State of Connecticut
Department of Social Services

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

To be submitted to the
U.S. Centers for Medicare and Medicaid Services (CMS)

DRAFT for Public Comment — Subject to Review and Revision

Updated February 1, 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 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 opioid addiction or other SUDs. Connecticut requests 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 will help reduce BH admissions at general hospitals.

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 behavioral health 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 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 July 1, 2021.

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]
This Demonstration is necessary to address critical unmet needs for residential SUD treatment that continue to exist despite significant improvements to the publicly-funded

[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.

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 a July 1, 2021 effective date. 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 (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 Functional Family Therapy (FFT) 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 to drive 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 detoxification (ASAM LOC 4).

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 at section 17a-22h

of the Connecticut General Statutes, with ValueOptions[3] 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 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.

[3] 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.

As of September 2020, Connecticut Medicaid and CHIP had 895,000 enrollees, including almost 20,000 CHIP enrollees (HUSKY B) and 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.

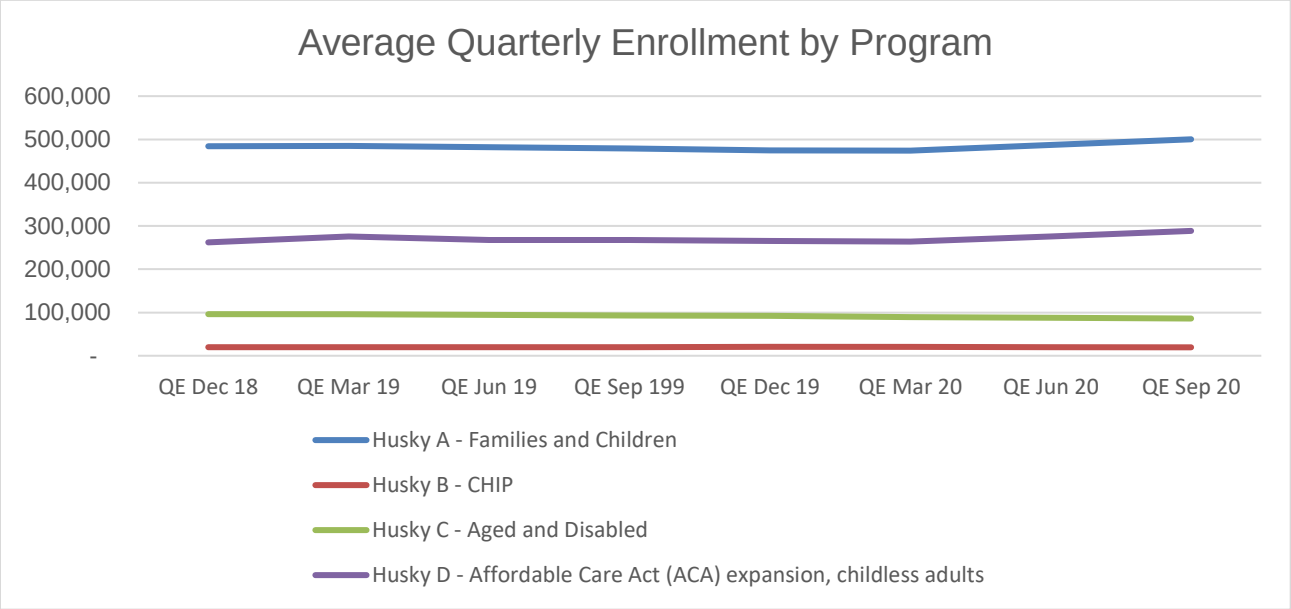
HUSKY D SUD Residential Benefits in State Fiscal Year 2019 (SFY19)

	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	2180	29,618	22.4
ASAM 3.7R State-operated facilities	773	24,284	30.5
ASAM 4.2D Medically-Managed Withdrawal Management at Natchaug Hospital	16	89	5
Observation/Flex Bed	8	8	1

Source: SFY19 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, HUSKY D and the Limited Benefit Services program through DCF. 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 Detoxification
- Inpatient Hospital Substance Use Detoxification

- Residential Treatment Center for Children through DCF
- Targeted Case Management (TCM) for Ages 19 and under
- Targeted Case Management (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 for people residing in IMDs providing an ASAM LOC. Building upon the successful implementation of the CT BHP, a section 1115 Demonstration is necessary to ensure Connecticut's Medicaid beneficiaries have access to the entire continuum of ASAM LOCs. With the CT BHP already in place, Connecticut has a strong foundation for this Demonstration.

