State of Connecticut
Department of Social Services

Division of Health Services

Health Information Exchange
Medicaid Enterprise System
Implementation Advance Planning Document
Operational Advance Planning Document
for FFY 2025 and FFY 2026

Version: 4.0
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Version Record			
Version Number	**Date**	**Reviewer**	**Comments**
1.0	7/31/21	CMS	Initial IAPD for MES funding for Connecticut's Statewide Health Information Exchange. First MES IAPD following HITECH IAPDs.
1.1	9/17/21	CMS	Revised to include actual costs for Medicaid APIs, technology reseller, and subcontractor
1.2	9/28/21	CMS	Revised to expand cost allocation methodology discussion to include benefit to the Medicaid program.
1.3	11/24/21	CMS	Conditional approval sought at population-based cost allocation percentage while discussions continue about provider-based cost allocation.
1.4	12/30/21	CMS	Cost allocation methodology revised beginning with the second quarter of FFY22.
1.5	2/17/22	CMS	Cost allocation methodology revised to split the dual eligible population between Medicaid and Medicare for the population count and determination of the percentage of the Medicaid population enrolled in Medicaid.
2.0	6/17/22	CMS	Update for FFYs 23 and 24
3.0	6/23/23	CMS	Update for FFYs 24 and 25
4.0	TBD	CMS	Combined IAPD/OAPD for MES funding for Health IT and Health Information Exchange for FFYs 25 and 26

Contents

Tables and Figures

Section 1: Executive Summary

In accordance with 45 CFR Part 95.610, the State of Connecticut Department of Social Services (Department or DSS) submits this combined Implementation Advance Planning Document Update (IAPD-U) and Operational Advanced Planning Document Update (OAPD-U) for Health Information Exchange (HIE) functionality for Medicaid Enterprise System (MES) funding.

The total Federal share requested in this APD for FFYs 25 and 26 is $11,093,921 and the State share is $2,199,718. There is also a total of $12,219,704 not allocated to Medicaid.

Table 1. Summary of DDI Budget Request

IAPD -- Summary of DDI Funding Request							
FFY	Total DDI Costs	Costs Allocated to Medicaid	90% Federal Share	10% State Share	Total Federal Share	State Share Total	Costs Not Allocated to Medicaid
FFY 25	$ 8,258,058	$ 4,999,247	$ 4,499,322	$ 499,925	$ 4,499,322	$ 499,925	$ 3,258,811
FFY 26	$ 8,433,199	$ 4,677,337	$ 4,209,603	$ 467,734	$ 4,209,603	$ 467,734	$ 3,755,862
Total	**$ 16,691,256**	**$ 9,676,584**	**$ 8,708,925**	**$ 967,658**	**$ 8,708,925**	**$ 967,658**	**$ 7,014,673**

Table 2. Summary of Operations Budget Request

OAPD -- Summary of Operations Budget Request									
FFY	Total Operations Costs	Costs Allocated to Medicaid	75% Federal Share	25% State Share	50% Federal Share	50% State Share	Total Federal Share	State Share Total	Costs Not Allocated to Medicaid
FFY 25	$ 4,252,312	$ 1,743,448	$ 856,466	$ 285,489	$ 300,747	$ 300,747	$ 1,157,213	$ 586,235	$ 2,508,864
FFY 26	$ 4,569,774	$ 1,873,607	$ 872,939	$ 290,980	$ 354,844	$ 354,844	$ 1,227,783	$ 645,824	$ 2,696,167
Total	**$ 8,822,086**	**$ 3,617,055**	**$ 1,729,405**	**$ 576,468**	**$ 655,591**	**$ 655,591**	**$ 2,384,996**	**$ 1,232,059**	**$ 5,205,031**

Table 3. Total Budget Request

Combined IAPD and OAPD Funding Request					
APD	Total Costs	Costs Allocated to Medicaid	Total Federal Share	State Share Total	Costs Not Allocated to Medicaid
IAPD	$ 16,691,256	$ 9,676,584	$ 8,708,925	$ 967,658	$ 7,014,673
OAPD	$ 8,822,086	$ 3,617,055	$ 2,384,996	$ 1,232,059	$ 5,205,031
Total	**$ 25,513,342**	**$ 13,293,639**	**$ 11,093,921**	**$ 2,199,718**	**$ 12,219,704**

Section 2: Acquisition of Service

DSS oversees the provision of Medicaid-related HIE services through a Memorandum of Agreement (MOA) with the Connecticut Office of Health Strategy (OHS), the state agency responsible for establishing a statewide HIE in Connecticut. MOAs are a standard practice for inter-agency contractual arrangements. See MOA history in the table below.

Table 4. DSS-OHS MOA related to EAS and other functionality

MOA version	Date signed	Date approved by CMS	Contract Period	Purpose
Original	9/30/2021	12/8/2021	10/1/2021 -9/30/2022	DSS has a Memorandum of Agreement with OHS to transfer approved Federal dollars. OHS is responsible for the remainder of the budget.
FFY23	6/28/2023	11/16/2022	10/1/2022 – 9/30/2023	DSS has a Memorandum of Agreement with OHS to transfer approved Federal dollars. OHS is responsible for the remainder of the budget.
FFY24		11/27/2023	10/1/2023 – 9/30/2024	DSS has a Memorandum of Agreement with OHS to transfer approved Federal dollars. OHS is responsible for the remainder of the budget.

Section 3: Program Summary

Business Objectives and Project Needs

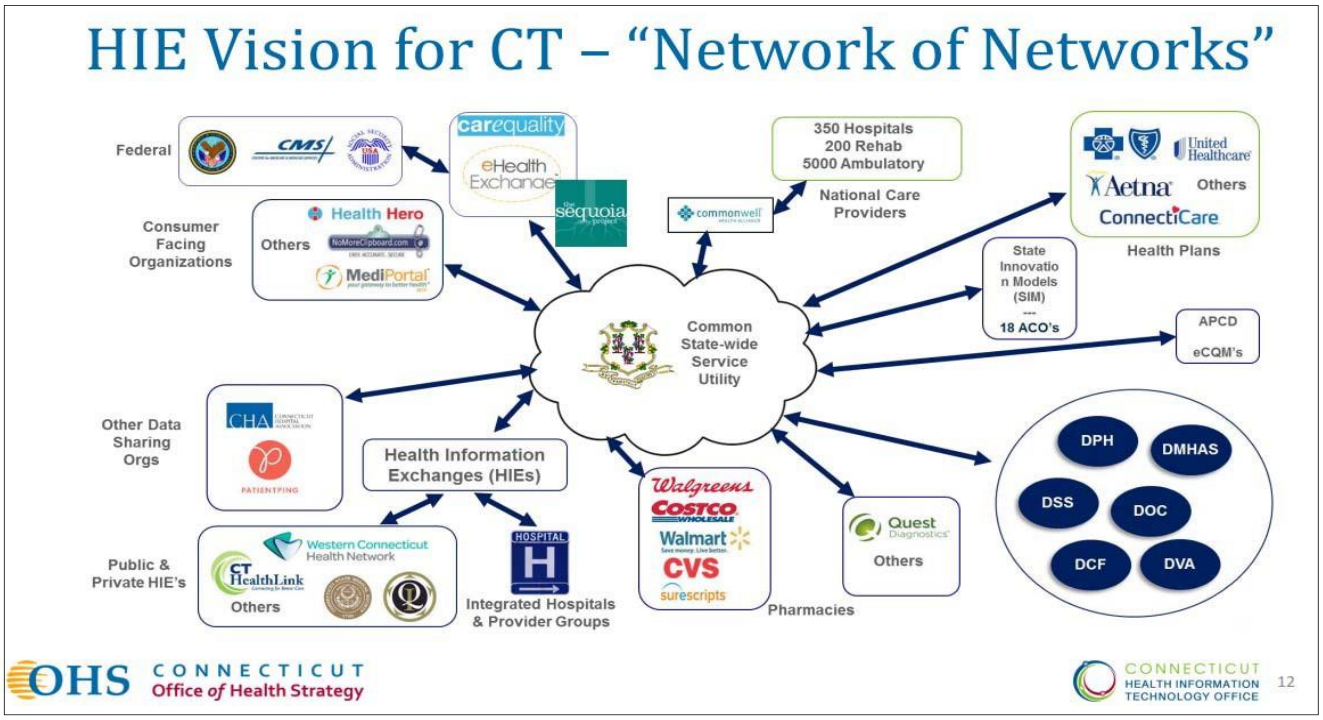
Connecticut General Statute Section 17b-59f and 17b-59g assigned authority to the executive director of the Office of Health Strategy (OHS), in consultation with the State Health Information Technology Advisory Council (HIT Advisory Council), to oversee the development and implementation of the statewide HIE and coordinate the state's health information technology and health information exchange efforts to ensure consistent and collaborative cross-agency planning and implementation. These statutes also establish the HIT Advisory Council with responsibility to advise the executive director of OHS and the Health Information Technology Officer (HITO) in developing priorities and policy recommendations for advancing the State's health information technology and HIE efforts and goals. Connecticut's HIT strategy enables the executive director of OHS to coordinate with Medicaid and other state and private partners to strengthen the State and Federal efforts to accelerate the adoption of health information technology, promote health information exchange, and encourage utilization of certified Electronic Health Records (EHR). These efforts include activities that enhance provider directories, quality measure reporting, care coordination among healthcare providers, and improve patient matching and attribution.

Connecticut is pursuing a network-of-networks model for statewide HIE. This model will support connectivity between existing HIE organizations offering data sharing services to providers and hospitals and will also support those providers and hospitals leveraging EHR functionality to connect and share health data through national interoperability initiatives. This model was deliberated and affirmed by the legislatively created statewide HIT Advisory Council. The HIE

services are being developed to support identified use cases and ensure healthcare organizations in Connecticut have the ability to exchange data in a secure, standard, and flexible environment, whether they are connecting through a community or private HIE service provider, using national standards for point-to-point exchange, or participating in a national interoperability initiative. Figure 1 depicts the HIE vision of Connecticut, where the statewide HIE:

- Provides a mechanism for providers and other caregivers to connect directly to the Statewide HIE Entity;
- Leverages existing data sharing initiatives;
- Establishes the ability to participate with national interoperability initiatives;
- Implements a common statewide service utility to support secure connectivity across the provider and caregiver community and the implementation of current and future use cases; and
- Provides mechanisms for the participation of community organizations, behavioral health providers, long-term and post-acute care providers, and others who may not have the technology or resources to participate in the same manner as those with certified electronic health record (EHR) systems.

Figure 1. Network of Networks



The statewide HIE, Connecticut's state designated entity for HIE, was incorporated as Health Information Alliance, Inc., a 501 (c)(3) nonprofit, and is doing business as Connie. After a Request for Quotes process in 2020, Connie contracted with the Chesapeake Regional Information System for our Patients (CRISP) for the initial technology stack to support HIE functionality.

State statute requires healthcare organizations to connect or begin the process to connect to the statewide HIE with an expectation that hospitals and clinical laboratories begin the process to connect within one year of the HIE becoming operational and all other licensed health care providers and organizations begin the process to connect within two years. May 3, 2021 is the official date for Connie's commencement of operations for purposes of provider compliance with regulatory timeframes for connections. One hundred percent of hospitals have met the mandate. Connie is in negotiations with several labs licensed in CT to create the connection to Connie. Nearly seventy percent of all other licensed health care providers and organizations in the state of CT have met the year 2 requirement. For a dynamic, up-to-date list of organizations actively sharing data with Connie, and what data is being shared, please go to https://conniect.org/for-organizations/

An initial HIE use case (UCS) for empanelment and alerts is in operation and received CMS certification on March 22, 2002. DSS worked with CMS to request certification for the Connie provider portals, provider directory, and eReferral functionalities. CMS made a decision that since these Use Cases have been previously certified in Maryland, for CRISP, they did not have to go through certification in Connecticut.

Funding in this combined IAPD-U/OAPD-U is being requested for planning and DDI related to the new UCS and enhancements discussed below.

