Extension Request

Demonstration Number: 11-W-00372/1 and 21-W-0069/1

Extension Request for the

“Connecticut Substance Use Disorder” Demonstration

to include all pending amendments

State of Connecticut

Pending Submission: March 31, 2026

Section 1115 Extension Request

Connecticut Application Certification Statement — Section 1115(a) Extension

This document, together with the supporting documentation outlined below, constitutes the State of Connecticut's (State's) application to the Centers for Medicare & Medicaid Services (CMS) to extend the "Connecticut Substance Use Disorder" Demonstration **11-W-00372/1 and 21-W-0069/1** to include all pending amendments for a period of five years pursuant to Section 1115(a) of the Social Security Act.

Type of Request (*select one only*):

_______Section 1115(a) extension with no program changes but with all pending amendments included

__X____Section 1115(a) extension with minor program changes

_______Section 1115(a) extension with major program changes

This constitutes the State's application to CMS to extend its Demonstration with a minor technical change. The State is requesting that CMS extend approval of the Demonstration subject to the same Special Terms and Conditions (STCs), waivers, and expenditure authorities currently in effect for the period of April 14, 2022, through March 31, 2027, with all pending amendments included with this extension request.

For the substance use disorder (SUD) portion of the Demonstration, the State is requesting that CMS extend approval of the SUD Demonstration subject to the same STCs, waivers, and expenditure authorities currently in effect for the period of April 14, 2022, through March 31, 2027, with one technical correction to the HUSKY A budget neutrality Without Waiver Limits. The State requests a minor technical correction to adjust the HUSKY A Medicaid Eligibility Group to align the Without Waiver limits with the actual case mix and fees observed in the HUSKY A experience consistent with the 2024 conversations with CMS staff.

The State is submitting the following items that are necessary to ensure that the Demonstration is operating in accordance with the objectives of Title XIX and/or Title XXI as originally approved. The State's application will be considered complete for purposes of initiating federal review and federal-level public notice when the State provides the information as requested in the below appendices.

- **Appendix A:** A historical narrative summary of the Demonstration project, which includes the objectives set forth at the time the Demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.
- **Appendix B:** Budget/allotment neutrality assessment and projections for the projected extension period. The State will present an analysis of budget/allotment neutrality for the current Demonstration approval period, including status of budget/allotment neutrality to date based on the most recent expenditure and member month data, and projections through the end of the current approval that incorporate the latest data. CMS will also review the State's Medicaid and State Children's Health Insurance Program Budget and Expenditure System expenditure reports to ensure that the Demonstration has not exceeded the federal expenditure limits established for the Demonstration. The State's actual

expenditures incurred over the period from initial approval through the current expiration date, together with the projected costs for the requested extension period, in compliance with CMS budget/allotment neutrality requirements outlined in the STCs.

- **Appendix C:** Interim evaluation of the overall impact of the Demonstration that includes evaluation activities and findings to date, in addition to plans for evaluation activities over the requested extension period. The interim evaluation should provide CMS with a clear analysis of the State's achievement in obtaining the outcomes expected as a direct effect of the Demonstration program. The State's interim evaluation must meet all of the requirements outlined in the STCs.
- **Appendix D:** Summaries of State quality review reports, State quality assurance monitoring and any other documentation of the quality of and access to care provided under the Demonstration. *Note: Connecticut does not have a managed care delivery system so external quality review and managed care quality reports are not available.*
- **Appendix E:** The State's Budget Neutrality Spreadsheets.
- **Appendix F:** Summary of the Pending 1115 Amendment.
- **Appendix G:** Documentation of the State's compliance with the public notice process set forth in 42 CFR 431.408 and 431.420 and the State's Demonstration contact.
  - Attachment 1. Connecticut Law Journal Notice
  - Attachment 2. Full Public Notice
  - Attachment 3. Abbreviated Public Notice
  - Attachment 4. Public Hearing Slides
  - Attachment 5. Public Notice Comments
  - Attachment 6. Tribal Consultation
  - Attachment 7. Tribal Consultation Comments

The State's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the State provides the information requested in Appendix A through Appendix G above, along with the Section 1115 Extension Template identifying the program changes being requested for the extension period. Please list all enclosures that accompany this document constituting the State's whole submission.

1. Section 1115 Extension Template
2. Renewal Appendices
3. Budget Neutrality Spreadsheets

The State attests that it has abided by all provisions of the approved STCs and will continuously operate the Demonstration in accordance with the requirements outlined in the STCs.

Signature: Andrea Barton Reeves, J.D. Commissioner Date: 12/05/2025

[Governor or Commissioner of DSS]

CMS will notify the State no later than 15 days of submitting its application of whether we determine the State's application meets the requirements for a streamlined federal review. The State will have an opportunity to modify its application submission if CMS determines it does not meet these requirements. If CMS reviews the State's submission and determines that any proposed changes significantly alter the original objectives and goals of the existing Demonstration as approved, CMS has the discretion to process this application full scope pursuant to regular statutory timeframes for an extension or as an application for a new Demonstration.

Renewal Appendices

Connecticut 1115 Demonstration Extension Appendix Documentation

The State of Connecticut (State or Connecticut) is proposing one minor technical change to the Substance Use Disorder (SUD) waiver authority.

The overall Hypothetical Budget Neutrality Agreement 1 under the Special Terms and Conditions (STCs) is budget neutral. However, in 2024, the Centers for Medicare & Medicaid Services (CMS) and Connecticut found that the HUSKY A Medicaid Eligibility Group (MEG) was exceeding the Without Waiver Costs. Because the State's STCs for its first waiver period did not include the updated Mid-Course Correction language, CMS requested that Connecticut wait until the renewal to update the HUSKY A MEG. Therefore, the State requests a minor technical correction to adjust the HUSKY A MEG to align the Without Waiver limits with the actual case mix and fees observed in the HUSKY A experience consistent with the 2024 conversations with CMS staff.

In addition, Connecticut is requesting that the following programs in the pending 1115 amendment be incorporated into the Demonstration extension:

- Reentry services for adults and youth transitioning from correctional facilities including social determinants of health supports for this population — submitted to CMS on March 27, 2024.

See Appendix F for a summary of the pending 1115 Amendment. Budget Neutrality projections for the complete extension (SUD and the reentry services) are included in this extension request.

No Authority Change Requested Except Minor Budget Neutral Technical Update

Through the SUD Demonstration, the State has maintained and expanded critical access to opioid use disorder (OUD) and other SUD services and continues to make delivery system improvements for these services to provide more coordinated and comprehensive SUD/OUD treatment for Medicaid beneficiaries. This Demonstration component will continue to provide the State with authority to provide high quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as an Institution for Mental Disease (IMD). The Demonstration will also build on the State's existing efforts to improve models of care focused on supporting individuals in the community and home, outside of institutions, and strengthen the continuum of all levels of care through SUD services based on the American Society of Addiction Medicine (ASAM) criteria and its nationally recognized assessment and placement tools that reflect evidence-based clinical treatment guidelines.

The State will continue to test whether the SUD Demonstration described in these STCs is likely to assist in promoting the objectives of Medicaid by achieving the following results:

1. Increased rates of identification, initiation, and engagement in treatment.
2. Increased adherence to and retention in treatment.
3. Reduced overdose deaths, particularly those due to opioids.

4. Reduced utilization of emergency department and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.
6. Improved access to care for physical health conditions among beneficiaries.

Programmatic Description of Waiver and Expenditure Authorities

Expenditure Authority Requested

The State requests a renewal of the expenditure authorities granted in the original Demonstration.

Title XIX Expenditure Authority:

1. **Residential and Inpatient Treatment Services for Individuals with Substance Use Disorder**. Expenditures for otherwise covered Medicaid services that are furnished to otherwise eligible individuals enrolled who are primarily receiving treatment and withdrawal management services for SUD as short-term residents in facilities that meet the definition of an IMD.

Title XXI Expenditure Authority:

1. **Residential and Inpatient Treatment for Individuals with Substance Use Disorder.** Expenditures for otherwise covered services that are furnished to otherwise eligible individuals of the Children's Health Insurance Program (CHIP) who are primarily receiving treatment and withdrawal management services for SUD as short-term residents in facilities that meet the definition of an IMD.

Under the authority of section 1115(a)(2) of the Act as incorporated into Title XXI by section 2107(e)(2)(A), State expenditures described below, shall, for the period of this Demonstration (April 1, 2027 through March 31, 2032) and based on the State's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the State's Title XXI plan. All requirements of Title XXI will be applicable to such expenditures for children who are residing in an IMD at the time of application or at the time of renewal and would be ineligible for coverage under CHIP pursuant to 2110(b)(2)(A).

Authorities requested for the pending amendment are summarized in Appendix F.

Appendix A

A historical narrative summary of the Demonstration project, which includes the objectives set forth at the time the Demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.

American Society of Addiction Medicine Implementation Update Including Demonstration Impact

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, requested a Demonstration Waiver pursuant to section 1115 of the Social Security Act from the 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 requested this Demonstration cover a complete array of American Society of Addiction Medicine (ASAM) levels of care (LOCs) as a component of an essential continuum of care for Medicaid-enrolled individuals with opioid addiction or other SUDs. Connecticut requested that the Demonstration be effective immediately upon approval to use Institutions for Mental Diseases (IMDs) as a Medicaid-covered setting.

The purpose of the Demonstration was to afford access to high quality, medically necessary treatment for opioid use disorder (OUD) and other SUDs. The State recognized the importance of a full continuum of treatment services, including residential services provided in a cost-effective manner and for a length of stay (LOS) governed by appropriate clinical guidelines. This Demonstration has proven critical to continue the federal funding needed to support the continuation of medically necessary services and SUD treatment in residential facilities that meet the definition of IMDs.

The State of Connecticut has been working for many years to address the growing prevalence of SUD among its residents. Prior to the Demonstration, Connecticut Medicaid members had access to early intervention, outpatient treatment, and recovery services. The introduction of coverage for services in, residential, and inpatient settings made the full continuum of SUD treatment services available to those covered by Medicaid in Connecticut. The Demonstration authorized the State to draw down a federal match on dollars spent on inpatient and residential SUD treatment services in IMDs. This Demonstration has been an essential step in assisting Connecticut residents in receiving treatment for SUDs and improving health outcomes, promoting long-term recovery, and reducing overdose deaths in Connecticut.

The State has utilized the Demonstration authority to align its SUD service array with the ASAM, third edition criteria. The State of Connecticut has made progress on implementation of the SUD component of the 1115 Demonstration waiver. The State continues to implement ASAM alignment as reported in its quarterly and annual reports to CMS.

History of the Demonstration

Introduction

This Demonstration built upon an extensive, existing array of Connecticut Medicaid covered behavioral health (BH) services, including evidence-based services, and improved upon and enhanced services that were previously funded only by non-Medicaid sources, including State funding and other federal funding.

Connecticut Medicaid covered all ambulatory ASAM LOCs 0.5 through 2.5, as well as medication-assisted treatment (MAT) and inpatient withdrawal management (ASAM level 4-WM) prior to the Demonstration. After the Demonstration's approval, Connecticut submitted a Medicaid State Plan Amendment (SPA) in conjunction with the 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, and 4). The Demonstration permitted 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.

The Demonstration also permitted 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 addressed the Demonstration goals, including improving health care outcomes for individuals with SUD (reducing hospital emergency department use and inpatient admissions, reducing hospital readmissions, and improving the rates of initiation, engagement, and retention in treatment).

Medicaid SUD Coverage Prior to the Demonstration

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

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,[1] and continued to climb. In calendar years 2019 and 2020, fatal drug overdose deaths in Connecticut rose 16.7% and 14.3% respectively from the previous year. The majority (82%) of overdose deaths in 2019 were related to fentanyl or fentanyl analogs.[2] The Demonstration was needed to address critical unmet needs for residential SUD treatment that continued to exist despite significant improvements to the publicly-funded treatment delivery system outside of Medicaid. Under the Department of Mental Health and Addiction Services (DMHAS) and Department of Children and Families (DCF), State-only funds and federal Substance Abuse and Mental Health Services

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[1] Centers for Disease Control and Prevention, National Center for Health Statistics (2020). Underlying Cause of Death 1999-2018 on CDC WONDER Online Database. 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.
[2] Connecticut Office of the Chief Medical Examiner, per CDC-SUDORS grant guidelines (April 19, 2021) as published in the CT Department of Public Health Drug Overdose Monthly Report, March 2021.

Administration block grant funds were used to support residential services for the uninsured and for individuals enrolled in Medicaid.

Prior to this Demonstration, Connecticut Medicaid had not adopted a complete array of SUD treatment services using a national placement criteria system (e.g., ASAM) or national provider standards. Most importantly, for some Medicaid covered individuals in need of SUD treatment, there were limited options for residential community-based SUD treatment services.

Residential SUD Treatment in Connecticut Prior to the Demonstration

In 2006, DCF, which oversees BH for children in the State and DSS, in conjunction with a legislatively mandated oversight council, formed the Connecticut Behavioral Health Partnership (CT BHP), authorized pursuant to State statute (section 17a–22h of the Connecticut General Statutes), with ValueOptions (Carelon)[3] serving as the Administrative Services Organization (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 youths, 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

[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. On March 1, 2023, Beacon changed its name to Carelon Behavioral Health (Carelon) as part of a broader rebranding effort by Elevance Health. This report will refer to this entity as Beacon.

ValueOptions clinical care managers in the CHNCT office and leveraged McKesson technology to identify the most at-risk members to ultimately impact health outcomes.

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

The HUSKY D benefits under the ABP are aligned with the underlying Medicaid State Plan benefits. Although Connecticut Medicaid did not reimburse for residential SUD services prior to the Demonstration, there was 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 available prior to the Demonstration.

Table A.1. HUSKY D SUD Residential Benefits in State Fiscal Year 2019 (SFY 2019) Prior to the Demonstration

ASAM LOC	Admissions	Total Days	Average LOS in Days
ASAM 3.1 Residential halfway house	350	25,081	71.7
ASAM 3.3 Long-term care	111	17,963	161.8
ASAM 3.5 Intermediate residential treatment	1,187	57,056	67.8
ASAM 3.5 Pregnant and parenting women	59	3,846	79.4
ASAM 3.7RE Enhanced co-occurring	624	12,095	29.1
ASAM 3.7 Intensive residential treatment	2,180	29,618	22.4
ASAM 3.7R State-operated facilities	773	24,284	30.5
ASAM 4.2D Medically-managed withdrawal management at Natchaug Hospital	16	89	5.0
Observation/Flex bed	8	8	1.0

Source: State Fiscal Year 2019 Behavioral Health Recovery Program Annual Report

Upon approval of the Demonstration, the CT BHP was composed of DSS, DMHAS, and DCF. CT BHP contracted with Beacon Health Options, the BH ASO, to authorize and coordinate Medicaid BH services (MH and SUD services) for HUSKY Health members in Connecticut. Covered benefits and services were administered by the CT BHP to members enrolled in HUSKY A, HUSKY B, HUSKY C, and HUSKY D. (Separate from its HUSKY Health/Medicaid responsibilities, the BH ASO also provides administrative support to a small set of services for the non-Medicaid DCF limited benefit group.)

Demonstration Implementation

Under the Demonstration and its corresponding Medicaid SPA, Connecticut expanded 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 Demonstration benefit service package included residential SUD services included under the Medicaid State Plan with an effective date of June 1, 2022. This comprehensive restructuring of the SUD benefit package and the transition to Medicaid reimbursement of residential and

inpatient IMD services ensured access to a comprehensive, coordinated system of SUD care for children and adults in Medicaid.

The Demonstration modernized the SUD treatment benefit to align with the most current edition of ASAM criteria for outpatient and residential treatment. Providers were trained using ASAM criteria (third edition) to provide multi-dimensional assessments that informed placement and individualized treatment plans, increased the use of community-based and non-hospital residential programs, and assured that inpatient hospitalizations were utilized appropriately for situations in which there is a need for safety, stabilization, or acute withdrawal management (ASAM LOC 4).

Connecticut operates under a FFS delivery system. The State began contracting with a BH ASO in 2006 to better manage the continuum of BH services. The existing, well-coalesced tri-agency Medicaid BH oversight structure uses a behavioral health ASO and BH plan of care. In keeping with the goal of modernization, DSS, in collaboration with its sister State agencies, DMHAS and DCF, implemented a comprehensive SUD benefit package of services provided by a Statewide network of SUD treatment service providers financed by Medicaid for Medicaid beneficiaries. DSS implemented the Medicaid SUD inpatient and residential services in April 2022 and June 2022, respectively.

Specific Interventions Under the Demonstration

Since the beginning of the Demonstration, Connecticut has operationalized the implementation plan approved by CMS for the SUD Demonstration. In addition to the Medicaid State Plan submitted to and approved by CMS for all ASAM LOCs, Connecticut Medicaid added Residential ASAM levels: 3.1 (Clinically Managed Low-Intensity Residential Services), 3.3 (Clinically Managed Population-Specific High-Intensity Residential Services), 3.5 (Clinically` Managed High-Intensity Residential Services) for adults, 3.5 (Clinically Managed Medium-Intensity Residential) for adolescents, 3.7 (Medically Monitored Intensive Inpatient Services), 3.7 Enhanced (Medically Monitored Intensive Inpatient Services for Co-Occurring Enhanced Treatment), and 3.7-WM (Medically Managed Inpatient Withdrawal Management) as Medicaid covered services. *Note: there are currently no providers in Connecticut that provide ASAM 3.2-WM despite it being covered in the Medicaid State Plan.*

Since the inception of the Demonstration, the Demonstration has served nearly 18,500 unique Medicaid individuals in these residential LOCs.

Table A.2: Number Served under the Demonstration DY1–DY4

	HUSKY A	HUSKY C	HUSKY D
Member Months	**6,373**	**2,671**	**55,485**
Unique Clients	**2,320**	**855**	**15,314**

Connecticut has implemented the activities necessary to ensure access to the critical LOCs for OUD and other SUDs. These activities included submitting and receiving approval for the SPA necessary to implement all required LOCs; developing and implementing an ASAM rate methodology that reflects the continuum of additional and modified services; executing contract amendments with State contractors to review providers and provide utilization management that includes new and updated service definitions and requirements; and billing system changes to allow for claim submission of new services (residential and inpatient). More details about each of these activities is noted in Table A.3 below.

Table A.3. Milestone 1 Activities under the Demonstration

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
Milestone 1	**Access to Critical Levels of Care for OUD and Other SUDs** Connecticut will improve access to OUD and SUD treatment services for Medicaid beneficiaries by offering a range of services at varying levels of intensity across a continuum of care because each type of treatment or level of care may be more or less effective depending on each beneficiary's individual clinical needs. To meet this milestone, Connecticut will provide coverage of the following services: • Outpatient services; • Intensive outpatient services; • MAT (medications, as well as counseling and other services, with sufficient provider capacity to meet the needs of the Medicaid beneficiaries in the State); • Intensive levels of care in residential and inpatient settings; and • Medically supervised withdrawal management. This milestone will be met within 12 to 24 months of Demonstration approval.	
Coverage of outpatient services	DSS will submit a SPA in the rehabilitative services benefit category to update the State's standards to be consistent with the latest edition of ASAM no later than 12 months following CMS approval of the Demonstration (by April 1, 2023).	**Complete** The State received approval effective July 1, 2022, for its SPA for rehabilitative services, which updates provider qualifications to be consistent with ASAM requirements. **SPAs:** The following approved SPAs have impact to or are related to the work under the Demonstration. • **SPA 22-0020** — This SPA establishes coverage and reimbursement for SUD services provided in outpatient and residential settings within the rehabilitative services benefit category. For applicable levels of care, this SPA implements and is consistent with the State's approved SUD Demonstration. • **SPA 22-0021** — This SPA updates the ABP to add coverage for SUD services under the rehabilitative services benefit category for services provided in outpatient and residential settings. On July 1, 2025, Connecticut began reimbursing all negative and positive SUD screenings by adding two new Screening, Brief Intervention & Referral to Treatment (SBIRT) billing codes to incent providers to conduct screenings and to report all

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
		screenings conducted via administrative data. This change is intended to improve early intervention rates under the Demonstration.
Coverage of intensive outpatient services	DSS will submit a Rehabilitative SPA to update the State's standards to be consistent with the latest edition of ASAM no later than 12 months following CMS approval of the Demonstration (by April 1, 2023).	Complete. See above.
Coverage of MAT (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the State)	DSS will submit a SPA in the rehabilitative services benefit category (*Rehabilitative SPA*) to update the State's MAT standards for Non-OUD, as well as for services provided after the end-date of the 1905(a)(29) OUD MAT SPA to be consistent with the latest edition of ASAM no later than 12 months following CMS approval of the Demonstration (by April 1, 2023).	Complete. See above.
Coverage of intensive levels of care in residential and inpatient settings	DSS will submit a Rehabilitative SPA to update the State's residential standards to be consistent with the latest edition of ASAM and to include coverage of residential SUD treatment no later than 12 months following CMS approval of the Demonstration (by April 1, 2023).	Complete. See above.
Coverage of medically supervised withdrawal management	DSS will submit a Rehabilitative SPA to update the State's standards to be consistent with the latest edition of ASAM and to include coverage of Medically supervised withdrawal management in a non-hospital setting no later than 12 months following CMS approval of the Demonstration (by April 1, 2023).	Complete. See above.

Under the extension, Connecticut intends to increase care coordination to: (1) ensure continued engagement and strengthen transitions of levels of care; (2) adopt the ASAM fourth edition in 2027; and (3) educate and train providers on new Medicaid coding and reimbursement to improve SBIRT rates. See table below.

Table A.4. Milestone 1: Intended Actions in the Demonstration Extension Below

Action	Summary of Intended Actions in Demonstration Extension
Milestone 1: Increase care coordination and adopt ASAM fourth edition.	Under the extension, Connecticut intends to increase care coordination to ensure continued engagement and strengthen transitions of levels of care and to adopt ASAM fourth edition in 2027.
Milestone 1: Training on new Medicaid coding and reimbursement to improve Early Intervention SBIRT rates.	Connecticut intends to educate and train providers on new Medicaid coding and reimbursement to improve SBIRT rates.

Connecticut has implemented the activities necessary to use the ASAM evidence-based, SUD-specific patient placement criteria. These activities included updating the DMHAS and DCF provider certification standards; updating the Advanced Behavioral Health (ABH) certification and Carelon Behavioral Health ASO contracts to include new services and Utilization Management (UM) of services to update SUD rules to align wherever possible; implementing training and technical assistance to align providers with ASAM standards; requiring Carelon to develop UM policies and procedures; reviewing Carelon UM policies and procedures and providing feedback to Carelon; implementing the UM process for residential placements; monitoring of benefits; and communicating changes to providers. More details about each of these activities is noted in Table A.5 below.

Table A.5. Milestone 2 Activities under the Demonstration

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
Milestone 2	**Use of Evidence-Based, SUD-Specific Patient Placement Criteria** Under this milestone, Connecticut will implement the latest edition of ASAM, which is evidence-based, SUD-specific patient placement criteria. To meet this milestone, Connecticut will ensure that: • Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, linked to the ASAM criteria. • Utilization management approaches are implemented to ensure that: – beneficiaries have access to SUD services at the appropriate level of care. – interventions are appropriate for the diagnosis and level of care; and – there is an independent process for reviewing placement in residential treatment settings. This milestone will be met within 12 to 24 months of Demonstration approval.	
Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional	DMHAS/DCF have statutory authority for SUD service provision. These agencies, or their designated contractor(s), will ensure that **providers receive training necessary** to implement the provider training portion of the Demonstration on behalf of DSS	On-going: Connecticut continues to provide training on all aspects of the Demonstration including making available ASAM training to providers continuously. Training for the implementation of the fourth edition of ASAM is expected to begin in fall 2025 and spring 2026. The State, Carelon, and ABH continue to provide technical support to providers for UM,

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
assessment tools that reflect evidence-based clinical treatment guidelines	and the Medicaid program within 12 months of approval by April 1, 2023. Training would include utilization of State-approved provider assessment tools using, and/or cross-walked to the six dimensions of ASAM criteria, for treatment planning and implementation of most recent ASAM edition patient placement criteria and program standards.	certification, and clinical ASAM training. The State conducted ASAM training for all providers related to the new program standards. All providers received reference materials on the ASAM placement criteria as part of the certification process. ABH facilitated ASAM training for SUD providers Statewide. ABH coordinates access to online trainings from The Change Companies on request from provider staff. The Change Companies' trainings consist of on-demand computer modules that staff complete at their own pace. Quizzes embedded in the training modules document learning comprehension as well as training completion for earned Continuing Education Units. Training in three subject areas was offered and required at the start of the Demonstration: Motivational Interviewing; Understanding the Stages of Change; and The ASAM Criteria. DSS, DCF, DMHAS, and ABH offer in-person training led by a trainer from Train for Change for participating provider staff. This two-day, application-focused training reviews the theoretical foundations of ASAM criteria, including individualized clinically-driven services, bio-psychosocial assessments, the six dimensions and transfer/discharge criteria. Participants practice application of criteria using case studies. A total of 17 n-person training events have been conducted from December 14, 2022 through July 1, 2025. **Complete** The State received approval effective July 1, 2022 for its SPA. See above.
	The Medicaid SPA (submitted by April 1, 2023) and related **Medicaid provider manuals** (completed by April 1, 2024) will establish the ASAM as requirements for providers to assess treatment needs and develop recommendations for placement in appropriate levels of care with the effective date of the Rehabilitative SPA compliant with the most recent edition of ASAM.	**Complete** Provider resources including ASAM Standards by Level of Care including provider bulletins can be found at: SubstanceUseDisorder Demonstration Project-Provider Resources https://portal.ct.gov/dss/health-and-home-care/substance-use-disorder-Demonstration-project/provider-resources?language=en_US Carelon Resources: CT specific manuals can be found at: Providers |

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
		CTBHP Providers https://www.ctbhp.com/ctbhp/en/home https://providers.ctbhp.com/providers/ Substance Use Disorder (SUD) Treatment Resources under the 1115 Demonstration Waiver | CTBHP Providers https://providers.ctbhp.com/substance-use-disorder-treatment-resources-1115/ **Complete: Provider Bulletins** DSS has issued the following guidance related to the Demonstration. Provider bulletins can also be found on the https://ctdssmap.com webpage. • PB 2022-21 — Implementation of Medicaid Reimbursement for SUD Inpatient Treatment at State Operated and Private Psychiatric Hospitals Pursuant to Section 1115 Demonstration Waiver for Services Previously Excluded from Coverage by Federal Law. • PB 2022-39 — Implementation of Medicaid and CHIP Reimbursement for SUD Treatment at Free-Standing Residential Treatment Facilities. • PB 2022-86 — Reimbursement for Intermediate SUD Treatment at Behavioral Health Clinics, Enhanced Care Clinics, and Outpatient Drug and Alcohol Abuse Centers. • PB 2022-91 — Ambulatory Withdrawal Management Billing Guidelines. • PB 2023-01 — Billing Clarification for Intermediate SUD Treatment at Behavioral Health Clinics, Enhanced Care Clinics, and Outpatient Drug and Alcohol Abuse. • PB 2023-09 — Reimbursement for Intermediate SUD Treatment at Outpatient Hospitals. • PB 2023-50 -- Reimbursement for Intermediate Substance Use Disorder (SUD) Treatment at Behavioral Health FQHCs • PB 2023-51 — Clinical Treatment Hours for SUD Intensive Outpatient Programs (IOPs) and Partial Hospitalization Programs (PHPs). • PB 2023-58 -- Addition of Screening, Brief Intervention, and Referral to Treatment

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
		(SBIRT) Codes to the Medical Clinic and Rehabilitation Clinic Fee Schedules • PB 2024-09 — POS 55 Requirements for SUD Residential Treatment Facilities. • PB 2025-53 -- New Coding and Reimbursement for Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services The State's ASO, Carelon, offers peer-or-peer reviews as needed throughout its UM process and meets with providers upon request if an authorization request is denied clarifying the rationale for the denial and offering technical assistance (TA) with the authorization documentation process.
Implementation of a utilization management approach such that (a) **beneficiaries have access to SUD services at the appropriate level of care**	DMHAS/DCF have statutory authority for SUD service provision. These agencies or their designated contractor(s), will work with providers to ensure **access for the Demonstration** on behalf of DSS and the Medicaid program within 12 months of Demonstration approval (by April 1, 2023). The DSS BH ASO will **provide a website with a provider search function for Medicaid beneficiaries** and providers at all LOCs (by April 2023).	**Complete** Each of the following levels of care were phased into the Demonstration. • Hospital Inpatient • Residential. • Behavioral Health Clinics, Enhanced Care Clinics, and Outpatient Drug and Alcohol Abuse Centers. • Hospital Outpatient. • Federally Qualified Health Centers. • Opioid Treatment Programs. **Complete** www.ctaddictionservices.com — The DMHAS residential bed registry is complete and up-to-date on a daily basis for all ASAM LOC. FindProvider(ctbhp.com) www.Ctbhp.com/ctbhp/en/home/find-providers has a search function for Alcohol/Chemical Dependency, Addictions non-chemical, ASAM certified addictionologist, chemical dependency assessment and referral, co-occurring disorders, gambling. This search function has been updated. https://public.tableau.com/app/profile/carelonbhct/viz/CTBHPMedicaidMATProviderMap/TreatmentProviders The public tableau includes a map and a printable table of BH and medical listings: • BH Enhanced Care Clinics.

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
	DSS will **direct the Medicaid BH ASO to use the most recent ASAM edition** for utilization review and to update the website, provider information and internal documentation (by April 1, 2023).	• Medications for SUD Provider Locator Map including clinics, IOP, PHP, IOP and PHP with housing, outpatient, and mobile vans. • Residential providers by all ASAM LOCs. • Medical Medicaid providers offering SUD medications. *Note: Carelon is for all LOCs.* The State's ASO, Carelon, utilizes ASAM third edition when assessing medical necessity for admission to all SUD levels of care. Carelon produces a monthly report for residential levels of care that highlights the percentage of initial and concurrent authorization requests. *Note: as of July 2, 2025, all Carelon websites are updated to the third edition of ASAM.* DSS will continue to monitor and review monthly, metrics related to authorizations, placement decisions, and care transitions with State partner agencies to identify training and technical assistance needs.
Implementation of a utilization management approach such that (b) **interventions are appropriate for the diagnosis and level of care**	DMHAS/DCF have statutory authority for SUD service provision. These agencies, or their designated contractor(s), will work with providers to **develop the program standards consistent with ASAM** for the Demonstration on behalf of DSS and the Medicaid program within 12 months of Demonstration approval (by April 1, 2023). DMHAS/DCF have statutory authority for SUD service	**Complete: Program Standards** Provider resources including ASAM standards by LOC including provider bulletins can be found at: Section1115DemonstrationWaiver for SubstanceUseDisorder(SUD)Treatment--ProviderResources https://portal.ct.gov/dss/health-and-home-care/substance-use-disorder-Demonstration-project/provider-resources Carelon resources: CT specific manuals can be found at: Providers|CTBHPProviders https://www.ctbhp.com/ctbhp/en/home https://providers.ctbhp.com/providers/ SubstanceUseDisorder(SUD)Treatment Resourcesunderthe1115Demonstration Waiver|CTBHPProviders https://providers.ctbhp.com/substance-use-disorder-treatment-resources-1115/ ASAM third edition criteria is currently being utilized by the State's ASO to assess medical

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
	provision. These agencies, or their designated contractor(s), will ensure that **providers are monitored and certified to provide the ASAM LOC** for which the provider is enrolled in the Medicaid program within 24 months of Demonstration approval (by April 1, 2024). With the effective date of the new SPA, **DSS Provider enrollment standards will require certification by DMHAS/DCF (or their designated contractor(s)) with an agreement also from DSS (or its designated contractor)** to provide the ASAM LOC for which they are enrolled by April 1, 2023. **Provisional certification for no more than 24 months** will be granted to providers if they meet milestones for implementing the new requirements under the Demonstration by October 1,	necessity for admission to all SUD levels of care. Continued monitoring for compliance with this criteria will be on-going. At the end of the two-year provisional certification period, 13 Outpatient Hospital ambulatory programs and 132 adult programs and 22 adolescent programs ambulatory programs met full certification under the Demonstration. Additional TA and site monitoring is planned for three of those programs in need of additional support. Each of the certified levels of care were phased into the Demonstration, undergoing a two-year provisional certification period to adopt the ASAM Criteria and State standards. Multiple monitoring visits occurred to ensure programs' continual progress towards achieving full certification. As of 9/19/2025, nearly 200 programs across levels of care are certified to provide SUD services. The ABH monitoring team provided training and assistance where needed, for providers to meet full certification. Survey reports were prepared and distributed to each provider program, following completion of the survey. **Complete** Provider enrollment standards are in the provider bulletins listed above. Provider certification thresholds are at the following website: https://portal.ct.gov/dss/health-and-home-care/substance-use-disorder-Demonstration-project/provider-resources?language=en_US and include the following documents: • Residential Certification Scoring and Milestone Guide. • Residential Monitoring Thresholds. • Provisional Certification Guidance for NEW Residential Programs. • Ambulatory Certification Scoring and Milestone Guide. • Ambulatory Provisional Certification Thresholds. DSS convened a workgroup with the ASO in July 2025 to:

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
	2023.	• Review and enhance the documentation for medical necessity to ensure the guidance and process are clear. • Establish a process for supporting providers through TA and/or training.
Implementation of a utilization management approach such that (c) **there is an independent process for reviewing placement in residential treatment setting**	DSS will **direct the Medicaid BH ASO to use the most recent ASAM edition for utilization review, prior authorization, and to update the website, provider information and internal documentation** within 24 months of Demonstration approval by April 1, 2024.	**Complete** Carelon's website has been updated to only reference third edition ASAM requirements. The State's ASO, Carelon began conducting an independent review process in July of 2022. Carelon resources: CT specific manuals can be found at: Providers|CTBHPProviders https://www.ctbhp.com/ctbhp/en/home https://providers.ctbhp.com/providers/ SubstanceUseDisorder(SUD)Treatment Resourcesunderthe1115Demonstration Waiver|CTBHPProviders https://providers.ctbhp.com/substance-use-disorder-treatment-resources-1115/ The State's ASO, Carelon, utilizes ASAM third edition when assessing medical necessity for admission to all SUD levels of care. Carelon produces a monthly report for residential levels of care that highlight the percentage of initial and concurrent authorization requests.