III. DEMONSTRATION OBJECTIVES

The objective of this Demonstration is to obtain critical access to a full array of SUD treatment services for Connecticut Medicaid/CHIP[4] 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.

There are only three SUD residential treatment programs in Connecticut with 16 treatment beds or fewer. Eligibility expansion and the opioid crisis have increased the need for residential treatment beds. Without IMD facilities, which have greater than 16

[4] Note: As indicated above, except as otherwise specified in this Demonstration, all references to Medicaid include both Medicaid and CHIP.

beds, there are not enough SUD residential treatment facilities 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 now available to more than 260,000 expansion-eligible individuals. Enhancing Medicaid funding at this juncture will assist the State's ability to address the surge of SUD treatment needs for Medicaid enrollees associated with the opioid crisis.

The Demonstration will remove Medicaid payment barriers in FFS for SUD residential treatment for individuals in need of these services. 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. As individuals move throughout the continuum in their SUD recovery, they may need to transition to LOCs of greater or lesser intensity depending on their individual clinical needs and treatment plans.

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
- IOP/PHP
- 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
- 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) that is funded with State general funds and federal SAMHSA block grant dollars (currently Advanced Behavioral health, Inc.) 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 the individuals as documented through prior authorization and utilization management process at the BH ASO.

On and after July 1, 2021, SUD treatment services provided in the Medicaid FFS delivery system will comply with the 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 utilization management of all LOCs and prior authorization of 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, consistent with provider training for all SUD treatment services regardless of site, provider type or LOC.

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 with provider qualifications 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, Medicaid policy manuals will be modified to include more detail about the ASAM residential program requirements, including the particular types of services, hours of clinical care and credentials of staff for residential treatment consistent with the most current edition of the ASAM criteria. This 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

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

Connecticut currently contracts for 948 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 combination of number of providers for each LOC because some providers serve multiple LOCs

DSS estimates the number of residential days for each residential LOC based on utilization in SFY 2019 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
ASAM 4	-	-	-	-
ASAM 4 WM	3,013	222	1,659	25,790

The State also expects to be able 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 provider network adequacy for these services. If services are unavailable within a specific geographic region, DSS will recruit qualified providers within the region or seek expansion from providers, including those that may be outside the defined geographical boundaries.

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

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 fraud, misuse and abuse. The required provisions 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 several years 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,

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

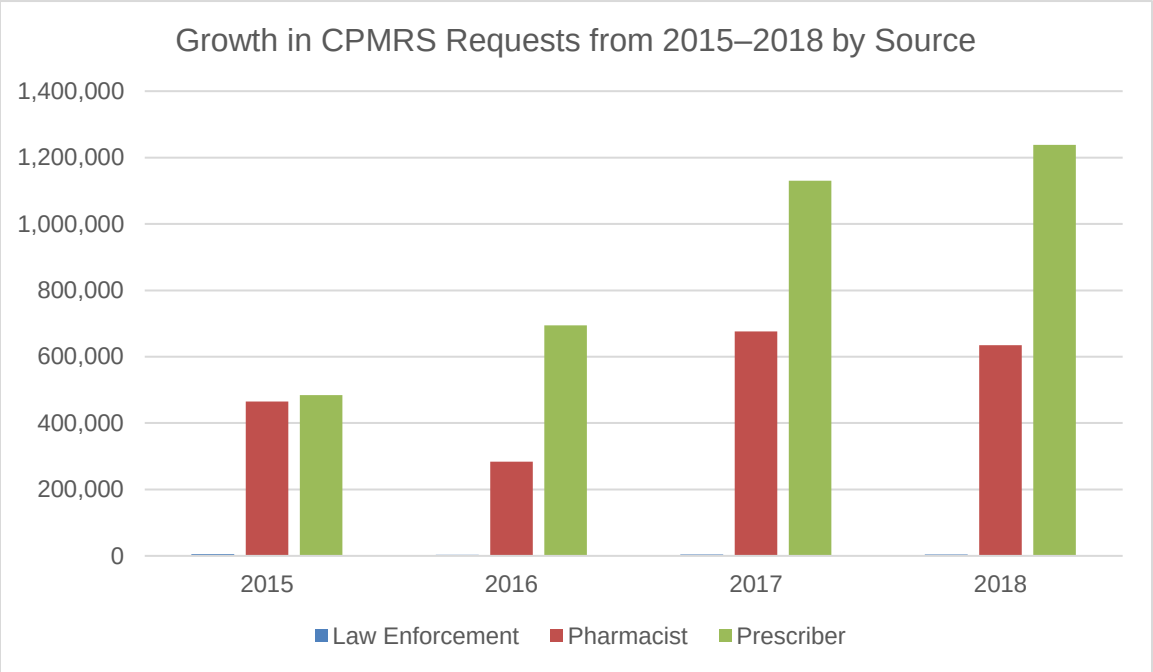
physicians' assistants, advanced practice registered nurses, dentists and podiatrists) to prescribe, dispense or administer naloxone to any person to prevent or treat a drug overdose, protects the prescriber from civil liability and criminal prosecution. The protection from civil liability and criminal 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 SFY19 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