The following section describes Needs and Objectives (N&O) addressed through this funding request.

N&O 1 Supporting Functionality Enhancements in Planning

FFY 25	FFY 26
eReferral Enhancement • eConsult (SF11)	To be decided
Provider Portal Enhancements • Post Acute Network Tool (SF 15) • Dental Health Records Enhancements (SF 23) • Maternal Health (SF 34) (NEW) • Opioid Overdose (SF 35) (NEW)	
Provider Directory Enhancement • Provider Directory - Link to eReferral (SF 22)	
Patient Portal Enhancement • Granular Consent (SF 36) (NEW)	

Outcomes and metrics for use cases in planning will be proposed in the next combined IAPD-U/OAPD-U when the use cases move into DDI. The descriptions below include high level descriptions of the anticipated benefits for the Medicaid program.

FFY 25 Supporting Functionality Enhancements in Planning

eReferral Enhancement

eConsult (SF 11)

eConsults are asynchronous, consultative, provider-to-provider communications within a shared electronic health record (EHR) or through an HIE. They are an important part of the solution for transferring medical advice between medical specialists and primary care providers in an efficient and effective manner.

Provider Portal Enhancements

Post-Acute Network Tool (SF 15)

When patients are transferred to Long Term Post-Acute Care (LTPAC) facilities following an acute hospital stay to continue their recovery or rehabilitation, the coordination of care and effective transition are critical to positive health outcomes. Smooth transitions of care are highly dependent upon having the right information about each patient available in a timely manner. LTPAC patients are more likely to have chronic conditions and co-morbidities that require them to frequently transition between multiple care providers. Medicare beneficiaries with multiple chronic conditions may see up to 16 physicians per year. When multiple physicians are treating an individual following a hospital discharge, 78 percent of the time information about the individual's care is missing. HIE can benefit these patients by improving communication among providers and assuring that individuals and their care teams have the right information available at the point of care to provide the best patient care.

Implementation of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires that assessment data in all LTPAC settings – Home Health Agencies (HHAs), Inpatient Rehabilitation Facilities (IRFs), Long Term Health Care (LTCH) and Skilled Nursing Facilities (SNF) – be standardized and interoperable. Connie will work with participating skilled nursing and other post-acute care settings to identify the appropriate data elements required to support electronic sharing of Long-Term Care/Post Acute Care (LTC/PAC bed availability, services provided, clinical notes, assessments, and coordinate care plans.

Dental Health Records Enhancements (SF 23)

Dental health information is an essential part of overall patient information and can inform other healthcare diagnosis and treatment. According to a literature review conducted by UCONN Health, electronic dental records (EDRs) are generally not as interoperable as EHRs. These systems are often more fragmented, and data is limited due to how dentists use their systems. Meaning dental data is often entered in procedure codes rather than diagnosis codes. In addition, there is usually little detail beyond procedure codes in dental systems because they are primarily used for billing. Therefore, dental data that may be of interest to medical providers may not exist in a structured format or at all in an EDR.

Nevertheless, the American Dental Association (ADA) Standards Committee on Dental Informatic developed a core data set for communication among dental and other health information systems in 2019. The standards include a number of diagnostic codes that when utilized within the EDR, will be of mutual benefit among dental and medical providers. ADA is working to socialize these standards among their membership to encourage adoption. Connie will set up a work group to review the standards and determine how the information is most effectively displayed within existing Connie services.

Maternal Health (SF 34) (NEW)

At the end of 2023, CMS announced a new comprehensive, evidence-based care model designed to improve maternal health outcomes by implementing a whole-person approach to pregnancy, childbirth, and postpartum care for women with Medicaid and Children's Health Insurance Program (CHIP) coverage. DSS, in turn, plans to adopt a maternity bundle payment model as part of their overarching goal to move towards paying for equitable care in a value-based way. A key component of the model is making mothers feel empowered, safe, and healthy throughout their pregnancy and postpartum.

Program components include access to midwives, freestanding birth centers, and doula services; monitoring pregnant women at home who are diagnosed with conditions that can lead to pregnancy-related complications, such as hypertension and gestational diabetes; and prescreening for health-related social needs to address the underlying conditions that put pregnancies at greater risk. During planning, Connie will investigate service enhancements that will better support this initiative. For example, leveraging the patient portal to share patient birthing plans more efficiently across providers; and/or designing a Maternal Health Check that summarizes the patient's pregnancy journey through encounters, lab results, medications, social need referrals, and other clinically relevant summaries.

Opioid Overdose (SF 35) (NEW)

In September of 2023, the Connecticut Opioid Response (CORE) Initiative drafted a report with recommendations on how best to address the state's opioid overdose crisis and reduce overdose deaths and opioid-related adverse personal and public health effects in the immediate, near, and long-term. Among the five recommendations was, "to improve the use of existing data and increase data sharing across relevant agencies and organizations," because "Confidentially tracking how individuals at risk of opioid overdose are interacting with various systems and subsequent overdose outcomes can only be achieved by linking and merging individual existing data that currently exist across different agencies within the state." Existing data collected by state agencies and other entities in the state relevant to addressing the opioid overdose crisis are collected in separate data systems. In addition, use of these data is constrained by insufficient support for data management and regulations protecting personal identifiable information and personal health information. Connecticut has made significant progress in improving publicly reported data pertinent to the overdose crisis since 2016. Nevertheless, despite

progress, the report classifies current efforts as one-time linkages, and expresses interest in addressing missed opportunities for the state to improve its data infrastructure.

To support overdose reduction efforts, Connie currently displays overdose alerts for patients from participating organizations. Moving forward, Connie will work with the state agencies specified in the CORE Initiative recommendations to identify where and how the Connie systems can further support their required processes for data sharing and protection, timely analysis, development of timely metrics, and development of public facing dashboards reporting timely data.

Provider Directory Enhancement

Provider Directory – Link to eReferral (SF 22)

A health provider directory supports management of healthcare provider information, both individual and organizational, in a directory structure. Provider directories are critical tools for executing value-based payment. This is because the information contained in them is essential for properly attributing patients to providers for measuring value. Attribution depends on accurately knowing which patients are associated with which providers or provider organizations. Value-based payment models require provider directories as a means of attributing quality/value to providers.

Successful participation in value-based payment arrangements requires supportive activities that depend on provider directories. This includes care coordination and referral management, which cannot be optimally performed without accurate and interoperable electronic provider directories.

To begin to leverage the Provider Directory as a provider relationship management tool for more direct and meaningful use, Connie will continue scoping the process to connect the Provider Directory to Connie's eReferral system.

Patient Portal Enhancement

Granular Consent (SF 36) (NEW)

In Connecticut, certain types of health information have additional protections. Connie refers to health information with enhanced protections under state law as "sensitive health information." Before sensitive information can be shared, state and federal laws often require patients to provide affirmative consent. The standard practice is for participating providers to obtain patient consent where required before contributing patient health information to Connie. Alternatively, Connie has implemented an affirmative consent tool to support the sharing of substance use disorder (SUD) data through Connie for treatment. Through Connie's consent process, patient has the following options:

- No disclosure (patient does not register consent for sharing any SUD data);
- Disclosure of only patient's attribution to a 42 CFR Part 2 provider; or
- Disclosure of patient attribution to 42 CFR Part provider and associated information about their treatment.

Data disclosures include any of the patient's treating providers. Patients are unable to register their preference in terms of which types of providers the patient wishes to limit disclosure to. A granular consent approach would contemplate enabling patients to identify additional limitations to their affirmative consent preferences. Further analysis in terms of technical limitations, patient preferences, and impact on care coordination will be reviewed during planning.

The following use cases and supporting functionality are no longer under consideration for DDI:

- eCQM (UCS 06)[1]
- Hospital Bed Capacity (UCS 08)[2]
- Population Health Navigator (UCS 09)[3]
- Radiology User Access SSO (SF 21)[4]

N&O 2 Supporting Functionality Service Enhancements in DDI

FFY 25	FFY 26
Patient Portal Enhancement • eConsent – Patient Mediated Affirmative Consent (SF 07)	To be decided
Provider Portal Enhancements • HRSN/SDOH Assessment (SF 14) • Medicaid Redetermination (SF 16) • Population Health Reports (SF 31) (NEW) • Data in Workflow (SF 32) (NEW)	
Empanelment and Encounter Notification Service Enhancement • Logic-based Alerts (SF 33) (NEW)	

Because these enhancements will build on existing technology that is or will be certified, no new outcomes and metrics are proposed.

FFY 25 Supporting Functionality Service Enhancements in DDI

Patient Portal Enhancement

eConsent – Patient Mediated Affirmative Consent (SF 07)

Patient Mediated eConsent functionality will reflect the patient perspective associated with SF 06 (Provider Mediated Affirmative Consent) which moved to Operations in Q3 of 2023. Patient Mediated Affirmative Consent will be accessed through the Patient Portal, leveraging the patient ID verification process required for Patient Portal Access. The eConsent functionality will support the interactive participation of patients and their authorized representatives to

[1] This functionality has been replaced with Population Health Reports.
[2] This functionality is not being pursued at this time.
[3] This functionality has been incorporated into Logic-based Alerts.
[4] This functionality has been replaced with Data in Workflow.

manage their consent choices for data that could be shared through the HIE. The consent tool is configurable and enables patients to register consent to allow their substance use disorder (SUD) data to be shared through the HIE with members of their care team. Features that will be further vetted for consideration as part of the tool will include, but are not limited to:

- Electronic signatures for patient consent,
- Follows HIE general designation of the program or person permitted to disclose SUD data and able to view data,
- Flexible expiration dates for consent registration
    - Consents made through the patient portal will be tracked in the provider portal consent history and providers accessing the SUD data will be appropriately tracked.

Provider Portal Enhancements

HRSN/SDOH Assessment (SF 14) (formerly known as “SDOH Assessment”)

Many national standards including National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS), CMS and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are adding requirements related to both completing HRSN/SDOH assessments for patients at the point of care and providing information or resources to clients indicating needs. Connie will ingest and display HRSN/SDOH screening and assessment data in the Connie Clinical Information application to disseminate identified social needs to providers. This requires mapping assessment questionnaires to the FHIR questionnaire and response model for participating systems.

Medicaid Redetermination (SF 16)

As part of the Consolidated Appropriations Act of 2022, Congress set March 31, 2023 as a firm end date for continuous Medicaid coverage. After that time, Connecticut needed to conduct eligibility redeterminations for approximately a million beneficiaries before the public health emergency ended. DSS was able to leverage their provider network to reach out notifying members they would need to go through the redetermination process for Medicaid soon and urge them to contact DSS to make sure their address and contact information was current. Supporting organizations communicated the messaging through mass emails, automated calls, text messages and for certain members, through direct outreach by a care manager.

In order to streamline and provide more targeted outreach using Medicaid member rosters with member redetermination dates on an ongoing basis, Connie will be able to flag patients who are coming up on redetermination in the next 90 days for their provider. Providers and/or care managers could then encourage their patients to update DSS on their contact information to ensure they do not lose eligibility. Streamlining outreach using a more ongoing and targeted mechanism is expected to decrease time and effort for both DSS and participating provider organizations in ensuring eligible members retain their

benefits. As this enhancement is of specific benefit to only Medicaid beneficiaries, SF 16 will be cost allocated at 100% Medicaid.

Population Health Reports (SF 31) (NEW)

DSS administers Medicaid programs and services for nearly a million people a year across eight counties. As DSS looks to reduce cost by incentivizing value-based care models, there is a greater need for DSS and their member providers to access patient health information in aggregated reports to better understand their patient population, identify gaps in care, and ultimately improve patient care and outcomes.

As an HIE, Connie contains a vast amount of patient clinical data across Connecticut's patient population from disparate health systems. From these disparate data sources Connie can create aggregated population health reports to assist DSS with monitoring member health trends and drilling down to member level detail for further practice or provider analysis. Connie will build reports with rich patient level data that will give DSS insight into their member's health trends. Initial reports considered for implementation will include, but are not limited to, readmissions to hospitals, avoidable hospitalizations, Emergency Department (ED) utilization, SNF/LTC length of stay, and reasons for hospitalizations. This enhancement is designed to support Medicaid population health and will be cost allocated at 100% Medicaid.