Under the extension, Connecticut intends to continue the training and to align providers with ASAM standards, including website maintenance, updates, provider forums, newsletters and the planned transition to the ASAM 4th Edition. Connecticut also intends to continue communication with providers, which are on-going activities as new providers and/or new staff at existing provider sites are identified. Connecticut intends to modify Medicaid coding and reimbursement to improve SBIRT rates.

Table A.6. Milestone 2: Intended Actions in the Demonstration Extension

Action	Summary of Intended Actions in Demonstration Extension
Milestone 2: Continue provider ASAM training and technical assistance.	Connecticut intends to continue the training and technical assistance to align providers with ASAM standards, as ongoing activities as new providers and/or new staff at existing providers are identified.

Action	Summary of Intended Actions in Demonstration Extension
Milestone 2: Continue provider communication.	Connecticut intends to continue communication with providers, as an on-going activity including website maintenance, updates, provider forums, and newsletters.
Milestone 2: Monitor and review authorization, placement decisions, and care transitions to identify and offer utilization management technical assistance.	DSS will continue to monitor and review monthly metrics related to authorizations, placement decisions, and care transitions with State partner agencies to identify training and technical assistance needs.
Milestone 2: Review and enhance documentation for medical necessity and establish a new provider technical assistance/training process.	DSS will continue to work with the ASO to collaborate on: • Reviewing and enhancing the documentation for medical necessity to ensure the guidance and process are clear. • Establish a process for supporting providers through technical assistance and/or training.

Connecticut has implemented the activities necessary to ensure the use of nationally recognized SUD-specific ASAM program standards to set provider qualifications across levels of care. These activities included certifying providers based on updated DSS/DMHAS/DCF standards; implementing training and technical assistance to align providers and ABH and Carelon reviewers with ASAM standards; updating ABH and Carelon contracts to reflect residential provider requirement changes, including requirements related to providing access to MAT in all SUD treatment settings; implementing Medicaid Management Information System (MMIS) system changes to allow for enrollment of providers by ASAM level; opening the State Medicaid enrollment to the new SUD provider types; and publishing SUD residential provider bulletin. More details about each of these activities are noted in Table A.7 below.

Table A.7. Milestone 3 Activities under the Demonstration

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
Milestone 3	**Use of Nationally Recognized SUD-Specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities** Through this Demonstration, Connecticut will receive federal financial participation for a continuum of SUD services, including services provided to Medicaid enrollees residing in residential treatment facilities that qualify as IMDs. To meet this milestone, Connecticut will ensure that the following criteria are met: • Implementation of residential treatment provider qualifications (in licensure requirements, policy manuals, managed care contracts [in Connecticut, this reference refers to the ASO contracts], or other guidance) that meet the ASAM criteria or other nationally recognized, SUD-specific program standards regarding the types of services, hours of clinical care, and credentials of staff for residential treatment settings. • Implementation of a State process for reviewing residential treatment providers to assure compliance with these standards. • Implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off-site.	

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
	This milestone will be met within 24 months of Demonstration approval.	
Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, contracts, or other guidance. Qualification should meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding, in particular, **the types of services, hours of clinical care, and credentials of staff for residential treatment settings**	With the effective date of the SPA, DSS will **update the Medicaid MMIS coding, rates, and billing guidance** to support provider enrollment and billing under the new Medicaid Rehabilitative SPA (effective date of SPA). **DSS, in conjunction with DMHAS and DCF, will update provider standards and certification developed by both State agencies within 18 months of Demonstration approval** (by October 1, 2023). Other operational guidance will be updated by each State agency to support the latest edition of ASAM standards as needed to provide timely provider training in Milestone 2 (no later than 24 months after Demonstration approval or by April 1, 2024).	**Complete** MMIS coding, rates, and billing guidance for residential providers are in the published **Provider Bulletins listed above.** Provider standards and Operational Guidance are at the following website: Section1115DemonstrationWaiverfor SubstanceUseDisorder(SUD)Treatment--ProviderResources https://portal.ct.gov/dss/health-and-home-care/substance-use-disorder-Demonstration-project/provider-resources?language=en_US Provider certification thresholds are at the following websites: **Certification and Monitoring** • 1115 SUD Certification Standards and Process https://portal.ct.gov/-/media/departments-and-agencies/dss/health-and-home-care/substance-use-disorder-Demonstration-project/1115-sud-certification-standards-and-process-12-apr-2024---final.pdf
Implementation of a State process for reviewing residential treatment providers to ensure compliance with these standards	Within 24 months of Demonstration approval, DSS provider enrollment standards will require certification by DMHAS/DCF (or their designated contractor[s]) with an agreement also from DSS (or its designated contractor) to provide the ASAM LOC for which they are enrolled: The monitoring of the providers will include both a review of the facility's infrastructure, as well as how the infrastructure is applied to ensure compliance with the new State standards consistent with the latest edition of ASAM. The monitoring will include initial certification, monitoring, and	**Complete** Connecticut established a four-phase monitoring process at the beginning of the Demonstration. DMHAS and ABH continued intensive ASAM certification monitoring by completing Phase 4 of monitoring with residential SUD programs. This phase focused on assessing the deficiencies identified in Phase 3 and helping where needed to meet full certification. Monitoring reports consist of ratings for the Chart Review, Milestone Core Activities, Milestone Administrative Activities, and Milestone Support Activities. In addition, ABH prepares Aggregate Reports for the State partners that sorts scores from all

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
	recertification (by April 1, 2024).	programs side by- -side for ease of comparative analysis. ABH prepares Collaborative Improvement Plans (CIP) for each program outlining areas still in need of improvement in order to demonstrate adherence with the standards for full certification. Providers thereafter complete their CIPs indicating planned initiatives with goals, interventions, and timeframes for each improvement opportunity. Providers must submit their completed CIP's to DSS/DMHAS/DCF for approval. At the end of the two-year provisional certification period, 42 residential SUD programs met full certification under the Demonstration. Additional TA and site monitoring was completed for three programs in need of additional support.
Implementation of requirement that residential treatment facilities offer MAT onsite or facilitate access off-site	None needed — Connecticut currently meets criteria.	This activity was complete in the original Demonstration application.

Under the extension, Connecticut intends to collaborate with all State agencies to transition to ASAM fourth edition. This will include ASAM fourth edition listening sessions, training sessions, and technical assistance. See table below.

Table A.8. Milestone 3: Intended Actions in the Demonstration Extension

Action	Summary of Intended Actions in Demonstration Extension
Milestone 3: Implement ASAM fourth edition	DSS intends to collaborate with DCF and DMHAS on an implementation plan for transitioning to ASAM fourth edition. This will include ASAM fourth edition listening sessions, training sessions, and technical assistance.
Milestone 3: Investigate provider reluctance to accept high dosage MAT beneficiaries	Connecticut will investigate reports that some facilities including ASAM 3.1 and sober houses have methadone dosage limits. The reason for this is unclear and may be a holdover from abstinence philosophy. Connecticut will address any instances of this practice when identified at specific providers.

As noted in Table A.9 below, Connecticut has experienced declining capacity in residential levels of care. However, Connecticut has implemented the activities necessary to ensure

sufficient provider capacity at Critical Ambulatory Levels of Care including for MAT for OUD. These activities included increasing rates for residential SUD treatment providers providing key levels of care including all levels of adolescent care and ASAM 3.1 and 3.5 levels of care for adults. In year 2 of the Demonstration, Connecticut also implemented a flex bed model allowing facilities to retain individuals in care at lower levels of care for a longer period of time. More details about each of these activities is noted in Table A.9 below.

Table A.9. Milestone 4 Activities under the Demonstration

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
Milestone 4	**Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD** To meet this milestone, Connecticut will complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care listed in Milestone 1. This assessment will determine the availability of treatment for Medicaid beneficiaries in each of these LOCs, as well as availability of MAT and medically supervised withdrawal management, throughout the State. This assessment will identify gaps in availability of services for beneficiaries in the critical LOCs and will assist with the development of plans for enhancement of capacity based on assessments of provider availability This milestone will be met within 24 months of Demonstration approval. *Note: It is necessary to ensure the complete implementation of the new service array in Medicaid prior to the capacity assessment being conducted.*	
Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the State including those that offer MAT: Outpatient Services Intensive Outpatient Services MAT (medications as well as counseling and other services) Intensive	The Medicaid BH ASO in conjunction with DMHAS, or its designee, will complete an assessment of the availability of Medicaid SUD providers accepting new patients at ambulatory ASAM levels of care including MAT within 12 months of Demonstration approval (by April 1, 2023). The Medicaid BH ASO in conjunction with DMHAS, or its designee, will complete an assessment of the availability of Medicaid SUD providers accepting new patients at residential ASAM levels of care within 24 months of Demonstration approval once all residential providers are enrolled in Medicaid and fully meet the latest edition of ASAM criteria (by April 1, 2024).	The on-going capacity monitoring real-time bed-tracking technology is complete. DMHAS has completed the updates to the State's residential capacity monitoring website and has aligned it with the most recent ASAM criteria. All requested programming changes are now in production. The capacity assessment is complete. Ambulatory capacity monitoring maintained by Carelon at FindProvider(ctbhp.com). It reports that 2111 SUD providers are accepting new clients in Connecticut. https://www.ctbhp.com/ctbhp/en/home/find-provider Since the beginning of the Demonstration, Connecticut has experienced reductions in residential capacity after the implementation of the Demonstration. In Demonstration year 2, the State's only SUD residential adolescent provider accepting Medicaid beneficiaries closed its 12-bed ASAM 3.5 program. The program

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
Care in Residential and Inpatient Settings Medically Supervised Withdrawal Management		struggled with low utilization for several years, including prior to the implementation of the SUD Demonstration activities. This coupled with increased staffing requirements under the Demonstration made the program financially unsustainable for the provider agency. As of 9/19/2025, there are currently no Medicaid-enrolled SUD residential adolescent providers. In 2025, the State added 11 new residential beds at the 3.1 LOC, which offset program closures, and 21 new beds at the 3.5 LOC. There is a total of 1,103 adult residential beds across the State. To offset the bed reductions in Demonstration year 2, the State implemented the Flex Bed model with residential treatment providers beginning May 1, 2023. This model allows current residential treatment providers to provide lower levels of residential care and flex their census of beds to meet the needs of members being served by their program at any given time. This process allows members to receive treatment in the facility where they are currently admitted, according to what is clinically appropriate and medically necessary given their clinical history and current stage of recovery and provide agencies the opportunity to have these services covered under the appropriate fee-for-service rates. Several programs are certified and provided additional levels of care on a routine basis. Two of these programs provide ASAM 3.7 care and flex to provide ASAM 3.5 care, and one program offers ASAM 3.5 care and flex to provide ASAM 3.1 care. This option improves access to lower levels of residential care where the State anticipates there may be a deficit in capacity to meet Statewide needs. The State has continued to monitor changes in capacity and utilization and assess whether additional efforts are needed to ensure adequate access at these levels of care. As of March 31, 2025, there were 125 adult-serving and 22 adolescent-serving

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
		ambulatory outpatient programs (all levels of care combined) with active certifications. This is a decrease from Demonstration Year 2, which is accounted for by agencies who had applied for provisional certification with intent to open programs, but some LOC were non-operational at the end of the provisional certification period and did not continue with pursuing full certification. Connecticut has implemented the following efforts to improve bed capacity and recruit more providers: • Simplified the rate structure to improve incentives for providers to increase bed capacity. • Increased adolescent treatment rates to improve access for this population and added 3.7 and 3.1 LOC to the continuum of care for adolescents. • Engaged providers in quarterly provider collaborative meeting series to share program updates, to provide TA and to hear and address provider concerns. • Continued to conduct a webinar series on all aspects of ASAM to provide TA to providers. Topics included: Individualized Program Schedules, Individualized Documentation Considerations — Part 1, Individualized Documentation Considerations — Part 2, Service Coordination/Case Management, Co-Occurring Capability Therapies. • Revised staffing ratios by increasing client to staff ratios where clinical treatment and oversight would not be impacted. Beginning December 2023, DSS has monitored and continues to monitor the number of MAT providers through monthly oversight meetings with State partners and project team meetings to address and ensure access to care is available to all members that require SUD services. . On July 1, 2025, DSS made changes to the rate structure to have a single fee for all

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
		LOC and added two LOCs for the adolescent population. Beginning January 1, 2025, DSS and State partners increased engagement efforts including site visits to providers to share information about the program; through informational meetings with interested providers; through ongoing training initiatives; and provider collaboratives that seek to provide engagement opportunities and TA. DSS plans to engage new providers to share updates on the program and changes to rates, eliminate barriers in program requirements that go beyond ASAM and create additional burdens on providers; continue to provide opportunities for TA and engagement through provider collaboratives, training series. DSS will continue to engage in a multi-pronged approach to address access if data continues to trend in the wrong direction.

Under the extension, Connecticut intends to: (1) continue the rate increases initiated in Year 4 of the initial Demonstration; (2) enhance provider recruitment initiatives; (3)increase access under the Demonstration. See table below.

Table A.10. Milestone 4: Intended Actions in the Demonstration

Action	Summary of Intended Actions in Demonstration Extension
Milestone 4: Refine bed tracking	Connecticut intends to continue the rate increases initiated in Year 4 of the initial Demonstration, to enhance provider recruitment initiatives, and to increase access under the Demonstration.
Milestone 4: Increase provider engagement to explain new initiatives to address capacity concerns	Connecticut will increase engagement efforts with providers for the adult and adolescent populations to ensure an understanding of the new initiatives to increase bed capacity through training and outreach.
Milestone 4: Monitor provider acceptance of the new residential rate structure	DSS has recently adopted a new rate structure to address provider concerns regarding rates and will continue to monitor capacity and continuity of care.

As noted in Table A.11 below, Connecticut has implemented the activities necessary to ensure **Implementation of Comprehensive Treatment and Prevention Strategies** Statewide in the application.

Table A.11. Milestone 5 Activities under the Demonstration

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
Milestone 5	**Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Misuse and OUD** To meet this milestone, Connecticut will ensure that the following criteria are met: • Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug misuse. • Expanded coverage of and access to naloxone for overdose reversal; and • Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs. Connecticut has detailed the strategies it has in place currently to address prescription drug misuse and opioid use disorders as well as plans to implement additional strategies. Attachment A describes the State's plans for improving its SUD health information technology infrastructure to improve its prescription drug monitoring program (PDMP).	
Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse	**Complete.** Met at time of application. Department of Public Health implemented prescribing guidelines to prevent opioid over use through a number of updates to Connecticut policy and law regulating prescribing of controlled substances and opioid medications. In 2019, Connecticut amended the Medicaid State Plan to reflect the new drug utilization review provisions required in federal law under the SUPPORT Act.	**Complete** Criteria met in application.
Expanded coverage of, and access to, naloxone for overdose reversal	**Complete.** Met at time of application. Connecticut passed a *Good Samaritan* law in 2011 that protects people, who call 911 seeking emergency medical services for an overdose, from arrest for possession of drugs/paraphernalia. Connecticut passed a law in 2012 allowing prescribers to prescribe, dispense, or administer naloxone to any person to prevent or treat a drug overdose and protects the prescriber from civil liability and criminal prosecution.	**Complete** Criteria met in application.

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
	In 2014, the protection was extended to any person administering the naloxone. In 2015, legislation permitted trained and certified pharmacist to prescribe and dispense naloxone directly. In 2018, prescribers may develop agreements with organizations wishing to train and distribute naloxone. Connecticut also had a State Opioid Response grant that distributed 12,000 naloxone kits.	

In addition, Connecticut is actively implementing PDMP functionality upgrades and increasing its use as outlined in the implementation plan. See Table A.12 for details about the status of these activities.

Table A.12. Milestone 5 Health Information Technology Activities under the Demonstration

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
Health Information Technology (HIT) Milestone Criteria		
Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD, : • Enhancing the State's HIT functionality to support its PDMP. • Enhancing and/or supporting clinicians in their usage of the State's PDMP.		
PDMP Functionalities		
Enhanced interState data sharing in order to better track patient specific prescription data	As data sharing is dependent on other States (including necessary changes to State law), there are no specific actions that can be listed here.	Connecticut has continued to work on interState data sharing. A current map can be found at: PrescriptionMonitoringProgram Dashboard-CPMRS|ConnecticutData https://data.ct.gov/stories/s/Prescription-Monitoring-Program-Dashboard-CPMRS/vfwt-grxc/ Connecticut shares prescription data with other States via PMP Interconnect or RxCheck. These are data sharing hubs that use end-to-end encryption to facilitate data sharing across State borders. Only authorized Connecticut Prescription Monitoring and Reporting System (CPMRS) roles have access

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
		through this mechanism. Authorized roles include prescribers and pharmacists. CPMRS has access to 39 States, Washington DC, Puerto Rico, and the Military Health System.
Enhanced *ease of use* for prescribers and other State and federal stakeholders	The Connecticut Department of Consumer Protection (DCP), the PDMP vendor (Appriss Health), and DSS, as the administrator of the EHR Incentive Program, will continue to onboard new electronic health record (EHR) and pharmacy dispensing vendors.	CPMRS offers enhanced identification to allow prescriber self-audit features to detect possible errors and forgeries. https://portal.ct.gov/dcp/prescription-monitoring-program/prescriber-information?language=en_US Prescribers have the ability to query their prescribing history (up to three years). This feature allows the prescriber to identify errors and/or forgeries for prescriptions that have been filled under their Drug Enforcement Agency registration number. If an error and/or forgery is detected, the prescriber can verify the findings by contacting the dispensing pharmacy or the prescriber. Connecticut mandated use of CPMRS, in 2015. DCP, the prescription drug monitoring program vendor (Appriss Health, which is now Bamboo Health), and DSS will continue to onboard new EHRs and pharmacy dispensing vendors.
Enhanced connectivity between the State's PDMP and any Statewide, regional or local Health Information Exchange (HIE)	DCP, in collaboration with Office of Health Strategy (OHS) and DSS, will continue to link the CPRMS with the HIE consistent with the Implementation Advance Planning Document (IAPD).	Connecticut's approach to HIE has been incremental for standing up the HIE and implementing functionality based on priorities established by the State. The base functionality has been implemented, but Connecticut continues to implement additional features and functionality. Connecticut has a combined Operational Advance Planning Document for the Operations and IAPD for the planned development/Design, Development and Installation process (submitted in 2024 and covers fiscal years 2025 and 2026). DCP in collaboration with OHS and DSS will continue to link the CPMRS with the HIE consistent with the IAPD. CONNIE is the designated HIE of Connecticut. As an HIE, CONNIE

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
		facilitates the secure and confidential exchange of health information among health care organizations such as doctors' offices, hospitals, laboratories, and radiology centers, ensuring seamless coordination of care. CONNIE is always expanding its selection of useful tools to help on-boarded organizations get the most out of CONNIE. One of the standout tools is the CONNIE Portal, a standalone, secure web-based access point to all of CONNIE's tools for participating organizations. The Portal provides streamlined access with secure login using two-factor verification. The CONNIE Dashboard, located on the home page, allows credentialed users to launch applications and conduct patient searches quickly and efficiently for all CONNIE tools in one location. Core services provide a secure platform for authorized participating organizations to access patient information available through CONNIE. Access to services is granted only upon adherence to CONNIE's data release policy, and participants must have signed a data sharing agreement. This policy was developed to ensure compliance with State and federal health information and interoperability rules. These rules collectively govern how and under what legal authority the data can be disclosed. https://www.conniect.org/_files/ugd/e7f8c9_fc6c7a93db3d4059a6c69643d84da3a4.pdf. Through the Clinical Information App users can view clinical information from other CONNIE participating organizations, including inpatient, outpatient and emergency department encounters; laboratory and radiology results; radiology images, medications, problems, and the patient's care team in one streamlined platform. CONNIE offers direct access to CPMRS

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
		for those registered with CPMRS. CONNIE also has Single Sign-On to CPMRS Narx report using the Prescription Drug Program (PMP).
Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns[4]	Connecticut is considering purchasing another new analytical tool from Appriss Health to: • Improve the ability to monitor all pharmacy and dispensing practitioners for uploading compliance. • Identify those practitioners and prescribers who are not compliant with the lookup mandate or other aspects of the law. DCP and/or DSS will evaluate the feasibility of utilizing predictive analytics to forecast increased risk of long-term prescription misuse based on initial prescribing characteristics.	DCP and DSS evaluated the feasibility of utilizing predictive analytics to forecast increased risk of long-term prescription misuse based on initial prescribing characteristics. NarxCare has been included in the CPMRS system. DCP, OHS, and DSS will continue to explore additional analytical tools to assist with enforcement to minimize the risk of inappropriate overprescribing. A new compliance module was implemented in 2022. CPMRS sends clinical alerts as indicators of patients that may be at a high risk for an overdose. Practitioners are asked to review the patient's CPMRS report and use it as a tool to determine the appropriate level of care. CPMRS generates a Prescriber & Dispenser Threshold alert when a specified number of Prescribers and or Dispensers is met or exceeded within a set time period. *Please Note: The State PMP has set the following threshold: five prescribers and five pharmacies within the last three months.* CPMRS generates a daily active morphine milligram equivalent (MME) threshold when the daily active MME is greater than or equal to specified values. CPMRS generates an Opioid & Benzodiazepine Threshold alert when Opioids and Benzodiazepines are prescribed concurrently.
Current and Future PDMP Query Capabilities		
Facilitate the State's ability to properly match patients	DCP, OHS, and DSS will work to identify management across systems for better integration.	On-going.

[4] Shah, A., Hayes, C. J., & Martin, B. C. (2017). Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. Morbidity and Mortality Weekly Report, 66(10), 265–269. http://dx.doi.org/10.15585/mmwr.mm6610a1. (See also "Use of PDMP" #2 below.)

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
receiving opioid prescriptions with patients in the PDMP (i.e., the State's Master Patient Index strategy with regard to PDMP query)		DCP, OHS, and DSS will continue to work to identify management across systems for better integration.
Use of PDMP — Supporting Clinicians with Changing Office Workflows/Business Processes		
Develop enhanced provider workflow/business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow	Connecticut will continue to integrate the CPMRS into the HIE as the infrastructure is built consistent with the newly approved IAPDs.	The Connecticut PMP Statewide initiative integrated the CPMRS into approved EHR/pharmacy management system (PMS) using Appriss Health's PMP Gateway service. The CPMRS integration with EHRs has continued to be available at no cost to users. https://portal.ct.gov/dcp/prescription-monitoring-program/prescription-monitoring-program?language=en_US CPMRS offers software access to streamline provider workflow, save time, and focus on patient care. The CPMRS can now be accessed through approved EHR and PMS where PDMP data and NarxCare analytics will be delivered directly into the provider workflow. Information is available to providers via a website: CPMRSIntegration. https://portal.ct.gov/dcp/drug-control-division/prescription-monitoring-program/cpmrs-integration?language=en_US For a limited time, CPMRS waived the initial set-up fee and user fees due to funding from CMS .
Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP — prior to the issuance of an opioid prescription	The PDMP administrator, along with the PDMP vendor (Appriss Health), are responsible for the development of processes and system testing for the inclusion of NarxCare.	CPMRS has implemented the NarxCare module. The CONNIE portal allows a Single Sign-On to CPMRS Narx report using the PDMP. NarxCare reports are generated within CONNIE automatically once the patient search results are returned.
Master Patient Index/Identity Management		

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery	DCP, OHS, and DSS will work to identify management across systems for better integration.	On-going
Overall Objective for Enhancing PDMP Functionality and Interoperability		
Leverage the above functionalities/ capabilities/supports (in concert with any other State HIT, TA, or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing — and to ensure that Medicaid does not inappropriately pay for opioids	Connecticut will explore additional analytical tools to assist with enforcement to minimize the risk of inappropriate overprescribing.	**Complete** See the description of the new clinical alerts implemented in CPMRS above.

Under the extension, Connecticut intends to: (1) continue to enhance interState data sharing; (2) enhance *ease of use* for prescribers and other State and federal stakeholders; (3) enhance connectivity between the State's PDMP and Statewide CONNIE system; and (4) continue to increase the use of PDMP by providers and pharmacists through continued promotion of the PDMP. See table below.

Table A.13. Milestone 5: Intended Actions in the Demonstration Extension

Action	Summary of Intended Actions in Demonstration Extension
Milestone 5: Increase the use of PDMP by providers and pharmacists	Connecticut intends to continue to increase the use of PDMP by providers and pharmacists through continued promotion of the PDMP.
Milestone 5: Identify opportunities for expanding PDMP functionality and use	Connecticut intends to continue to identify opportunities for expanding PDMP functionality and use as noted in the three items below: • Enhance interState data sharing in order to better track patient specific prescription data. • Enhance *ease of use* for prescribers and other State and federal stakeholders. • Enhance connectivity between the State's PDMP and Statewide HIE.

As noted in Table A.14 below, Connecticut has implemented the activities necessary to ensure improved care coordination and transitions between LOCs. These activities included collaboration with providers to enhance care coordination activities and enhanced policy development to ensure adequate care coordination across the SUD continuum. More details about each of these activities is noted in Table A.14 below.

Table A.14. Milestone 6 Activities under the Demonstration

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
Milestone 6	**Improved Care Coordination and Transitions between Levels of Care** Connecticut will implement policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD and other SUDs, with community-based services and supports following stays in these facilities. The table below outlines Connecticut's current procedures for care coordination and transitions between LOCs to ensure seamless transitions of care and collaboration between services, including: • Current content of specific policies to ensure these procedures. • Specific plans to help beneficiaries attain or maintain a sufficient level of functioning outside of residential or inpatient facilities; and • Current policies or plans to improve care coordination for co-occurring physical and mental health conditions. This milestone will be met within 12 months to 24 months of Demonstration approval.	
Additional policies to ensure coordination of care for co-occurring physical and mental health conditions	DSS will work with DMHAS and DCF to incorporate strong discharge planning and transition planning into the residential and ambulatory LOC at the provider level using new ASAM standards within 12 months of Demonstration approval by April 1, 2023. Service coordination in all ASAM LOCs will be required. Service coordination includes, but is not limited to, provider-specific and LOC-specific activities that enhance and improve linking members between Medicaid treatment services and enhance and improve the likelihood of engagement in treatment. Within 12 months of Demonstration approval, DSS, DMHAS, and DCF will review all of the existing care management models reimbursed via State dollars, Medicaid administrative dollars and Medicaid fee-for-service payments across the State and ensure care	**Complete** The State has adopted new ASAM standards including policies requiring facilities to support beneficiaries' transition from residential and inpatient LOCs. DSS has incorporated strong discharge planning and transition planning into the residential and ambulatory LOC at the provider level using new ASAM standards. These standards require service coordination in all levels of care linking members between Medicaid treatment services and enhancing and improving the likelihood of engagement in treatment. The State has developed a rate structure that supports these facilities in implementing care coordination work. The State is working to define care coordination activities for intermediate levels of care and incorporating these into the State's provider standards. The State continues to work on a redesign of outpatient services that will include care coordination activities. DMHAS, DCF, and ABH have incorporated care coordination reviews as part of the

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
	management for the SUD population includes a strong transition management component between LOCs by April 1, 2023. Within 12 months, DSS will, based on the budget analysis, determine if the target population in the Targeted Case Management (TCM) SPA can be expanded to include SUD-only (i.e., TCM co-occurring SUD versus SUD-only) by April 1, 2023.	monitoring tool for certification review and ASAM criteria adoption audits under the Demonstration. The State continues to monitor care coordination efforts and activities at SUD programs. The State reviewed all existing care management models to identify clear referral pathways and identify any potential gaps. Steps were initiated to address gaps in care coordination identified. The State completed a fiscal analysis of expanding TCM services to the SUD-only population. This analysis looked at two different options: 1) the SUD-only population more broadly and 2) the SUD-only population whose clinical acuity is assumed to be more significant given their recent participation in withdrawal management and inpatient care. The estimated costs associated with either of these options are greater than the State can pursue at this time.

Under the extension, Connecticut intends to continue to collaborate with providers to enhance care coordination activities. See table below.

Table A.15. Milestone 6: Intended Actions in the Demonstration Extension

Action	Summary of Intended Actions in Demonstration Extension
Milestone 6: Collaborate with providers to enhance care coordination activities	Connecticut intends to continue collaboration with providers to enhance care coordination activities.

Evaluation Design

Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, the independent evaluator, facilitated meetings with the State of Connecticut (State or Connecticut) team to develop the evaluation design plan for the waiver. These meetings included the development of driver diagrams, development of research questions, development of hypotheses, developing the analytic methods employed in the evaluation, and assessing the methodological limitations. The meetings began with the approval of the Demonstration in early 2022. The State finalized the draft evaluation design and submitted the plan to the Centers for Medicare & Medicaid Services (CMS) on October 6, 2022. The plan was revised on February 2, 2023 and March 20, 2023. CMS approved the evaluation design on May 22, 2023.

Monitoring Protocol

The State submitted the SUD Monitoring Protocol to CMS on August 22, 2022, and CMS approved it on May 22, 2023. Mercer calculated the performance metrics consistent with the

CMS issued Technical Specifications. The State has submitted regular quarterly and annual Monitoring Reports for all quarters and has fully complied with all requirements surrounding the monitoring protocol.

To complete these activities, the State held meetings with Mercer to review required performance measure specifications and discussed the evaluation design and waiver milestones. Connecticut and Mercer completed service and coding crosswalks to ensure that the performance measures are calculated consistently with the technical specifications. The deviations in coding and programming from the CMS specifications for performance measures based on factors such as data availability and Connecticut specific coding practices were identified, evaluated, and documented. In addition, Connecticut and Mercer selected the Health Information Technology performance measures including two metrics for the prescription drug monitoring program. A reporting schedule of performance measures was developed.

Evidence of Progress under the Demonstration and Current Status of Substance Use Disorder in Connecticut

Drug overdose deaths continue to be a leading cause of injury-related deaths in the United States[5], and despite Demonstration efforts, the number of SUD deaths in Connecticut continues to remain high. Deaths within Connecticut due to drug misuse, alcohol, or suicide outpace the country as a whole. According to the Centers for Disease Control and Prevention (CDC), the 2022 Connecticut age-adjusted rate for unintentional drug-induced mortality was 38.3 per 100,000 population compared to the 2022 national rate of 30.1.[6] In Connecticut, residents are more likely to die from unintentional drug overdose than a motor vehicle crash. The majority of these deaths are linked to overdose of illicit opioids.[7]

Connecticut mandates the use of its prescription drug monitoring program by prescribers and dispensers. Most overdose deaths are not associated with prescription opioids. In a 2024 study, Connecticut found that 10.4% of the matched drug overdose decedents were prescribed one or more opioid prescriptions between 2020 and 2023; 22.1% had one or more pharmacies dispensing opioid prescriptions within 180 days prior to their deaths; and 22.0% had one or more controlled substance prescribers writing opioid prescriptions prior to their death. The data indicate that prescription opioid medications could have contributed to some of the decedents' cause of death as 10.4% of the decedents had an opioid prescription 30 days prior to fatal overdose. However, as noted above, the majority of these deaths were linked to overdose of illicit opioids.