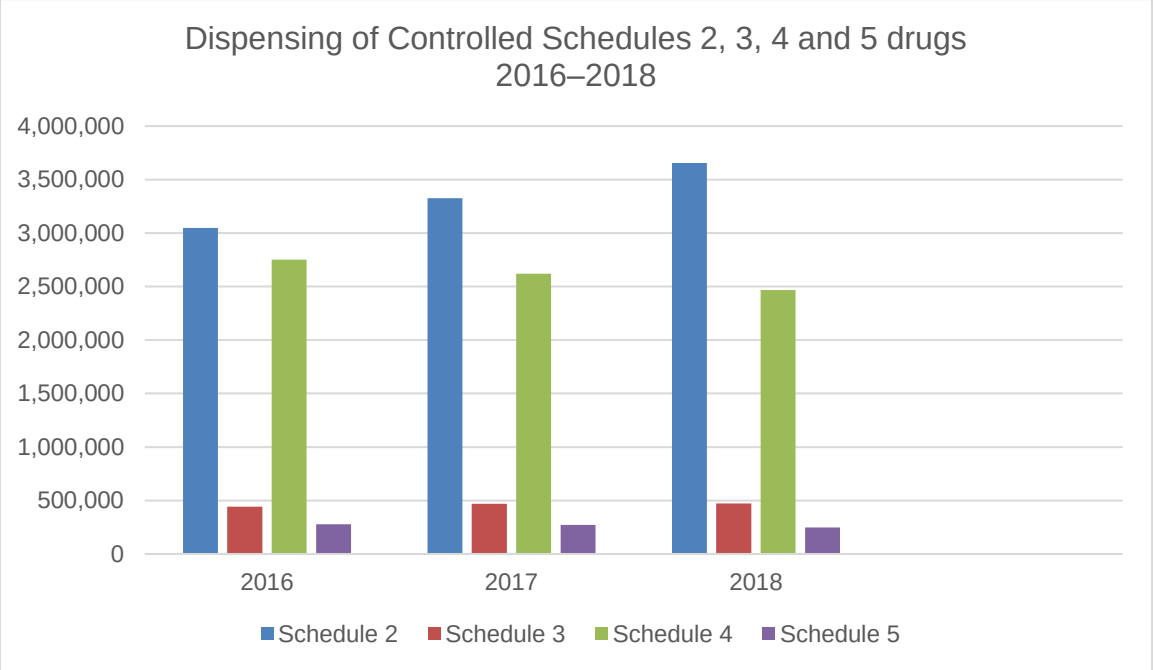
Connecticut first mandated prescriber use of the CPMRS, the State's PDMP, in 2015 with additional provisions added in 2016. CPMRS is a tool to track the dispensing of controlled prescription drugs to patients. CPMRS is designed to monitor this information for suspected abuse or diversion (i.e., channeling 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.