Data in Workflow (SF 32) (NEW)

Connie is continuously focused on improving access to HIE data within the provider workflow. Moving from a workflow where users leave their EHR to log into a separate HIE portal to embedding all HIE data within the EHR-native window via the SMART on FHIR app was the first major improvement. Connie's next iteration of workflow improvement will be to seamlessly incorporate pieces of HIE data within their EHR at the right point in the clinical workflow. For example, a user could enter an order for a CT scan within their EHR and a clinical decision support rule would alert the user that the same CT scan image had recently been captured and is available within Connie for viewing. Implementation of data-in-the-workflow can be flexible based on the capability and preferences of the participant. Some variables that can impact the scope of the implementation include:

- the types of data incorporated (e.g. images, contact information, public health alerts);
- whether the user is alerted to the fact of data (i.e. a flag) or the data is incorporated directly into the EHR; and
- the manner in which the data is incorporated (e.g. pushed for ingestion or available through an API call), which may be determined by technical capabilities or participant preferences.

Putting data directly into existing clinical workflows that can impact clinical decisions can increase the review of relevant data, minimize time clinicians spend searching in Connie and improve patient care and outcomes. The scope of work may include, but is not limited to, improving data quality of the data being collected that would enable data-in-the-

workflow, API modifications, integration work between the shared infrastructure and the participant EHR, and working with the participant to implement the workflow.

Empanelment and Encounter Notification Service Enhancement

Logic-Based Alerts (SF 33) (NEW)

Providers need timely, actionable information to improve patient health outcomes. Streamlining workflows, providing actionable information in the hands of the provider without barriers greatly improves the provider's ability to address and prevent health concerns from escalating.

A logic-based alert is a highly actionable alert triggered by the Empanelment and Encounter Notification service. Logic-Based Alerts follow pre-defined rules designed for a specific purpose that only trigger when all conditions are met, resulting in an alert to a provider for a very targeted purpose. Any discrete data element can be used within the rule-based logic, including coding standards (e.g. Current Procedural Terminology [CPT], International Classification of Diseases, Tenth Revision [ICD10] and Logical Observation Identifiers Names and Codes [LOINC]), to identify specific circumstances to send an alert to the patient's care team for improved care coordination, reduced readmissions, and a better patient experience. For example, Connie could provide real-time alerts that notify a patient's care team when their high-risk patients have hospital encounters for specific conditions (e.g. COVID-19, Congestive Heart Failure [CHF], Asthma), procedures (e.g. Mammography, Joint Replacement) or key lab tests results (e.g. COVID-19, Pregnancy, Pre-Diabetes). Flagging specific situations where the provider can intervene to provide preventative care, identify certain patients that would benefit from case management, or enroll patients in state-led programs is critical for improved patient outcomes. Connie will work to identify, develop, and implement Logic-Based Alerts, which will be delivered within a provider's workflow through the Connie Portal, or available at the point-of-service for providers.

The following supporting functionality is no longer under consideration for DDI:

Electronic Test Order and Results[5] (SF 30)

FFY 26 Supporting Functionality Enhancements in DDI

Topics for use case/supporting functionality DDI in FFY26 are to be determined.

[5] This functionality is not being pursued at this time.

N&O 3 Supporting Functionality Enhancements moving from DDI to Operations

FFY 25 UCS/Supporting Functionality Moving from DDI to Operations

Patient Portal (UCS 11)

A patient portal is a secure online website that gives patients, convenient, 24-hour access to personal health information from anywhere with an internet connection. Just making a portal available to patients will not ensure that they will use it. A portal should be engaging, user-friendly, and support patient-centered outcomes. It should also enable a patient to understand the information available about their provider, their health, support a patient's need to have a single source of information about their health and healthcare, assist a patient in identifying information discrepancies and directing a patient to where they can address inaccuracies and manage the information they have consented to sharing including the permitted purposes.

Connie's Patient Access Principles Policy articulates that Connie will provide patients timely and direct access to their electronic health information within Connie to (a) align with federal and state information blocking and interoperability rules, and (b) to strive to attain the Patient Access goals of the State-wide Health Information Exchange as describe in Connecticut State Statute **Sec. 17b-59d:**

(1) Allow real-time, secure access to patient health information and complete medical records across all health care provider settings;
(2) Provide patients with secure electronic access to their health information;
(3) Allow voluntary participation by patients to access their health information at no cost; and
(4) Promote the highest level of interoperability.

To begin to meet these expectations, in FY 2024 Connie developed an initial iteration of the Patient Portal. Using a secure username and password, with patient ID validation, patients are able to view their health information available within Connie. Connie is working towards a complete display of patient clinical data to include patient demographics, care team, encounters, lab results, medications, noted problems, immunizations, health related social needs recorded, and referrals to CT healthcare consumers through the Connie Patient Portal.

Value Proposition:

- Empowering patients in the healthcare decision making, supporting value-based healthcare systems
- Medicaid members will have more timely access to more detailed clinical information in support of goals of the CMS Interoperability and Patient Access final rule (CMS-9115-F)

Proposed Patient Portal Outcome:

CT Medicaid attests Medicaid providers and Medicaid beneficiaries use of the HIE patient portal technical investments will improve health outcomes by allowing them to be more active participants in their health care.

Proposed Patient Portal Metrics:

- # of unique patients accessing the portal
- # of unique Medicaid members accessing the portal

Rationale for Proposed Patient Portal Outcome and Metrics:

The Patient Portal gives patients 24/7 electronic access to their health information, allowing them to be active participants in their health care which has been shown through studies to: reduce anxiety, positively impact consultations, better doctor-patient relationship, increase awareness and adherence to medication, and improve patient outcomes (e.g., improving blood pressure and glycemic control in a range of study populations). In addition, patient access to their health information was found to improve self-reported levels of engagement or activation related to self-management, enhanced knowledge, and improve recovery scores, and organizational efficiencies in a tertiary level mental health care facility.

Section 4: Results of Activities Included in the Last Approved HIE MES APD

Major Activities Summary

The following activities have moved to production since the last approved HIE MES APD:

- Advanced Health Care Directives (AHCD)
- Immunizations
- Provider Mediated eConsent
- Emergent Imaging
- Connie Patient Access API
- Dental Data/Care Team Enhancement

Section 5: Statement of Alternative Considerations

This combined IAPD-U/OAPD-U supports planning and development aligned with the Medicaid Enterprise System to add use case services to the Connecticut HIE as well as to enhance existing use case services. The use case activities proposed in this funding request utilize the services of Connie, the state designated entity for health information exchange in Connecticut. Through participation on the HITAC and on Connie's Operational Advisory Committee, DSS has an opportunity to influence the priority of Connie's use case development. Cost allocated

Medicaid funding provides additional incentive with associated assurance that needed use cases will be developed and aligned with MES needs. Utilizing Connie in this way, where DSS and Medicaid invest in a portion of the cost based on cost allocation, is a cost-effective approach to meeting the needs of the agency. OHS with HITAC advice determined that a federated model for HIE was best for the state, and that there should be a separate entity to operate the HIE. This work was mandated in Connecticut General Statute 17b-59a (3) (d) which directs OHS to oversee the development and implementation of the State-wide Health Information Exchange in compliance with 17b-59d. Connie is now the designated statewide HIE utilizing CRISP as an integration partner, which was selected through a competitive request for quotes process, as the core technical infrastructure. With the investment made in the HIE, the state considers developing these use cases with and through Connie as being the best path forward. The alternative would be to invest the full amount to develop these services and restrict them to the Medicaid agency.

Section 6: Proposed Activity Schedule

Connie Implementation Roadmap and Schedule

Table 5. Connie Phased Implementation Roadmap

Implementation FFY	Use Case Service	Supporting Function
2021	Empanelment and Alerts	MPI
2022	Provider Portals, Provider Directory, eReferrals	Clinical data, PMP Access, Best Possible Medication History (BPMH), Image Exchange
2023	---	Advanced Health Care Directives (AHCD), Immunizations, Provider Mediated eConsent, Emergent Imaging, Dental Health Records, Connie Patient Access API
2024	Patient Portal	Empanelment and Alerts Enhancement • Connie Encounters Worklist Referral Enhancement • Health Related Social Needs/Social Determinants of Health (HRSN/ SDOH) referrals[6] Provider Portal Enhancements • Problem List Filters • Allergy Lists • BPMH – Pharmacy data • Electronic Test Order and Results (ETOR) Consent Enhancements • Continuity of Care Document (CCD) Sensitive Data Filters – Provider Mediated Affirmative (PrMA)
2025	---	Patient Portal Enhancement • Patient Mediated Affirmative Consent (PrMA) Provider Portal Enhancements • HRSN/SDOH Assessment • Medicaid Redetermination • Data in the Workflow (New) • Population Health Reports (New)

[6] Formerly referred to as SDOH (screening, referral, resource directory analytics)

Implementation FFY	Use Case Service	Supporting Function
		Empanelment and Encounter Notification Service Enhancement • Logic-based Alerts (New)
2026	---	eReferral Enhancements • eConsult Patient Portal Enhancements • Granular Consent (New) Provider Portal Enhancements • Dental Health Records • Post-Acute Network Tool • Maternal Health (New) • Opioid Overdose (New) Provider Directory Enhancement • Provider Directory – Link to eReferral

As fully described in Section 3 of this combined IAPD-U/OAPD-U, Connecticut seeks funding to enhance HIE UCS along with SF and data sources. The following table lists the Connie UCS and SF supported by federal funding. Support for functionality in planning, DDI and operations is being requested in this combined IAPD-U/OAPD-U.

Table 6. HIE Use Case Services (UCS) and Supporting Functions (SF)

= Operations or Go Live in FFY24 | = DDI in FFY25 | = Planning in FFY26

Implementation FFY	ID	Name	Supports Use Case	FFY 25 Status	Certification Required
2021	**UCS 01**	**Empanelment and Alerts**	n/a	Operations	Certified
2022	**UCS 02**	**Provider Portals: Web-Based Portal (LogOnce Technology) and InContext App (Smart on FHIR Portal)**	n/a	Operations	Certified
2022	SF 01	Clinical Data	UCS 02	Operations	Not Required (NR)
2022	SF 02	PMP access	UCS 02	Operations	NR
2022	SF 03	Best Possible Medication History (BPMH)	UCS 02	Operations	NR

Implementation FFY	ID	Name	Supports Use Case	FFY 25 Status	Certification Required
2022	SF 08.1	Image Exchange	UCS 02	Operations	NR
2022	**UCS 03**	**eReferral**	n/a	Operations	NR
2022	**UCS 04**	**Provider Directory**	n/a	Operations	NR
2023	SF 04	Advance Health Care Directives	UCS 02	Operations	NR
2023	SF 05	Immunizations	UCS 02	Operations	NR
2023	SF 06	eConsent (Provider Mediated Affirmative Consent)	UCS 02	Operations	NR
2023	SF 08.2	Stroke Network/Emergent Imaging	UCS 02	Operations	NR
2023	SF 09	Dental Health Records	UCS 02	Operations	NR
2023	SF 10	Connie Patient Access API	UCS 02	Operations	NR
2024	**UCS 11**	**Patient Portal**	n/a	Operations	Required
2024	SF 12	HRSN/SDOH referral	UCS 03	Operations	NR
2024	SF 13	Connie Encounters Worklist	UCS 01	Operations	Required
2024	SF 17	Problem List Filters	UCS 02	Operations	NR
2024	SF 18	Allergy List	UCS 02	Operations	NR
2024	SF 19	BPMH-Pharmacy Data	UCS 03	Operations	NR
2024	SF 20	CCD Sensitive Data Filters (PrMA Enhancement)	UCS 02	Operations	NR
2025	SF07	Patient Mediated Affirmative Consent	USC 11	DDI	NR
2025	SF 14	HRSN/SDOH Assessment	UCS 02	DDI	NR
2025	SF 16	Medicaid Redetermination	UCS 02	DDI	NR
2025	SF 32	Data in Workflow (New)	UCS 02	DDI	TBD
2025	SF-31	Population Health Reports	UCS 02	DDI	To Be Determined (TBD)
2025	SF 33	Logic-based Alerts (New)	UCS 01	DDI	NR
2026	SF 11	eConsult	UCS 03	Planning	NR
2026	SF 36	Granular Consent (New)	UCS 11	Planning	NR
2026	SF 23	Dental Health Records – Enhancements	UCS 02	Planning	NR
2026	SF 15	Post-Acute Network Tool	UCS 02	Planning	NR

Implementation FFY	ID	Name	Supports Use Case	FFY 25 Status	Certification Required
2026	SF 34	Maternal Health (New)	UCS 02	Planning	NR
2026	SF 35	Opioid Overdose (New)	UCS 02	Planning	NR
2026	SF 22	Provider Directory – link to eReferral	UCS 04	Planning	NR

The activities required to complete the proposed HIE objectives are provided in the Proposed HIE Activity Schedule included below.

