Services
Medical Policy Unit
Re: SUD 1115 Demonstration Waiver
2/18/21

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Please know, whatever assistance we may be able to provide you in support of this request, we're happy too.

Respectfully,

Gloria Merritt, RN, MSN

VP BH Clinical Services, Elara Caring

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