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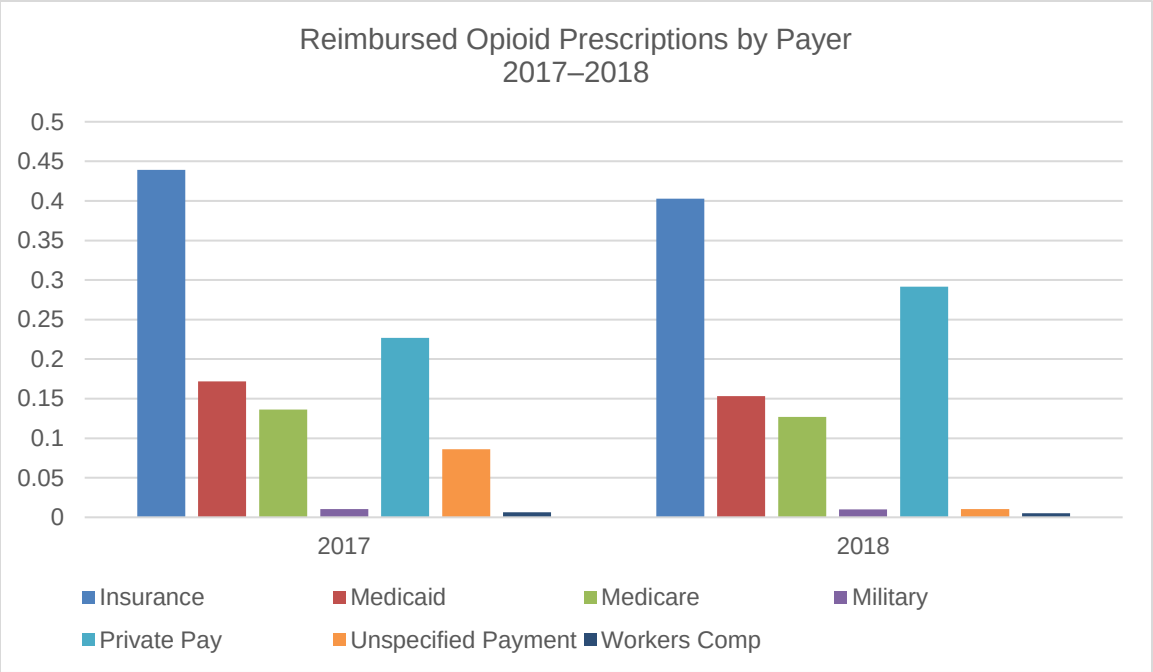
Consistent with the overall data, the number of Medicaid-reimbursed opioid prescriptions have dropped, as well as Medicaid's percentage of payments for opioids dispensed.



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 medical records and pharmacy dispensing 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.

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.

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

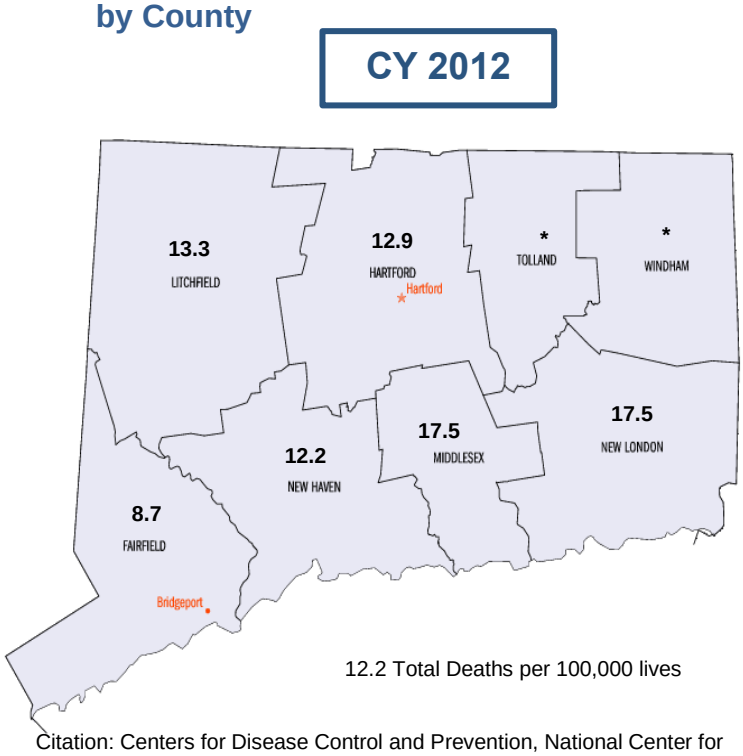
The Connecticut Alcohol and Drug Policy Council (ADPC) is a legislatively mandated body established pursuant to state law in section 17a-667 of the Connecticut General

[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.

Statutes, which is comprised of representatives from all three branches of State government, consumer and advocacy groups, private service providers, individuals in recovery from SUDs and other stakeholders, tasked with developing a coordinated statewide response to alcohol, tobacco and other drug use in Connecticut. 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.

Over the last several years, Medicaid has played a crucial role in the ADPC. 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.