Table 7. Proposed HIE Activity Schedule

Activity	Start Date *(Federal Fiscal Calendar)*	End Date *(Federal Fiscal Calendar)*
UCS 11 Patient Portal		
1.0 Planning and stakeholder engagement	Q2 23	Q4 23
2.0 Design Develop and Implement	Q1 24	Q4 24
3.0 Begin operations for certification	Q1 25	Q2 25
4.0 Complete certification process	Q2 25	TBD
5.0 Operational	Q1 25	n/a
SF 07 (UCS 11) Patient Mediated Affirmative Consent		
1.0 Planning and stakeholder engagement	Q3 24	Q1 25
2.0 Design Develop and Implement	Q2 25	Q3 25
3.0 Begin operations for certification	n/a	n/a
4.0 Complete certification process	n/a	n/a
5.0 Operational	Q4 25	n/a
SF 13 (UCS 01) Connie Encounters Worklist		
1.0 Planning and stakeholder engagement	Q3 23	Q1 24
2.0 Design Develop and Implement	Q2 24	Q4 24
3.0 Begin operations for certification	Q1 25	Q2 25
4.0 Complete certification process	Q2 25	Q3 25
5.0 Operational	Q1 25	n/a
SF 14 (UCS 02) HRSN/SDOH Assessment (formerly known as "SDOH Assessment")		
1.0 Planning and stakeholder engagement	Q2 24	Q4 24
2.0 Design Develop and Implement	Q1 25	Q3 25
3.0 Begin operations for certification	n/a	n/a
4.0 Complete certification process	n/a	n/a
5.0 Operational	Q4 25	n/a
SF 16 (UCS 02) Medicaid Redetermination		
1.0 Planning and stakeholder engagement	Q2 24	Q4 24
2.0 Design Develop and Implement	Q1 25	Q2 25
3.0 Begin operations for certification	n/a	n/a

4.0 Complete certification process	n/a	n/a
5.0 Operational	Q3 25	n/a
New SF 31 (UCS 02) Population Health Reports		
1.0 Planning and stakeholder engagement	Q2 24	Q4 24
2.0 Design Develop and Implement	Q1 25	Q2 25
3.0 Begin operations for certification	n/a	n/a
4.0 Complete certification process	n/a	n/a
5.0 Operational	Q3 25	n/a
New SF 32 (UCS 02) Data in Workflow		
1.0 Planning and stakeholder engagement	Q3 24	Q4 24
2.0 Design Develop and Implement	Q1 25	Q3 25
3.0 Begin operations for certification	n/a	n/a
4.0 Complete certification process	n/a	n/a
5.0 Operational	Q4 25	n/a
New SF 33 (UCS 02) Logic-based Alerts		
1.0 Planning and stakeholder engagement	Q2 24	Q4 24
2.0 Design Develop and Implement	Q1 25	Q3 25
3.0 Begin operations for certification	n/a	n/a
4.0 Complete certification process	n/a	n/a
5.0 Operational	Q4 25	n/a

Section 7(a): Personnel Resource Statement

DDI

DSS HIE Staffing Resource Requirements

DSS dedicates State personnel to oversee and manage CMS funded HIE activities through the Medical Operation's Health Information Technology Unit. DSS created an HIE Funding Oversight Committee to provide DSS governance over Medicaid funds provided to OHS for the statewide HIE and to ensure that Medicaid needs are met.

DSS HIE State Personnel Resources are described in more detail in the Table 5 below. Cost Allocation is not required for this Medicaid-specific work.

Table 8. DSS HIE State Personnel Resources for DDI - FFY 25 and FFY 26

IAPD -- DSS State Personnel Resources							
DSS Staff Title	FFY 2025			FFY 2026			Description of Responsibilities
	% of Time	Project Hours	Prorated Cost with Benefits	% of Time	Project Hours	Prorated Cost with Benefits	
Medical Operations Manager	50%	$ 1,040	$ 133,949	50%	1,040	$ 141,334	Responsible for the overall administration and operations of the Medicaid Mangement Information System and lead DSS laison
Health Program Supervisor	100%	$ 2,080	$ 245,072	100%	2,080	$ 258,947	Reports directly to the Medical Operations Manager and assists with the administration and operations of the statewide HIE.
Health Program Associate	50%	$ 1,040	$ 104,747	50%	1,040	$ 107,339	Reports directly to the Medical Operations Manager and assists with administration and development of the statewide HIE as
HIE Business Lead Manager	100%	$ 2,080	$ 187,086	100%	2,080	$ 191,763	DSS subject matter expert. Provides expertise in Connecticut's current Medicaid business environment and evaluates that HIE funding deliverables meet Medicaid business requirements. Also
HIE Supervising Accountant	50%	$ 1,040	$ 99,238	50%	1,040	$ 105,279	Position reports to DSS Agency Chief Financial Officer and is responsible for assisting in oversight on financial, fiscal, and
HIE Grants and Contracts Specialist	25%	$ 520	$ 44,933	25%	520	$ 47,669	Position reports to DSS Agency Chief Financial Officer and is responsible for assisting in oversight of HIE contracts.
Total:			$ 815,026			$ 852,331	

Table 9. DSS Other State Costs for DDI - FFY 25 and FFY 26

IAPD -- DSS Other State Costs	FFY 2025	FFY 2026
Cost Category		
System Hardware	$ -	$ -
System Software	$ -	$ -
Travel/Conferences	$ 15,000	$ 15,000
Supplies	$ -	$ -
Total:	$ 15,000	$ 15,000

OHS HIE Staffing Resource Requirements

OHS also dedicates State personnel for HIE planning and oversight responsibilities identified in the Connecticut General Statutes. Personnel and contract resources will be used by OHS to:

- Chair the HIE Board of Directors and administratively oversee the HIE:
- Chair and support the HITAC (and its subcommittees) as an advisory body;
- Develop initial high-level functional needs for HIE use cases that are not fully defined;
- Develop policies for statewide race, ethnicity, and language data collection for state agencies and for providers participating in the HIE as required by P.A. 21-35
- Follow up the 5-year Statewide Health IT Plan currently being developed to begin planning and develop recommendations;
- Continued coordination of statewide HIT efforts as required by the general statutes
- Prepare and submit an Annual Health IT report to the legislature;
- Set standards as defined in the general statutes regarding HIE, including in the areas of
    - Security
    - Privacy
    - Data content
    - Structures and format
    - Vocabulary
    - Transmission protocols

Table 10. OHS HIE State Personnel Resources for DDI - FFY 25 and FFY 26

IAPD - OHS State Personnel Resources							
Connecticut Office of Health Strategy Staff Title	FFY 2025			FFY 2026			Description of Responsibilities
	% of Time	Project Hours	Prorated Cost with Benefits	% of Time	Project Hours	Prorated Cost with Benefits	
N&O 1: State Staff							
Health Information Technology Officer (HITO)	86%	1,778	$ 304,822	86%	1,778	$ 313,967	Health Information Technology Officer- responsible for the overall success of the State's HIE strategy. Resides as Chair of the Health Information Alliance Board. Continues Administrative oversight on all HIE related projects.
HIE Program Manager	86%	1,778	$ 162,792	86%	1,778	$ 167,676	Responsible for the HIE portfolio. Responsible for the HIE service solution - vendor analysis, procurement, implementation & roll-out. Reports to the HITO.
HIT Planning Manager 1	36%	749	$ 68,544	36%	749	$ 70,600	Responsible for implementing systems to improve health equity and address social determinants of health. Responsible for the strategic planning, stakeholder engagement, statewide councils, inter-agency planning and data governance. Reports to the HITO.
HIT Planning Manager 2	23%	468	$ 42,840	23%	468	$ 44,125	Responsible for HIE sustainability and utilization and public health data exchange, for interagency data sharing with state-operated data systems, and making Connie infrastructure a shared public utility service. Measures and assesses how providers utilize HIE at the point of care to improve care quality, care coordination, and drive better health outcomes for individual patients and communities. Reports to the HITO.
HIT Project Manager	36%	749	$ 90,734	36%	749	$ 93,456	Responsible for HHS interagency data sharing & coordination and establishing electronic data standards. Supports behavioral health (BH) providers with adoption to EHR and HIE, enabling improved coordination between BH providers, and integration between primary care and BH care. Supports the HITO in the planning, developing, and implementation of a financial incentive program for BH providers with TA and training. Reports to the HITO.
Consumer Information Representative	53%	1,092	$ 70,129	53%	1,092	$ 72,233	Provides support to the Health Information Alliance Board. Support for the HITO at it relates to the Health Information Technology Advisory Council. Works on HIE related
Consumer Information Representative-Lead	68%	1,404	$ 117,679	68%	1,404	$ 121,209	Provides support to the Health Information Alliance Board. Support for the HITO at it relates to the Health Information Technology Advisory Council. Works on HIE related
OHS Administrative Assistant	38%	780	$ 62,172	38%	780	$ 64,037	Responsible for all scheduling, filing, office administration and duties to support the HIT Unit. Reports to the HITO.
Communication Manager	23%	468	$ 46,399	23%	468	$ 47,791	Develops all HIT PMO marketing materials, outside communications (emails, newsletters, signage/banners) and coordinates stakeholder engagement, outreach efforts.
Fiscal Administrator Supervisor	11%	234	$ 27,833	11%	234	$ 28,668	Supports the fiscal and contractual administration of the HIT and HIE portfolio and will oversee the audit functions.
Fiscal Administrative Officer	68%	1,404	$ 121,628	68%	1,404	$ 125,277	Supports the fiscal and contractual administration of the HIT and HIE portfolio and will oversee the audit functions.
Grants and Contracts Specialist	8%	156	$ 17,499	8%	156	$ 18,024	Contract communication liaison with OPM and Attorney General. Assigned to research, prepare, communicate and ensure execution of all HIE related contract compliance activities and justifications. Reports to Fiscal Administrative Supervisor.
Supervising Attorney	15%	312	$ 50,543	15%	312	$ 52,059	Lead counsel for OHS. Supervises, modifies and approves staff attorney's work product.
Staff Attorney	15%	312	$ 31,034	15%	312	$ 31,965	OHS attorney who oversees the HIT and HIE legal portfolio including HIE contracts, legal communications and HIE regulations. Reports to the Supervisory Attorney.
Total:			**$ 1,214,649**			**$ 1,251,089**	

Table 11. OHS Other State Costs for DDI - FFY 25 and FFY 26

IAPD - OHS Other State Costs		
Cost Category	FFY 2025	FFY 2026
Hardware/Software	$ 3,600	$ 3,600
Equipment/Supplies	$ 6,300	$ 6,300
Out of State Travel and Conference Costs	$ 13,500	$ 13,500
Totals:	**$ 23,400**	**$ 23,400**

OPERATIONS

In FFY 25, OHS will begin allocating part of OHS staff time to HIE operations as indicated in the OHS State Personnel Resources Table below.