The Connecticut Department of Public Health is funded by the CDC to participate in the State Unintentional Drug Overdose Reporting System (SUDORS) to collect comprehensive data on unintentional and undetermined intent overdose deaths within the State. Data is abstracted from multiple data sources including death certificates, medical examiner reports, and postmortem toxicology results. SUDORS captures information on variables such as demographics, circumstances, scene evidence, and substances contributing to the death for each overdose death. SUDORS brings together multiple sources of data to get a better understanding of the

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[5] https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/injury-prevention/reduce-overdose-deaths-involving-opioids-ivp-20

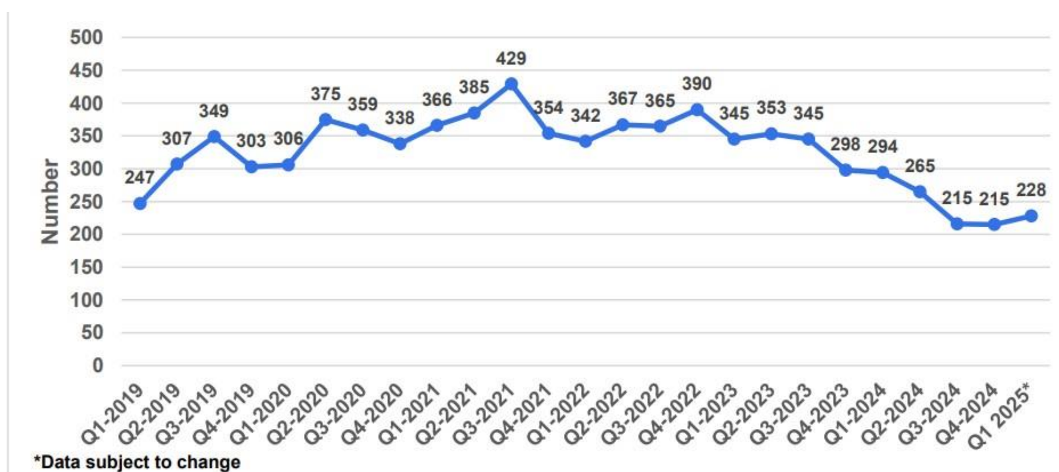
[6] Centers for Disease Control and Prevention. (n.d.). Opioid and drug overdose statistics. Connecticut Department of Public Health. https://portal.ct.gov/dph/health-education-management--surveillance/the-office-of-injury-prevention/opioid-and-drug-overdose-statistics

[7] Connecticut Department of Public Health. (n.d.). Opioid and drug overdose statistics. https://portal.ct.gov/dph/health-education-management--surveillance/the-office-of-injury-prevention/opioid-and-drug-overdose-statistics

characteristics and circumstances related to unintentional and undetermined drug overdose deaths.[8]

In 2024, according to SUDORS, there were 349 less deaths, a 26.1% decrease, compared to 2023 (N=1,338). A decreasing trend in drug overdose deaths has been seen consecutively for the last three years from 2021–2024.[9] The chart below represents the counts of confirmed drug overdose deaths by quarter (Figure A.16). Quarterly drug overdose data (Figure A.16) show that for the years 2019, 2020, and 2022, Quarter 1 had the lowest number of unintentional and undetermined intent drug overdose deaths within each specific year. Between 2019–2024, Quarter 4 of 2024 had the lowest number. The data from 2025 are preliminary and subject to change due to pending cases.[10]

Figure A.16. Number of Unintentional and Undetermined Intent Drug Overdose Deaths, Connecticut, Q1 2019-Q1 2025*.



Source: Data source: Office of the Chief Medical Examiner and SUDORS https://portal.ct.gov/-/media/dph/injury-and-violence-prevention/opioid-overdose-data/monthly-death-reports/2019-june-2025_drug-overdose-deaths-monthly-report_connecticut_7-22-2025-final.pdf *Data are subject to change

Drug Overdose Death Demographics

For the Connecticut deaths between July 2020 and December 2024, most people who died from drug overdoses were aged 35 to 64 years old and male.

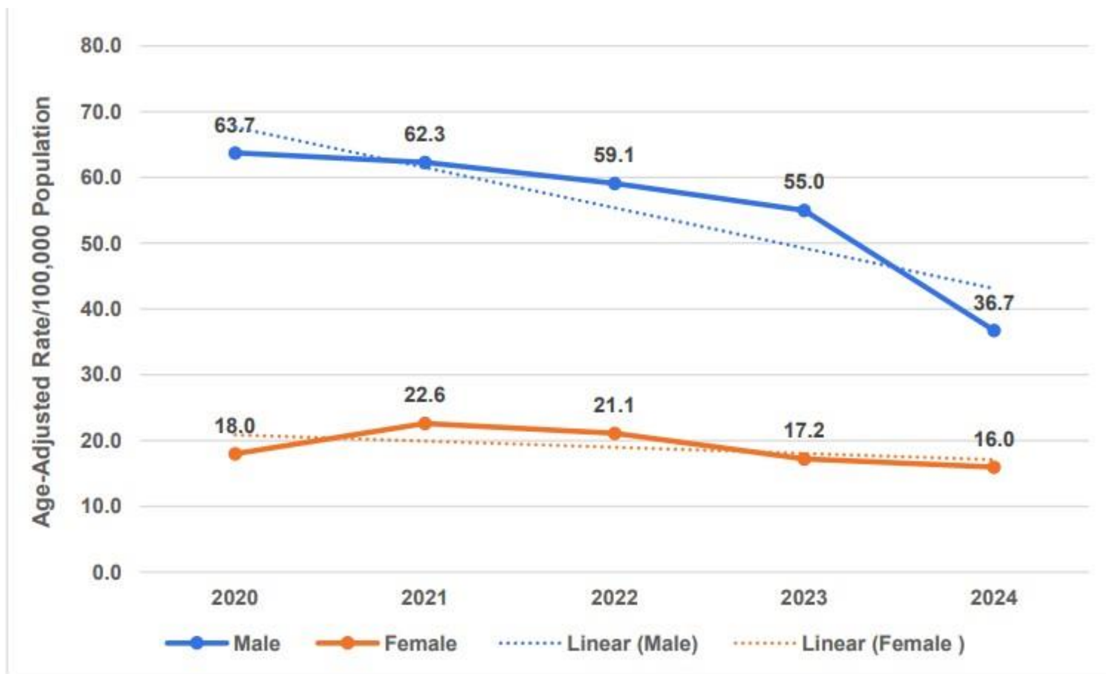
Age-adjusted drug overdose death rates were higher in males compared to females during 2020 through 2024. The line graph below (Figure A.17) represents the age-adjusted rates of drug overdose death by gender during 2020 through 2024. Overall linear trends from 2020 to 2024 show that the age-adjusted drug overdose death rates decreased in males whereas there was very little change in female death rates.

[8] https://portal.ct.gov/dph/health-education-management--surveillance/the-office-of-injury-prevention/opioid-and-drug-overdose-statistics

[9] Connecticut Department of Public Health. (2025). 2019-June 2025 Drug Overdose Deaths Monthly Report. Retrieved from https://portal.ct.gov/dph/health-education-management--surveillance/the-office-of-injury-prevention/opioid-and-drug-overdose-statistics

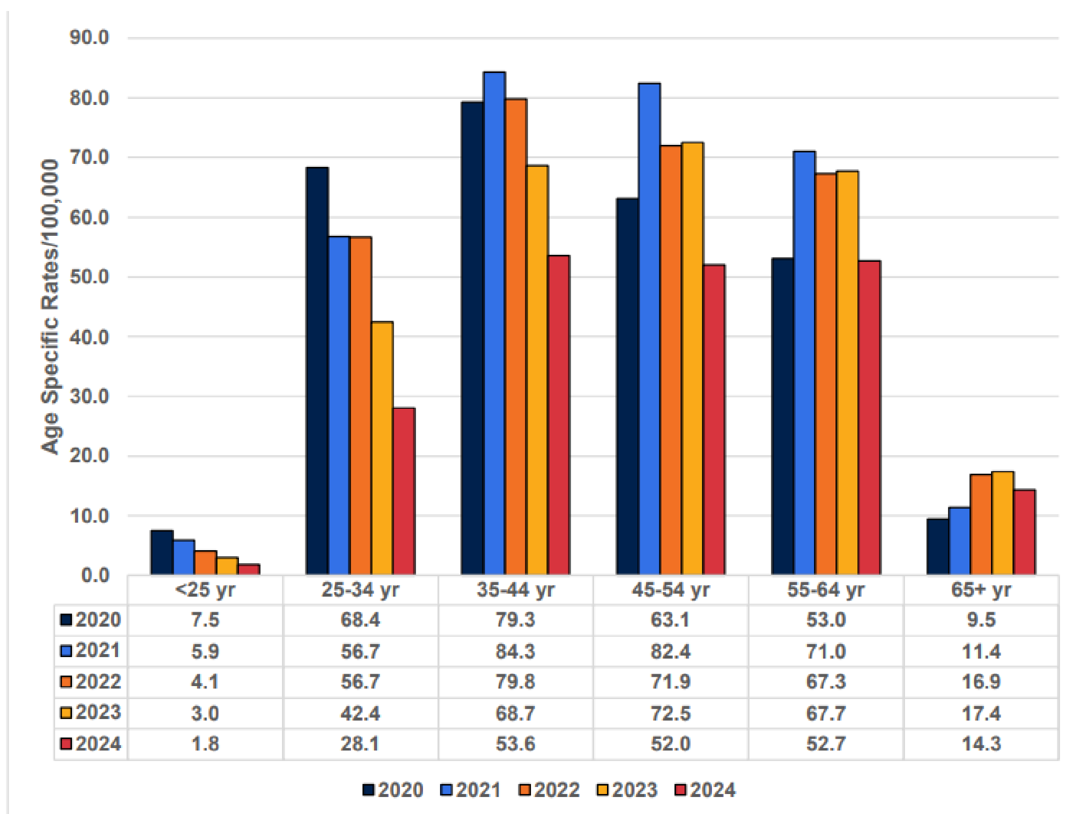
[10] Connecticut Department of Public Health. (2025). 2019-June 2025 Drug Overdose Deaths Monthly Report. Retrieved from https://portal.ct.gov/dph/health-education-management--surveillance/the-office-of-injury-prevention/opioid-and-drug-overdose-statistics

Table A.17. Age-Adjusted Rate of Unintentional and Undetermined Intent Drug Overdose Deaths per 100,000, by Sex, Connecticut 2020-2024



Age-specific drug overdose death rates were highest among those 35 to 64 years old in Connecticut during 2020–2024. Age-specific drug overdose death rates were calculated per 100,000 population and were highest among the middle-aged population, specifically the 35 years–44 years old, 45 to 54 years old, and 55 to 64 years old age groups in 2020-2024. The data show that across all age groups there has been a declining trend in 2024 compared to the previous years. The chart below (Figure 6) represents the annual age-specific unintentional and undetermined intent drug overdose mortality rates in Connecticut, by age group 2020–2024.

Table A.18. Age Specific Rates of Unintential and Undetermined Drug Overdose Deaths per 100,000 Population, by Age Group, Connecticut, 2020-2024



	<25 yr	25-34 yr	35-44 yr	45-54 yr	55-64 yr	65+ yr
2020	7.5	68.4	79.3	63.1	53.0	9.5
2021	5.9	56.7	84.3	82.4	71.0	11.4
2022	4.1	56.7	79.8	71.9	67.3	16.9
2023	3.0	42.4	68.7	72.5	67.7	17.4
2024	1.8	28.1	53.6	52.0	52.7	14.3

Future Goals of the Program

Extension of the waiver will continue to provide access to residential and inpatient treatment settings, expand the availability of intensive outpatient, withdrawal management, and medication-assisted treatment services, and increase access to all substance use disorder treatment for members with SUD including alcohol use disorder. The on-going activities identified above under each milestone will continue to ensure that the most appropriate levels of care are available for patients and improved treatment outcomes. See summary of activities anticipated under the extension in the table below to further reduce SUD related deaths.

Table A.19. Summary of Intended Actions in Demonstration Extension

Action	Summary of Intended Actions in Demonstration Extension
Milestone 1: Increase care coordination and adopt American Society of Addiction Medicine (ASAM) fourth edition	Under the extension, Connecticut intends to increase care coordination to ensure continued engagement and strengthen transitions of levels of care and to adopt ASAM fourth edition in 2027.
Milestone 1: Training on new Medicaid coding and reimbursement to improve early intervention Screening, Brief	Connecticut intends to publicize and train providers on new Medicaid coding and reimbursement to improve SBIRT rates.

Action	Summary of Intended Actions in Demonstration Extension
Intervention, and Referral to Treatment (SBIRT) rates.	
Milestone 2: Continue provider ASAM training and technical assistance	Connecticut intends to continue the training and technical assistance (TA) to align providers with ASAM standards, as an ongoing activity as new providers and/or new staff at existing providers are identified. The State's Administrative Services Organization (ASO), Carelon, will continue to meet with providers upon request if an authorization request is denied clarifying the rational for the denial and offering TA with the authorization documentation process.
Milestone 2: Continue provider communication	Connecticut intends to continue communication with providers, as an on-going activity including website maintenance, updates, provider forums, and newsletters.
Milestone 2: Monitor and review authorization, placement decisions, and care transitions to identify and offer utilization management TA	DSS will continue to monitor and review monthly metrics related to authorizations, placement decisions, and care transitions with State partner agencies to identify training and TA needs.
Milestone 2: Review and enhance documentation for medical necessity and establish a new provider TA/training process	DSS will continue to work with the ASO to collaborate on: • Reviewing and enhancing the documentation for medical necessity to ensure the guidance and process are clear. • Establish a process for supporting providers through TA and/or training.
Milestone 3: Implement ASAM fourth edition	DSS intends to collaborate with the Department of Children and Families and Department of Mental Health and Addiction Services on an implementation plan for transitioning to ASAM fourth edition. This will include ASAM fourth edition listening sessions, training sessions, and TA.
Milestone 3: Investigate provider reluctance to accept high dosage MAT beneficiaries	Connecticut will investigate reports that some facilities including ASAM 3.1 and sober houses have methadone dosage limits. The reason for this is unclear and may be a holdover from abstinence philosophy. Connecticut will address any instances of this practice when identified at specific providers.
Milestone 4: Refine bed tracking	Connecticut intends to continue the rate increases initiated in Year 4 of the initial Demonstration, to enhance provider recruitment initiatives, and to increase access under the Demonstration.
Milestone 4: Increase provider engagement to explain new initiatives to address capacity concerns	Connecticut will increase engagement efforts with providers for the adult and adolescent populations to ensure understanding of the new initiatives to increase bed capacity through training and outreach. Strategies include:

Action	Summary of Intended Actions in Demonstration Extension
	• Simplify the rate structure to improve incentives for providers to increase bed capacity. • Increase adolescent treatment rates to improve access for this population and add 3.7 and 3.1 levels of care to the continuum of care for adolescents. • Engage providers in quarterly provider collaborative meeting series to share program updates, to provide TA, and to hear and address provider concerns. • Continue to conduct a webinar series on all aspects of ASAM to provide TA to providers. • Revise staffing ratios by increasing client to staff ratios where clinical treatment and oversight would not be impacted.
Milestone 4: Monitor provider acceptance of the new residential rate structure	DSS adopted a new rate structure in July 2025 to address the provider concerns regarding rates and will continue to monitor capacity and continuity of care.
Milestone 5: Increase the use of prescription drug monitoring program (PDMP) by providers and pharmacists	Connecticut intends to continue to increase the use of PDMP by providers and pharmacists through continued promotion of the PDMP.
Milestone 5: Identify opportunities for expanding PDMP functionality and use	Connecticut intends to continue to identify opportunities for expanding PDMP functionality and use as noted in the three items below: • Enhance interState data sharing in order to better track patient specific prescription data. • Enhance ease of use for prescribers and other State and federal stakeholders. • Enhance connectivity between the State's PDMP and Statewide Health Information Exchange.
Milestone 6: Collaborate with providers to enhance care coordination activities	Connecticut intends to continue collaboration with providers to enhance care coordination activities.

Appendix B

Budget neutrality assessment, and projections for the projected extension period. The State will present an analysis of budget neutrality for the current Demonstration approval period, including the status of budget neutrality to date based on the most recent expenditure and member month data, and projections through the end of the current approval that incorporate the latest data. Centers for Medicare & Medicaid Services (CMS) will also review the State's Medicaid Budget and Expenditure/Children's Health Insurance Program Budget and Expenditure System expenditure reports to ensure that the Demonstration has not exceeded the federal expenditure limits established for the Demonstration. The State's actual expenditures incurred over the period from initial approval through the current expiration date, together with the projected costs for the requested extension period, must comply with CMS budget/allotment neutrality requirements outlined in the STCs).

Analysis of Current Demonstration for SUD

CMS approved a hypothetical per member per month (PMPM) budget neutrality agreement for the State for this Demonstration. The existing waiver and budget neutrality reflects three Medicaid Eligibility Groups (MEGs) as follows:

- **MEG 1 (HUSKY A)**: This MEG includes all Medicaid eligible beneficiaries, whose household income is below 133% of the Federal Poverty Limit (FPL) and receiving services in an Institution for Mental Disease (IMD) for a substance use disorder (SUD) diagnosis. HUSKY A includes low-income Medicaid members parents/caregiver relatives and children.
- **MEG 2 (HUSKY C)**: This MEG includes all Medicaid eligible beneficiaries, who are older adults or people with disabilities and receiving services in an IMD for SUD diagnosis.
- **MEG 3 (HUSKY D):** This MEG includes the Medicaid expansion eligible beneficiaries, whose household income is above below 133% of the FPL and receiving services in an IMD for a SUD diagnosis. HUSKY D beneficiaries receive the Alternative Benefit Plan (ABP) covered services as required under federal law. The HUSKY D benefits under the ABP are aligned with the underlying Medicaid State Plan benefits.

Table B.1: Master MEG Chart

MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description
HUSKY A	Hypo 1	X		X	Low-income Medicaid enrollees, parents/caregiver relatives, and children
HUSKY C	Hypo 1	X		X	Aged, Blind, and Disabled
HUSKY D	Hypo 1	X		X	Medicaid expansion enrollees

The approved Without Waiver (WOW) costs using the trend rates and per capita cost approved for each eligibility group for each year of the Demonstration are listed in the Table B.2 below. Demonstration Year (DY) 1 began April 14, 2022, with the SUD Demonstration approval. The extension would be effective April 1, 2027. The table below identifies the MEGs that were approved for Hypothetical Budget Neutrality Test 1. MEGs that are designated *WOW Only*/Both are the components used to calculate the budget neutrality expenditure limit. MEGs that are

indicated as *WW Only/Both* are counted as expenditures against this budget neutrality expenditure limit.

Table B.2. Approved Budget Neutrality for Hypothetical Budget Neutrality Test 1

MEG	PC or Agg*	WOW Only, WW Only, or Both	Base Year SFY2019	Trend	DY 1	DY 2	DY 3	DY 4	DY 5
HUSKY A	PC	Both	$4,821.33	4.5%	$5,562.82	$5,813.15	$6,074.74	$6,348.10	$6,633.76
HUSKY C	PC	Both	$11,950.54	3.9%	$13,532.81	$14,060.59	$14,608.95	$15,178.70	$15,770.67
HUSKY D	PC	Both	$8,019.71	5.7%	$9,602.90	$10,150.27	$10,728.84	$11,340.38	$11,986.78

The State reports expenditures on the 1115 waiver schedules by Date of Payment for the Date of Service. The State is using the correct budget neutrality forms for the SUD 1115 quarterly report. See Table B.3 With Waiver Costs below for Schedule C reported amounts as of Demonstration Year 3.

A summary of the Without and With waiver costs for the initial Demonstration to date are below in Table B.3 showing that the Demonstration is budget neutral under **Hypothetical Budget Neutrality Test 1** in each year of the Demonstration.

Table B.3. Summary of Current Demonstration Hypothetical Budget Neutrality Test 1

	DY1	DY2	DY3	DY4Q1
Without Waiver	$167,568,762	$215,788,746	$215,966,736	$45,064,371
With Waiver	$96,476,908	$155,729,721	$157,028,414	$46,607,377
Variance	$71,091,854	$60,059,025	$58,938,322	$(1,543,006)

Details of the Without and With Waiver costs by MEG are shown below in Table B.4.

Table B.4 Detailed Hypothetical Budget Neutrality Test 1

Without-Waiver Total Expenditures						
MEG		**Trend**	**DY1**	**DY2**	**DY3**	**DY4Q1**
Hypothetical 1 Per Capita						
SUD HUSKY A	Eligible Member Months	1.00%	1,816	2,044	2,109	404
	PMPM Cost	4.50%	$5,562.82	$5,813.15	$6,074.74	$6,348.10
	Total Expenditure	5.55%	$10,102,081	$11,882,079	$12,811,627	$2,564,632
SUD HUSKY C	Eligible Member Months	1.00%	652	895	933	191
	PMPM Cost	3.90%	$13,532.81	$14,060.59	$14,608.95	$15,178.70
	Total Expenditure	4.94%	$8,823,392	$12,584,228	$13,630,150	$2,899,132

Without-Waiver Total Expenditures						
MEG		Trend	DY1	DY2	DY3	DY4Q1
Hypothetical 1 Per Capita						
SUD HUSKY D	Eligible Member Months	1.00%	15,479	18,849	7,665	3,492
	PMPM Cost	5.70%	$9,602.90	$10,150.27	$10,728.84	$11,340.38
	Total Expenditure	6.76%	148,643,289	$191,322,439	$189,524,959	$39,600,607
Total			**$167,568,762**	**$215,788,746**	**$215,966,736**	**$45,064,371**
With-Waiver Total Expenditures						
MEG		**Trend**	**DY1**	**DY2**	**DY3**	**DY4Q1**
Hypothetical 1 Per Capita						
SUD HUSKY A			$9,831,162	$14,466,649	$16,154,924	$4,370,299
SUD HUSKY C			$3,817,448	$5,988,245	$6,196,675	$2,013,577
SUD HUSKY D			$82,828,298	$135,274,827	$134,676,815	$40,223,501
Total			**$96,476,908**	**$155,729,721**	**$157,028,414**	**$46,607,377**
Hypotheticals Variance			**$71,091,854**	**$60,059,025**	**$58,938,322**	**$(1,543,006)**

In the table above from DY2–DY4Q1, the HUSKY A MEG With Waiver costs exceed the Without Waiver Costs. In the first quarter of DY4Q1, the HUSKY A excess With Waiver costs result in the overall Demonstration not meeting budget neutrality for that quarter.

HUSKY A Budget Neutrality Issues

As can be seen in Table B.5 below, the HUSKY A MEG exceeds budget neutrality in DY2: $5,813.15 is the PMPM Without Waiver limit and $7,077.62 is the actual PMPM cost. Similarly, in DY3, $6,074.74 is the Without Waiver limit and $7,659.99 is the actual PMPM cost. The DY4Q1 Without Waiver limit is $6,348.10 and the actual PMPM cost is $10,817.57.

Table B.5 HUSKY A MEG Comparison of Without Waiver and With Waiver for DY1–DY4Q1

Without Waiver Total Expenditures — Approved in Demonstration					
MEG		DY1	DY2	DY3	DY4Q1
Hypothetical 1 Per Capita					
SUD HUSKY A	Eligible Member Months	1,816	2,044	2,109	404
	PMPM Cost	$5,562.82	$5,813.15	$6,074.74	$6,348.10
	Total Expenditure	$10,102,081	$11,882,079	$12,811,627	$2,564,632

With Waiver Total Expenditures —Actuals					
MEG		**DY1**	**DY2**	**DY3**	**DY4Q1**
Hypothetical 1 Per Capita					
SUD HUSKY A	Eligible Member Months	1,816	2,044	2,109	404
	PMPM Cost	$5,413.64	$7,077.62	$7,659.99	$10,817.57
	Total Expenditure	$9,831,162	$14,466,649	$16,154,924	$4,370,299
Total		**$9,831,162**	**$14,466,649**	**$16,154,924**	**$4,370,299**
Without Waiver — With Waiver Difference		**$270,919.12**	**$(2,584,570.40)**	**$(3,343,297.34)**	**$(1,805,666.60)**

Between May 2024and August 2024, Connecticut and CMS held conferences to discuss and document the HUSKY A budget neutrality issues that resulted in the actual costs exceeding the Without Waiver budget neutrality limit for that MEG beginning in DY2. CMS requested that Connecticut submit a detailed explanation of the reasons the budget neutrality limits were exceeded in the HUSKY A MEG, including an explanation of any missing data and a comparison of the projected incidence versus the actual incidence in recent experience under the Demonstration.

CMS and Connecticut examined the actual utilization of SUD IMDs and the non-IMD costs compared to projections as well as the causes of the differences (see below under the Background Section). CMS agreed that the overall Hypothetical Budget Neutrality Agreement 1 under the STCs was still budget neutral as noted in the section above. Because the State's original STCs did not include the updated CMS Mid-Course Correction language, CMS requested that Connecticut update the HUSKY A MEG Without Waiver limit at renewal. Therefore, at this time, the State requests that the HUSKY A Medicaid Eligibility Group Without Waiver limits be aligned with the actual expenditures observed under HUSKY A experience.

Background

HUSKY A person-level utilization data was not available prior to the approval of the Demonstration because SUD residential services for HUSKYA adults were only available under the State's Substance Abuse Prevention and Treatment (SAPT) block grant, which did not require separate person-level utilization data. Because person-level data was not available, the State's actuary, Mercer Government Health Consulting Services (Mercer), estimated utilization of HUSKY A individuals for residential services and other Medicaid services under the Demonstration. Mercer based all HUSKY A estimates on the utilization of Mental Health (MH) IMDs and the utilization of HUSKY D members in 100% State-funded SUD IMDs. Mercer also estimated the utilization for HUSKY C members with the available data.

As a result of the Demonstration, Medicaid now reimburses for services provided in SUD IMDs and Connecticut has actual HUSKY A, HUSKY C, and HUSKY D experience for IMDs and other fee-for-service (FFS) Medicaid services. HUSKY C and HUSKY D actual utilization has remained under the approved budget neutrality limits for the Demonstration. However, HUSKY A actual utilization and expenses have exceeded the budget neutrality limits in years DY2-DY4Q1.

There are two primary causes for the actual costs exceeding the approved waiver budget neutrality limit for the HUSKY A MEG:

- The HUSKY D non-IMD FFS utilization used to predict HUSKY A non-IMD FFS for individuals in IMDs underestimated the HUSKY A actual experience for non-SUD services.
- The actual incidence of SUD IMD utilization differed from the MH IMD utilization that was used as a proxy in the budget neutrality calculations. A utilization mix of residential services for American Society of Addiction Medicine (ASAM) 3.1, 3.5, and 3.7/3.7 Withdrawal Management (WM) was assumed in the development of the budget neutrality projections. However, Connecticut underestimated the incidence of utilization for ASAM 3.7 relative to 3.1 and the utilization in small facilities that have higher fees.

HUSKY A Data Availability

As Stated earlier, HUSKY A utilization data within the State's SAPT block grant was aggregated and thus unavailable for the budget neutrality projections, so Mercer utilized HUSKY D experience to estimate non-SUD PMPM costs. Mercer relied on HUSKY D (Expansion adults) data, which was 100% State-funded for SUD IMDs. See below for the initial utilization projections based on the HUSKY D population used by Mercer for the HUSKY A population in the absence of historical data.

However, with Medicaid now covering IMDs, actual HUSKY A utilization data is available for IMDs and non-IMD services. As discussed with CMS in the summer of 2024 and show in Table B.6 and Table B.7 below, HUSKY A IMD/SUD actual calendar year 2023 (CY23) costs were a little higher than projections ($4,273 projected compared to $4.998. actual), which would be accounted for in the higher utilization of ASAM 3 and 3.7-WM levels of care than expected in this population. However, it is the actual HUSKY A non-IMD expenditures that were not anticipated: The actual PMPM of $2,167 PMPM, was considerably higher than the projected HUSKY A non-IMD costs of $548 PMPM. In particular, Mercer believes that the non-IMD expenditures for pregnant women (i.e., prenatal care) in the HUSKY A MEG were not well represented by the HUSKY D projections. As the Demonstration has been implemented and early intervention with pregnant women has increased, more pregnant women are receiving earlier and more complete prenatal care at a higher cost in addition to their SUD treatment.

Table B.6: HUSKY A: Projections in Budget Neutrality

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	Estimated SUD PMPM Cost	Estimated Non-SUD PMPM Cost	Estimated PMPM Cost
HUSKY A	$ 12,007,533.00	$ 1,540,416.67	$ 2,810.00	$ 4,273.00	$ 548.00	$ 4,821.00

Table B.7: HUSKY A: Actual Experience

Medicaid Eligibility Group (MEG)	Actual Total Expenditures for SUD Medical Assistance Provided in an IMD	Actual Total Expenditures for All Other non-SUD/IMD Title XIX State Plan Medical Assistance	Actual Eligible Member Months for All Medical Assistance Provided in an IMD	Actual SUD PMPM Cost	Actual Non-SUD PMPM Cost	Actual PMPM Cost
HUSKY A	$ 14,960,925.00	$ 4,524,220.97	$ 2,088.00	$ 4,998.42	$ 2,166.77	$ 7,165.19

Actual Incidence of SUD IMD Utilization

The budget neutrality projections for HUSKY A SUD IMD utilization were developed from MH IMD utilization. However, the actual utilization of SUD IMDs has been found to differ significantly from the MH IMD basis that was used for projections. The second key factor is the actual incidence of SUD utilization differed from the MH IMD utilization that Mercer relied upon to predict the HUSKY A utilization. Mercer's calculations used MH IMD utilization as a proxy for the SUD IMD utilization. However, the actual incidence of SUD IMD utilization differed significantly

in reality from MH IMD utilization. Specifically, an average HUSKY A case mix for SUD IMD residential incidence based on MH IMD utilization ($4,273 PMPM) was substantially different for SUD IMD residential incidence using different ASAM levels, including 3.1, 3.5, and 3.7/3.7WM ($4,998). Specifically, Mercer underestimated the utilization for ASAM 3.7 (a more expensive level of care) compared to ASAM 3.1 (a less expensive Level of Care), as well as the number of small facilities with higher fees in the HUSKY A population (e.g., HUSKY A has a disproportionate number of women in 3.5 Pregnant and Parenting Women Facilities with fewer than 12 beds, which have higher fees than larger facilities able to take advantage of more economies of scale).

HUSKY A MEG Update Needed

As a result of the differences in actual utilization of SUD IMDs and the non-IMD costs compared to what was projected in budget neutrality, CMS and Connecticut agreed that an update to the HUSKY A MEG at renewal would be necessary. The decision to wait until the renewal was made because the overall Hypothetical Budget Neutrality Agreement 1 was still budget neutral and because the State's STCs did not include the updated Mid-Course Correction language.

Under the renewal, the State requests a minor technical change to the budget neutrality limits of the HUSKY A MEG. The amendment would align the Without Waiver limits more closely with the actual case mix and fees observed in actual experience from CY23 and provide a more accurate representation of the costs and utilization associated with SUD IMDs for the HUSKY A adult population.

Budget Neutrality — Caseload and Expenditure Estimates Waiver Period 2

This section presents the Connecticut approach for budget neutrality estimates in the next waiver period including the data and assumptions used in the development of the cost and caseload estimates supporting this extension request.

Federal policy requires that section 1115 Demonstration applications be budget neutral to the federal government. This means that an 1115 Demonstration cannot cost the federal government more than what would have otherwise been spent absent the 1115 Demonstration.

The particulars of budget neutrality, including methodologies, are subject to negotiation between the Department of Social Services (DSS) and CMS.

DSS proposes to continue the per capita budget neutrality model for the populations covered under the Demonstration by Medicaid Eligibility Group (MEG). This proposed Demonstration will not reduce or negatively impact current Medicaid enrollment or the State's Children's Health Insurance Program allotment.

The five-year Demonstration extension covers the period between April 1, 2027 and March 31, 2032, each Demonstration Year (DY) is outlined in Table B.8.

Table B.8. Demonstration Extension Periods

	DY6	DY7	DY8	DY9	DY10
Begin Date	4/1/2027	4/1/2028	4/1/2029	4/1/2030	4/1/2031
End Date	3/31/2028	3/31/2029	3/31/2030	3/31/2031	3/31/2032

Current Demonstration Period

The current Demonstration covers the period between April 14, 2022 and March 31, 2027, and is identified as DY1 through DY5. The budget neutrality Appendix E includes the State's Budget Neutrality Spreadsheets with the current budget neutrality PMPM limits, actual member months and expenditures, and the difference between the waiver limits and actual expenditures. Actual member months and expenditures are included for DY1 through DY4Q1. Projections are used for the remaining DY4 and DY5 because the data is not complete at the time of this application submission.

Renewal Period Demonstration Proposals

The budget neutrality reflects a renewal and new Demonstration proposals as outlined in Table B.9.

Table B.9. Demonstration Proposals and Effective Dates

Demonstration Proposal	Effective Date
Renewal of Institution for Mental Diseases for Substance Use Disorder (SUD-IMD)	Renewal Effective Date: April 1, 2027
Reentry services for adults and youth transitioning from correctional facilities	Amendment submitted March 27, 2024 Renewal Effective Date: April 1, 2027
Social Determinants of Health (SDOH), housing supports for individuals receiving Reentry services under the Demonstration	Amendment Submitted March 27, 2024 Renewal Effective date: April 1, 2027

Caseload and Total Computable Expenditure Projections DY6 to DY10

SUD-IMD Renewal

The SUD-IMD without waiver reflects actual DY1–DY4Q1 member months and PMPMs, DY4-DY5 continue to use prior waiver projections. For the HUSKY C and HUSKY D MEGs, the renewal period DY6–DY10 is projected from DY5 using the trend factors from the current Demonstration budget neutrality. The HUSKY A MEG utilizes actual PMPM costs and member months for projections.