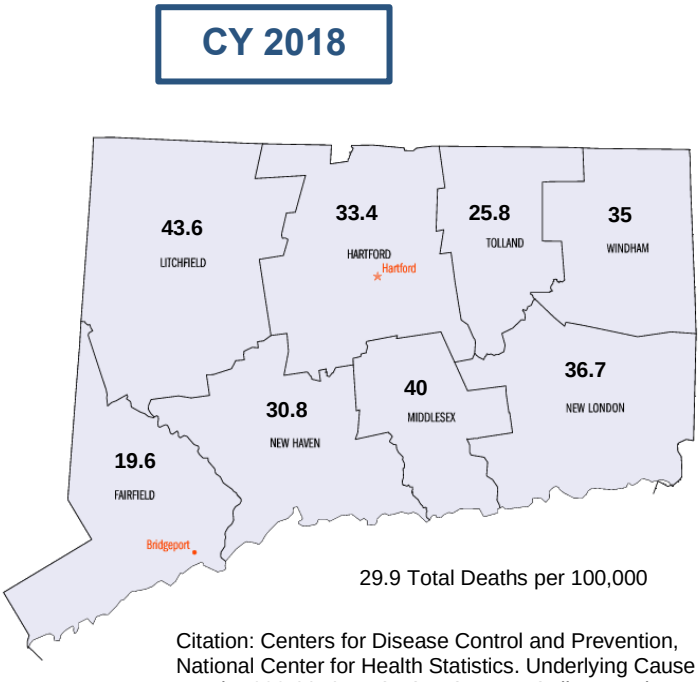
Figure 1: Rate of Unintentional Drug-Related Overdose Deaths per 100,000 People by County



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

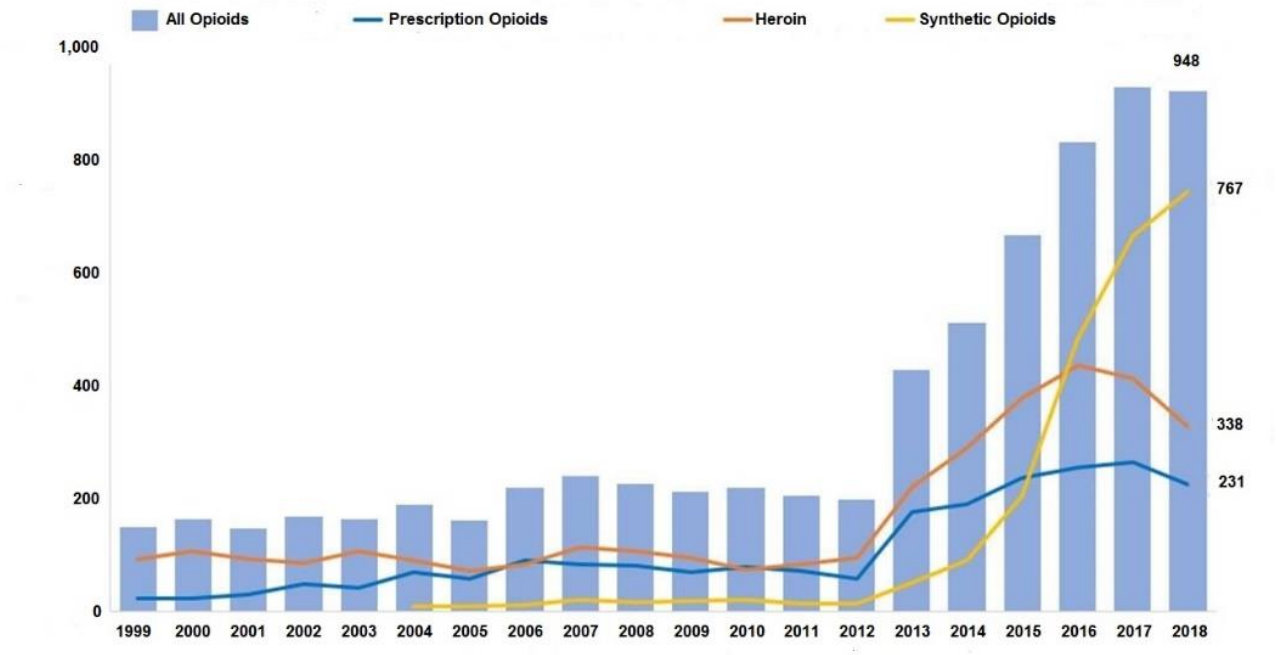
Citation: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2018 on CDC WONDER Online Database, released in 2020. Data are from the Multiple Cause of Death Files, 1999-2018, as compiled from data provided by the 57 vital statistics jurisdictions 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]