Table 12. OHS HIE State Personnel Resources for Operational Use Cases FFY 25 and FFY 26
Total OHS Staffing Costs Before Cost Allocation

OAPD -- OHS State Personnel Resources							
Connecticut Office of Health Strategy Staff Title	FFY 2025			FFY 2026			Description of Responsibilities
	% of Time	Project Hours	Prorated Cost with Benefits	% of Time	Project Hours	Prorated Cost with Benefits	
N&O 1: State Staff							
Health Information Technology Officer (HITO)	10%	198	$ 33,869	10%	198	$ 34,885	Health Information Technology Officer- responsible for the overall success of the State's HIE strategy. Resides as Chair of the Health Information Alliance Board. Continues Administrative oversight on all HIE related projects.
HIE Program Manager	10%	198	$ 18,088	10%	198	$ 18,631	Responsible for the HIE portfolio. Responsible for the HIE service solution - vendor analysis, procurement, implementation & roll-out. Reports to the HITO.
HIT Planning Manager 1	4%	83	$ 7,616	4%	83	$ 7,844	Responsible for implementing systems to improve health equity and address social determinants of health. Responsible for the strategic planning, stakeholder engagement, statewide councils, inter-agency planning and data governance. Reports to the HITO.
HIT Planning Manager 2	3%	52	$ 4,760	3%	52	$ 4,903	Responsible for HIE sustainability and utilization and public health data exchange, for interagency data sharing with state-operated data systems, and making Connie infrastructure a shared public utility service. Measures and assesses how providers utilize HIE at the point of care to improve care quality, care coordination, and drive better health outcomes for individual patients and communities. Reports to the HITO.
HIT Project Manager	4%	83	$ 10,082	4%	83	$ 10,384	Responsible for HHS interagency data sharing & coordination and establishing electronic data standards. Supports behavioral health (BH) providers with adoption to EHR and HIE, enabling improved coordination between BH providers, and integration between primary care and BH care. Supports the HITO in the planning, developing, and implementation of a financial incentive program for BH providers with TA and training. Reports to the HITO.
Consumer Information Representative	18%	364	$ 23,376	18%	364	$ 24,078	Provides support to the Health Information Alliance Board. Support for the HITO at it relates to the Health Information Technology Advisory Council. Works on HIE related communications and outreach.
Consumer Information Representative- Lead	23%	468	$ 39,226	23%	468	$ 40,403	Provides support to the Health Information Alliance Board. Support for the HITO at it relates to the Health Information Technology Advisory Council. Works on HIE related communications and outreach.
OHS Administrative Assistant	13%	260	$ 20,724	13%	260	$ 21,346	Responsible for all scheduling, filing, office administration and duties to support the HIT Unit. Reports to the HITO.
Communication Manager	8%	156	$ 15,466	8%	156	$ 15,930	Develops all HIT PMO marketing materials, outside communications (emails, newsletters, signage/banners) and coordinates stakeholder engagement, outreach efforts.
Fiscal Administrator Supervisor	4%	78	$ 9,278	4%	78	$ 9,556	Supports the fiscal and contractual administration of the HIT and HIE portfolio and will oversee the audit functions.
Fiscal Administrative Officer	23%	468	$ 40,543	23%	468	$ 41,759	Supports the fiscal and contractual administration of the HIT and HIE portfolio and will oversee the audit functions.
Grants and Contracts Specialist	3%	52	$ 5,833	3%	52	$ 6,008	Contract communication liaison with OPM and Attorney General. Assigned to research, prepare, communicate and ensure execution of all HIE related contract compliance activities and justifications. Reports to Fiscal Administrative Supervisor.
Supervising Attorney	5%	52	$ 16,848	5%	104	$ 17,353	Lead counsel for OHS. Supervises, modifies and approves staff attorney's work product.
Staff Attorney	5%	104	$ 10,345	5%	104	$ 10,655	OHS attorney who oversees the HIT and HIE legal portfolio including HIE contracts, legal communications and HIE regulations. Reports to the Supervisory Attorney.
Total:			$ 256,054			$ 263,735	

Table 13. OHS Other State Costs

OAPD -- OHS Other State Costs		
Cost Category	FFY 2025	FFY 2026
Hardware/Software	$ 400	$ 400
Equipment/Supplies	$ 700	$ 700
Out of State Travel and Conference Costs	$ 1,500	$ 1,500
Totals:	**$ 2,600**	**$ 2,600**

Section 7(b): Contract Resource Statement

DDI

DSS HIE Contract Resource Requirements

The Department will continue to partner with vendors to support:

1. EPMO. DSS will continue EPMO Portfolio Management activities under the Direction of the DSS Commissioner to support DSS staff with project management and subject matter expertise

for the implementation, oversight, and funding of HIT/HIE activities in support of the CT DSS Medicaid Program.

2. HIE Technical Lead. This consultant will continue to work with the CT DSS Medicaid Program to define, select, and implement solutions to meet the needs of the business in support of Medicaid.

For DSS contractor costs, cost allocation is not required for this Medicaid-specific work.

Table 14. DSS Contract Resources for DDI - FFY 25 and FFY 26

IAPD -- DSS Contract Resources			
	FFY 2025	FFY 2026	Responsibilities
1. EPMO HIT/HIE Portfolio Management			
HealthTech Solutions	$ 700,000	$ 700,000	The contract is for a team of consultants to provide project management and subject matter expertise to DSS for the implementation, management, oversight, and funding of HIT/HIE activities in support of the Connecticut Medicaid Program. SME support will include HIT/HIE planning, technical expertise, creation/editing of Advance Planning Documents, and coordination with the EPMO and other Medicaid projects.
2. HIE Technical Lead			
Slalom Consulting Services	$ 500,000	$ 500,000	One FTE consultant to work with DSS Medicaid Program to define, select and implement solutions to meet the needs of the business in support of Medicaid. Also works with statewide entity to roll out HIT solutions for Medicaid recipients and other constituents. Provides expertise in Connecticut's current Medicaid technical environment, vendors and processes. Evaluates funding milestones against technical and use case requirements and specifications. Assists in identifying the appropriate transition teams and workgroups for HIE collaboration and provides input to transition task requirements as identified DSS assets are transitioned to the statewide HIE.
Total Contractor Resources	**$ 1,200,000**	**$ 1,200,000**	

OHS HIE Contract Resource Requirements

OHS will continue to partner with CedarBridge Group LLC to support planning and workstream support associated with projects and activities identified in this combined IAPD-U/OAPD-U. OHS also proposes adding a HIT Consultant role.

OHS HIE Contractor Resources for FFY 25 and FFY 26 are also detailed in the table below detailing the total OHS contractor costs before cost allocation.

Table 15. OHS Contracts/Contractor Resources for DDI - FFY 25 and FFY 26

IAPD - OHS Contract Resources			
Connie Vendor Resources	**FFY 2025**	**FFY 2026**	**Description of Responsibilities**
Connie Resources*			
Core Infrastructure Costs	$ 739,141	$ 836,977	
Connie Operations Personnel	$ 1,935,422	$ 1,952,177	
Connie Operational Costs	$ 438,039	$ 471,225	
Connie Contracted Professional Services	$ 761,381	$ 715,000	
Use Case Services Subtotal	**$ 3,873,983**	**$ 3,975,379**	
IAPD - Other OHS Contract Resources: Planning and Workstream Support			
CedarBridge Group LLC (or an alternative contractor selected through RFP)	$ 900,000	$ 900,000	The HIT Consultant provides portfolio management for the HIT projects, subject matter expertise, strategic facilitation for internal and external stakeholder meetings; and assists the development of proposals, funding requests and written materials.
Covendis (or alternative contractor)	$ 216,000	$ 216,000	The HIT Consultant provides portfolio management for the HIT projects, subject matter expertise, strategic facilitation for internal and external stakeholder meetings; and assists the development of proposals, funding requests and written materials.
Other OHS Contracting Subtotal	**$ 1,116,000**	**$ 1,116,000**	
OHS Contractor Total	**$ 4,989,983**	**$ 5,091,379**	

** The HIA Board has contracted with CRISP for interface and integration services, ongoing operating services and the development of new use cases.*

OPERATIONS

Connie operational costs for the HIE in FFYs 25 and 26 are summarized in the following table while Connie costs are broken out by Use Case Service (UCS) in the next section.

Table 16: OHS Contract Resources for HIE Operations in FFYs 25 and 26

OAPD -- OHS Contract Resources	FFY 2025	FFY 2026
Connie Resources		
Core Infrastructure Contracts	$ 1,548,825	$ 1,654,385
Connie Operations Personnel	$ 1,213,425	$ 1,344,207
Connie Administrative Personnel	$ 341,958	$ 386,970
Connie Administrative Costs	$ 389,451	$ 417,877
Connie Contracted Professional Services / Core Infrastructure (Portal Vendor)	$ 500,000	$ 500,000
OHS Operations Contract Total	**$ 3,993,658**	**$ 4,303,439**

Connie Operating Costs by Use Case Service

FFY25 and FFY26 operational costs for the certified use cases are shown in Table 17 below.

Table 17: Connie Operational Costs for Certified Use Cases in FFYs 25 and 26

Connie Certified Services Costs by Use Case	FFY25	FFY26
Connie Enpanelment and Encounter Alert Service		
Personnel - Eligible for Enhanced Funding	$ 531,483	$ 512,725
Personnel - Not Eligible for Enhanced Funding	$ 153,003	$ 147,603
Administrative Costs	$ 154,918	$ 159,392
Core Infrastructure (Explorer)	$ 683,909	$ 627,100
Total Empanelment and Encounter Alert Service	**$ 1,523,313**	**$ 1,446,820**
Connie Connect Portal Service		
Personnel - Eligible for Enhanced Funding	$ 389,135	$ 375,400
Personnel - Not Eligible for Enhanced Funding	$ 112,024	$ 108,070
Administrative Costs	$ 113,426	$ 116,702
Core Infrastructure (CRISP)	$ 500,736	$ 620,527
Total Connie Connect Portal	**$ 1,115,320**	**$ 1,220,699**
eReferral Service		
Personnel - Eligible for Enhanced Funding	$ 108,158	$ 104,341
Personnel - Not Eligible for Enhanced Funding	$ 31,137	$ 30,038
Administrative Costs	$ 31,526	$ 32,437
Core Infrastructure (CRISP)	$ 139,178	$ 155,714
Total eReferral Service	**$ 309,999**	**$ 322,530**
Provider Directory Service		
Personnel - Eligible for Enhanced Funding	$ 104,914	$ 101,211
Personnel - Not Eligible for Enhanced Funding	$ 30,203	$ 29,137
Administrative Costs	$ 30,581	$ 31,464
Core Infrastructure (CRISP)	$ 135,003	$ 151,044
Total Provider Directory Service	**$ 300,700**	**$ 312,856**
Patient Portal (not yet certified)		
Personnel - Eligible for Enhanced Funding	$ 79,734	$ 250,530
Personnel - Not Eligible for Enhanced Funding	$ 15,593	$ 72,122
Administrative Costs	$ 59,000	$ 77,882
Core Infrastructure (CRISP)	$ 90,000	$ 100,000
Contracted Professional Services / Core Infrastructure (Portal Vendor)	$ 500,000	$ 500,000
Total Patient Portal Service	**$ 744,327**	**$ 1,000,534**

Section 8: Proposed Budget

The HIE technology provided by CRISP is an integrated technology stack. OHS, Connie, and CRISP have estimated the incremental costs associated with each of the listed UCS and SF. Connie has provided a budget estimate that includes personnel and administrative needs as well as contracted services from CRISP and other consulting vendors. OHS and DSS have also estimated the associated personnel and contracting needs to meet the statutory and Medicaid agency requirements associated with the proposals presented in this combined IAPD-U/OAPD-U.

This combined IAPD-U/OAPD-U presents Connecticut's HIE MES funding request for operations and DDI for FFY 25 and FFY 26. The funding details are summarized in the table below.

This HIE MES combined IAPD-U/OAPD-U is for the period from October 1, 2024 through September 30, 2026.

The total Federal share requested in this APD for FFYs 25 and 26 is $11,093,921 and the State share is $2,199,718. There is also a total of $12,219,704 not allocated to Medicaid.