The projected DY5 member months and per capita were trended utilizing the current budget neutrality approved trend factors to develop DY6 through DY10, as illustrated in Table B.10 below.

Table B.10. SUD-IMD Renewal Projections

Without-Waiver Total Expenditures							
MEG		Trend	Projection DY6	Projection DY7	Projection DY8	Projection DY9	Projection DY10
Hypothetical 1 Per Capita							
SUD HUSKY A	Eligible Member Months	1.00%	2,173	2,195	2,217	2,239	2,261
	PMPM Cost	4.50%	$12,009.67	$12,550.10	$13,114.86	$13,705.03	$14,321.75
	Total Expenditure	5.55%	$26,097,007	$27,547,475	$29,075,638	$30,685,552	$32,381,480
SUD HUSKY C	Eligible Member Months	1.00%	2,621	2,647	2,673	2,700	2,727
	PMPM Cost	3.90%	$16,385.73	$17,024.77	$17,688.74	$18,378.60	$19,095.36
	Total Expenditure	4.94%	$42,946,988	$45,064,565	$47,281,990	$49,622,210	$52,073,051
SUD HUSKY D	Eligible Member Months	1.00%	20,791	20,999	21,209	21,421	21,635
	PMPM Cost	5.70%	$12,670.03	$13,392.22	$14,155.57	$14,962.44	$15,815.30
	Total Expenditure	6.76%	$263,422,520	$281,223,185	$300,225,577	$320,510,473	$342,164,044
Total			**$332,466,515**	**$353,835,224**	**$376,583,205**	**$400,818,235**	**$426,618,575**
With-Waiver Total Expenditures							
MEG		**Trend**	**Projection DY6**	**Projection DY7**	**Projection DY8**	**Projection DY9**	**Projection DY10**
Hypothetical 1 Per Capita							
SUD HUSKY A			$26,097,007	$27,547,475	$29,075,638	$30,685,552	$32,381,480
SUD HUSKY C			$42,946,988	$45,064,565	$47,281,990	$49,622,210	$52,073,051
SUD HUSKY D			$263,422,520	$281,223,185	$300,225,577	$320,510,473	$342,164,044
Total			**$332,466,515**	**$353,835,224**	**$376,583,205**	**$400,818,235**	**$426,618,575**

Justice Involved Reentry Renewal

Connecticut has submitted estimates for Justice Involved Reentry Budget Neutrality for DY4 and DY5 to CMS at the writing of the renewal request for Hypothetical Budget Neutrality Test 2. See Table B.11.

Table B.11. Hypothetical Budget Neutrality Test 2 Justice Involved Re-Entry Initial Waiver Estimates DY4–DY5

Without-Waiver Total Expenditures					
MEG		**Trend**	**PC or Agg**	**Projection DY4**	**Projection DY5**
Hypothetical Budget Neutrality Test 2					
JI Services	Eligible Member Months	1.00%		53,455	53,833
	PMPM Cost	6.90%	PC	$1,318.36	$1,382.17
	Total Expenditure	7.97%		$70,472,562	$74,405,821
JI Non-Services	Total Expenditure	0.00%	Agg	$46,443,183	$46,443,183
Total				**$116,915,746**	**$120,849,004**

With-Waiver Total Expenditures					
MEG		**Trend**	**PC or Agg**	**Projection DY4**	**Projection DY5**
Hypothetical Budget Neutrality Test 2					
JI Services	Eligible Member Months	1.00%		53,455	53,833
	PMPM Cost	6.90%	PC	$1,318.36	$1,382.17
	Total Expenditure	7.97%		$70,472,562	$74,405,821
JI Non-Services	Total Expenditure	0.00%	Agg	$46,443,183	$46,443,183
Total				**$116,915,746**	**$120,849,004**

This data was used to project DY6–DY10 of the waiver for the justice involved (JI) Services and JI Non-Services MEGs. See Table B.12. The trend rates reflect the latest pending amendment request.

Table B.12: Hypothetical Budget Neutrality Test 2 Justice Involved Re-entry DY6–DY10 Projections

Without-Waiver Total Expenditures								
MEG		**Trend**	**PC or Agg**	**Projection DY6**	**Projection DY7**	**Projection DY8**	**Projection DY9**	**Projection DY10**
Hypothetical Budget Neutrality Test 2								
JI Services	Eligible Member Months	1.00%		54,371	54,915	55,464	56,019	56,579
	PMPM Cost	6.90%	PC	$1,477.54	$1,579.49	$1,688.47	$1,804.98	$1,929.52
	Total Expenditure	7.97%		$80,335,204	$86,737,574	$93,649,438	$101,113,011	$109,170,341
JI Non-Services	Total Expenditure	0.00%	Agg	$46,443,183	$46,443,183	$46,443,183	$46,443,183	$46,443,183
Total				**$126,778,387**	**$133,180,757**	**$140,092,621**	**$147,556,195**	**$155,613,524**

With-Waiver Total Expenditures								
MEG		**Trend**		**Projection DY6**	**Projection DY7**	**Projection DY8**	**Projection DY9**	**Projection DY10**
Hypothetical Budget Neutrality Test 2								
JI Services	Eligible Member Months	1.00%		54,371	54,915	55,464	56,019	56,579
	PMPM Cost	6.90%	PC	$1,477.54	$1,579.49	$1,688.47	$1,804.98	$1,929.52
	Total Expenditure	7.97%		$80,335,204	$86,737,574	$93,649,438	$101,113,011	$109,170,341
JI Non-Services	Total Expenditure	0.00%	Agg	$46,443,183	$46,443,183	$46,443,183	$46,443,183	$46,443,183
Total				**$126,778,387**	**$133,180,757**	**$140,092,621**	**$147,556,195**	**$155,613,524**

SDOH Renewal

Connecticut has submitted estimates for SDOH Budget Neutrality for DY4 and DY5 to CMS at the writing of the renewal request for Capped Hypothetical Budget Neutrality Test 3. See Table B.13.

Table B.13 Capped Hypothetical Budget Neutrality Test 3 SDOH DY4-FY5

Without-Waiver Total Expenditures				
MEG		**Trend through DY6**	**Projection DY4**	**Projection DY5**
Capped Hypothetical Test 3				
JI SDOH	Eligible Member Months	1.00%	31,476	31,791
	PMPM Cost	0.00%	$1,557.00	$1,557.00
	Total Expenditure	1.00%	$49,008,132	$49,498,587
JI SDOH Infrastructure	Total Expenditure	1.00%	$8,648,494	$8,735,045
Total			**$57,656,626**	**$58,233,632**
With-Waiver Total Expenditures				
MEG		**Trend through DY6**	**Projection DY4**	**Projection DY5**
Capped Hypothetical Test 3				
JI SDOH	Eligible Member Months	1.00%	31,476	31,791
	PMPM Cost	0.00%	$1,557.00	$1,557.00
	Total Expenditure	1.00%	$49,008,132	$49,498,587
JI SDOH Infrastructure	Total Expenditure	1.00%	$8,648,494	$8,735,045
Total			**$57,656,626**	**$58,233,632**

This data was used to project DY6–DY10 of the waiver for the SDOH MEGs. See Table B.14. The trend rates for DY4–DY6 reflect the latest pending amendment request. No trend rate is requested from DY6–DY10.

Table B.14: Capped Hypothetical Budget Neutrality Test 3 SDOH DY6-DY10 Projections

Without-Waiver Total Expenditures							
MEG		Trend through DY6	Projection DY6	Projection DY7	Projection DY8	Projection DY9	Projection DY10
Capped Hypothetical Test 3							
JI SDOH	Eligible Member Months	1.00%	32,109	32,109	32,109	32,109	32,109
	PMPM Cost	0.00%	$1,557.00	$1,557.00	$1,557.00	$1,557.00	$1,557.00
	Total Expenditure	1.00%	$49,993,713	$49,993,713	$49,993,713	$49,993,713	$49,993,713
JI SDOH Infrastructure	Total Expenditure	1.00%	$8,822,420	$8,822,420	$8,822,420	$8,822,420	$8,822,420
Total			**$58,816,133**	**$58,816,133**	**$58,816,133**	**$58,816,133**	**$58,816,133**

With-Waiver Total Expenditures							
MEG		Trend through DY6	Projection DY6	Projection DY7	Projection DY8	Projection DY9	Projection DY10
Capped Hypothetical Test 3							
JI SDOH	Eligible Member Months	1.00%	32,109	32,109	32,109	32,109	32,109
	PMPM Cost	0.00%	$1,557.00	$1,557.00	$1,557.00	$1,557.00	$1,557.00
	Total Expenditure	1.00%	$49,993,713	$49,993,713	$49,993,713	$49,993,713	$49,993,713
JI SDOH Infrastructure	Total Expenditure	1.00%	$8,822,420	$8,822,420	$8,822,420	$8,822,420	$8,822,420
Total			**$58,816,133**	**$58,816,133**	**$58,816,133**	**$58,816,133**	**$58,816,133**

Appendix C

Interim evaluation of the overall impact of the Demonstration that includes evaluation activities and findings to date, in addition to plans for evaluation activities over the requested extension period. The interim evaluation should provide CMS with a clear analysis of the State's achievement in obtaining the outcomes expected as a direct effect of the Demonstration program. The State's interim evaluation must meet all of the requirements outlined in the STCs.

The Interim Evaluation and Evaluation Design will be inserted here in future versions.

Appendix D

Summaries of quality review reports, State quality assurance monitoring, and any other documentation of the quality of and access to care provided under the Demonstration.

*Note: EPSDT report summaries are not included because the renewal portion is for SUD only***.**

The State of Connecticut's Substance Use Disorder (SUD) 1115 Demonstration waiver operates in a fee-for-service delivery system and is subject to the monitoring of the State Medicaid agency, Department of Social Services, and the Connecticut Behavioral Health Partnership.

Connecticut Behavioral Health Partnership

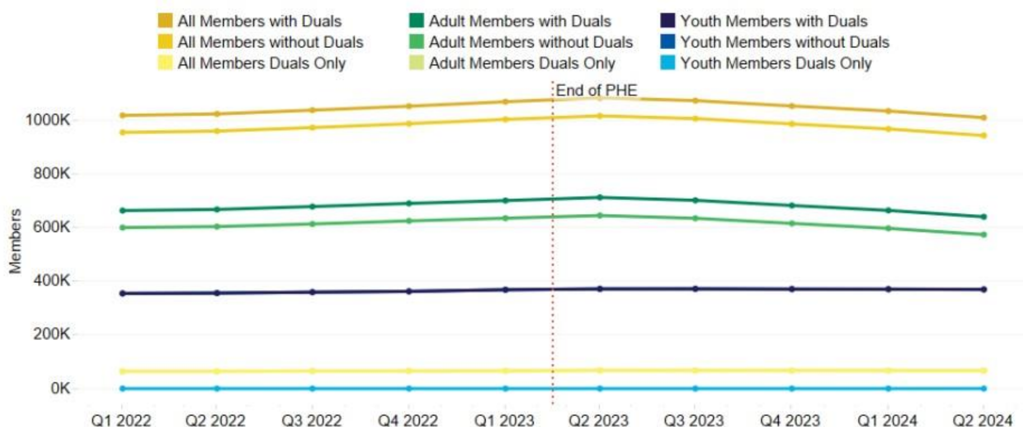
The Connecticut Behavioral Health Partnership (CT BHP) was established to provide a multi-agency approach to streamline and build collaboration in the behavioral health system. Its goals are to promote positive outcomes and to improve access to care for all individuals. The partnership is a collaboration between the State of Connecticut's (State or Connecticut) Department of Social Services (DSS), the Department of Children and Families (DCF), and the Department of Mental Health and Addiction Services (DMHAS) who jointly contract with and manage a contract with Carelon Behavioral Health (Carelon) as the State's Medicaid Administrative Services Organization (ASO). The partnership management focuses on special populations, reporting, and advanced data analytics designed to improve system outcomes. Carelon's contract includes authorization and utilization review, capacity tracking and managing grievances and appeals for the SUD Demonstration. In addition, DMHAS and DCF contract with Advanced Behavioral Health, Inc. to conduct the certification and monitoring processes of providers under the Demonstration.

Utilization Management

As the State's Utilization Review ASO, Carelon oversees and manages utilization review, authorization requests, provider capacity, and grievance and appeal processing. Carelon uses Tableau dashboards to track and report on membership and utilization semi-annually. Reports are separated by adult and youth populations.

Consistent with Connecticut's quarterly and annual monitoring reports to CMS, Carelon reported that total Connecticut Medicaid decreased by 73,958 members (-6.8%) from 1,082,724 members in Q2 2023 to 1,008,766 members in Q2 2024. The decreases in membership over the past four quarters are likely due to the expiration of the Public Health Emergency (PHE) for the COVID-19 and the unwinding of the Medicaid continuous coverage requirement authorized under the Families First Coronavirus Response Act. Despite the recent membership decreases, HUSKY Health membership remains 12.5% higher than membership in 2020 prior to declaration of the PHE.

Figure D.1. Total HUSKY Health Membership by Quarter

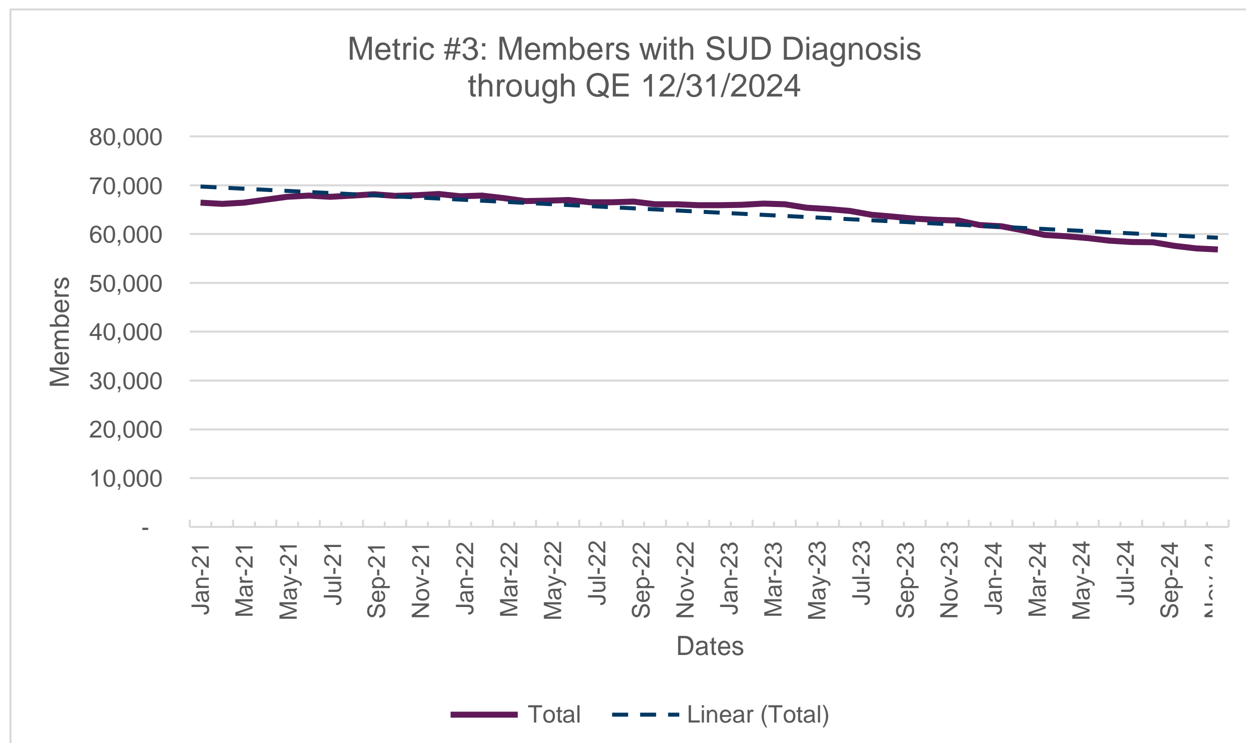


Carelon performs Utilization Management according to the population (youth, adult, pregnant and parenting women) and American Society of Addiction Medicine (ASAM) level of care standards. Provider support and technical assistance are provided as needs are identified.

Medicaid Individuals with SUD Diagnosis

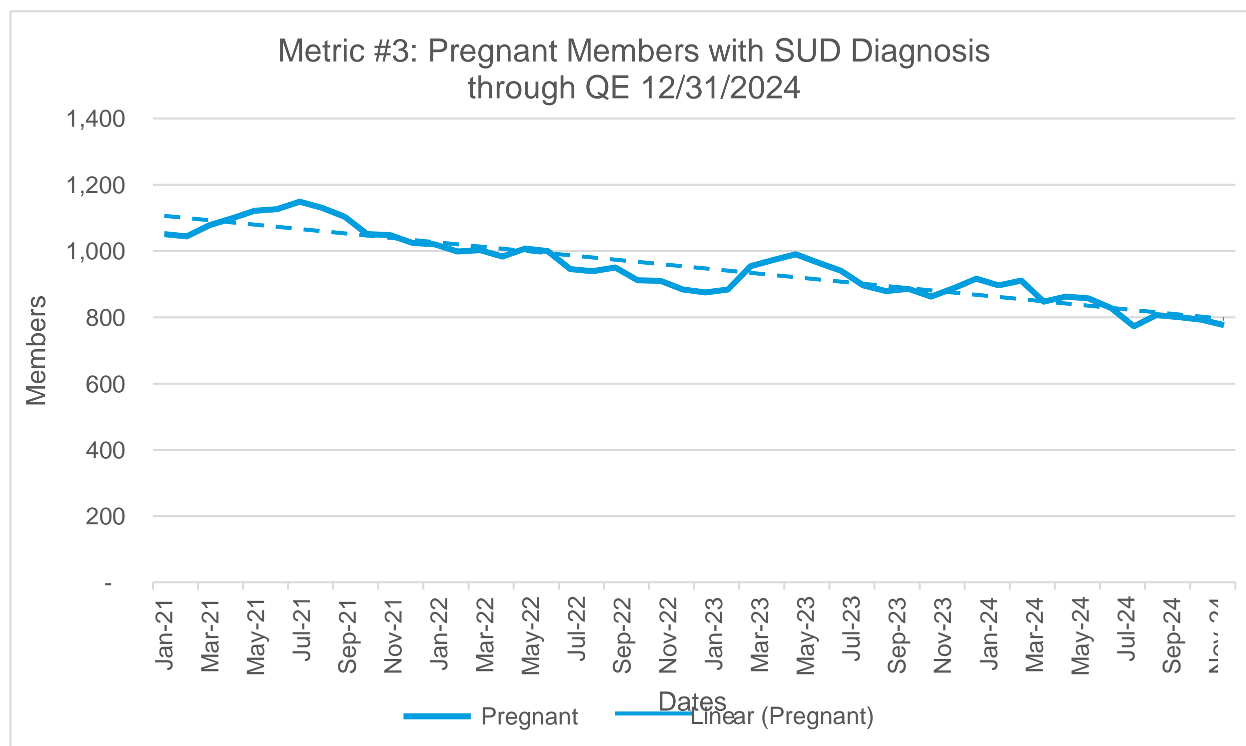
The overall number of individuals with SUD diagnoses under the Demonstration have declined. This is likely related to the end of the PHE and the eligibility unwinding.

Figure D.2. Metric #3 Members with SUD Diagnosis



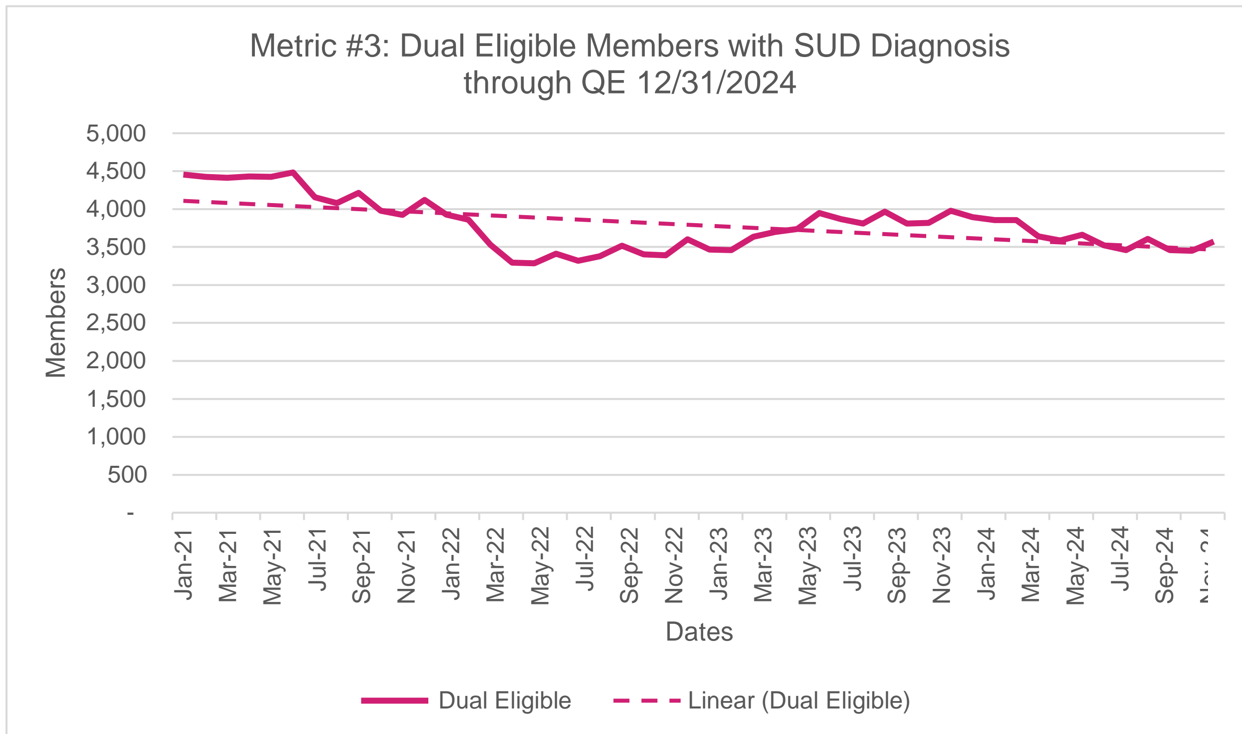
Several subpopulations exhibit this declining trend. See Pregnant Women below which has declined steadily since the Demonstration's inception.

Figure D.3. Metric #3 Pregnant Members with SUD Diagnosis



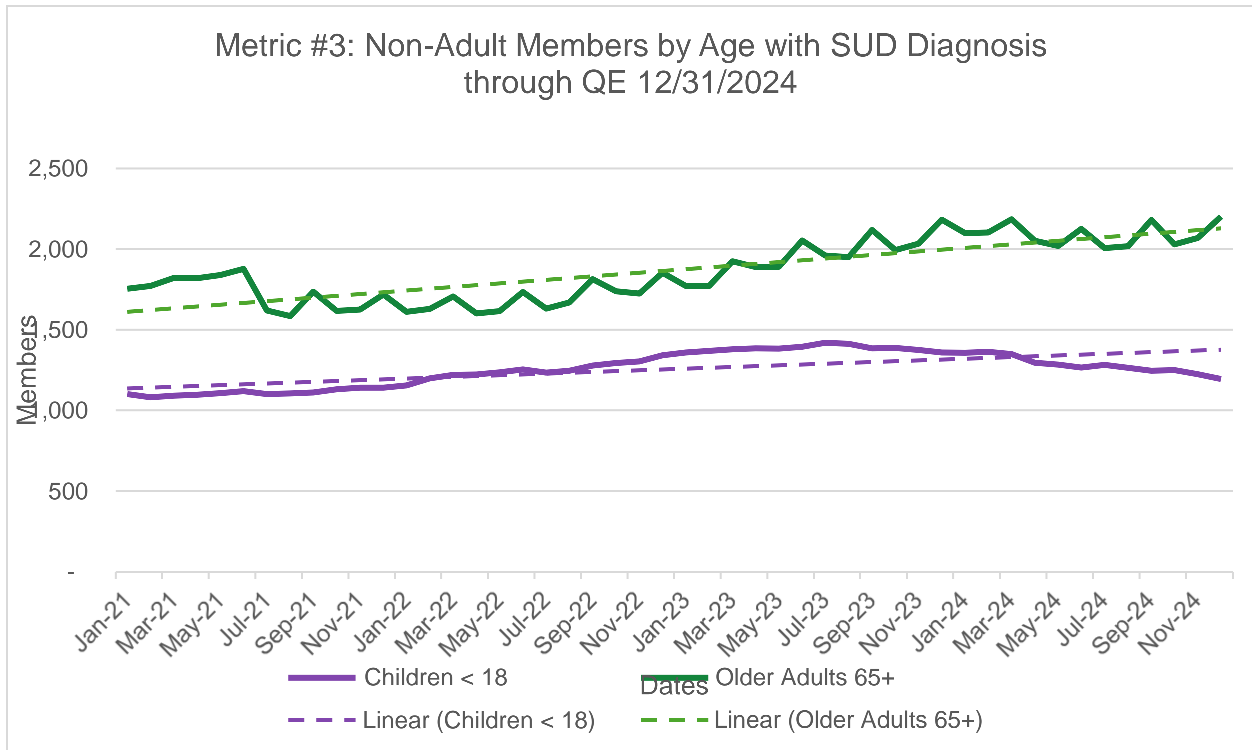
Dual eligible members declined with the inception of the Demonstration, but increased through the end of 2023. The decline in 2024 is probably due to the eligibility unwinding at the end of the PHE.

Figure D.4. Metric #3 Dual Eligible Members with SUD Diagnosis



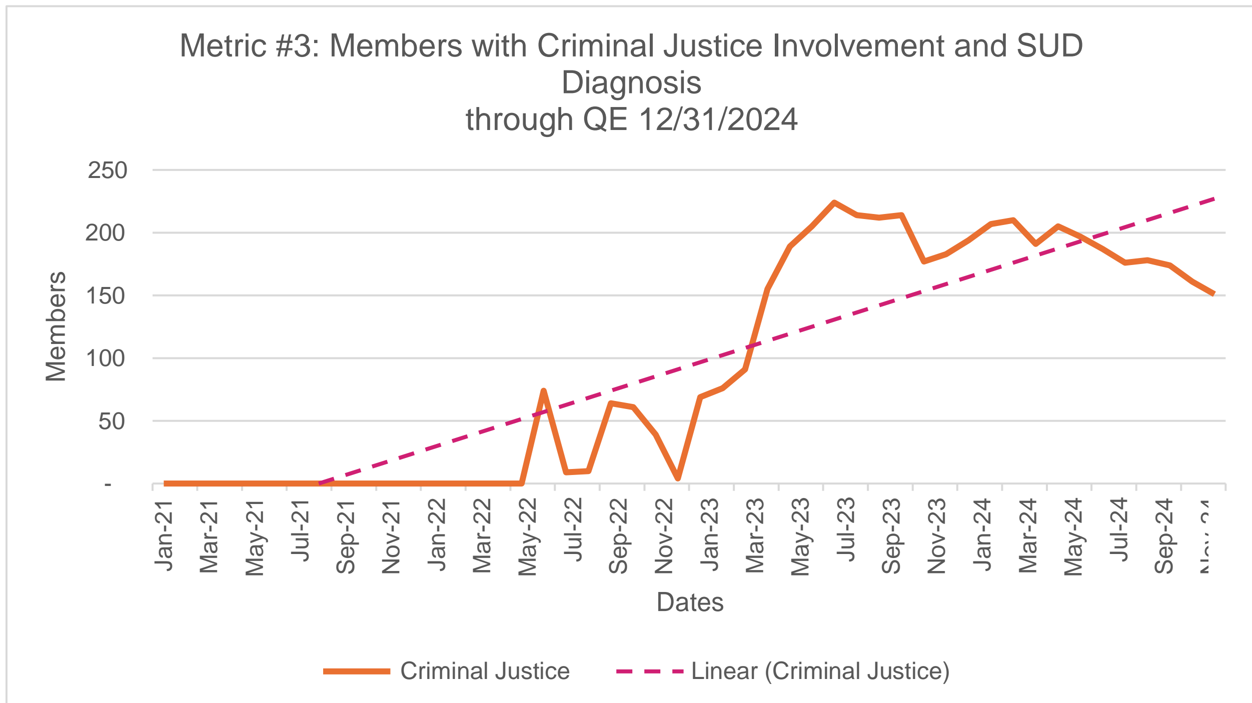
Older adults age 65 years and older with an SUD diagnosis have steadily increased under the Demonstration while the number of youth increased until the end of the PHE when eligibility unwinding began.

Figure D.5. Metric #3 Non-Adult Members with SUD Diagnosis



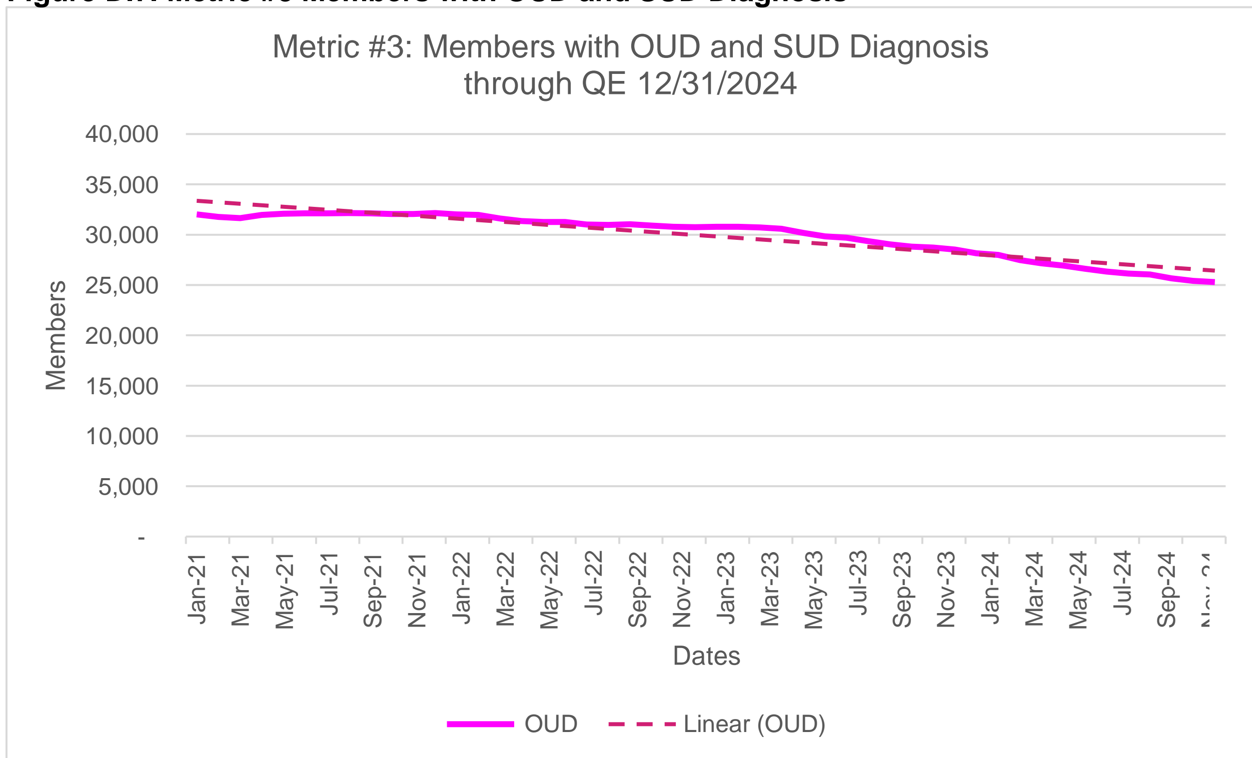
Prior to the Demonstration, Connecticut did not track Medicaid members with criminal involvement and SUD diagnosis. Beginning in June 2022, Connecticut was able to track individuals with the Department of Correction or Judicial Branch Court Support Services Division involvement post release from prison. Over time, there has been an overall trend of increasing services to the criminal justice involved population.

Figure D.6. Metric #3 Members Criminal Justice Involvement and SUD Diagnosis



The graph below shows the number of Medicaid members over time with a SUD or OUD diagnosis. With the public health emergency unwinding there has been a decreasing number of individuals overall with an SUD or OUD diagnosis.

Figure D.7. Metric #3 Members with OUD and SUD Diagnosis



Quality Performance Improvement Project for Changing Pathways Model (Withdrawal Management)

Carelon and the CT BHP have undertaken a quality initiative to promote, replicate, and sustain the Changing Pathways model across the alcohol and drug treatment centers (ADTCs) providing ASAM medically monitored intensive inpatient withdrawal management services (ASAM 3.7 WM level of care). Changing Pathways uses principles of implementation science to transform the care HUSKY Health members receive when initiating their recovery from opioid use disorders (OUDs). Among the foundational aspects of Changing Pathways is the shift in practice from traditional protocol-driven withdrawal management to the person-centered initiation of medications for opioid use disorder (MOUD). All the elements of promoting the adoption of evidence-based practices, including context-specific solutions, stakeholder engagement, capacity building, evaluation and feedback, interdisciplinary collaboration, and multi-level approaches have been central themes during initiative meetings.