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

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

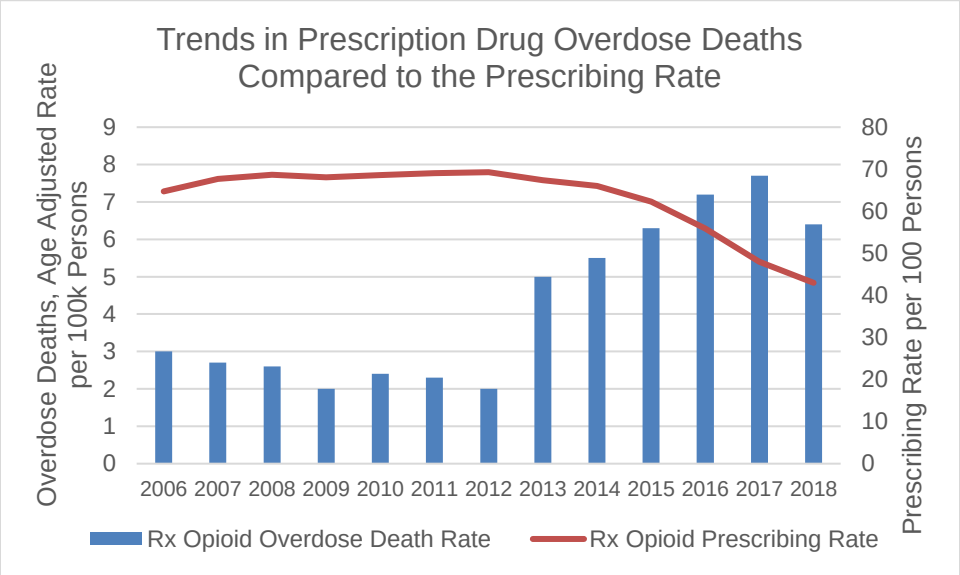


Source: CDC WONDER
https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/connecticut-opioid-summary
In 2018, Connecticut providers wrote 43.0 opioid prescriptions for every 100 persons compared to the national average rate of 51.4 opioid prescriptions. Since 2012, this represents a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

DSS has been particularly assertive in promoting changes designed to reduce unnecessary opioid prescribing for Medicaid members because it has been aware that the U.S. Centers for Disease Control and Prevention (CDC) reported 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 abuse 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 systems. All Medicaid services will continue to be delivered in a FFS delivery system.

VII. ELIGIBILITY

[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.

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 ASAM criteria effective July 1, 2021.

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 mental health evidence-based practices for children such as MST and FFT.

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 readmissions rates. A mid-point evaluation will be completed and an evaluation at the end of the five-year waiver period. 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 which 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 abuse or dependence 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 LOC 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 re-admission rates for hospital stays?

  - Evaluation Hypothesis 3.2.1: The Demonstration will improve follow-up after discharge from EDs and decrease re-admissions 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 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 (1115 Waiver) 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 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 effective July 1, 2021.

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 historical data and modeling assumptions to developed 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, 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 not FFS delivery systems. As a result, Mercer relied on the SFY 2016–2019 time period utilization in Connecticut state-only and non-Medicaid federal block grant funded SUD programs priced at a proxy state's 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 for an effective date of July 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 another state's fee schedule for specific ASAM levels would be the most expedient manner to establish a baseline. Mercer compiled four years of historic data that consists of FFS information from the non-Medicaid funded programs priced at ASAM rates from the proxy state's Medicaid program, including consideration for unit cost variation over the historic data period. Data prior to 2016 was not available to include in these BN templates because in 2015, Connecticut reduced the SUD residential bed capacity available for non-Medicaid state-only payment by DMHAS to address a State budget shortfall thus subsequent data is not comparable prior to 2016 data. There are notable differences in the data quality, cost structure and mix of utilization between SFY2015 and all subsequent historic years. As a result, SFY 2015 data was not utilized. Mercer expects that the remaining four years of historic experience is sufficient in understanding historic State expense trends.

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 historic SFY2016 through SFY2019 state specific utilization data priced at the proxy state's ASAM residential fee schedule 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 SFY2016 through SFY2019. For the SFY2016 through SFY2019 historic years, Mercer reviewed utilization information that included service delivery changes. 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 SFY2016 through SFY2019. 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 $3,931 for HUSKY A, $6,007 for HUSKY B, $9,309 for HUSKY C and $6,108 for HUSKY D is appropriate.