Table 18. Summary of HIE to MES IAPD Proposed Budget

IAPD -- Summary of DDI Funding Request							
FFY	Total DDI Costs	Costs Allocated to Medicaid	90% Federal Share	10% State Share	Total Federal Share	State Share Total	Costs Not Allocated to Medicaid
FFY 25	$ 8,258,058	$ 4,999,247	$ 4,499,322	$ 499,925	$ 4,499,322	$ 499,925	$ 3,258,811
FFY 26	$ 8,433,199	$ 4,677,337	$ 4,209,603	$ 467,734	$ 4,209,603	$ 467,734	$ 3,755,862
Total	**$ 16,691,256**	**$ 9,676,584**	**$ 8,708,925**	**$ 967,658**	**$ 8,708,925**	**$ 967,658**	**$ 7,014,673**

Table 19. Summary of HIE to MES OAPD Proposed Budget

OAPD -- Summary of Operations Budget Request									
FFY	Total Operations Costs	Costs Allocated to Medicaid	75% Federal Share	25% State Share	50% Federal Share	50% State Share	Total Federal Share	State Share Total	Costs Not Allocated to Medicaid
FFY 25	$ 4,252,312	$ 1,743,448	$ 856,466	$ 285,489	$ 300,747	$ 300,747	$ 1,157,213	$ 586,235	$ 2,508,864
FFY 26	$ 4,569,774	$ 1,873,607	$ 872,939	$ 290,980	$ 354,844	$ 354,844	$ 1,227,783	$ 645,824	$ 2,696,167
Total	**$ 8,822,086**	**$ 3,617,055**	**$ 1,729,405**	**$ 576,468**	**$ 655,591**	**$ 655,591**	**$ 2,384,996**	**$ 1,232,059**	**$ 5,205,031**

Table 20. Total Proposed Budget

Combined IAPD and OAPD Funding Request					
FFY	Total Costs	Costs Allocated to Medicaid	Total Federal Share	State Share Total	Costs Not Allocated to Medicaid
FFY 25 IAPD	$ 8,258,058	$ 4,999,247	$ 4,499,322	$ 499,925	$ 3,258,811
FFY 25 OAPD	$ 4,252,312	$ 1,743,448	$ 1,157,213	$ 586,235	$ 2,508,864
FFY 26 IAPD	$ 8,433,199	$ 4,677,337	$ 4,209,603	$ 467,734	$ 3,755,862
FFY 26 OAPD	$ 4,569,774	$ 1,873,607	$ 1,227,783	$ 645,824	$ 2,696,167
Total	**$ 25,513,342**	**$ 13,293,639**	**$ 11,093,921**	**$ 2,199,718**	**$ 12,219,704**

Table 21. Proposed HIE Budget for FFY 25 and 26

Total Project Costs, Cost Allocation, and FFP

FFY 25 IAPD Total Project Costs, Cost Allocation, and FFP

FFY 25	Total Project Costs	Cost Allocation		Federal and State Participation			Portion Not Allocated to Medicaid
		Medicaid Percentage	Costs Allocated to Medicaid	FFP	Federal Share	State Share	
DSS Costs							
Enhanced	$ 2,030,026	100%	$ 2,030,026	90%	$ 1,827,023	$ 203,003	$ -
OHS Costs*							
Enhanced	$ 2,354,049	41%	$ 965,160	90%	$ 868,644	$ 96,516	$ 1,388,888.88
HIE Costs 100% Medicaid							
Enhanced	$ 704,623	100%	$ 704,623	90%	$ 634,161	$ 70,462	$ -
HIE Costs Enhanced Funding Allocated							
Enhanced	$ 3,169,360	41%	$ 1,299,438	90%	$ 1,169,494	$ 129,944	$ 1,869,922.40
Total Project Costs	$ 8,258,058		$ 4,999,247		$ 4,499,322	$ 499,925	$ 3,258,811.28

* Excluding HIE Costs which are shown separately

FFY 26 IAPD Total Project Costs, Cost Allocation, and FFP

FFY 26	Total Project Costs	Cost Allocation		Federal and State Participation			Portion Not Allocated to Medicaid
		Medicaid Percentage	Costs Allocated to Medicaid	FFP	Federal Share	State Share	
DSS Costs							
Enhanced	$ 2,067,331	100%	$ 2,067,331	90%	$ 1,860,598	$ 206,733	$ -
OHS Costs*							
Enhanced	$ 2,390,489	41%	$ 980,100	90%	$ 882,090	$ 98,010	$ 1,410,388.22
HIE Costs							
Enhanced	$ 3,975,379	41%	$ 1,629,905	90%	$ 1,466,915	$ 162,991	$ 2,345,473.61
Total Project Costs	$ 8,433,199		$ 4,677,337		$ 4,209,603	$ 467,734	$ 3,755,861.83

* Excluding HIE Costs which are shown separately

FFY 26 OAPD Total Project Costs, Cost Allocation, and FFP

FFY 26	Cost Allocation			Federal and State Participation			Portion Not Allocated to Medicaid
	Total Project Costs	Medicaid Percentage	Costs Allocated to Medicaid	FFP	Federal Share*	State Share	
DSS Costs							
Enhanced	$ -		$ -	75%	$ -	$ -	$ -
Administrative	$ -		$ -	50%	$ -	$ -	$ -
OHS Costs*							
Enhanced	$ -	41%	$ -	75%	$ -	$ -	$ -
Administrative	$ 266,335	41%	$ 109,197	50%	$ 54,599	$ 54,599	$ 157,137.81
HIE Costs							
Enhanced	$ 2,838,826	41%	$ 1,163,919	75%	$ 872,939	$ 290,980	$ 1,674,907
Administrative	$ 1,392,491	41%	$ 570,921	50%	$ 285,461	$ 285,461	$ 821,570
Total Project Costs	$ 4,497,652		$ 1,844,037		$ 1,212,998	$ 631,039	$ 2,653,615

** The Patient Portal UCS is expected to go live on 10-1-24 and is inlcuded at 50/50 FFP in the FFY25 budget until certified and enhanced funding is approved in a subsequent OAPD-

FFY 26 OAPD Total Project Costs, Cost Allocation, and FFP							
FFY 26	Cost Allocation			Federal and State Participation			Portion Not Allocated to Medicaid
	Total Project Costs	Medicaid Percentage	Costs Allocated to Medicaid	FFP	Federal Share*	State Share	
DSS Costs							
Enhanced	$ -		$ -	75%	$ -	$ -	$ -
Administrative	$ -		$ -	50%	$ -	$ -	$ -
OHS Costs*							
Enhanced	$ -	41%	$ -	75%	$ -	$ -	$ -
Administrative	$ 266,335	41%	$ 109,197	50%	$ 54,599	$ 54,599	$ 157,137.81
HIE Costs							
Enhanced	$ 2,838,826	41%	$ 1,163,919	75%	$ 872,939	$ 290,980	$ 1,674,907
Administrative	$ 1,464,613	41%	$ 600,491	50%	$ 300,246	$ 300,246	$ 864,122
Total Project Costs	$ 4,569,774		$ 1,873,607		$ 1,227,783	$ 645,824	$ 2,696,167

** The Patient Portal UCS is expected to go live on 10-1-24 and is inlcuded at 50/50 FFP in the FFY25 budget until certified and enhanced funding is approved in a subsequent OAPD-

The breakdown by quarters of the FFP follows in the Table 22, below.

Table 22. Federal Financial Participation by Quarter for FFY 25 and FFY 26

Quarter	To Be Reported on CMS-37
FFY 2025 Q1 (Oct24 – Dec24)	$1,414,134
FFY 2025 Q2 (Jan25 – Mar25)	$1,414,134
FFY 2025 Q3 (Apr25 – Jun25)	$1,414,134
FFY 2025 Q4 (July25 – Sep25)	$1,414,134
FFY 2026 Q1 (Oct25 – Dec25)	$1,359,347
FFY 2026 Q2 (Jan26 – Mar26)	$1,359,347
FFY 2026 Q3 (Apr26 – Jun26)	$1,359,347
FFY 2026 Q4 (July26 – Sep26)	$1,359,347

Section 9: Cost Allocation Plan for HIE Implementation Activities

Connecticut requests operational funding at 41% in this combined IAPD/OAPDU using the same recently approved cost allocation methodology updated with the 2023 Connecticut population.

Cost Allocation Methodology Approved Effective 1-1-22

DSS proposed a cost allocation methodology based on the anticipated percentage of HIE transactions attributable to the Connecticut Medicaid population. CMS approved this methodology on February 23, 2022. Due to a lag in receiving updated Medicare data, Connecticut proposes to retain the original approved cost allocation methodology but with updated population numbers which bring the cost allocation percentage to 41% as described below.

As a newly forming HIE, transactional data is not yet available. As a proxy for HIE utilization by payer, DSS evaluated the per capita number of medical transactions (paid medical claims) in Connecticut by insurance coverage in a two part methodology:

- Part 1 estimates the intensity of utilization by payer group using 2019 APCD data.
- Part 2 predicts future HIE utilization by applying the weighted utilization determined in Part 1 to the updated 2023 population.

Part 1: Medical Utilization Intensity by Payer Group (no change from approved CAM)

APCD Data. Data for medical transaction volume for calendar year (CY) 2019 was provided by OHS from the State's All Payer Claims Database (APCD). APCD data is available for Medicaid, Medicare, and Commercial payers which includes state employee and retiree data. Data for the uninsured and ERISA plan participants are not available in the APCD.

The following analysis was based on APCD medical enrollment and medical claims data for CY 2019. Pharmacy data was excluded due to a lag in the availability of Medicare data.

APCD data includes the number of "Unique Individuals" with medical coverage by payer (Column B) and the number of "Medical Member Months" (Column C) by payer. Because individuals may change insurance status within a year, DSS annualized medical members by dividing the number of Medical Member Months by 12 for each payer. See "Adjusted Medical Members" in Column D the table below.

APCD data also provided the "Number of Medical Transactions (Paid Medical Claims)" by payer (Column E). Dividing Column E by Column D yields the "Average Annual Medical Transactions Per Person" (Column F) for the available payers.

Table 23: APCD Data – Medical Transactions (Paid Medical Claims) by Payer

A	B	C	D	E	F
Payer	**Unique Individuals**	**Medical Member Months**	**Adjusted Medical Members (Member Months/12)**	**Number of Medical Transactions (Medical Claims Paid)**	**Average Annual Medical Transactions Per Person (Based on 12 Months of Coverage)**
Medicaid [1]	896,612	9,342,999	778,583	28,691,308	37
Medicare [2]	714,510	8,220,235	685,020	22,154,399	32
Commercial [3]	1,001,610	10,436,371	869,698	11,550,791	13
ERISA [4]					
Uninsured [5]					

Source: Connecticut's All Payer Claims Database

[1] Medicaid data includes dual eligibles.

[2] Medicare data includes all Medicare medical plans.

[3] Commercial includes data for individuals covered by health insurance companies as well as state employees and retirees.

[4] Data for individuals covered by ERISA plans are not available.

[5] Data for uninsured individuals are not available.

The data show that Medicaid members have the highest medical claims per year with an average of 37, followed closely by Medicare with an average of 32, and at a distance by Commercially insured with an average of 13 claims per year. These differences in per capita medical claims by payer suggest that HIE transactions will likely vary by payer as well and should be reflected in fair share determinations related to HIE costs.

Part 2: HIE Utilization Intensity by Payer Group

HIE Transactions by Payer. Using medical claims as a proxy for future HIE transactions requires a couple more steps. To predict HIE transactions by payer, DSS must:

1. Estimate data for the uninsured
2. Account for the proportion of the Connecticut population represented by each payer

Population Estimates updated for 2022.The number of Connecticut residents in each group in CY 2023 was estimated as follows:

1. DSS supplied the number of Medicaid beneficiaries and dual eligibles for CY 2023.
2. OHS supplied the number of Medicare beneficiaries for CY 2023 from a CMS website.
3. OHS supplied the number of Commercial and ERISA beneficiaries for CY 2023 from the OHS APCD.
4. The uninsured population was estimated by subtracting Medicaid, Medicare, Commercial, and ERISA covered lives from the total CY 2023 Connecticut population.