Despite concerted efforts by the CT BHP and Carelon to promote the Changing Pathways model, traditional withdrawal management for the treatment of OUD has remains the common practice. Statewide, the volume of members initiated on MOUD decreased from 24.3% (n = 523) in Q3 and Q4 2023 to 21.1% (n = 399) in Q1 and Q2 2024. Carelon regional network managers (RNMs) convened in-State Provider Analysis and Reporting (PAR) meetings with providers to continue to leverage MOUD initiation data during provider discussions to gain critical insights and reinforce the practice of offering MOUD at both the provider and system level. Initiative conversations also focused on the initiation of MOUD and its impact on associated quality measures (e.g., leaving treatment against medical advice [AMA], readmissions, and connections to MOUD post inpatient episode).

Despite efforts by the CT BHP and Carelon to promote the Changing Pathways model, as of Q1/Q2 of 2024, MOUD inductions during 3.7 WM episodes had declined since the model's launch. Several factors have contributed to this including leadership turnover and organizational culture changes contribute to this issue, as new staff require retraining to maintain model fidelity, affecting implementation and accurate MOUD documentation. The prevalence of fentanyl further complicates MOUD initiation during 3.7 WM episodes, prompting some providers to delay treatment until patients stabilize in residential settings. Additionally, stigma and past negative experiences lead some members to reject Changing Pathways as a recovery option. Moreover, MOUD initiation demands more staff resources compared to traditional withdrawal management, underscoring the need for financial incentives, such as higher reimbursement rates for MOUD services or a value-based payment model, to integrate and sustain Changing Pathways as a life-saving treatment in withdrawal management.

Carelon has also leveraged overdose data to support conversations around the adoption and implementation of harm reduction practices. Statewide data from calendar year 2021 (CY21) to CY23 indicated that members who were not initiated on MOUD during their 3.7 WM episode had an overdose rate of 6.6% in the 90 days following their discharge, in comparison to those individuals who were initiated on MOUD at 5.0%. These findings also encouraged dialogue surrounding the practice of MOUD initiations as an evidence-based practice.

The CT BHP and Carelon have also focused on addressing alcohol use disorders (AUDs) due to their high prevalence and significant health impact on HUSKY Health members. RNMs continued to leverage data during 3.7 WM PAR meetings to address the growing proportion of individuals with an AUD. A review of the 3.7 WM ADTC data continued to demonstrate an upward trend in the percentage of members presenting to treatment with a primary AUD

diagnosis, increasing from 62.7% (n = 2,998) in Q1 and Q2 2022 to 65.9% (n = 3,070) in Q1 and Q2 2024. As such, PAR and workgroup meetings were used to raise awareness of this trend and promote the use of three Food and Drug Administration-approved medications (i.e., disulfiram, acamprosate, and naltrexone), and other best practices for the treatment of AUD.

In Q1 and Q2 2024, the 3.7 WM level of care had a seven-day readmission rate of 9.1%. The population with a primary diagnosis of AUD continued to drive this measure, with a seven-day readmission rate of 10.0% compared to those with a primary diagnosis of OUD at 7.6%. Providers identified housing insecurity, transportation barriers, and medication adherence as factors impacting this quality measure.

Adopting a more integrated treatment approach that addresses the prevalence of co-occurring mental health and substance use disorders, the 2024 PAR cycle leveraged claims-based data to highlight the low percentage of 3.7 WM providers documenting a mental health (MH) diagnosis on claims. During PAR meetings, many providers acknowledged the high prevalence of co-occurring substance use and MH conditions within the population they serve, with several providers conducting formal screenings for MH conditions. However, the documented identification of a MH diagnosis is often omitted on the claim. Providers acknowledged that further education of administrative staff completing these tasks would support accurate documentation, and thus a more comprehensive picture of the members being served. In the first half of 2024, documentation practices varied widely among 3.7 WM providers, with the rate of capturing MH diagnoses on claims ranging from 0% to 41.1%. Providers were encouraged to present a comprehensive clinical profile of the population they serve, including MH diagnoses, to support thorough discharge planning and facilitate connections to aftercare. Claims-based data will continue to be shared in each PAR cycle to promote the documentation of a member's complete clinical presentation.

Currently, there remains variation in social determinants of health (SDoH) screening practices across all seven 3.7 WM providers. Several providers have embedded SDoH screening as part of the triage and biopsychosocial assessment process, as required by federal entities such as the Health Resources and Services Administration for providers designated as a federally qualified health center (FQHC). Some providers reported using the functional assessment guide Daily Living Activities–20 (DLA–20), while other providers have opted to build this function into their electronic health record. During the Q1 and Q2 2024 PAR cycle, conversations ensued regarding the importance of screening to identify disparities, personalize treatment plans, and ensure connections to appropriate resources.

Annual System Evaluation

Carelon, on behalf of the CT BHP, completes an overall system evaluation across a variety of domains and target areas and quality measures on an annual basis. Reporting on utilization specific to the ASAM levels of care are separate and summarized above. Activities and results from the 2023 and 2024 reports that pertain to substance use have been pulled and highlighted below.

Implement/maintain the Adult PAR Program for Inpatient, Intensive Outpatient Program (IOP), 3.7 Withdrawal Management, Emergency Department, and Methadone Maintenance. Hold post-PAR system enhancement meetings to support ongoing clinical, quality, and performance improvement strategy development. Maintain the standalone Enhanced Care Clinic/Mystery Shopper Program.

PAR activities for various levels of care included:

- On a semiannual basis, RNMs applied a multi-systems approach to promote health care, strengthen care connections, improve documentation, and cultivate a cohesive Statewide strategy among inpatient, ambulatory, and community-based programs. The goal was to improve the delivery of MOUD and alcohol use disorder (MAUD) services throughout Connecticut's Medicaid behavioral health care system. These behavioral health partners were engaged in PAR discussions to capture actionable insights, explore next steps, and improve the flow of communication.

- Throughout 2024, the PAR program remained the primary platform for promoting, replicating, and sustaining the Changing Pathways model across alcohol and drug treatment centers (ADTCs)offering ASAM 3.7 withdrawal management (3.7 WM) level of care. The shift from traditional withdrawal management to the initiation of MOUD was a central theme during PAR meetings.

- RNMs continued to leverage medications for substance use disorder data as part of the PAR meeting process to gain critical insights and inform practice changes at both the provider and system levels. PAR discussions focused on the initiation of MOUD and its associated impact on related quality measures, including members leaving treatment AMA, readmissions, opioid poisoning pre/post-discharge, and connections to MOUD. To promote standardization of the Changing Pathways model and sustain the practice of initiating MOUD during treatment, RNMs conducted regular quality and performance improvement activities with all 3.7 WM providers. These activities included documentation training and the use of ad hoc system enhancement meetings to foster collaboration among community providers and establish a deeper understanding of referral pathways. Additionally, monthly data on MOUD initiations was made available to providers.

- In preparation for the launch of the 2025 inpatient and residential PAR program, Carelon focused on several key activities in 2024 to support the system of care including: (1) developing data analytic capabilities to report on the utilization of inpatient and residential levels of care for SUD treatment, (2) fostering better relationships among providers across the continuum of care through a series of connect-to-care meetings, and (3) educating providers on the ASAM levels of care to assist in determining the appropriate level of care for HUSKY Health members. These activities not only support the expansion of access to vital SUD services, but also promote a more integrated, collaborative approach to the delivery of care. By strengthening provider relationships, employing data analytics to track utilization trends, enhancing education on ASAM Quality Management and Clinical Program Evaluation criteria, and offering training on the latest treatment best practices, Connecticut is making significant strides toward improving the quality and effectiveness of its SUD treatment system.[11]

[11] https://portal.ct.gov/dss/health-and-home-care/substance-use-disorder-Demonstration-project?language=en_US

Utilization by Level of Care[12] — Adult

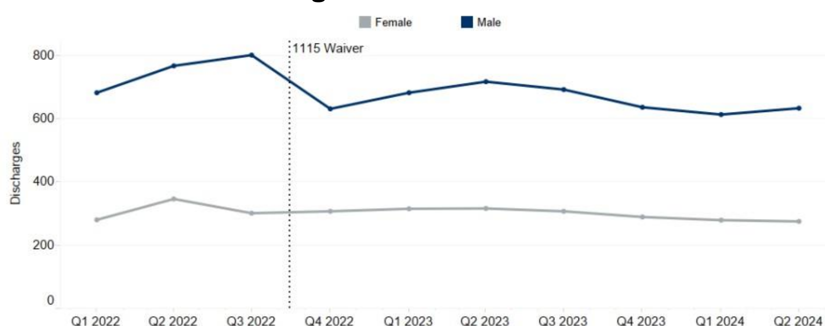
Carelon produces utilization reports used by DSS for monitoring utilization under the Demonstration.

ASAM 4.0-WM

The January 2024 through June 2024 report found that the ASAM 4.0-WM utilization discharge volume for non-dual adult members was down 19.3% in Q2 2024 from a high of 1,125 discharges in Q2 2022. At the same time, the average length of stay (ALOS) decreased slightly from 6.0 days in Q1 2024 to 5.6 days in Q2 2024, but remained relatively stable over time. The rate of 4.0-WM admissions per 1,000 members remained consistent, with 0.6 admits/1,000 in Q1 2022 and 0.5 admits/1,000 in Q2 2024. The number of 4.0 WM days per 1,000 members also remained nearly identical over time, with 3.1 days/1,000 in Q1 2022 and 3.0 days/1,000 in Q2 2024.

As can be seen in the figure below, males accounted for 69.7% (n = 633) of 4.0 WM discharges in Q2 2024. Carelon also reported that the male proportion is an overrepresentation of 25.2 percentage points compared to their proportion in the total adult HUSKY Health population of 44.5%. However, Carelon also noted that the ALOS is nearly identical by gender.

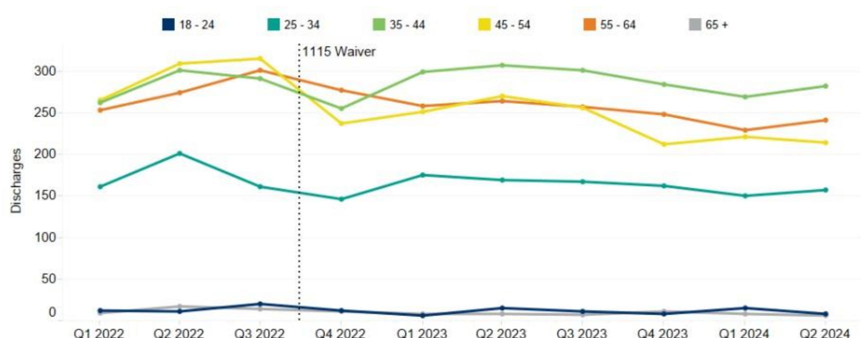
Figure D.8. Discharge Volume by Gender for ASAM 4.0-WM Medically Managed Intensive Inpatient Withdrawal Management



In the figure below, Carelon demonstrated the relationship of utilization between different adult age groups over time prior to and after the inception of the Demonstration. The 35 years-44 years old age group's utilization has remained higher than other age groups throughout the Demonstration period.

[12] (2024). Adult semiannual report executive summary: Final Q1-Q2 2024. https://s18637.pcdn.co/wp-content/uploads/sites/76/Adult-Semiannual-Report-Executive-Summary-Final-Q1-Q2-2024.pdf

Figure D.9. Discharge Volume by Age Group for ASAM 4.0-WM Medically Managed Intensive Inpatient Withdrawal Management



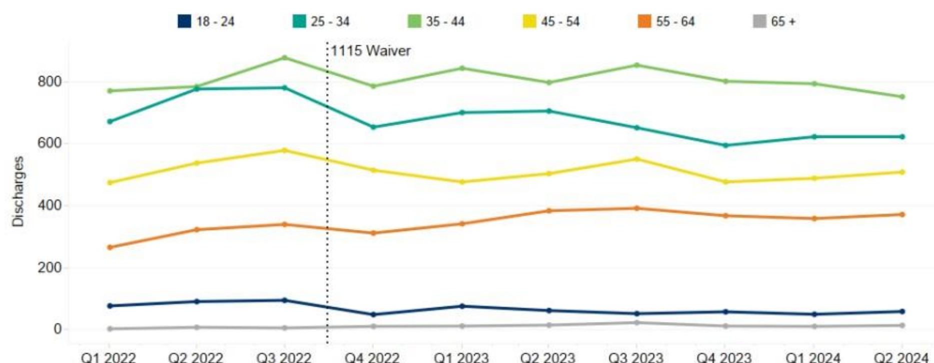
ASAM 3.7-WM

The Carelon report also found that the **ASAM 3.7-WM Medically Monitored Intensive Inpatient Withdrawal Management** at ADTCs utilization discharge volume for non-dual adult members has remained consistent over time, with 2,329 discharges in Q2 2024 compared to 2,264 discharges in Q1 2022. The ALOS for 3.7-WM ADTC providers also remained consistent at 4.5 days in Q2 2024 compared to 4.3 days in Q1 2022.

In Q2 2024, most 3.7 WM discharges at ADTCs were from members identifying as White (50.6%), non-Hispanic or with an unknown ethnicity (87.6%), male (72.3%), between the ages of 35 years–44 years old (32.3%), and enrolled in HUSKY D (88.4%) — consistent with demographic trends previously observed for this level of care. Males were overrepresented by 27.8 percentage points within this level of care compared to their percentage in the adult HUSKY Health population without dual membership of 44.5%.

As can be seen in the figure below, similar to the utilization of ASAM 4-WM, the 35 to 44 years old age group has the largest utilization. Notably, discharge volume by the 55 to 64 years old age group has increased by 39.8% from 266 in Q1 2022 to 372 in Q2 2024.

Figure D.10. Medically Monitored Intensive Inpatient Withdrawal Management (ASAM 3.7-WM) ADTC Discharge Volume by Age Group



Utilization of ASAM 3.7-WM at State Institutions/Psychiatric Facilities began at Connecticut Valley Hospital (CVH) on April 15, 2022 as part of the implementation of the Demonstration. Discharge volume has increased most quarters since this level of care began and, more recently, increased slightly from 286 discharges in Q4 2023 to 312 discharges in Q2 2024.

ALOS has remained relatively consistent over time, fluctuating between 5.1 and 5.9 days since authorizations began for this level of care. In Q2 2024, demographics for discharges from 3.7 WM at CVH were similar to the demographics for discharges from 3.7 WM at ADTCs, where the majority were from members identifying as White (51.3%), non-Hispanic, or with an unknown ethnicity (84.0%), male (68.9%), between the ages of 35 and 44 years old (32.4%), and enrolled in HUSKY D (83.3%).

ASAM 3.7

Carelon began authorizing medically monitored intensive inpatient treatment (ASAM 3.7) at a State institution or psychiatric hospital on April 15, 2022, as a part of the implementation of the Demonstration . CVH was the only provider with this specific provider type and specialty for this level of care. Discharge volume increased from 125 discharges in Q4 2023 to 157 discharges in Q1 2024, then remained consistent with 147 discharges in Q2 2024. Of note, CVH reopened 30 additional ASAM 3.7 level of care beds taken off-line due to the COVID-19 Pandemic in January 2024. This may have contributed to the increase in discharge volume in the first half of 2024 (n = 304) compared to the latter half of 2023 (n = 253). ALOS increased steadily each quarter since authorizations began for this level of care until it reached 26.0 days in Q4 2023. Since then, ALOS decreased to 21.3 days in Q1 2024 and remained steady with 22.2 days in Q2 2024. The majority of discharges in Q2 2024 were from members identifying as White (47.6%), non-Hispanic, or with an unknown ethnicity (81.0%), male (69.4%), between the ages of 35 and 44 years old (32.7%), and enrolled in HUSKY D (88.4%).

In addition, Carelon BH CT, on behalf of CT BHP, began authorizing medically monitored (3.7) and medically monitored enhanced (3.7E) intensive inpatient treatment services at ADTCs on July 1, 2022. Discharge volume for medically monitored intensive inpatient treatment (3.7) has remained consistent since this level of care began. There were 572 discharges in Q1 2024 and 562 discharges in Q2 2024. Overall, the ALOS was 19.0 days in Q1 2024 and 18.9 days in Q2 2024. The majority of discharges for this level of care in Q2 2024 were from members identifying as White (52.5%), non-Hispanic or with an unknown ethnicity (84.9%), male (74.0%), between the ages of 35-44 (34.5%), and enrolled in HUSKY D (MLIA) (88.6%). Next, medically monitored co-occurring enhanced inpatient treatment (ASAM 3.7E) discharge volume increased from 158 discharges in Q1 2024 to 189 discharges in Q2 2024. The Statewide provider ALOS was 20.0 days in Q2 2024. The majority of discharges for this level of care in Q2 2024 were from members identifying as White (50.3%), non-Hispanic or with an unknown ethnicity (89.9%), female (60.8%), between the ages of 35-44 (29.1%), and enrolled in HUSKY D (MLIA) (88.4%). The 3.7E level of care was the only inpatient service across mental health and substance use disorder treatment discussed in this report where females constituted the majority of discharges, representing between 52.3% and 65.8% of discharges each quarter since authorizations began.

ASAM 3.5, 3.5 Pregnant or Parenting Women, 3.3, and 3.1

Carelon began authorizing four different ASAM levels of residential services (ASAM 3.5, 3.5 Pregnant or Parenting Women [PPW], 3.3, and 3.1) for the treatment of SUDs on July 1, 2022 with the implementation of the Demonstration. First, clinically managed high-intensity residential services (ASAM 3.5) accounted for the majority of discharges for SUD residential services in the first half of 2024, with 661 discharges in Q1 2024 and 675 discharges in Q2 2024. Compared to the first half of 2023 (n = 1,212), discharge volume was 10.2% higher in Q1 and Q2 2024 (n = 1,336). Of the 11 providers for this level of care, APT Foundation had the highest volume of discharges at 27.4% (n = 185) in Q2 2024, followed by Southeastern Council on Alcoholism which accounted for 21.8% (n = 147) of discharges.

IOP and Partial Hospitalization

Carelon enhanced its reporting to begin differentiating IOP and partial hospitalization (PHP) services between mental health (MH) and SUD effective November 15, 2022, with the implementation of the Demonstration. In Q2 2024, IOP–SUD (ASAM 2.1) represented 44.9% (n = 2,413) of admissions for non-dual adult members. In this time, IOP – MH represented 17.3% (n = 931) of LOC admissions. The majority of IOP–SUD (ASAM 2.1) admissions in Q2 2024 were by males (64.9%) aged 35 to 44 years old (34.4%), while the majority of IOP–MH admissions were by females (57.6%) aged 25 to 34 years old (32.2%). Males were overrepresented among IOP–SUD (ASAM 2.1) admissions, accounting for 64.9% of admissions while representing 44.5% of the total adult HUSKY Health population without dual membership in Q2 2024. White members were also overrepresented among IOP–SUD (ASAM 2.1) and IOP–MH admissions as they accounted for 45.1% and 52.0% of admissions, respectively, while representing 35.8% of the total adult HUSKY Health population in Q2 2024.

Authorization and Utilization — Youth[13]

Carelon reported that the one ASAM 3.5 Adolescent program closed at the end of January 2023, and since then, DCF has been meeting with potential in-State and out-of-State adolescent providers to engage interest to enroll as new HUSKY Health providers. In the meantime, Carelon and the CT BHP support families and providers in finding treatment alternatives for youth in need of this ASAM residential level of care by assigning intensive case management and/or peer support as indicated.

IOP and PHP

Beginning November 15, 2022, with the implementation of the Demonstration, Carelon began to separately report IOP and PHP. In Q2 2024, there were 11 admissions to IOP–SUD services and two youth admissions to PHP–SUD services. Of these 13 admissions, eight were male, all were between the ages of 13 years–17 years old, 10 identified as White and three were of an unknown race, all were non-Hispanic or of an unknown ethnicity, and all reported English as their primary language.

Improving Capacity and Access

Carelon oversees the Medications for Substance Use Disorders Provider Locator Map, which provides an interactive and searchable database for HUSKY Health members seeking behavioral health providers that offer medications for substance use disorders. Users can filter their search by medication type, age, provider name (if known), and geographic location within the State of Connecticut. Additionally, a downloadable table in text format is available for printing or electronic sharing. Members can also search for providers that assist with substance use recovery. To be included on the map, providers must be enrolled in the HUSKY Health/Connecticut Medicaid network. Data points available on the map:

1. Provider
2. Level of care
3. Address
4. Contact number
5. Medication type offered
6. Ages served

[13] Carelon Behavioral Health Connecticut (2024). *Utilization Management for Youth Members. Executive Summary & Analysis by Level of Care.* Retrieved from: https://s18637.pcdn.co/wp-content/uploads/sites/76/Youth-Semiannual-Report-Executive-Summary-Final-Q1-Q2-2024.pdf

7. Public transportation available
8. Handicap accessibility
9. Any additional information the provider offers that is specific to their location, services and/or treatment.

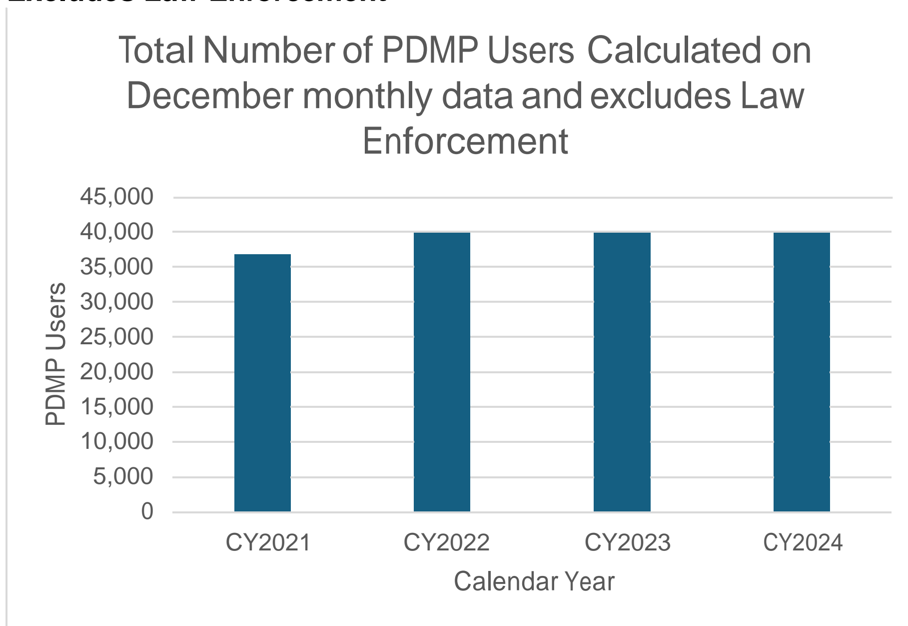
Carelon has a Provider Data Verification (PDV) form which serves as a resource for providers to refresh their referral details for the Provider Search website. This form enables Carelon to keep accurate records of essential practice information, such as identifying providers who are currently accepting new clients. PDV forms are accessible to individual billing practitioners, group practices, and clinic or facility entities. They are distributed to the network quarterly and can be accessed at any time on the website. The form specifically asks providers two questions: (1) Are you currently accepting new members for all populations? and (2) Are medications for substance use disorder treatment available (and if so, please list the type of medications prescribed or dispensed).

Substance Use Disorder Health Information Technology Annual Metrics

Connecticut tracks three metrics to document the outcomes from the State's interventions to improve health information technology. The first metric tracks the total number of Prescription Drug Monitoring Program (PDMP) users. This metric is calculated using the monthly PDMP data from December of each year and excludes law enforcement officer access.

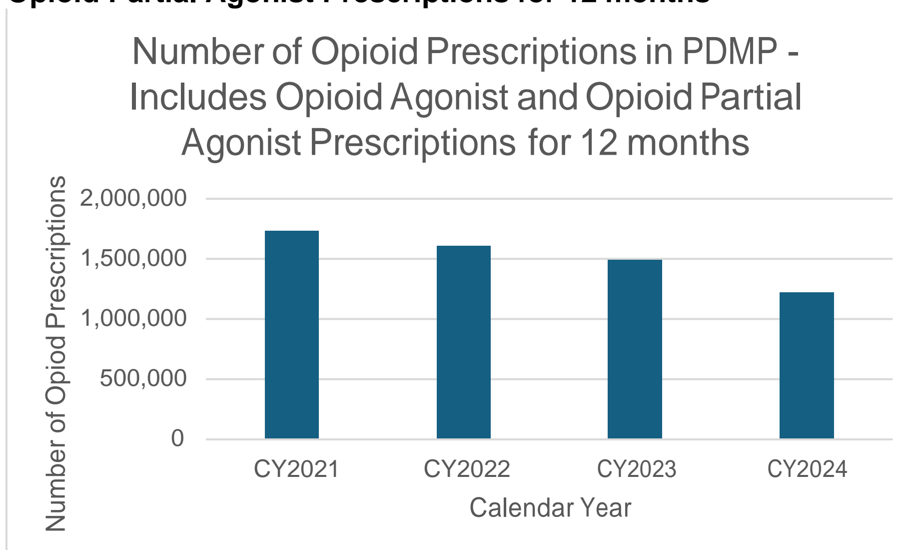
In the figure below, the number of PDMP users has increased since the beginning of the Demonstration (1.8% in calendar year 2023 [CY23] and 1.07% in CY24).

Figure D.11. Total Number of PDMP Users Calculated on December Monthly Data and Excludes Law Enforcement



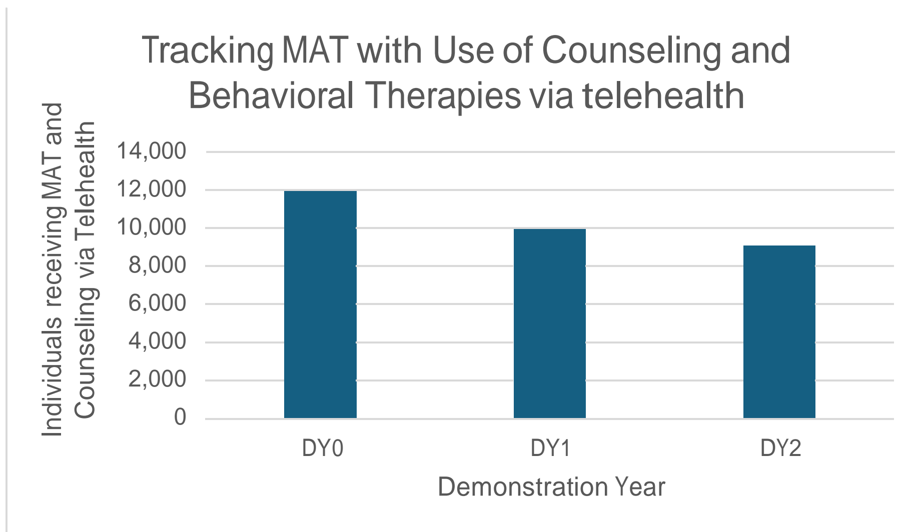
In the figure below, the number of opioid prescriptions in the PDMP has continued to decrease since the beginning of the Demonstration (-7.12% in CY23, and -18.47% in CY24).

Figure D.12. Number of Opioid Prescriptions in PDMP — Includes Opioid Agonist and Opioid Partial Agonist Prescriptions for 12 months



In the figure below, Connecticut's efforts to improve the use of medication-assisted treatment (MAT) with telehealth provided counseling or behavioral therapies has dropped substantially since the ending of the PHE (-14.91% in the first year of the Demonstration and -10.48% in the second year of the Demonstration). There continue to be over 9,000 individuals receiving SUD counseling associated with MAT via telehealth in the second year of the Demonstration.

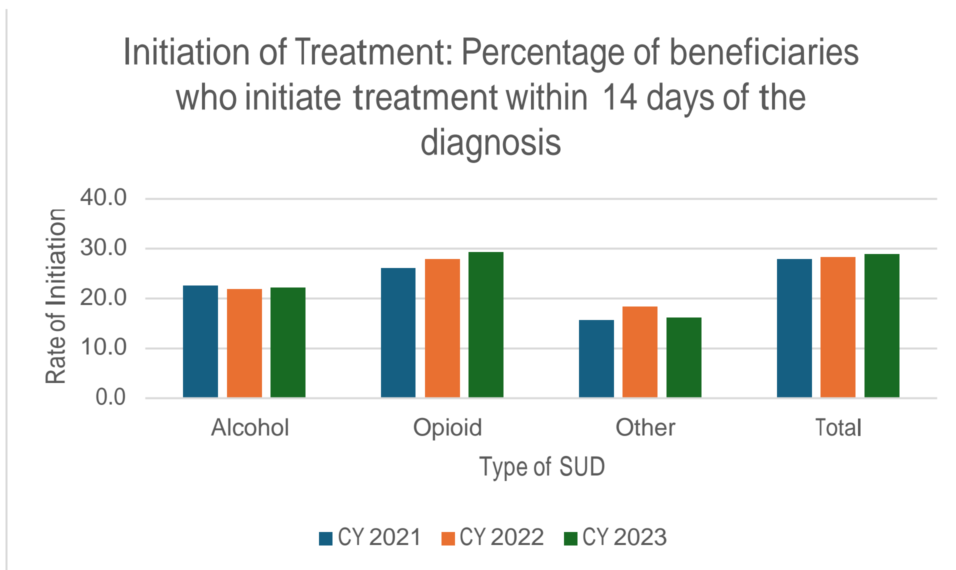
Figure D.13. Tracking MAT with Use of Counseling and Behavioral Therapies via Telehealth



Performance Metrics

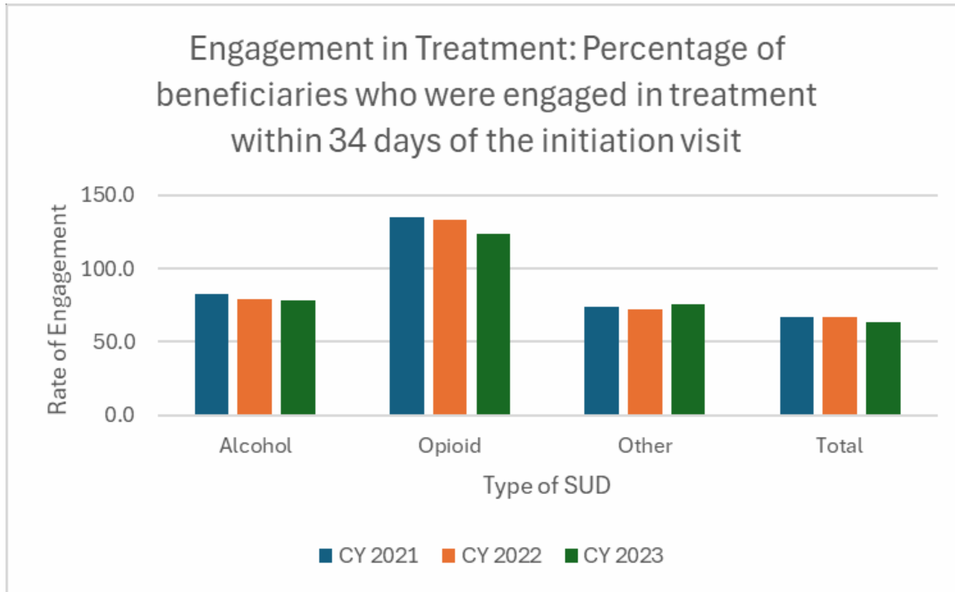
Connecticut routinely calculates SUD metrics using technical specifications from national stewards. In the second year of the Demonstration (CY23), Connecticut interventions under the Demonstration increased initiation of treatment for alcohol, opioids, and SUD overall, but initiation of treatment for other substances decreased (-12.2%).

Figure D.14. Percentage of Beneficiaries Who Initiate Treatment within 14 Days of the Diagnosis



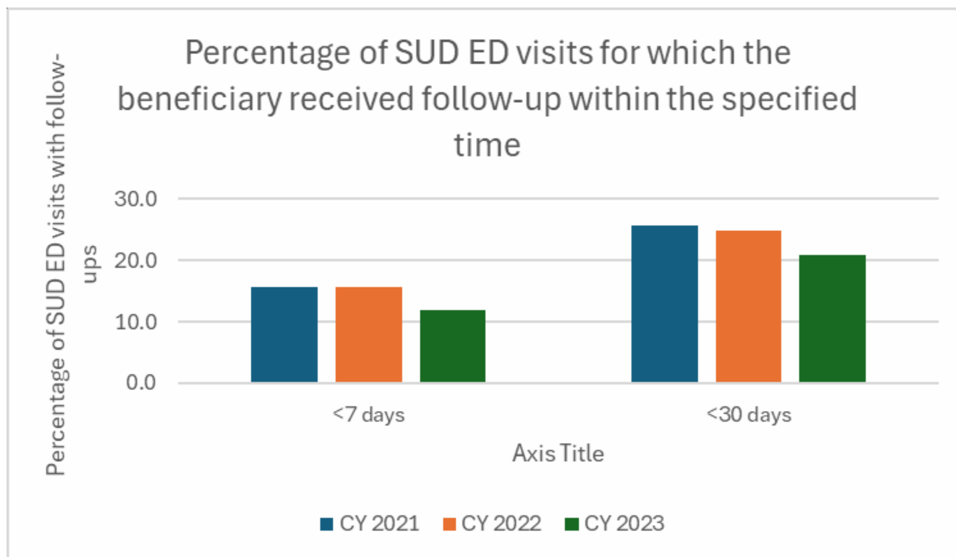
For Engagement in Treatment, the percentage of beneficiaries engaging in treatment within 34 days of the initiation visit increased for other SUD types from year one to year two by 4.4%, but decreased for alcohol, opioids, and SUDs overall (-1.2%, -7.2%, and -4.3%, respectively).