Modeling Assumptions

From the historical base data, Mercer developed projected per capita costs for the four MEGs: HUSKY A (TANF related), HUSKY B (CHIP), HUSKY C (Disabled) and HUSKY D (Adult expansion).

The SFY2019 (base year) per capita costs as outlined above were projected forward 36 months from the midpoint of SFY2019 to the midpoint of the SFY2022, which is represented as demonstration year (DY) 01. Note that the State is requesting an

effective date for its 1115 waiver of July 1, 2021 for SFY2022 (DY01). Beyond DY01, 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 compared these trend rates, by MEG, to the rolling four-year observed trend (illustrated in Appendix A). The assumed per capita trend rate is the lesser of the OACT projections and observed trend by MEG. 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 SFY2019 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 $7,119 to $8,611 resulting in total cost estimates for all MEGs of $1,010,743,859. 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.

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

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

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. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. All estimates are based upon the information and data available 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

A summary of feedback from commenters received during the public comment period will be provided in Attachment B after the public comment period has completed.

Public Notice Process

Information on the 1115 Demonstration application and a copy of the public notice is available on DSS' website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project. Additional information regarding the public notice process, including public hearings, will be updated after the public comment period has completed.

Tribal Consultation

Connecticut has two federally recognized tribes, the Mashantucket Pequot Tribal Nation and the Mohegan Tribe. The State will solicit feedback from both tribes by sending emails to the tribal representatives 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 website with the relevant documents). This process follows the state's approved tribal consultation SPA. Additional information regarding the tribal consultation will be updated after that process has been completed.

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

SUD Historical Spending Data - 5 Years

Historical Years Definition: | State Fiscal Year

HUSKY A	2015	2016	2017	2018	2019	4-YEARS (2016-2019)
TOTAL EXPENDITURES		$9,128,629	$10,613,226	$11,557,808	$9,504,394	
ELIGIBLE USER MONTHS		2,958	3,434	3,158	2,810	
PMPM COST		$3,086.08	$3,090.63	$3,660.43	$3,382.35	
TREND RATES						
TOTAL EXPENDITURE			16.26%	8.90%	-17.77%	
ELIGIBLE USER MONTHS			16.09%	-8.05%	-11.01%	
PMPM COST			0.15%	18.44%	-7.60%	3.10%

HUSKY B	2015	2016	2017	2018	2019	4-YEARS (2016-2019)
TOTAL EXPENDITURES		$411,216	$599,545	$642,859	$628,633	
ELIGIBLE USER MONTHS		97	127	116	111	
PMPM COST		$4,239.34	$4,720.82	$5,541.89	$5,663.36	
TREND RATES						
TOTAL EXPENDITURE			45.80%	7.22%	-2.21%	
ELIGIBLE USER MONTHS			30.93%	-8.66%	-4.31%	
PMPM COST			11.36%	17.39%	2.19%	10.10%

HUSKY C	2015	2016	2017	2018	2019	4-YEARS (2016-2019)
TOTAL EXPENDITURES		$18,920,584	$21,734,474	$21,014,123	$22,068,297	
ELIGIBLE USER MONTHS		2,677	2,811	2,580	2,415	
PMPM COST		$7,067.83	$7,731.94	$8,146.59	$9,138.01	
TREND RATES						
TOTAL EXPENDITURE			14.87%	-3.31%	5.02%	
ELIGIBLE USER MONTHS			5.01%	-8.24%	-6.38%	
PMPM COST			9.40%	5.36%	12.17%	8.90%

HUSKY D	2015	2016	2017	2018	2019	4-YEARS (2016-2019)
TOTAL EXPENDITURES		$91,605,607	$94,423,320	$101,410,466	$107,576,039	
ELIGIBLE USER MONTHS		19,774	19,153	19,151	19,152	
PMPM COST		$4,632.63	$4,929.95	$5,295.31	$5,616.96	
TREND RATES						
TOTAL EXPENDITURE			3.08%	7.40%	6.08%	
ELIGIBLE USER MONTHS			-3.14%	-0.01%	0.01%	
PMPM COST			6.42%	7.41%	6.07%	6.60%