Per Capita Medical Claims Estimates. As shown in Table 23 below, per capita medical claims for the two missing groups were estimated using the following assumptions:

1. The number of ERISA per capita medical transactions (paid medical claims) will equal the Commercial average
2. The number of uninsured per capita medical transactions will be about half that of the Commercially insured

Weighted Averages. Because population size varies among the payers, DSS used a weighted average of per capita medical claims to estimate the volume of medical transactions by payer type. DSS determined the percentage of the 2023 Connecticut population using the known numbers and estimates discussed above and data for the total Connecticut population from the Census Bureau. The percentage of the population (Column C) for each coverage group was multiplied by the respective Medical Transactions Per Capita (Column D) to yield a weighted value for medical transactions per capita by payer (Column E).

The Weighted Medical Transactions Per Capita for each payer (Column E) was converted to a percentage by comparing each weight to the sum for all payers to derive an estimate of the Percentage of HIE Transactions (Column F) that would be attributable to each payer group.

Example. Future Medicaid utilization of the HIE was determined as follows:

1. 2023 CT Medicaid Population Percentage
   Purpose: Determine the portion of CT residents enrolled in Medicaid
   Calculation:
   a. Numerator: Medicaid enrollees from the APCD minus half of the dual eligibles (Column B Medicaid line)
   b. Denominator: Total CT Population from the Census Bureau (Column B Total line)
   c. Quotient: Percentage of CT Population (Column C)
   d. Equation: (919,049 / 3,617176) * 100 = 25.4%

2. Weighting Medical Transactions
   Purpose: Account for the number of people in each payer group and the different medical utilization rates of each group
   Calculation:
   a. Factor 1: Percentage of CT Medicaid Population (Column C) from the step above
   b. Factor 2: Medical Transactions Per Capita (Column D)
   c. Product: Weighted Medical Transactions Per Capita (Column E)
   d. Equation: 25.4% * 37 = 9.4

3. Estimated Share of HIE Transactions
   Purpose: Convert weighted medical transactions per capita to a percentage for use as a cost allocation percentage
   Calculation:

a. Numerator: Weighted Medical Transactions Per Capita (Column E Medicaid Line) from the step above
b. Denominator: Sum of Weighted Medical Transactions Per Capita (Column E Sum line) from the step above
c. Quotient: Estimated Percentage of HIE Transactions (Column F)
d. Equation: (9.4 / 22.77) * 100 = 41%

Revised Medicaid Cost Allocation Percentage

The foregoing analysis predicts that Medicaid medical members will account for 41% of HIE transactions. Consequently, DSS is proposing a Medicaid cost allocation percentage of 41% for HIE activities in FFY 25 and FFY 26. (See Table 23 below for details on cost allocation calculations.)

Note on Sustainability

The transition from HITECH to MES funding is occurring as Connie, the state designated entity for HIE, is beginning operations. A financial sustainability plan is being developed for Connie. However, for the next few fiscal years state funds are available to OHS to cover the state match as well as costs not allocated to Medicaid. A portion of the state's insurance fund is allotted to the OHS budget item relating to Connie and covers the state match and other costs not allocated to Medicaid.

Table 24: Cost Allocation Calculations

Using the Weighted Average of Medical Transactions Per Capita to Predict Future HIE Volume by Payer (*estimated*)

A			B	C	D	E	F
Payer	**Population**	**Duals Adjustment[2]**	**Revised Population**	**Percentage of 2023 CT Population**	**Medical Transactions Per Capita [9]**	**Weighted Medical Transactions Per Capita [10]**	**Estimated Percentage of HIE Tranactions [11]**
Medicaid[1]	960,800	(41,751)	919,049	25.4%	37 [6]	9.40	41%
Medicare	726,928	41,751	768,679	21.3%	32 [6]	6.80	30%
Commercial (non-ERISA)[3]	882,018		882,018	24.4%	13 [6]	3.17	14%
ERISA	859,337		859,337	23.8%	*13* [7]	3.09	14%
Uninsured [4]	*188,093*		*188,093*	*5.2%*	*6* [8]	0.31	1%
Total CT Population [5]	3,617,176		3,617,176	100%		22.77	1

Source: 2023 data from Connecticut's All Payer Claims Database unless otherwise noted

[1] DSS is the source for data on the Medicaid population and number of dual eligibles.

[2] Distributing duals between Medicaid and Medicare by subtracting half of duals (83,502/2 = 41,751) from Medicaid beneficiaries and adding half to the count of Medicare beneficiaries.

[3] Commercial beneficiaries include individuals covered by health insurance companies as well as state employees and retirees.

[4] Uninsured estimate is the remainder of the CT 2023 population after accounting for Medicaid, Medicare, Commercial, and ERISA beneficiaries.

[5] Source: Census QuickFacts v2023

[6] Source: APCD data - see table above.

[7] Estimate based on assumption that ERISA beneficiary utilization will be closer to commercially insured beneficiary utilization than Medicaid or Medicare beneficiary utilization.

[8] Estimate based on assumption that uninsured patient utilization will be approximately half of utilization by commercially insured beneficiaries.

[9] Medicaid Transactions (Paid Medicaid Claims) Per Capita, as described in the table above, is the volume of medical transactions per capita by bayer category.

[10] Weighted Medical Transactions Per Capita is the relative size of each patient group (Percentage of the 2023 CT Population) multiplied by Medical Transactions Per Capita for each patient group.

[11] The Estimated Percentage of HIE Transactions for each patient group is estimated by dividing each group's Weighted Medical Transactions Per Capita by the total Weighted Medical Transactions Per Capita.

Section 10: Assurances, Security, Interface Requirements, and Disaster Recovery Procedures

The table below indicates the Department of Social Services willingness to comply with the Code of Federal Regulation (CFR) and the State Medicaid Manual (SMM) Citations.

Table 25. Assurances

Standard	Yes	No	Explanation for any "No" responses.
Procurement Standards (Competition / Sole Source)			
42 CFR Part 495.348	X		
SMM Section 11267	X		
45 CFR Part 95.615	X		
45 CFR Part 92.36	X		
Access to Records, Reporting, and Agency Attestations			
42 CFR Part 495.350	X		
42 CFR Part 495.352	X		
42 CFR Part 495.346	X		
42 CFR Part 433.112(b)(5) – (9)	X		
45 CFR Part 95.615	X		
SMM Section 11267	X		
Software & Ownership Rights, Federal Licenses, Information Safeguarding, HIPAA Compliance, and Progress Reports			
42 CFR Part 495.360	X		
45 CFR Part 95.617	X		
42 CFR Part 431.300	X		
42 CFR Part 433.112	X		
Security and interface requirements to be employed for all State HIT systems.			
45 CFR 164 Securities and Privacy	X		