Figure D.15. Percentage of Beneficiaries Who Were Engaged in Treatment within 34 Days of the Initiation Visit



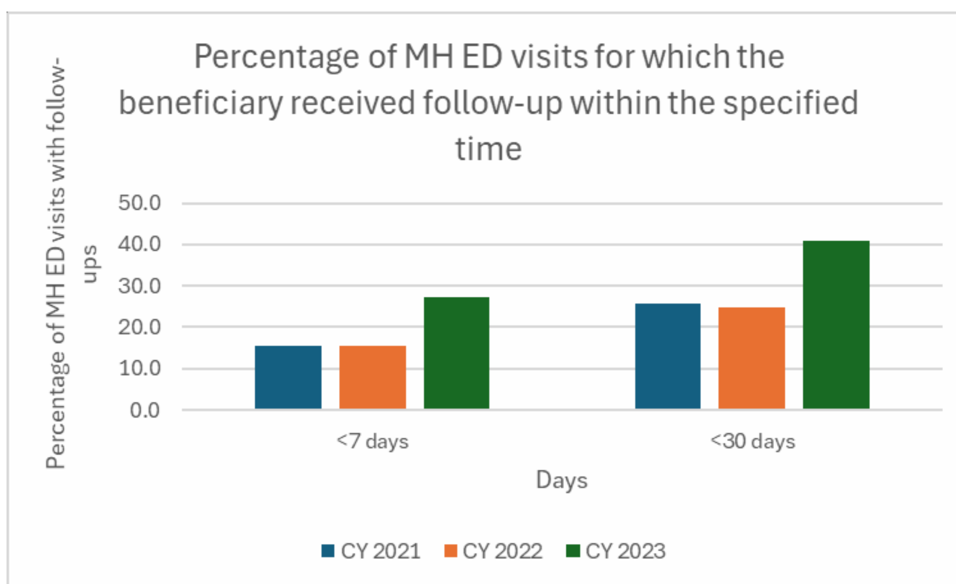
The Demonstration did not have a positive effect on follow-up after SUD emergency department (ED) visits for beneficiaries ages 18 years or older with a principal diagnosis of alcohol and other drug or other drug dependence: follow-up after seven days decreased by 23.3% and follow-up after 30 days dropped by 16.0%.

Figure D.16. Percentage of SUD ED Visits for which the Beneficiary Received Follow-Up within the Specified Time



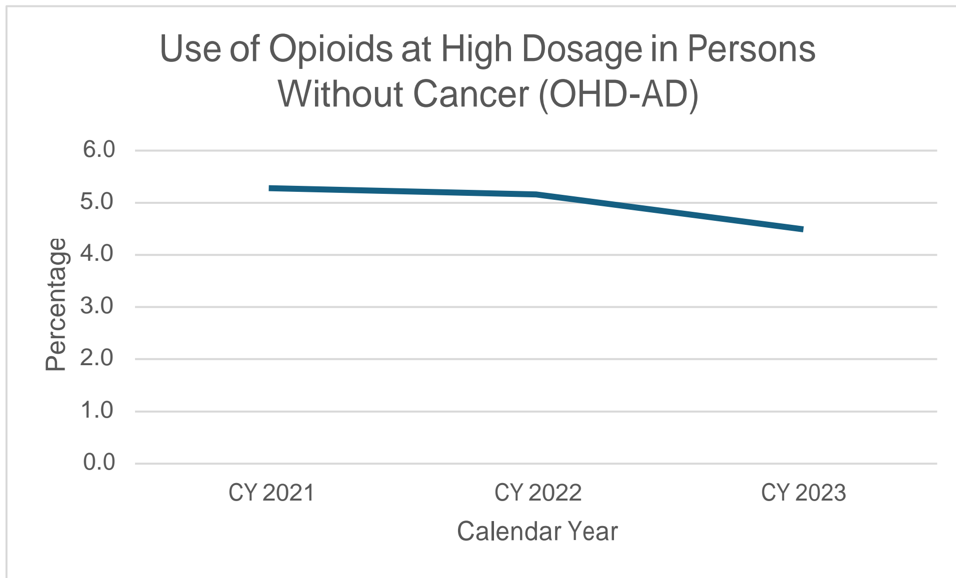
In contrast, the percentage of ED visits for beneficiaries age 18 years and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness, increased following the implementation of the Demonstration by 12.0% for seven days and 10.6% for follow-up after 30 days.

Figure D.17. Percentage of MH ED Visits for which the Beneficiary Received Follow-Up within the Specified Time



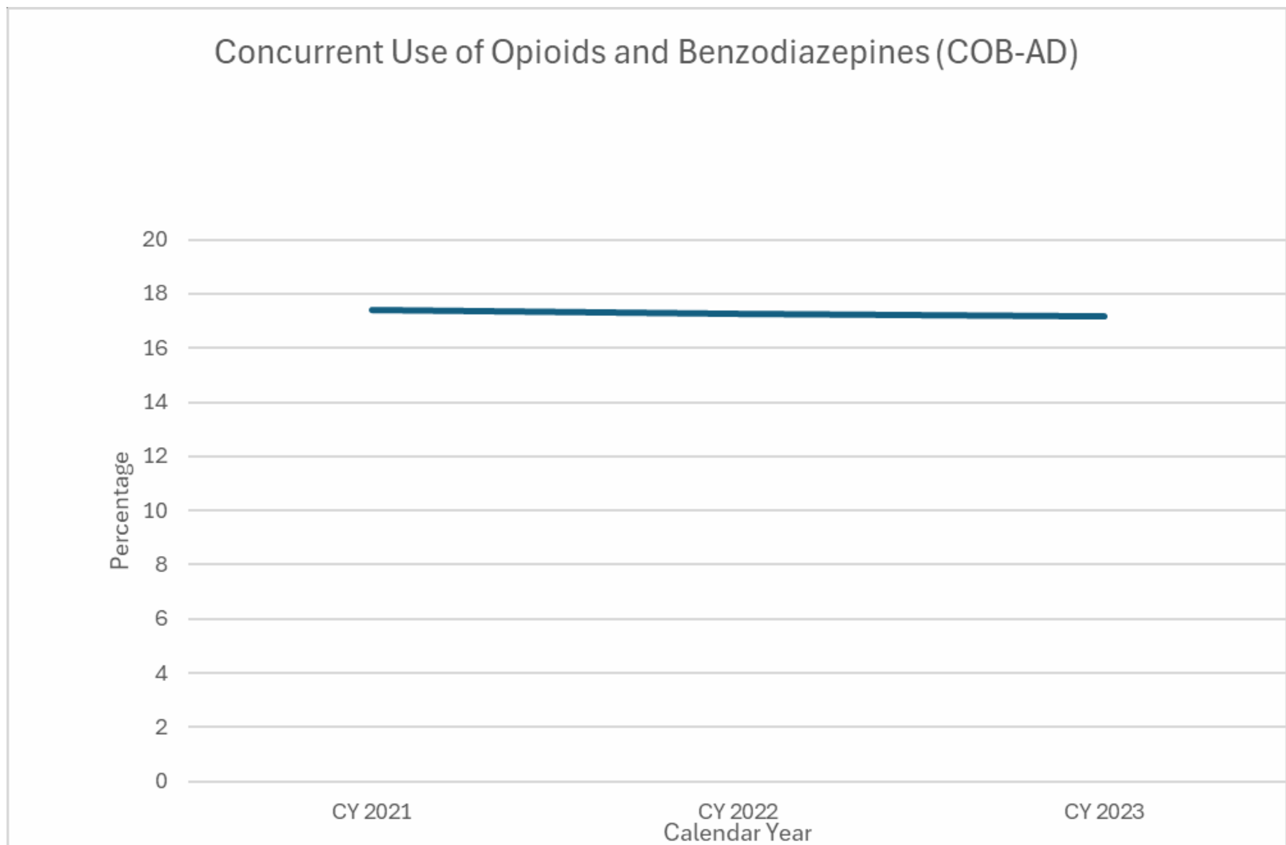
Two specific metrics show improvement with the implementation of the Demonstration. In these two metrics, decreased utilization were positive outcomes. The Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) improved from a rate of 5.16 to 4.49 by decreasing 13.0% in year two of the Demonstration.

Figure D.18. Use of OHD-AD



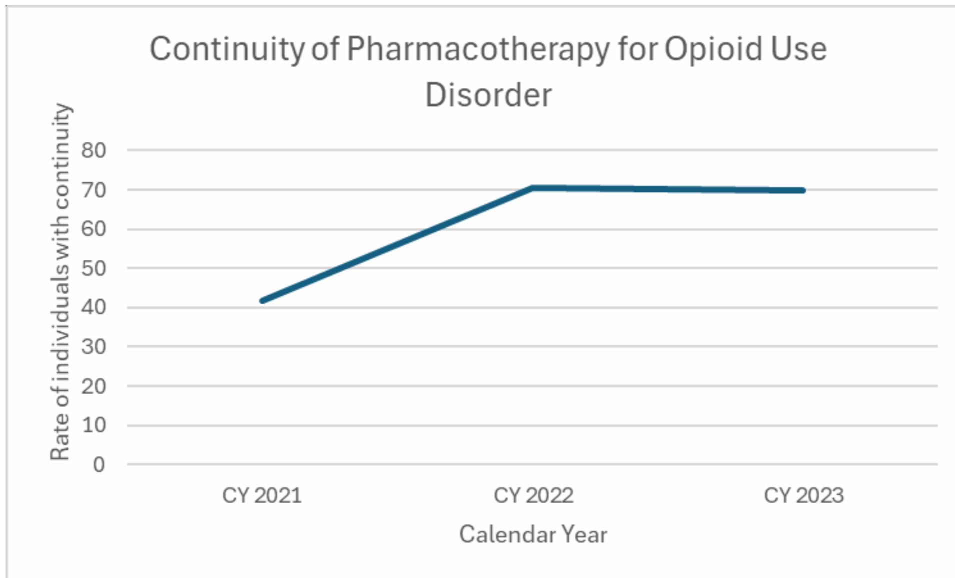
Similarly, the Concurrent Use of Opioids and Benzodiazepines (COB-AD) improved by decreasing from a rate of 17.25 to 17.15 or a decrease of 0.6% in year two of the Demonstration.

Figure D.19. Concurrent Use of COB-AD



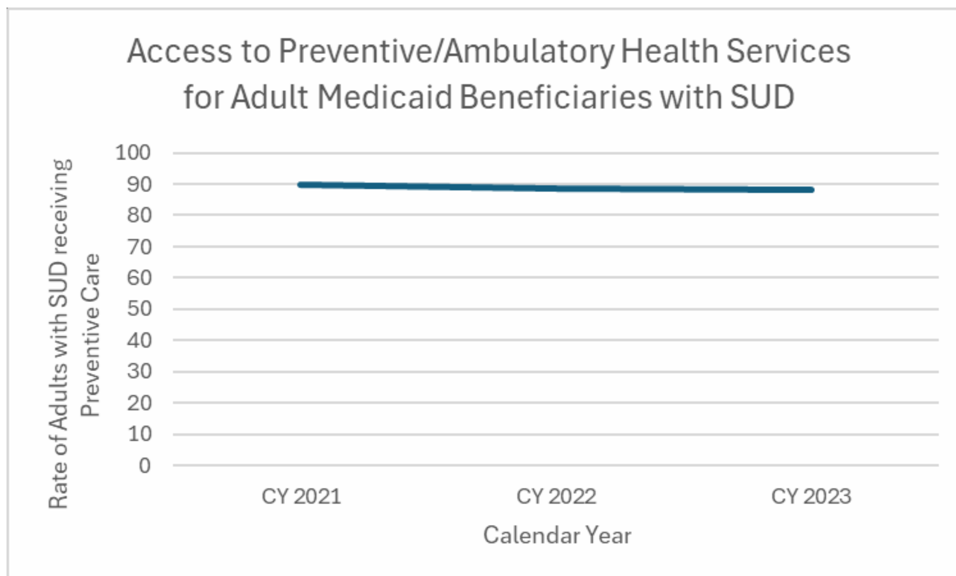
Connecticut almost doubled the rate of individuals with continuity of pharmacotherapy for Opioid Use Disorder (OUD) (increasing from a rate of 41.8 to 70.5) in year one of the Demonstration. However, the second year of the Demonstration decreased slightly (-0.9%) but still rounded to a rate of 70.

Figure D.20. Continuity of Pharmacotherapy for Opioid Use Disorder



Connecticut slightly declined in adult Medicaid beneficiaries access to preventive and ambulatory health services. Prior to the Demonstration, 89.6% of Medicaid adults with SUD received preventive and ambulatory health services. In CY22 and CY23, the second and third years of the Demonstration, only 88.5% and 88.0% received preventive and ambulatory health services respectively.

Figure D.21. Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD



The following table demonstrates that the number of Medicaid beneficiaries with SUD and OUD has dropped since 2021 probably due to the eligibility unwinding at end of the PHE.

Table D.1. Number of Medicaid Beneficiaries with SUD and OUD

DY Metrics	DY0 Metrics	DY1 Metrics	DY2 Metrics	% Change DY0 to DY1	% Change DY1 to DY2
Medicaid Beneficiaries with SUD Diagnosis (annually)	81,628	80,484	77,777	-1.40%	-3.36%
Medicaid Beneficiaries with OUD Diagnosis (annually)	36,714	36,051	34,214	-1.81%	-5.10%

The table below demonstrates that the number of beneficiaries treated in an Institution for Mental Diseases (IMD) for SUD and OUD has increased annually with the implementation of the Demonstration by 8.35% and 9.62% in Year 1 and by 27.88 and 17.67% in year 2 of the Demonstration.

Table D.2. Number of Beneficiaries Treated in IMDs for SUD and OUD

DY Metrics	DY0 Metrics	DY1 Metrics	DY2 Metrics	% Change DY0 to DY1	% Change DY1 to DY2
Medicaid Beneficiaries Treated in an IMD for SUD	5,797	6,281	8,032	8.35%	27.88%
Medicaid Beneficiaries Treated in an IMD for OUD	4,140	4,534	5,335	9.52%	17.67%

More noticeable is that the average length of stay in IMDs is increasing year over year since the inception of the Demonstration. Prior to the Demonstration, the overall stay in IMDs was 4.4 days for all individuals with SUD. By Demonstration Year 2, individuals with SUD were staying an average of 17.7 days. For OUD, the increase was even greater going from a 4.3 day stay prior to the Demonstration to an 18.6 day stay after the Demonstration.

Table D.3. Average Length of Stay in IMDs

		DY0 Metrics	DY1 Metrics	DY2 Metrics	% Change DY0 to DY1	% Change DY1 to DY2
Average Length of Stay in IMDs in days	SUD	4.4	11.7	17.7	162.56%	51.50%
Average Length of Stay in IMDs for OUD in days	OUD	4.3	11.8	18.6	176.48%	57.16%

In the table below, Connecticut has had SUD provider availability for MAT increase annually (10.42% in Year 1 and 9.43% in Year 2), but there was a slight decrease in the overall number of providers in Year 2 (-3.40%).

Table D.4. SUD Provider Availability

DY Metrics	DY0 Metrics	DY1 Metrics	DY2 Metrics	% Change DY0 to DY1	% Change DY1 to DY2
SUD Provider Availability — All Types	1,778	1,796	1,735	1.01%	-3.40%
SUD Provider Availability — MAT	48	53	58	10.42%	9.43%

For the State of Connecticut, the number and rate of drug overdose deaths has declined by 5.97% from CY21 to CY22 and 9.53% from CY22 to CY23.

Table D.5. Drug Overdose-Related Deaths from CY21–CY23

DY Metrics		CY21 Metrics	CY22 Metrics	CY23 Metrics	% Change CY21 to CY22	% Change CY22 to CY23
Drug Overdose Deaths (count)		1,607	1,511	1,367	-5.97%	-9.53%
Overdose Deaths (rate)		44.57%	41.67%	37.79%	-6.51%	-9.30%
Overdose Deaths (rate): age <18	<18	1.66%	0.68%	0.69%	-58.78%	0.44%
Overdose Deaths (rate): age 18-64	18-64	68.04%	62.14%	55.03%	-8.67%	-11.45%
Overdose Deaths (rate): age 65+	65+	14.93%	17.93%	19.87%	20.12%	10.83%
Overdose Deaths (rate): OUD	OUD	39.69%	37.45%	33.62%	-5.64%	-10.23%

The hospital readmission rate among Medicaid beneficiaries with SUD declined in the first year of the Demonstration, but as the number of individuals and the lengths of stay in IMDs grew, the number of hospital readmissions has also increased.

Table D.6. Hospital Readmissions Among Beneficiaries with SUD

	DY0 Metrics	DY1 Metrics	DY2 Metrics	% Change DY0 to DY1	% Change DY1 to DY2
Hospital Readmissions Among Beneficiaries with SUD	22.68%	22.36%	23.67%	-1.41%	5.87%

Access to Critical Levels of Care for OUD and Other SUDs (Milestone 1)

The following figure shows the number of individuals utilizing any service under the Demonstration prior to and after the implementation of Demonstration. Similar to the number of individuals with SUD diagnoses, the number of individuals receiving treatment has been affected by the eligibility unwinding at the end of the PHE.