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
HUSKY A	$ 9,504,394	$ 1,540,417	2,810	$ 3,930.54
HUSKY B	$ 628,633	$ 38,179	111	$ 6,007.32
HUSKY C	$ 22,068,297	$ 412,410	2,415	$ 9,308.78
HUSKY D	$ 107,576,039	$ 9,406,233	19,152	$ 6,108.20
All MEGs	$ 139,777,363	$ 11,399,240	24,488	$ 6,173.50

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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

	Trend Rate	FY2015 SUD IMD User Months	Months of Trend	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05
HUSKY A	1.0%	2,810	36	2,895	2,924	2,953	2,983	3,013
HUSKY B	1.0%	111	36	114	115	116	117	118
HUSKY C	1.0%	2,415	36	2,488	2,513	2,538	2,563	2,589
HUSKY D	1.0%	19,152	36	19,732	19,929	20,128	20,329	20,532

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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.	2,895	2,924	2,953	2,983	3,013	
HUSKY A	PMPM Cost	$ 3,930.54	3.1%	$ 4,307.53	$ 4,441.06	$ 4,578.73	$ 4,720.67	$ 4,867.01	
HUSKY A	Total Expenditure			$ 12,470,299	$ 12,985,659	$ 13,520,990	$ 14,081,759	$ 14,664,301	$ 67,723,008
HUSKY B	Eligible User Months	111	n.a.	114	115	116	117	118	
HUSKY B	PMPM Cost	$ 6,007.32	5.0%	$ 6,954.22	$ 7,301.93	$ 7,667.03	$ 8,050.38	$ 8,452.90	
HUSKY B	Total Expenditure			$ 792,781	$ 839,722	$ 889,375	$ 941,894	$ 997,442	$ 4,461,215
HUSKY C	Eligible User Months	2,415	n.a.	2,488	2,513	2,538	2,563	2,589	
HUSKY C	PMPM Cost	$ 9,308.78	5.0%	$ 10,776.08	$ 11,314.88	$ 11,880.62	$ 12,474.65	$ 13,098.38	
HUSKY C	Total Expenditure			$ 26,810,887	$ 28,434,293	$ 30,153,014	$ 31,972,528	$ 33,911,706	$ 151,282,428
HUSKY D	Eligible User Months	19,152	n.a.	19,732	19,929	20,128	20,329	20,532	
HUSKY D	PMPM Cost	$ 6,108.20	5.0%	$ 7,071.01	$ 7,424.56	$ 7,795.79	$ 8,185.58	$ 8,594.86	
HUSKY D	Total Expenditure			$ 139,525,169	$ 147,964,056	$ 156,913,661	$ 166,404,656	$ 176,469,666	$ 787,277,208

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.	2,895	2,924	2,953	2,983	3,013	
HUSKY A	PMPM Cost	$ 3,930.54	3.1%	$ 4,307.53	$ 4,441.06	$ 4,578.73	$ 4,720.67	$ 4,867.01	
HUSKY A	Total Expenditure			$ 12,470,299	$ 12,985,659	$ 13,520,990	$ 14,081,759	$ 14,664,301	$ 67,723,008
HUSKY B	Eligible Member Months	111	n.a.	114	115	116	117	118	
HUSKY B	PMPM Cost	$ 6,007.32	5.0%	$ 6,954.22	$ 7,301.93	$ 7,667.03	$ 8,050.38	$ 8,452.90	
HUSKY B	Total Expenditure			$ 792,781	$ 839,722	$ 889,375	$ 941,894	$ 997,442	$ 4,461,215
HUSKY C	Eligible Member Months	2,415	n.a.	2,488	2,513	2,538	2,563	2,589	
HUSKY C	PMPM Cost	$ 9,308.78	5.0%	$ 10,776.08	$ 11,314.88	$ 11,880.62	$ 12,474.65	$ 13,098.38	
HUSKY C	Total Expenditure			$ 26,810,887	$ 28,434,293	$ 30,153,014	$ 31,972,528	$ 33,911,706	$ 151,282,428
HUSKY D	Eligible Member Months	19,152	n.a.	19,732	19,929	20,128	20,329	20,532	
HUSKY D	PMPM Cost	$ 6,108.20	5.0%	$ 7,071.01	$ 7,424.56	$ 7,795.79	$ 8,185.58	$ 8,594.86	
HUSKY D	Total Expenditure			$ 139,525,169	$ 147,964,056	$ 156,913,661	$ 166,404,656	$ 176,469,666	$ 787,277,208

MERCER

Attachment B: Public Comments

Summary of public comments to be added after the public comment period has completed.