Appendix A: System Diagrams

Figure 2. CRISP System Diagram

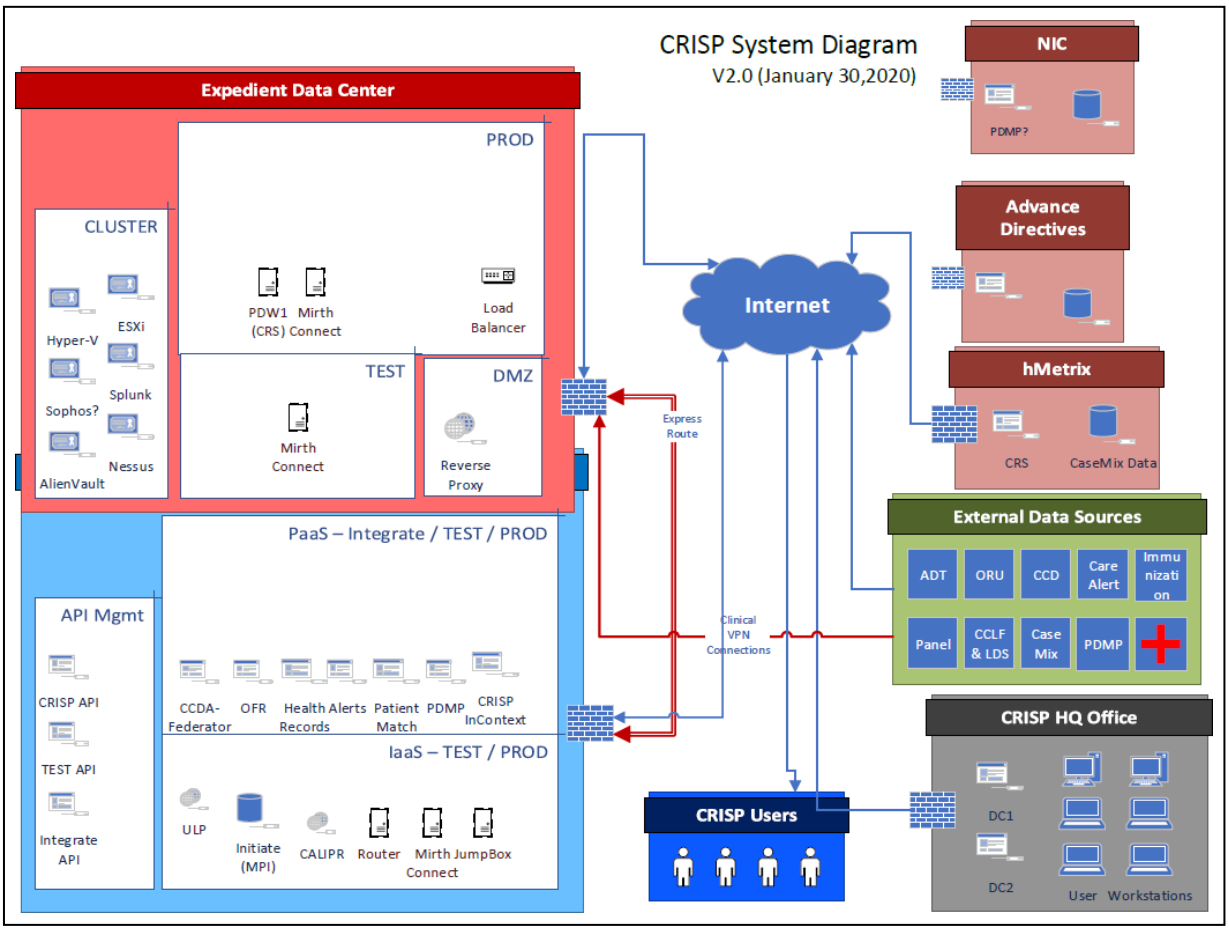


Figure 3. CRISP Shared Services System Diagram

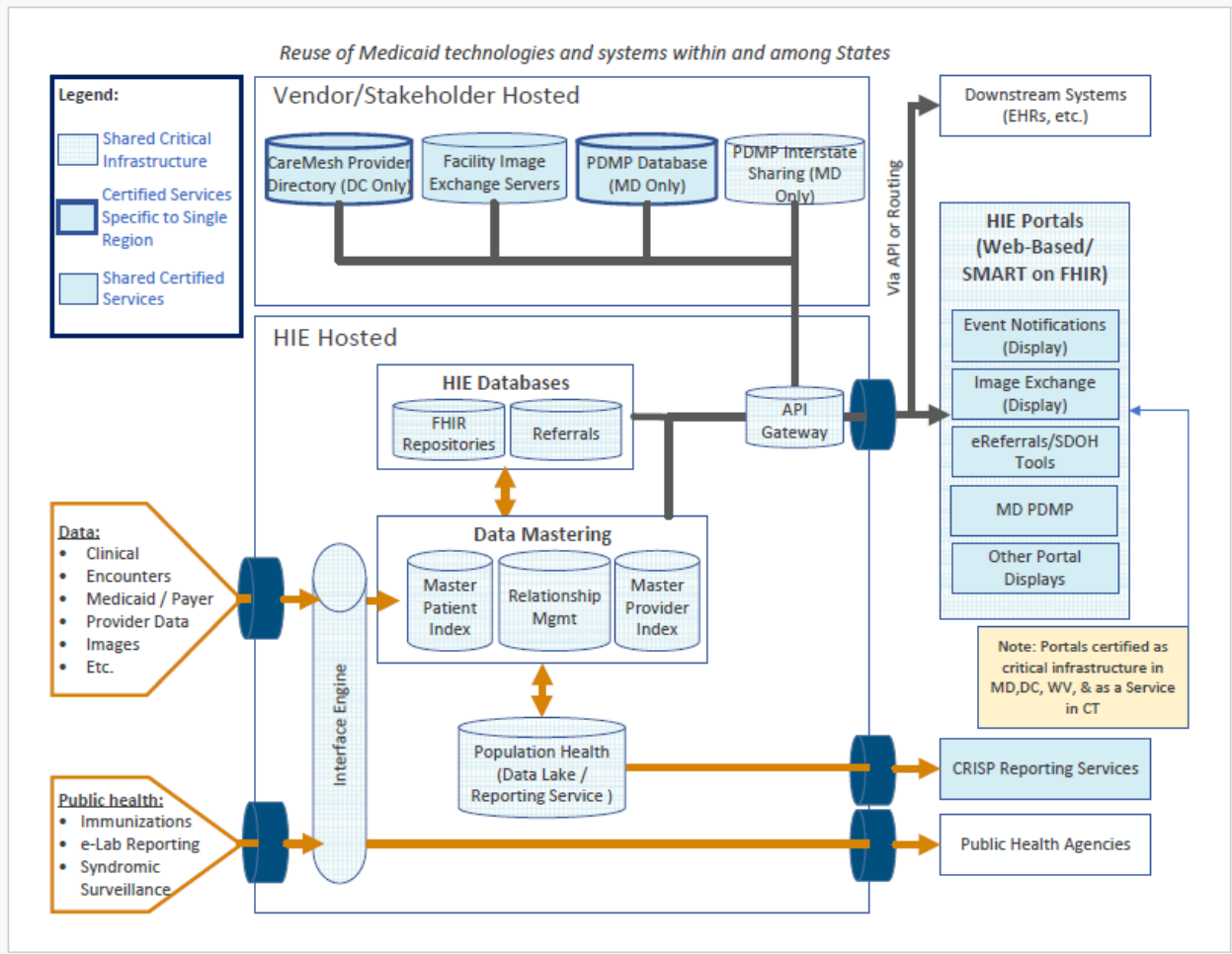


Figure 4. PMP Integration Workflow

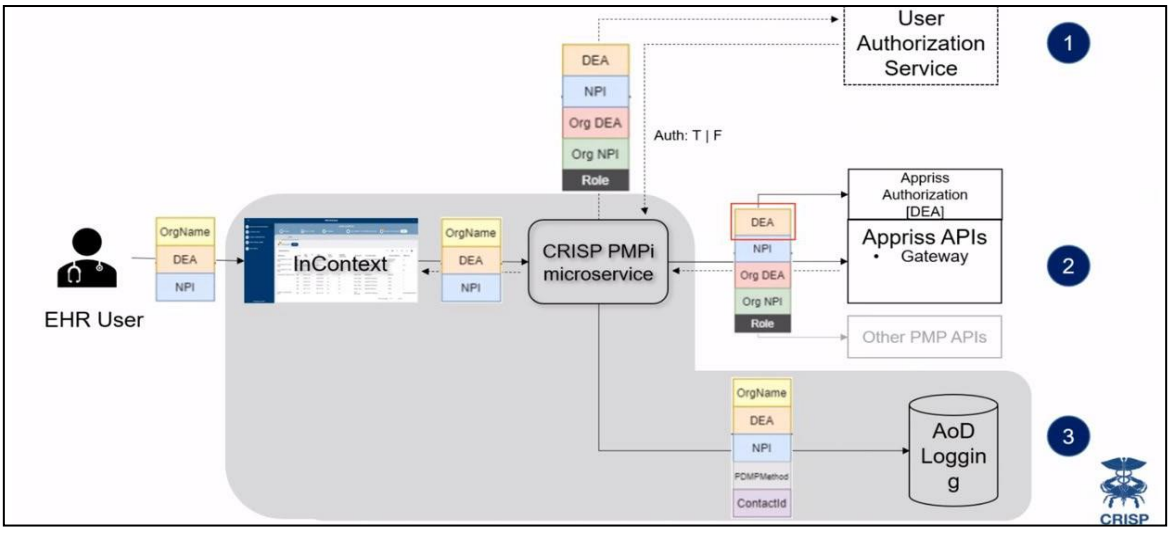
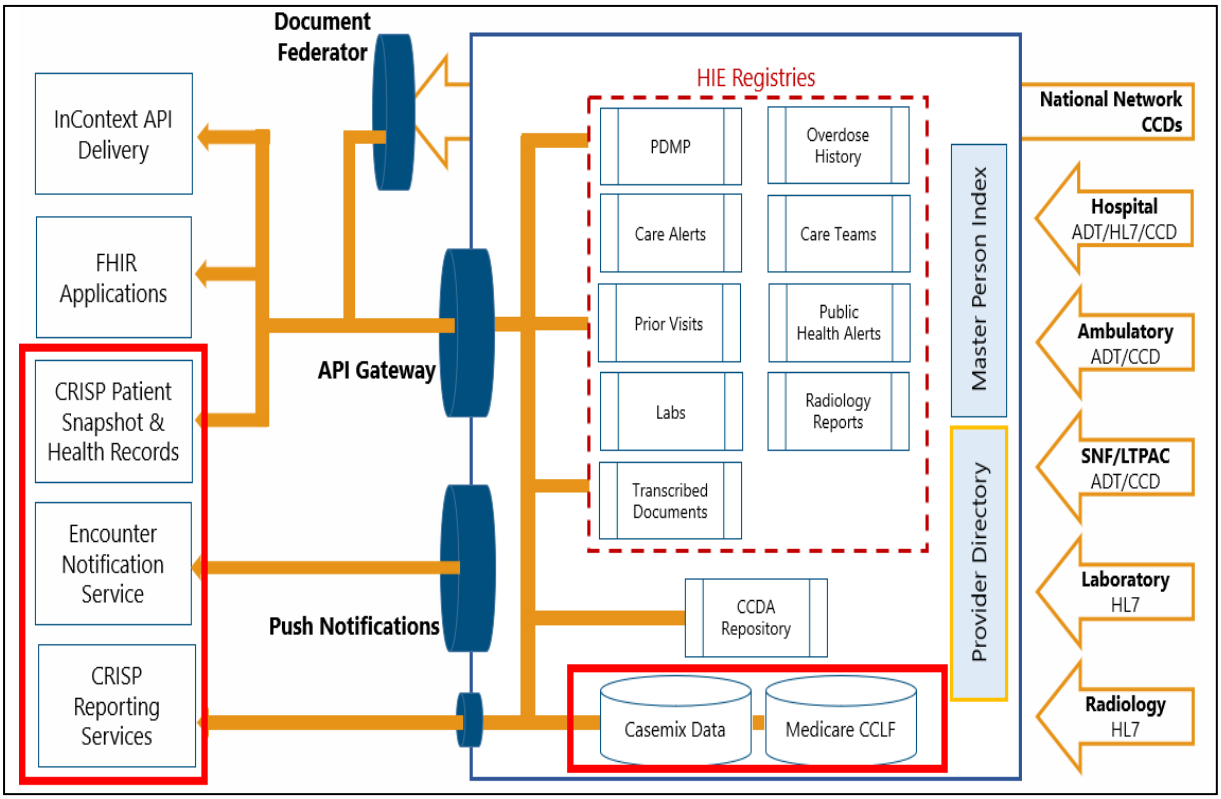


Figure 5. CRISP Data Flow



Appendix B: Standards and Conditions

Table 26. CT's MITA Standards and Conditions

Standard and Condition	Description of how CT Medicaid will meet these Standards and Conditions
1 - Modularity Standard	• Medicaid Provider Directory, Alerting, Direct Exchange, and the Business intelligence are being implemented as separate modules
2 - MITA Condition	• Connecticut strives to adhere to the Seven Conditions and Standards as outlined in MITA 3.0 There is ongoing emphasis on continuous movement toward maturity. • Wherever practicable MITA principles are deployed in terms of business, technical, and architectural standards.
3 - Industry Standards Condition	• Connecticut is aligning with industry standards with respect to development and testing of systems supporting Medicaid HIT initiatives. • Connecticut already uses Direct Secure Messaging, through a contractual agreement with the health information service provider. • Currently Connecticut's EHR Incentive program is engaged in: ○ Aligning to the MITA 3.0 principles by utilizing common industry standards whenever available. ○ Providing web-based access and integration. ○ Supporting MITA business process maturity to level 3 or 4.
4 - Leverage Condition	• As new systems are developed the State actively strives to assess components and solutions that have high applicability for reuse within the State and by other states. • Open-source, cloud-based, and commercial products will be utilized where practicable. • Customization will be avoided and minimized wherever possible. Medicaid Provider Directory, Alerting, Direct Exchange and the Business intelligence leverage existing assets and Commercial Off The Shelf products.
5 - Business Results Condition	• The State seeks to improve abilities for the analysis and reporting of enterprise information in a timely and accurate manner to providers, recipients, and the public. Medicaid Provider Directory, Alerting, Direct Exchange and the Business intelligence will benefit the Department's goal of better outcomes.

Standard and Condition	Description of how CT Medicaid will meet these Standards and Conditions
6 – Reporting Condition	• Connecticut strives to develop and maintain appropriate reports to contribute to program evaluation, continuous improvement in business operations, and transparency and accountability •
7 - Interoperability Condition	• Connecticut's approach will ensure seamless interoperability between systems, both existing and those to be developed, including any statewide HIT/E efforts. Connecticut will ensure interoperability by continuing to adhere to standards-based protocols and architectures for all projects outlined in this combined IAPD-U/OAPD-U.

Appendix C: Acronyms

Acronym	Description
ADT	Admissions, Discharges, Transfers
AIMS	APHL Informatics Messaging Services
APHL	Association of Public Health Laboratories
API	Application Programming Interface
ASO	Administrative Services Organization
CAM	Cost Allocation Methodology
CCD	Consolidated Clinical Document
CMS	Centers for Medicare and Medicaid Services
Connie	Connecticut's Health Information Exchange, assumed name of the HIE Entity, Health Information Alliance, Inc.
CPMRS	Connecticut Prescription Monitoring and Reporting System
CRISP	Chesapeake Regional Information System for our Patients, technology vendor for the CT statewide HIE
CT	Connecticut
DDI	Design, Development, Implementation
DME	Durable Medical Equipment
DSS	Department of Social Services
eCR	Electronic Case Reporting
EHR	Electronic Health Record
EPMO	Enterprise Project Management Office
FFY	Federal Fiscal Year
FHIR	Fast Healthcare Interoperability Resources
Health IT	Health Information Technology
HIA	Health Information Alliance, Inc., the statewide HIE Entity, which is using the assumed name "Connie"
HIE	Health Information Exchange
HIE Entity	Health Information Alliance, Inc., doing business as Connie
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HITAC or HIT Advisory Council	State Health Information Technology Advisory Council
HITECH	Health Information Technology for Economic and Clinical Health Act
HITO	Health Information Technology Officer
IAPD	Implementation Advance Planning Document
IAPD-U	Implementation Advance Planning Document Update
ICM	Intensive Care Management

Acronym	Description
IT	Information Technology
MDM	Medical Document Management
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information System
MOA	Memorandum of Agreement
N&O	Needs and Objectives
OAPD	Operations Advance Planning Document
OAPD-U	Operations Advance Planning Document - Update
OHS	Office of Health Strategy
ORU	Observation Result
PA	Physician's Assistant
PMP	Prescription Monitoring Program
PrMA eConsent	Provider Mediated Affirmative eConsent
QDSOA	Qualified Data Sharing Organization Agreement
RAI	Request for Additional Information
SMA	State Medicaid Agency