Figure D.22. Metric #6: Members Receiving any SUD Services

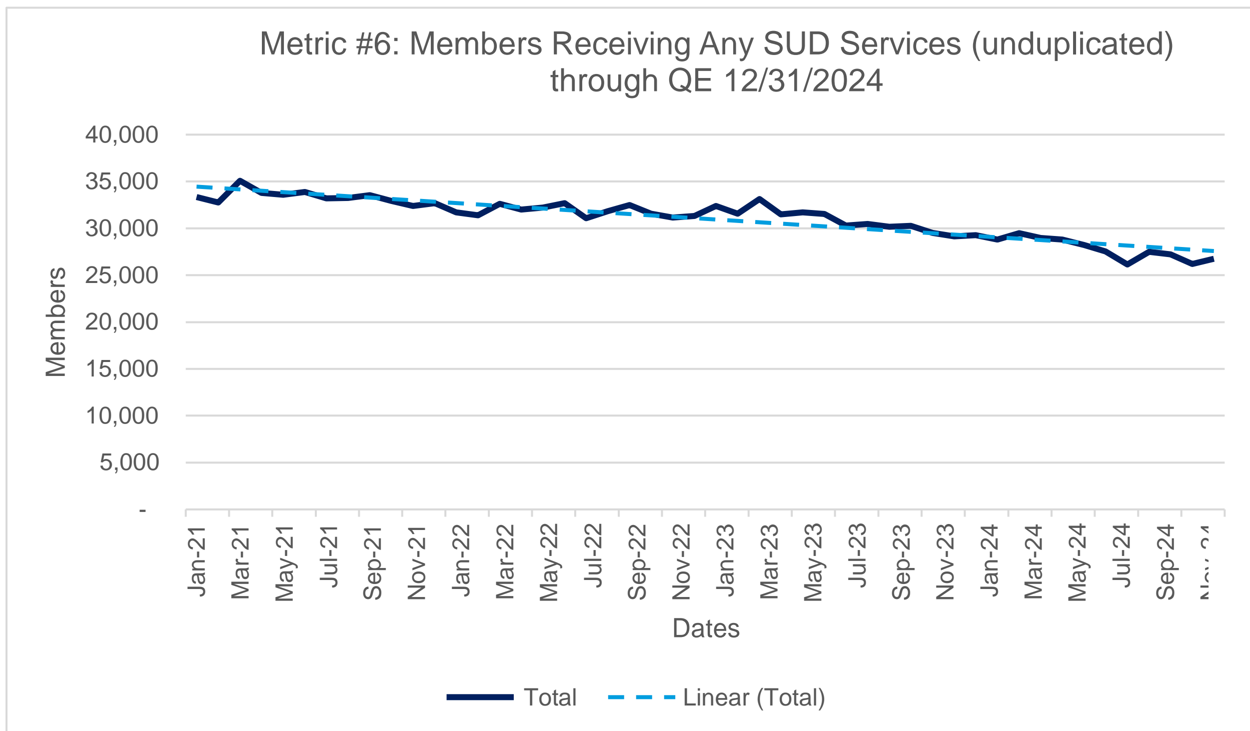


Figure D.23. Metric #6: Pregnant Members Receiving any SUD Services

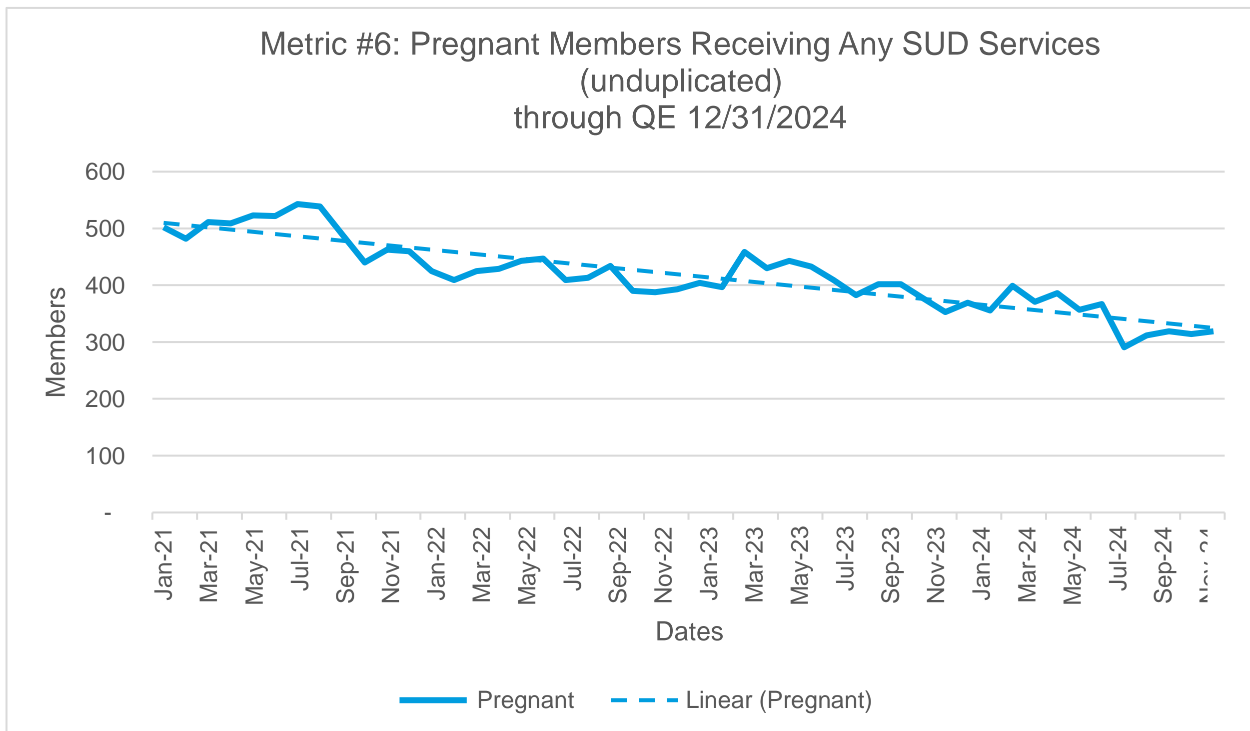


Figure D.24. Metric #6: Dual Eligible Members Receiving any SUD Services

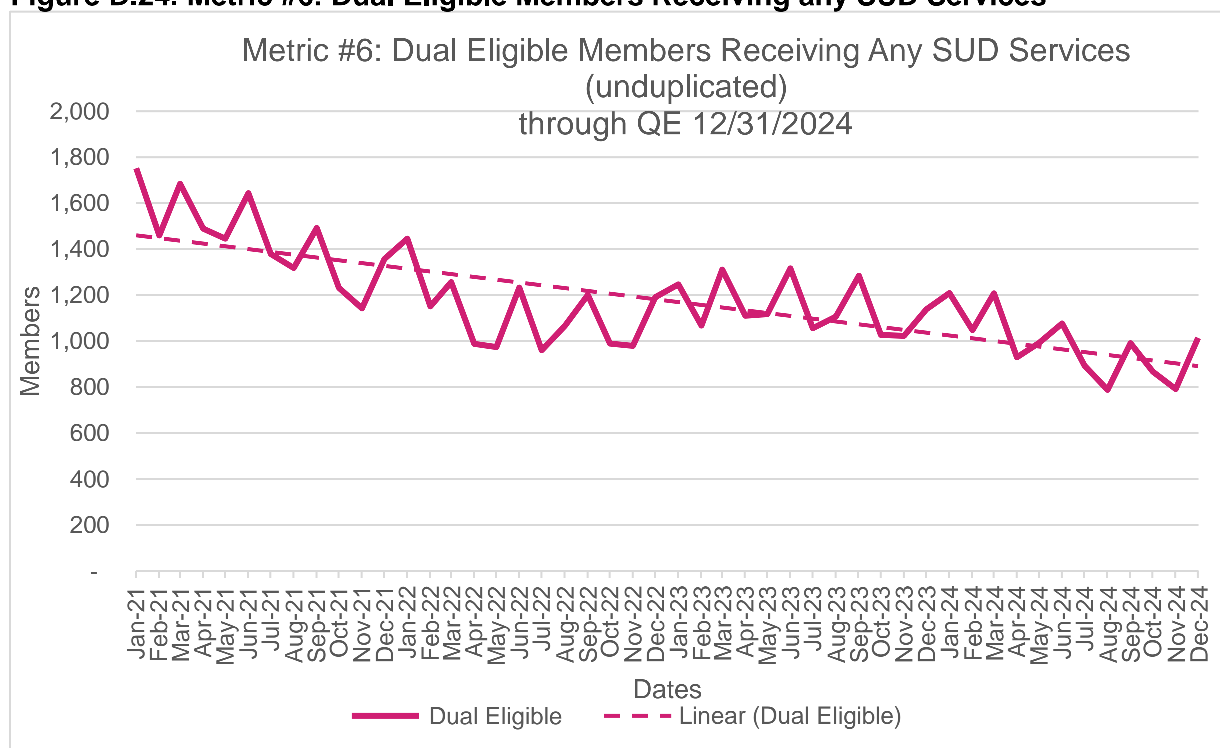


Figure D.25. Metric #6: Non-Adult Members by Age Receiving any SUD Service

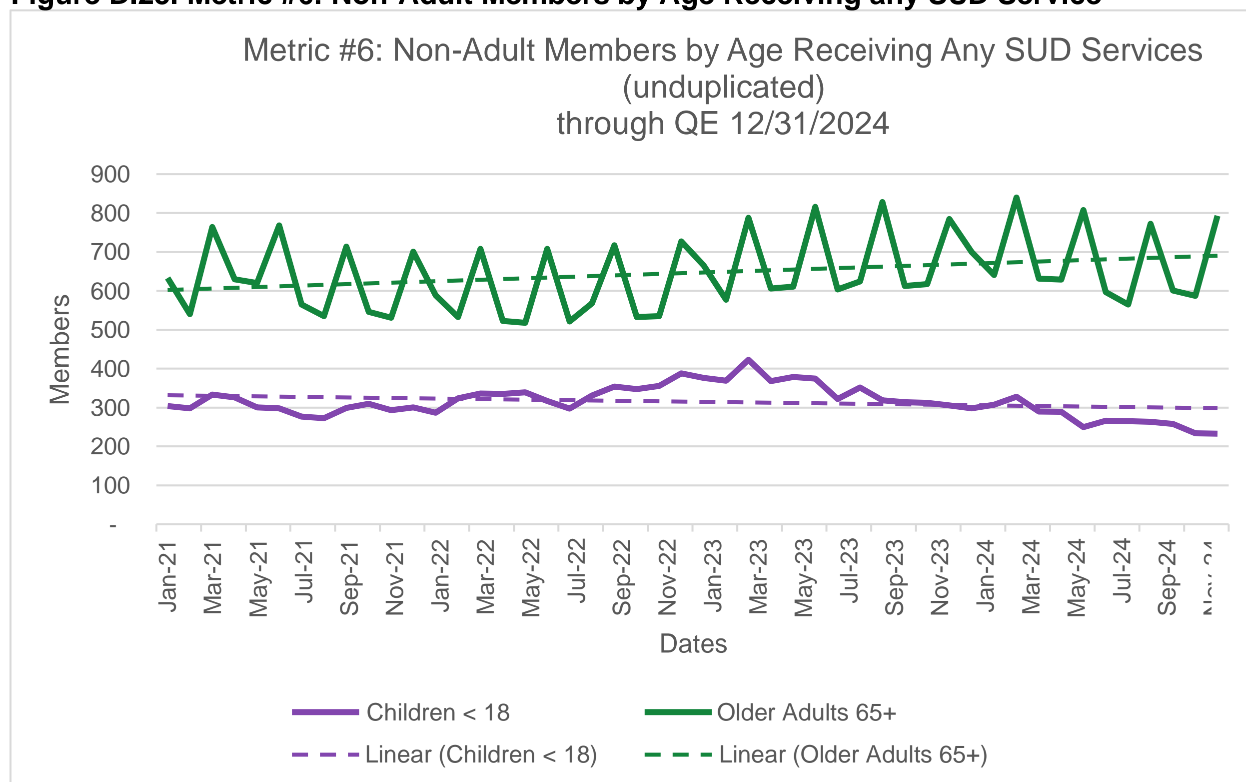


Figure D.26. Metric #6: Members with OUD Diagnosis Receiving any SUD Services

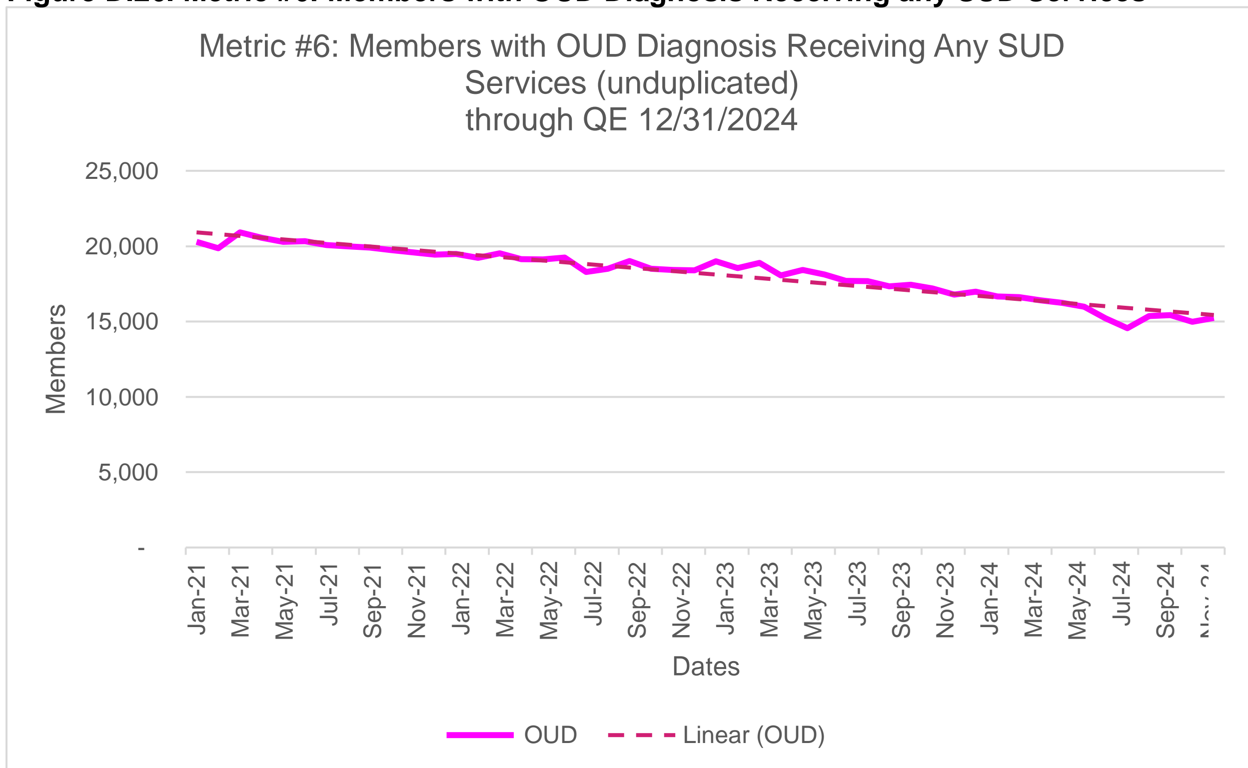
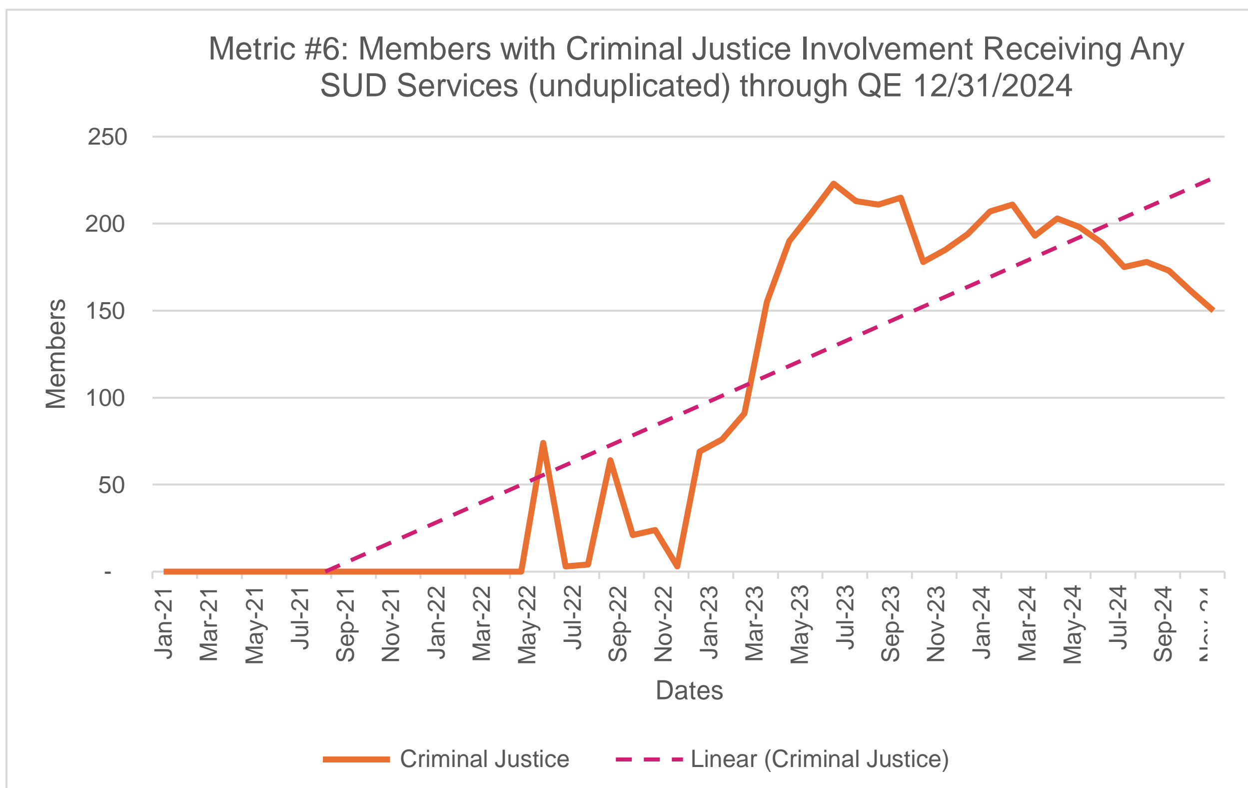
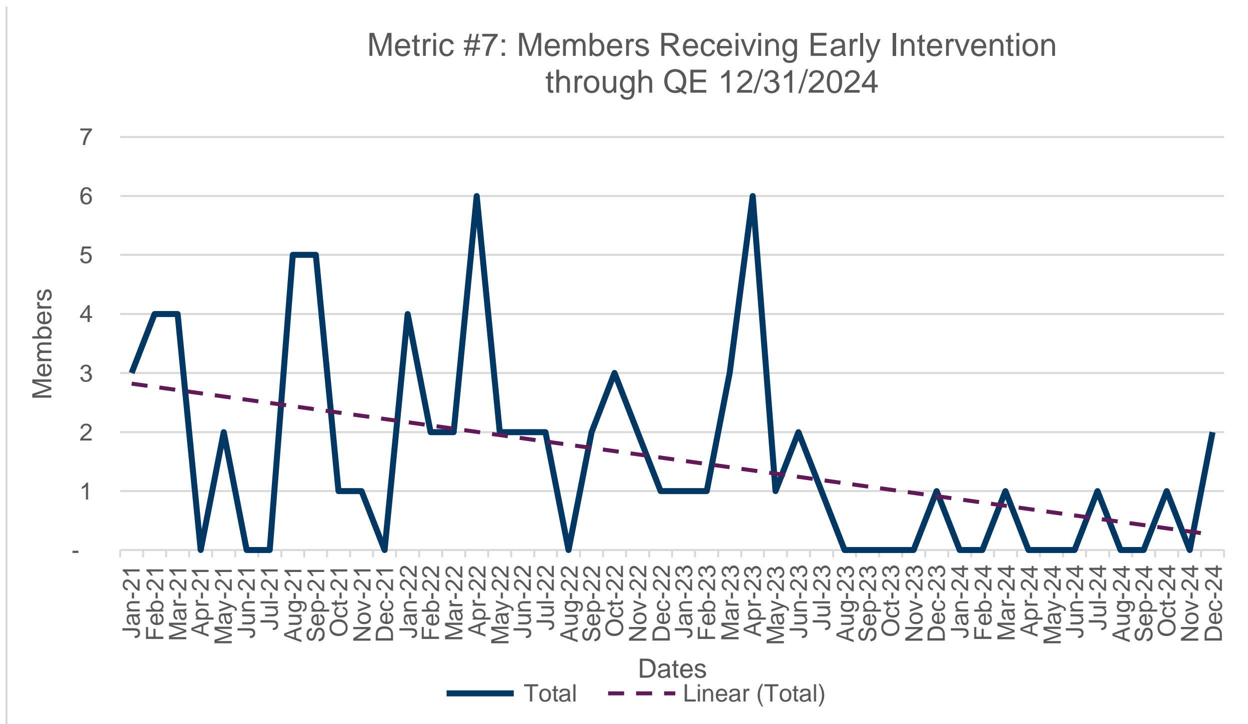


Figure D.27. Metric #6: Members with Criminal Justice Involvement Receiving any SUD Services



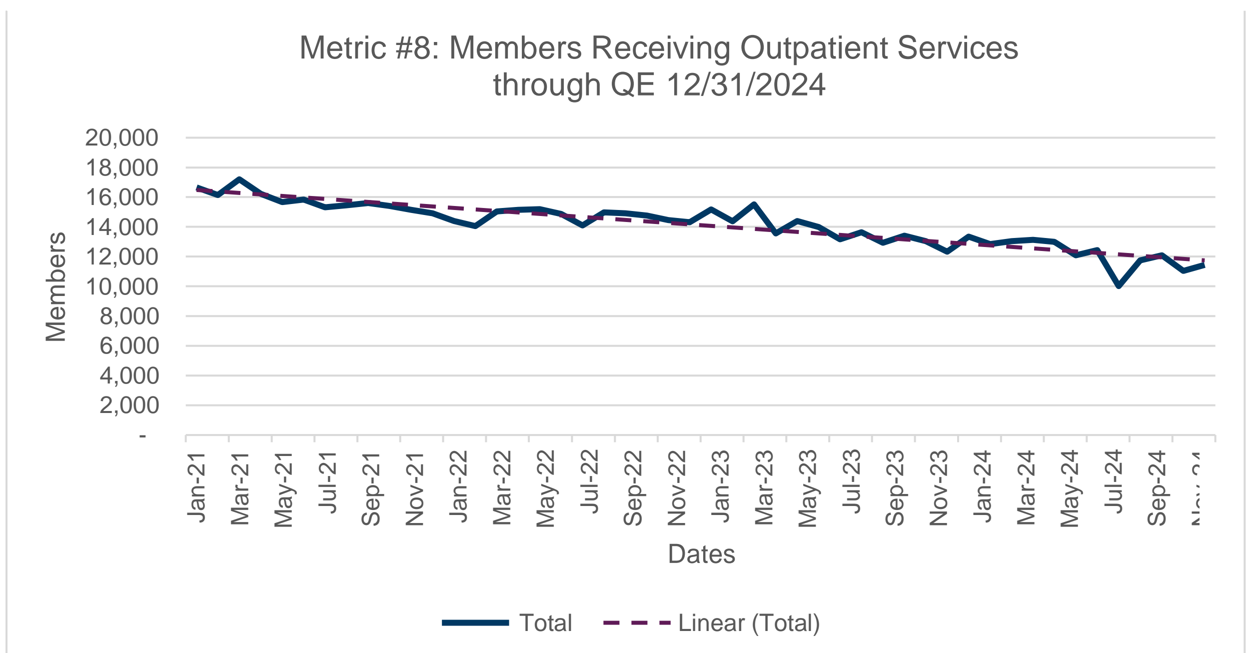
The graph below shows utilization of Medicaid members receiving Early Intervention.

Figure D.28. Metric #7: Members Receiving Early Intervention



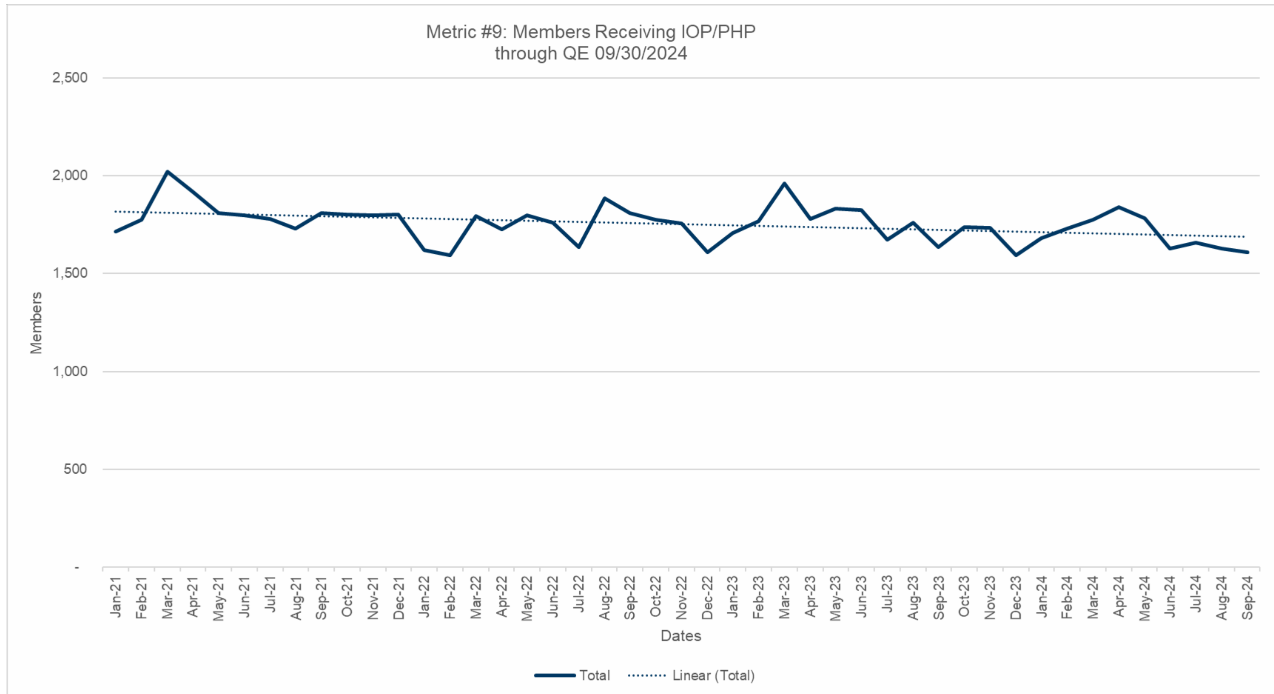
The graph below shows utilization of outpatient services prior to the Demonstration and after the Demonstration beginning on April 14, 2022.

Figure D.29. Metric #8: Members Receiving Outpatient Services



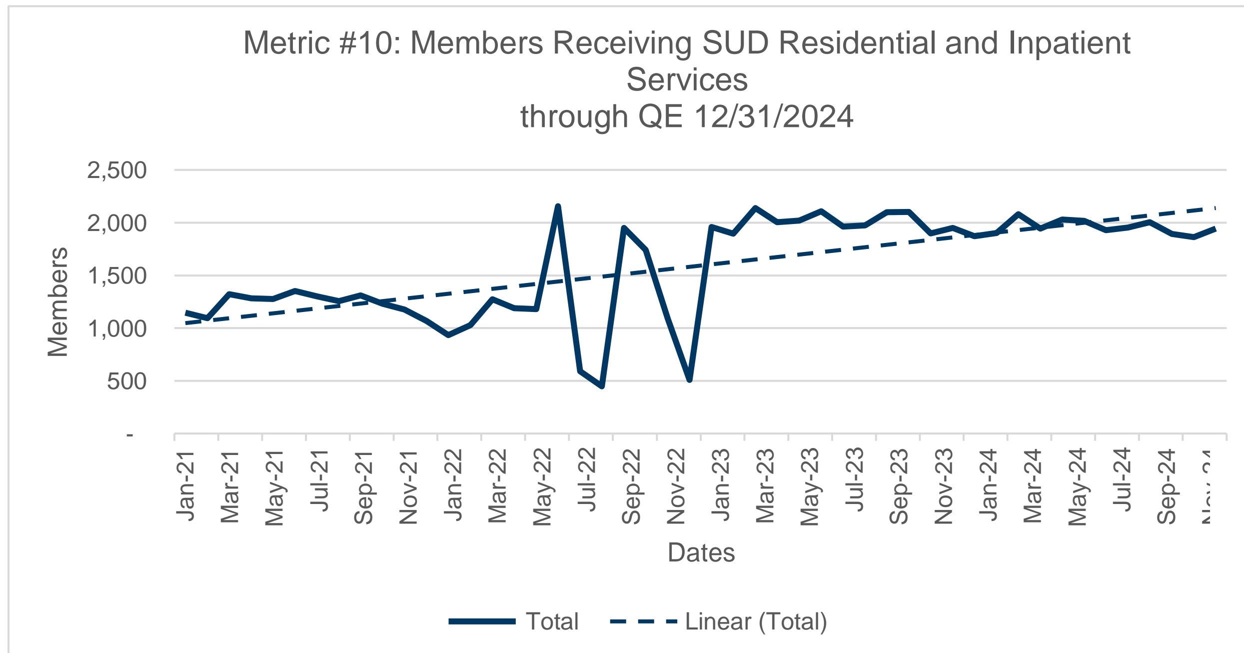
The table below shows Medicaid members receiving Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP) services prior to and after the inception of the Demonstration on April 14, 2022.

Figure D.30. Metric #9: Members Receiving IOP/PHP



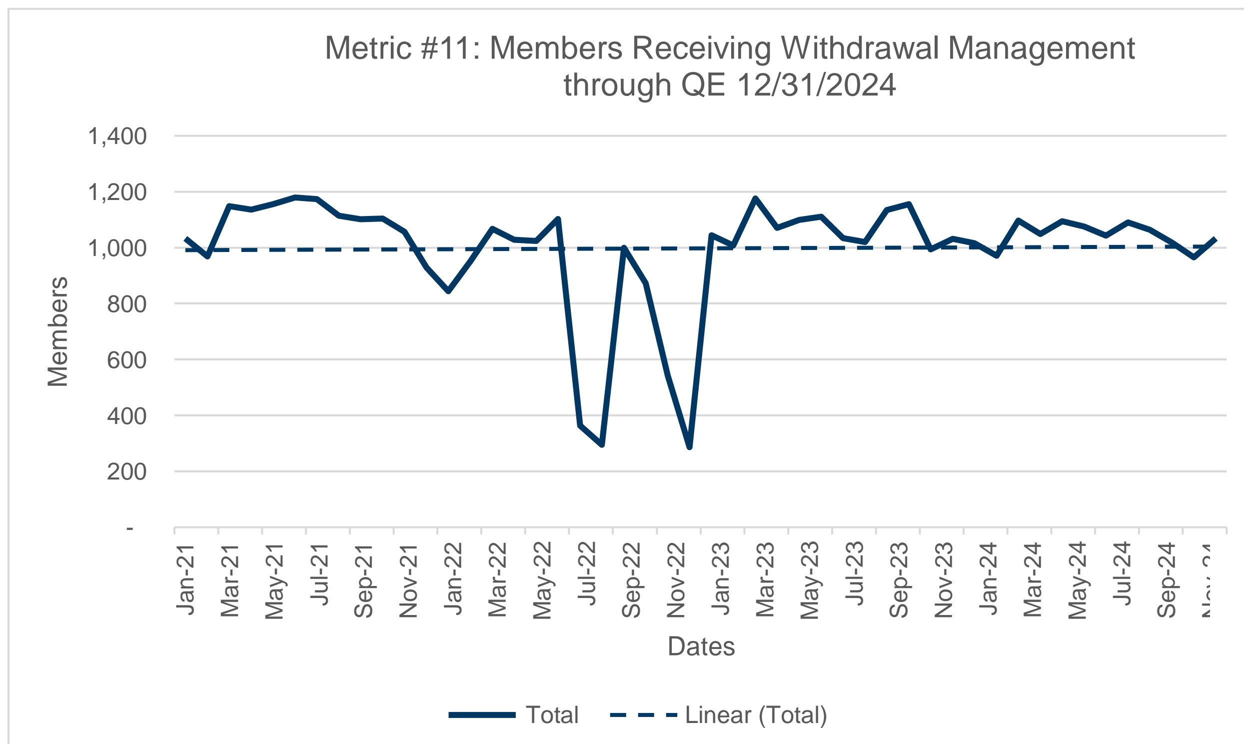
The figure below shows members receiving residential and inpatient care prior to and after the implementation of the Demonstration on April 14, 2022. The three months with very little utilization in 2022 represent months when providers were unable to process claims within three months of the date of service, which is the uniform data lag for these metrics. While utilization did occur in those months, the claims were submitted more than three months following the date of service.

Figure D.31. Metric #10: Members Receiving SUD Residential and Inpatient Services



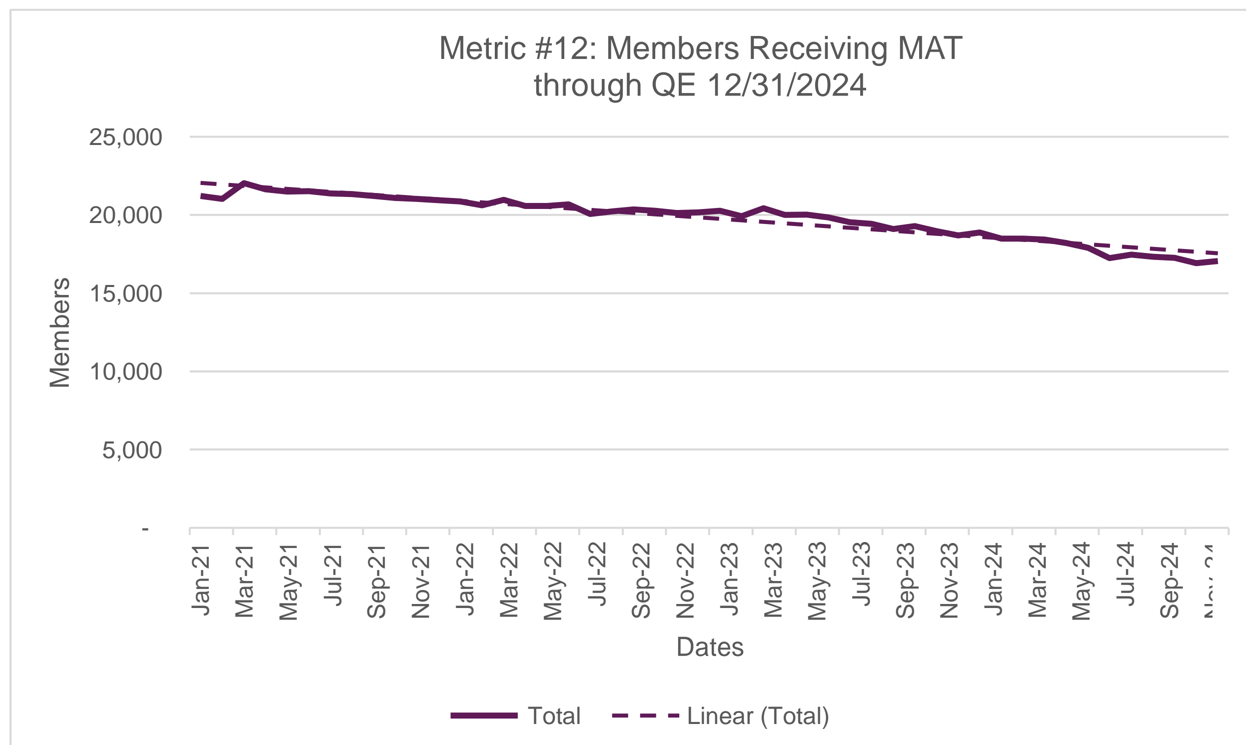
The next graph demonstrates the number of members receiving withdrawal management prior to and after the Demonstration implementation on April 14, 2022. The three months with little utilization also reflect months when providers held claims for longer than three months after the date of service prior to submitting the claims to Gainwell.

Figure D.32. Metric #11: Members Receiving Withdrawal Management



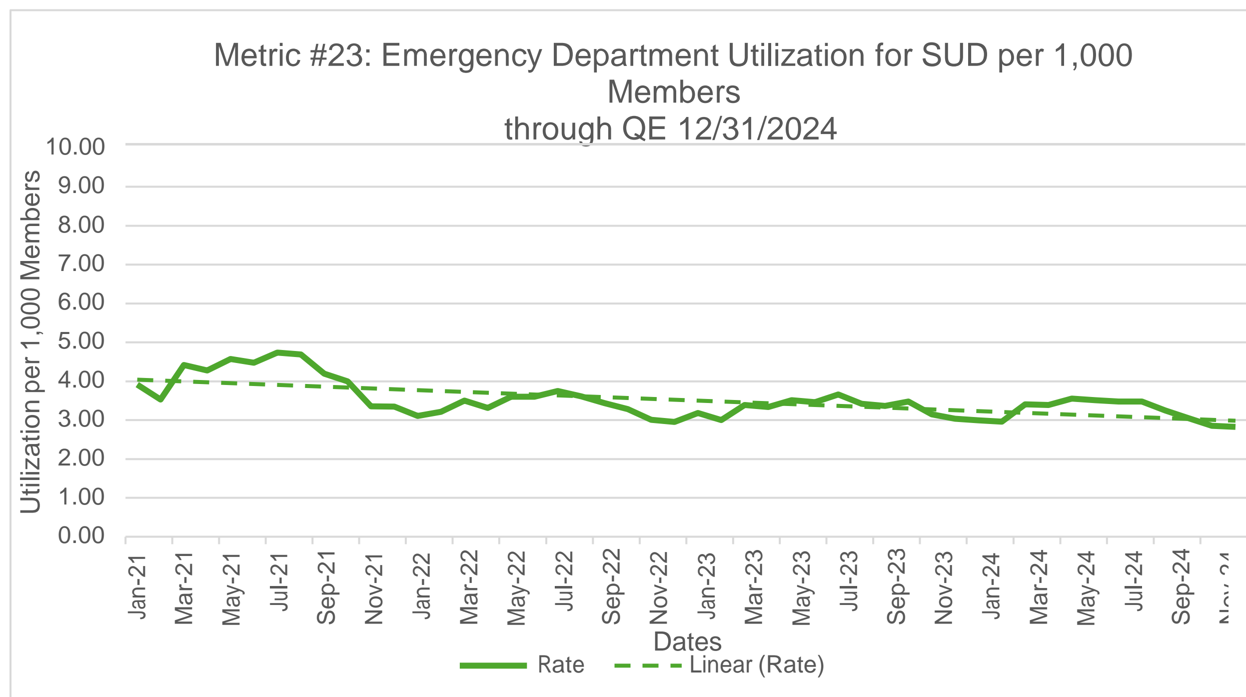
In the figure below, Connecticut reports the number of members receiving Medication- Assisted Treatment (MAT) prior to and after the Demonstration implementation on April 14, 2022. As noted in the annual metrics above, the number of providers who are providing MAT is increasing. However, as seen in these graphs, the overall number of individuals receiving MAT funded by Medicaid is decreasing.

Figure D.33. Metric #12: Members Receiving MAT



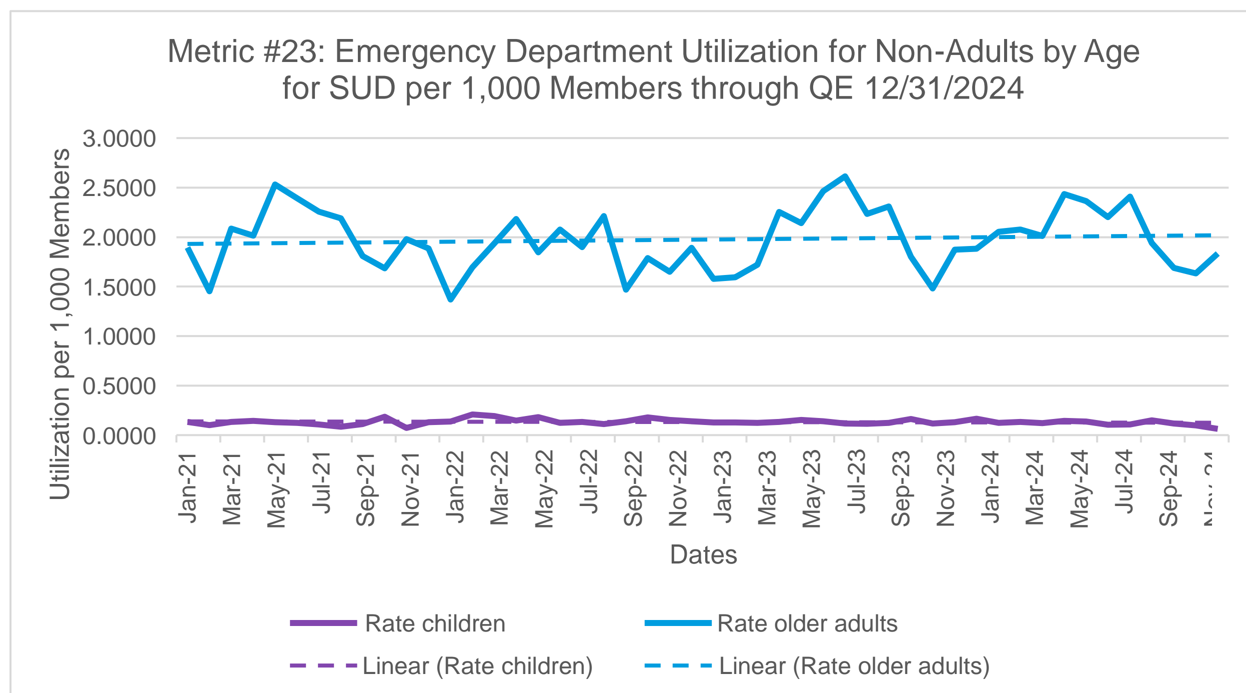
In the figure below, Connecticut demonstrates that the ED for SUD per 1,000 members after the Demonstration has declined overall.

Figure D.34: Metric #23: Emergency Department Utilization



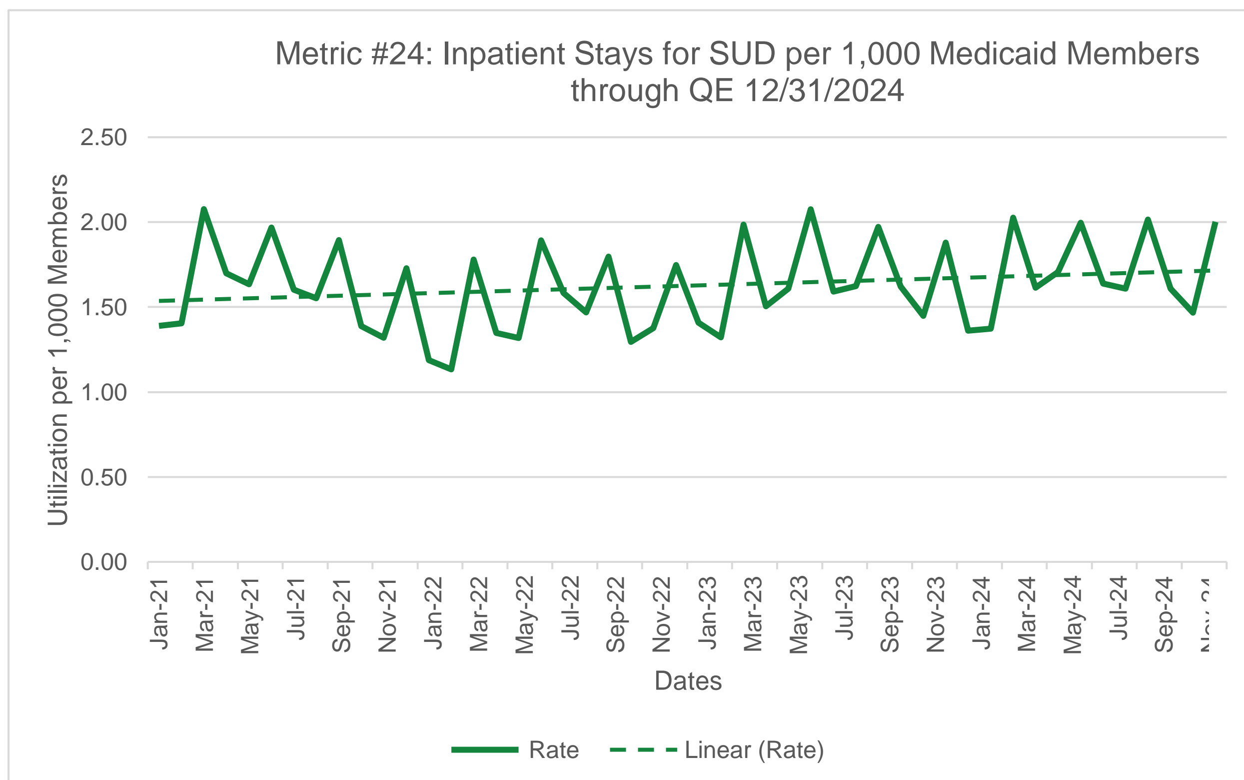
However, the number of older adults receiving ED visits for SUD has risen slightly with the beginning of the Demonstration. The number of youth has remained relatively constant.

Figure D.35: Metric #23: Emergency Department Utilization for Non-Adults by Age



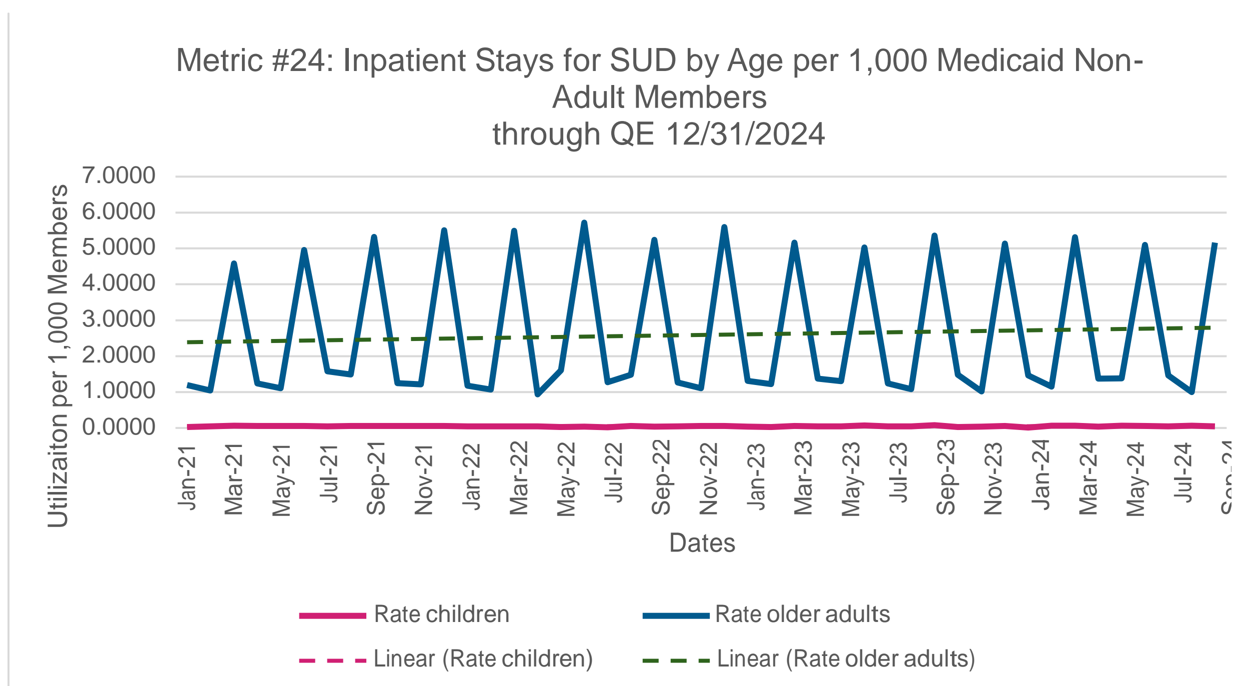
The SUD inpatient hospitalization rate shows overall increases since the beginning of the Demonstration.

Figure D.36: Metric #24: Inpatient Stays for SUD



There appears to be a positive trend line indicating an increase in hospital utilization for older adults since the inception of the Demonstration.

Figure D.37: Metric #24: Inpatient Stays for SUD by Age



Integrated System for the Treatment of SUDs Performance Target

The Connecticut Behavioral Health Partnership (CT BHP) and Carelon Behavioral Health supported the development of an integrated system of care for the treatment of SUDs. This performance target sought to improve the outcomes of care for the population that accesses inpatient and residential levels-of-care for the treatment of SUDs and to identify and address disparities in utilization, treatment, and outcomes for HUSKY Health Members with a SUD.

In 2024, the scope of the SUD performance target (PT) broadened to support providers and the network in the implementation of the Demonstration. A central component of this has been the development of data analytic capabilities that offer a comprehensive approach to monitoring service utilization and improving access to these new levels of care. The 2024 SUD PT contained the following mutually agreed upon interventions and activities:

- Continue the implementation of the Demonstration utilization management processes and system transformation.
- Introduce American Society of Addiction Medicine (ASAM) 3.7, 3.7E, 3.5, 3.5 PPW, 3.3, and 3.1 participating provider programs.
- Promote and support provider education and public awareness on topics related to SUD.
- Develop data analytic capabilities to report on the utilization of inpatient (ASAM 3.7/3.7E) and residential (ASAM 3.5, 3.3, and 3.1) levels of care for the treatment of SUD.
- Study the characteristics and outcomes of care for the population that accesses inpatient or residential levels of care for treatment of SUD.

All interventions were successfully completed, and key highlights and accomplishments included:

- Continued to support 3.7 withdrawal management (3.7 WM), inpatient psychiatric facility (IPF), and ED providers through regional network management standard practices.
- Promoted and championed collaboration among providers and other key stakeholders when members transition through the continuum of care.
- Identified several key providers for outreach regarding Carelon's Peer Support program, and conducted meetings to educate these providers about the role and the value of the support that the Carelon peers can provide and explain the process for initiating referrals.
- Identified SUD inpatient and residential providers across the State to participate in inter-provider meetings focused on improving referral pathways, developing working relationships, and connecting members to the next level of care.
- Held a workgroup meeting to introduce the SUD inpatient and residential Provider Analysis and Reporting (PAR) program that will launch in 2025.
- Convened the first Statewide inpatient/residential levels of care workgroup with an audience of providers from ASAM 4.0 WM, adult IPFs, ED, and ASAM 3.1–3.7 inpatient/residential levels of care.
- Incorporated the exploration of screening for social determinants of health into PAR strategies across all levels of care, which will remain a central focus with the launch of the 2025 inpatient/residential PAR program.
- Hosted two educational forums: one on substance use, society, and social impact and one on the best practices for reentry into the community after incarceration for individuals with SUDs.

- Developed a data reporting mechanism to capture core quality measures at the episode level to depict the utilization trends of SUD inpatient/residential rehabilitation services delivered to HUSKY Health members.
- Updated the existing Carelon episode of care methodology to allow for the adoption of the flex bed concept.
- Conducted a comprehensive descriptive analysis of authorization lengths by SUD residential providers for ASAM level of care 3.1 through 3.7 using records from April 2022 to September 2024, which included demographic trend.

Provider Certification and Monitoring[14]

As noted above, Advanced Behavioral Health (ABH) certifies and monitors providers under the Demonstration. ABH also collaborates with the State partners, facilitates provider ASAM training and provides access to educational resources and conducting individual provider meetings to review standards required for certification under the Demonstration.

For provider certification, ABH utilizes a team of three licensed social workers, two licensed professional counselors, and one licensed marriage and family therapist, led and overseen by a supervisory staff of a licensed professional counselor and licensed clinical social worker. An administrative team, designated quality team, and information technology staff also support the team.

ABH utilized a 4-phase monitoring and certification approach to support providers in building and administering their programs. ABH developed specific tools to evaluate staffing, training, and ASAM adherence including identification, documentation, and treatment by level of care (LOC) and service provision. ABH, The Department of Mental Health and Addiction Services, and the Department of Children and Families have participated in ongoing interrater reliability exercises utilizing the Demonstration's certification tools to ensure consistency and accuracy. ABH evaluated each provider based on the populations served, LOC, and specific facility site. In 2025, there were approximately 300 provider certification applications reviewed by ABH since the inception of the Demonstration. Between April 2024 - May 2025, ABH completed a combined total of 240 monitoring visits (223 adults, 17 adolescents).

Residential Phase 1 Monitoring

The two-year residential provisional certification period commenced on June 1, 2022. To give providers time to begin implementation of the required standards, monitoring surveys (Adult and Adolescent) began November 2022. Providers were advised to select three medical records that they felt best represented their compliance with the ASAM criteria and Connecticut State Standards. During Phase 1, the clinical survey teams conducted 50 chart monitoring surveys of provider programs, by facility and LOC. ABH distributed provider-specific reports on the survey results for all chart monitoring activities, as well as reports that address compliance with *core activities* as outlined by the Connecticut SUD Demonstration Residential Provisional/Certification Guide to all residential providers.

Provider policies and procedures were also requested from the Providers during this time. Requested policies and procedures included: ASAM criteria attestation, bio-psychosocial assessment, drug screening, nursing assessment and withdrawal management, physical examination, medication policy & MAT, treatment plans, progress notes and other documentation, payer utilization process, continued service reviews, transfer/discharge

[14] Advanced Behavioral Health, Inc, CT 1115 SUD Demonstration Waiver Monitoring Program, Mid-Point Assessment

planning, activities, services and evidenced-based practices, services for family/significant others, other supports, direct affiliations, & referral process, access to emergency services, staffing requirements, and staff training.

Representatives from ABH, the Department of Mental Health and Addiction Services, the Department of Children and Families, and the Department of Social Services met with each agency to review the results of this monitoring phase, provide technical assistance and develop quality improvement strategies in preparation for Phase 2.

Residential Phase 2 Monitoring

The second phase of adult and adolescent provider surveys were conducted between May 2023 and July 2023. The Clinical Survey Team surveyed a total of 47 programs. The Teams surveyed three provider-selected treatment charts per program and reviewed administrative documentation covering program operations such as licensure, staffing, treatment modalities, and affiliations with other providers for coordination of care. In order to achieve full certification, programs were required to meet the minimum requirements for *core activities, administrative activities, and support activities that* are outlined in the Connecticut SUD Demonstration Residential Provisional/Certification Guide, published in May 2022.

Representatives from ABH, the Department of Mental Health and Addiction Services, the Department of Children and Families, and the Department of Social Services met with each agency to review the results of this monitoring phase, provide technical assistance and develop quality improvement strategies in preparation for Phase 3.

Residential Phase 3 Monitoring

Between October 2023 and February 2024, the clinical survey teams conducted 46 surveys of provider programs, by facility and LOC. LOC 3.5 Rushford at Stonegate was the only program provisionally certified under the Demonstration to provide SUD residential adolescent services. This facility closed operations during this phase, effective February 07, 2024, and was therefore omitted from the Phase 3 review process.

Phase 3 introduced a new method for sampling, with charts selected randomly by the clinical survey team rather than provider-selected charts. In addition, the sampling size was expanded based on The National Committee for Quality Assurance (NCQA) Health Care Accreditation, Health Plan Accreditation Organization — NCQA 8 and 30 file sample procedure where eight initial charts were reviewed in full and any elements found to be deficient were reviewed further in an additional 22 charts. The clinical survey teams also reviewed administrative documentation covering program operations such as licensure, staffing, treatment modalities, and affiliations with other providers for coordination of care. Programs were required to meet the minimum requirement of 75% for *Core Activities,* with 100% met for Core 3 and Core 9, as outlined in Connecticut's Provider Certification Standards and Process, published April 12, 2024. All residential treatment providers have met 100% compliance with required program policies and procedures.

Representatives from ABH, the Department of Mental Health and Addiction Services and the Department of Social Services met with each agency to review the results of this monitoring phase, provide technical assistance and develop quality improvement strategies in preparation for Phase 4

Residential Phase 4 Monitoring

Phase 4 (April 2024– May 2024) focused on re-surveying programs that scored below 75% for any Core Activities , with a focus on deficient areas of documentation. Programs that scored 75% or better in all sections of the Core Activities and scored 100% for Core 3 and Core 9 passed through with their prior Phase 3 scores. The clinical survey teams reviewed a randomly selected sampling of eight charts eligible in the survey period and any previously deficient administrative documentation covering program operations.

Findings from chart reviews and administrative documentation reviews comprise the *Milestone* Standards introduced in Phase 2. The Milestone ratings score adherence to the *Core Activities*, *Administrative Activities*, and *Support Activities* required by the Connecticut SUD Demonstration Residential Provisional/Certification Guide, revised in May 2023.

Table D.7. ABH Demonstration Year 1 Certification Monitoring

CT 1115 SUD Demonstration Provider Certification Totals								
April 2022-March 2023								
ASAM Level of Care	Number of Providers Provisionally Certified		Number of Providers Certified Level 1		Number of Conditional Certifications		Total Number of Active Programs 3/31/2023	
Ambulatory Outpatient	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent
1-WM	33	7	0	0	0	0	33	7
2-WM	10	7	0	0	0	0	10	7
2.1	94	26	0	0	0	0	94	26
2.5	25	8	0	0	0	0	25	8
Total	162	48	0	0	0	0	162	48
Residential Programs								
3.1	7	0	0	0	0	0	7	0
3.3	2	0	0	0	0	0	2	0
3.5	11	1	0	0	0	0	11	1
3.5 PPW	5	0	0	0	0	0	5	0
3.7 R	7	0	0	0	0	0	7	0
3.7- Co-Occurring Enhanced	3	0	0	0	0	0	3	0
3.7 Withdrawal Management	7	0	0	0	0	0	7	0
Total	42	1	0	0	0	0	42	1
Total Active Programs As of 3/31/2023 Combined							204	49

*Full certification for residential and ambulatory programs did not go into effect until June of 2024. Each program participated in 4 phases of certification monitoring during the two year provisional certification period.

CT 1115 SUD Demonstration Provider Certification Totals								
April 2022-March 2023								
ASAM Level of Care	Number of Providers Provisionally Certified		Number of Providers Certified Level 1		Number of Conditional Certifications		Total Number of Active Programs 3/31/2023	
Ambulatory Outpatient	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent
1-WM	33	7	0	0	0	0	33	7
2-WM	10	7	0	0	0	0	10	7
2.1	93	26	0	0	0	0	93	26
2.5	26	8	0	0	0	0	26	8
Total	162	48	0	0	0	0	162	48
Residential Programs								
3.1	7	0	0	0	0	0	7	0
3.3	2	0	0	0	0	0	2	0
3.5	11	1	0	0	0	0	11	1
3.5 PPW	5	0	0	0	0	0	5	0
3.7 R	7	0	0	0	0	0	7	0
3.7- Co-Occurring Enhanced	3	0	0	0	0	0	3	0
3.7 Withdrawal Management	7	0	0	0	0	0	7	0
Total	42	1	0	0	0	0	42	1
Total Active Programs As of 3/31/2023 Combined							204	49

*Full certification for residential and ambulatory programs did not go into effect until June of 2024. Each program participated in 4 phases of certification monitoring during the two year provisional certification period.

Table D.8. ABH Demonstration Year 2 Certification Monitoring

CT 1115 SUD Demonstration Provider Certification Totals								
April 2023-March 2024								
ASAM Level of Care	Number of Providers Provisionally Certified		Number of Providers Certified Level 1		Number of Conditional Certifications		Total Number of Active Programs 3/31/2024	
Ambulatory Outpatient	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent
1-WM	0	1	0	0	0	0	33	8
2-WM	0	0	0	0	0	0	10	7
2.1	17	1	0	0	0	0	109	27
2.5	2	1	0	0	0	0	29	9
Total	19	3	0	0	0	0	181	51
Residential Programs								
3.1	0	0	0	0	0	0	7	0
3.3	0	0	0	0	0	0	2	0
3.5	0	0	0	0	0	0	11	0
3.5 PPW	0	0	0	0	0	0	5	0
3.7 R	0	0	0	0	0	0	7	0
3.7- Co-Occurring Enhanced	0	0	0	0	0	0	3	0
3.7 Withdrawal Management	0	0	0	0	0	0	7	0
Total	0	0	0	0	0	0	42	0
Total Active Programs As of 3/31/2024 Combined							223	51

*Full certification for residential and ambulatory programs did not go into effect until June of 2024. Each program participated in 4 phases of certification monitoring during the two year provisional certification period.

In Year 3 of the Demonstration, ABH conducted 240 on-site visits of providers including reviews at every LOC.

Table D.9. Overall Demonstration 3 Monitoring Site Visits

CT 1115 SUD Demonstration Site Visit Totals		
Demonstration Year 3 - April 1, 2024-March 31,2025		
	Adult	Adolescent
ASAM Level of Care	**Total Number of Monitoring Site Visits**	
Ambulatory Outpatient		
2.1	127	4
2.5	26	1
Total	153	5
Resdiential		
3.1	3	0
3.3	2	0
3.5	11	0
3.5 PPW	2	0
3.7 R	6	0
3.7- Co-Occurring Enhanced	3	0
3.7 Withdrawal Management	5	0
Total	32	0
Hospitals		
2.1	17	8
2.5	7	4
Total	24	12
FQHC		
2.1	14	0
2.5	0	0
Total	14	0
Total Ambulatory	191	17
Total Residential	32	0
Grand Total	223	17

Total Adol and Adult Monitoring Visits
240

Table D.10. ABH Demonstration Year 3 Certification Monitoring

CT 1115 SUD Demonstration Provider Certification Totals								
April 2024-March 2025								
ASAM Level of Care	Number of Providers Provisionally Certified		Number of Providers Certified		Number of Conditional Certifications		Total Number of Active Programs 3/31/2025	
Ambulatory Outpatient	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent
1-WM	0	0	0	0	3	0	3	0
2-WM	0	0	0	0	0	0	0	0
2.1	0	0	85	6	4	9	96	15
2.5	0	0	19	1	7	6	26	7
Total	0	0	104	7	14	15	125	22
Residential Programs								
3.1	0	0	6	0	1	0	7	0
3.3	0	0	2	0	0	0	2	0
3.5	0	0	10	0	1	0	11	0
3.5 PPW	0	0	5	0	0	0	5	0
3.7 R	0	0	7	0	0	0	7	0
3.7- Co-Occurring Enhanced	0	0	3	0	0	0	3	0
3.7 Withdrawal Management	0	0	7	0	2	0	7	0
Total	0	0	40	0	2	0	42	0
Total Active Programs As of 3/31/2025 Combined							167	22
*Conditional certification was implemented at the end of the provisional certification periods for new programs to the Demonstration and those that couldn't be audited due to an insufficient number of medical records. The numbers above do not included the State Hospital.								

CT 1115 SUD Demonstration Provider Certification Totals								
April 2024-March 2025								
ASAM Level of Care	Number of Providers Provisionally Certified		Number of Providers Certified		Number of Conditional Certifications		Total Number of Active Programs 3/31/2025	
Ambulatory Outpatient	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent
1-WM	0	0	0	0	3	0	3	0
2-WM	0	0	0	0	0	0	0	0
2.1	0	0	84	6	5	9	96	15
2.5	0	0	19	1	7	6	26	7
Total	0	0	103	7	15	15	125	22
Residential Programs								
3.1	0	0	6	0	1	0	7	0
3.3	0	0	2	0	0	0	2	0
3.5	0	0	10	0	1	0	11	0
3.5 PPW	0	0	5	0	0	0	5	0
3.7 R	0	0	7	0	0	0	7	0
3.7- Co-Occurring Enhanced	0	0	3	0	0	0	3	0
3.7 Withdrawal Management	0	0	7	0	0	0	7	0
Total	0	0	40	0	2	0	42	0
Total Active Programs As of 3/31/2025 Combined							167	22
*Conditional certification was implemented at the end of the provisional certification periods for new programs to the Demonstration and those that couldn't be audited due to an insufficient number of medical records. The numbers above do not included the State Hospital.								

Residential Services Certification

Phase 4 surveying determined which programs scored at or above the minimum requirements for Certification Level I or Level II, as outlined in Connecticut's Provider Certification Standards and Process, published April 12, 2024. At this point, one ASAM 3.5 program had closed their facility on June 1, 2024, and was therefore not awarded a certification.

Level I Certification (Three Years): Programs must meet the minimum requirements for *Core Activities*, with 100% met for Core 3 and Core 9, and minimum 75% met for all other Core Activities in order to achieve Level I Certification for a three-year period. In total, 38 of the 41 total residential programs achieved Level I Certification, effective June 1, 2024, through June 1, 2027.

Level II Certification (Six Months): Programs not meeting thresholds in Level I achieved Level II Certification for a six-month period and were placed on a Medicaid Corrective Action Plan (MCAP) issued and overseen by the DSS. A total of three programs were certified at Level II, effective June 1, 2024, through December 1, 2024, and were surveyed again to measure their progress in meeting the Level I Certification requirements towards the end of the six-month period.

Residential Phase 5 Monitoring

Phase 5 monitoring surveys were conducted from September 2024 through October 2024 for the residential programs that were certified at Level II for a six-month period effective June 1, 2024, through December 1, 2024, following the implementation of program-specific MCAP's. The three operating programs that were surveyed during this phase met the requirements for Level I Certification under the Demonstration and are now certified as Level I through May 31, 2027.

The table below demonstrates the residential provider self-report compliance in 2022 compared to the final results in 2024. In addition, provider policies and procedures were also requested from the providers during initial reviews. The site visit results are divided into three areas plus the policies and procedures, which are explained in the chart below.

Table D.11. On-site Review areas

Area	Content
Core Activities	The Core requirements bulleted immediately below must meet a score of 100% for Level 1 and Level 2 certification: • Evidence that facility offers pharmacotherapies (including medication for addiction treatment — MAT) as a treatment option through direct provision or in collaboration with other enrolled Medicaid providers as permitted. • Evidence of a daily schedule of activities designed to meet individualized treatment needs in alignment with the minimum required treatment hours outlined in the Connecticut Substance Use Disorder Services Policy and Clinical Assumptions Grid. A score of 75% must be achieved in each standard below for certification. • Evidence of individualized/variable length of stay based on ASAM assessment and ASAM continued stay criteria. • Individualized progress notes in the individual's record that clearly reflect implementation of the treatment plan and the individual's response to therapeutic intervention for all disorders treated, as well as subsequent amendments to the plan. • An individualized, comprehensive biopsychosocial assessment is conducted utilizing the ASAM criteria and Connecticut Substance Use Disorder Services Policy and Clinical Assumptions Grid. • ASAM diagnostic and dimensional criteria are utilized for the appropriate level of care during screening, admission, continued stay, and discharge processes. The ASAM transfer/discharge criteria are applied to discharge planning processes. Transfer or discharge plans are utilized and include obtaining necessary release(s) of information to refer to appropriate aftercare services, including clinical recovery supports. Plans are written in conjunction with the individual and their primary counselor and service coordinator. • Formal reviews necessary for payers are dictated by clinical/medical necessity as determined by a clinical assessment utilizing all six dimensions of the ASAM criteria. Payer utilization management processes are utilized. • Individualized treatment plans are completed, reviewed, and signed in accordance with the ASAM criteria, Connecticut Substance Use Disorder Services Policy and Clinical Assumptions Grid, and provider manual and State regulations. • Facility does not preclude admission of individuals based on MAT profile and active medication prescriptions. If agency cannot support a medication need

Area	Content
	internally, they have policies in place to ensure communication with prescribing physician is ongoing or appropriate referrals are made.
Administrative Activities	• Acknowledgement signed by the chief executive officer agreeing to the timeframes and agreeing that if full certification is not achieved within 24-months, Medicaid enrollment for the non- certified level of care will terminate. • Department of Public Health licensure appropriate for the ASAM LOCs for which the Full Certification is requested. • Emergency services available 24 hours a day/7 days a week for LOC: 3.7WM or 4.0WM and 16 hours a day//7 days per week for LOC: 3.1, 3.3, 3.5, 3.5Adol, 3.5PPW, 3.7, 3.7RE. • Minimal onsite staffing requirements are met. • Program has policy and procedures for drug screen supervision, testing and review, and evidence of compliance. • Has policy and procedures for medication monitoring and evidence of monitoring individual's adherence in taking any medications. • A physical examination, performed within a reasonable time and in accordance with any timeframes outlined in the ASAM criteria and Connecticut Substance Use Disorder Services Policy and Clinical Assumptions Grid, as determined by the individual's medical condition and consistent with facility policy or legal requirements. • Policies related to provisional certification are in place as evidenced through documentation. • Evidence of completion of required staff trainings on ASAM criteria. • Weekly clinical SUD service hours align with the ASAM criteria, Connecticut Substance Use Disorder Services Policy and Clinical Assumptions Grid, and DSS provider regulation, bulletin, and manual. • Admission hours align with Connecticut Substance Use Disorder Services Policy and Clinical Assumptions Grid and DSS provider regulation, bulletin, and manual.
Support Activities	• Necessary support systems align with the ASAM criteria and Connecticut Substance Use Disorder Services Policy and Clinical Assumptions Grid. • Documentation of training plans for each staff, reflective of responsibilities and clinical activities is present in personnel record. • Documentation of supervision sessions for each staff in accordance with ASAM standards and Connecticut Substance Use Disorder Services Policy and Clinical Assumptions Grid are present in personnel records. • Evidence of staff trainings on motivational interviewing and transtheoretical stages of change in personnel records. • Treatment services align with the ASAM criteria, Connecticut Substance Use Disorder Services Policy and Clinical Assumptions Grid, and DSS provider regulations, bulletin, and manual. • With individual's consent, offers services with and for the individual's family and significant others other than educational sessions. • Evidence of motivational enhancement and engagement strategies appropriate to the individual's stage of readiness and desire to change. • Evidence of planned community reinforcement is present in clinical records. • Programs have direct affiliations with other levels of care, or close coordination through referral to more or less intensive levels of care.

Area	Content
	• Evidence that supervisors conduct and document face-to-face clinical supervision at rates in accordance with the ASAM criteria and Connecticut Substance Use Disorder Services Policy and Clinical Assumptions Grid. • Uses a range of evidence-based practices (EBPs)/therapies by staff who are trained in accordance with identified model(s) as reflected on the training plans/educational records including motivational interviewing, enhancement, and engagement strategies.
Policies and Procedures	• ASAM Criteria Attestation, • Bio-Psychosocial Assessment, • Drug Screening, • Nursing Assessment and Withdrawal Management, • Physical Examination, • Medication Policy & MAT, • Treatment Plans, • Progress Notes and Other Documentation, • Payer Utilization Process, • Continued Service Reviews, • Transfer/Discharge Planning, • Activities, • Services and EBPs, • Services for Family/Significant Others, • Other Supports, • Direct Affiliations, & Referral Process, • Access to Emergency Services, • Staffing Requirements, and • Staff Training.

Adoption and implementation of Administrative standards and Support standards is required of all providers participating in the Demonstration. Any provider not meeting these requirements at the end of the provisional certification period for the level(s) of care for which services are provided will be placed on a Quality Improvement Plan and may be subject to a Medicaid audit. The table below compares the providers self-reported compliance with standards in 2022 to the Phase 4 ABH external site review results in 2024 by LOC.

Table D.12. Statewide Results of Residential Compliance in Terms of % Met Standards

		Phase 4 Site Visit Results — 2024		
All providers by LOC	**% Met Standards — Self-Report 2022**	**CORE Standards**	**ADMIN Standards**	**SUPPORT Standards**
Organization Wide	83%			
ASAM 3.1	77%	96%	95%	87%
ASAM 3.3	72%	97%	96%	94%
ASAM 3.5	77%	95%	95%	90%
ASAM 3.5 Adol	82%	-	-	-
ASAM 3.5 PPW	79%	98%	97%	91%
ASAM 3.7	85%	92%	92%	92%

		Phase 4 Site Visit Results — 2024		
All providers by LOC	% Met Standards — Self-Report 2022	CORE Standards	ADMIN Standards	SUPPORT Standards
ASAM 3.7RE	77%	96%	96%	96%
ASAM 3.7WM	94%	97%	96%	88%
ASAM 4.0WM	95%			

Ambulatory Services Certification

Certification for Ambulatory levels of care (ASAM 2.5, ASAM 2.1, ASAM 2-WM and ASAM 1-WM) was comprised of three cohorts with unique 24-month provisional certification timeframes. The first cohort, Behavioral Health Clinics, Enhanced Care Clinics and Outpatient Drug and Alcohol Abuse Centers, were provisionally certified beginning November 15, 2022. The second cohort, Outpatient Hospitals, were provisionally certified beginning March 1, 2023. The third cohort, Behavioral Health Federally Qualified Health Centers (FQHCs) were provisionally certified beginning July 1, 2023.Phase 4 surveys determined which programs scored above the minimum requirements for Certification Level I and Certification Level II as outlined in Connecticut's Provider Certification Standards and Process, published April 12, 2024. It also determined which programs achieved Conditional Certification as well as which Programs Certification had expired.

Level I Certification (Three Years): Programs were required to meet the minimum requirements for *Core Activities*, with 100% met for Core 3 and Core 9, and minimum 75% met for all other Core Activities in order to achieve Level I Certification for a three-year period.

Level II Certification (Six Months): Programs not meeting thresholds in Level 1 achieved Level II Certification for a six-month period and placed on a MCAP issued and overseen by DSS.

Conditional Certification (One Year): Programs that were actively running, but had a lack of medical records to review were issued a one-year conditional certification. They will be surveyed to measure their progress in meeting the Level I Certification requirements upon availability of eligible medical records.

Provisional Certification Expiration/Non-Operational: Programs that initially applied for Provisional Certification but are non-operational received a letter that their Provisional Certification had ended. . Most of these programs did not exist pre-Demonstration and is not a reflection of a decrease in overall provider capacity. Rather, the Demonstration created an opportunity for additional providers to add new levels of care (i.e., withdrawal management) and several agencies applied for provisional certification with aspirations of opening these levels of care but ultimately did not move forward. Programs are eligible to apply for certification at a future time should they proceed with opening any of the certifiable levels of care.

Behavioral Health Clinics (BHC), Enhanced Care Clinics (ECC) and Outpatient Drug and Alcohol Abuse Centers (OPC)

Upon completion of the provisional certification period, this provider cohort had the following certification outcomes:

- **Level I Certification (Three Years):** Seventy ambulatory adult programs and two adolescent programs achieved Level I Certification, effective November 16, 2024 – November 15, 2027.
- **Level II Certification (Six Months):** Eighteen adult programs and zero adolescent programs were certified at Level II, effective November 16, 2024 – May 15, 2024. They will be surveyed again to measure their progress in meeting the Level I Certification requirements towards the end of the six-month period.
- **Conditional Certification (One Year):** Eleven adult programs and six adolescent programs were conditionally certified, effective November 16, 2024 - November 15, 2025.
- **Provisional Certification Expiration/Non-Operational**: Fifty adult and twenty-eight adolescent programs received a letter that their Provisional Certification ended effective November 15, 2024.

Table D.13. Statewide Results of Clinic Compliance in Terms of Percentage Met Standards

Ambulatory	Phase 2 Site Visit Results	Phase 4 Site Visit Results Data Period: 6/01/22–11/16/24 in Phase 4		
All Providers by LOC	**Phase 2 Average of CORE, ADMIN, and SUPPORT Standards**	**CORE Standards**	**ADMIN Standards**	**SUPPORT Standards**
ASAM 2.1	81%	92%	92%	92%
ASAM 2.1 ADOL	83%	97%	91%	96%
ASAM 2.5	67%	94%	89%	88%
ASAM 2.5 ADOL	68%	97%	98%	99%

Outpatient Hospitals

Upon completion of the provisional certification period, this provider cohort had the following certification outcomes:

- **Level I Certification (Three Years):** Thirteen ambulatory adult programs and five adolescent programs achieved Level I Certification, effective March 2, 2025 - March 1, 2028.
- **Level II Certification (Six Months):** Three adult programs and zero adolescent programs were certified at Level II, effective March 2, 2025 - August 31, 2025. They will be surveyed again to measure their progress in meeting the Level I Certification requirements towards the end of the six-month period.
- **Conditional Certification (One Year):** Zero adult programs and seven adolescent programs were conditionally certified, effective March 2, 2025 - March 1, 2026.
- **Provisional Certification Expiration/Non-Operational:** Eleven adult and three adolescent programs received a letter that their Provisional Certification ended effective March 1, 2025.

Table D.14 Statewide Results of Outpatient Hospital Compliance in Terms of Percent Met Standards

OPH	Phase 2 Site Visit Results	Phase 4 Site Visit Results Data period: 6/01/22-07/2/25 in Phase 4		
All Providers by LOC	**Phase 2 Average of CORE, ADMIN, and SUPPORT Standards**	**CORE Standards**	**ADMIN Standards**	**SUPPORT Standards**
ASAM 2.1	76%	95%	97%	97%
ASAM 2.5	71%	97%	97%	97%
		Data period: 6/01/22–03/02/25 in Phase 4		

Behavioral Health Federally Qualified Health Centers (FQHCs)

Upon completion of the provisional certification period, this provider cohort had the following certification outcomes:

- **Level I Certification (Three Years):** Six ambulatory adult programs and zero adolescent programs achieved Level I Certification, effective July 2, 2025 - July 1, 2028.
- **Level II Certification (Six Months):** One adult program and zero adolescent programs were certified at Level II, effective July 2, 2025 - December 31, 2025. They will be surveyed again to measure their progress in meeting the Level I Certification requirements towards the end of the six-month period.
- **Conditional Certification (One Year):** One adult program and zero adolescent programs were conditionally certified, effective July 16, 2025 - July 15, 2026.
- **Provisional Certification Expiration/Non-Operational:** Two adult and zero adolescent programs received a letter that their Provisional Certification ended effective July 1, 2025.

Table D.15. Statewide Results of Behavioral Health FQHC Compliance in Terms of Percent Met Standards

FQHC	Phase 2 Site Visit Results	Phase 4 Site Visit Results Data period: 6/01/22-03/02/25 in Phase 4		
All Providers by LOC	**Phase 2 Average of CORE, ADMIN and SUPPORT Standards**	**CORE Standards**	**ADMIN Standards**	**SUPPORT Standards**
ASAM 2.1	79%	96%	99%	99%
ASAM 2.5				
		Data period: 6/01/22–07/2/25 in Phase 4		

Grievance and Appeal Reporting

Connecticut has consistently reported substance use disorder (SUD) related grievances and appeals. The table below outlines the rate of SUD grievances relative to all behavioral health grievances in Demonstration Year 1 (DY1) through DY3. The rate pf SUD grievances increased from DY1 (4%) to DY2 (5.6%) and decreased in DY3 (3.1%). Grievances include complaints about access and quality from members.

Table D.16. Reported SUD Grievances

	DY1	DY2	DY3	% Change DY2 to DY3
Numerator: SUD	4	6	3	-50%
Denominator: All Behavioral Health	99	107	97	-9%
Metric	**4%**	**5.6%**	**3.1%**	**-45%**

There were four SUD -related grievances in DY1, representing 4.0% of grievances for all behavioral health services in the same time period. The four grievances were related to two different providers, each with two grievances. The reason codes were related to Quality of Care (n = 2), Quality of Practitioner (n = 1), and Service Issues (n = 1). The level of care associated with the four grievances were as follows: one for methadone maintenance (OTP-1), one for inpatient withdrawal management (3.7WM) and two for Intensive outpatient services (2.1). The two grievances categorized as Quality of Care involved member dissatisfaction with their treatment and were able to be resolved via the complaints and grievances process. Neither grievance was determined to rise to the level of a potential Quality of Care Concern (QOCC) as defined by the Carelon Member Safety program.

There were six SUD related grievances in DY2, representing 5.6% of grievances for all behavioral health services in the same time period. Each of the six grievances were regarding a different provider, indicating no particular trend. The reason codes were all related to service issues except one that was determined to be a potential Quality of Care Concern (QOCC). The level of care associated with the six grievances were as follows: one for Residential Rehabilitation 3.1, two for Methadone Maintenance, two for Inpatient Withdrawal Management and one for Outpatient Suboxone Medication Management. The number of grievances continues to be low, with an increase of two from four in DY1 to six in DY2.

The one potential QOCC was related to a Methadone Maintenance provider in DY2. This concern related to two QOCC categories: Inappropriate Sexual Behavior and Clinical Treatment. It was reviewed by the Carelon QOCC committee and given a determination of Unable to be Determined following a review of the record set. Unable to be Determined indicates that there was not enough information available to give either a Founded or Unfounded determination. There were three SUD related grievances in DY3, representing 3.1% of grievances for all behavioral health services in the same time period. Two of the grievances were related to Service Issues and one was determined to be a potential QOCC. The levels of care associated with the three grievances were one for Partial Hospitalization Program (2.5) and two for Intensive Outpatient (2.1). The total number of grievances continues to be low, with a decrease of 50.0% from six in DY2 to three in DY3.

The one potential QOCC was related to an intensive outpatient provider under the sub-category of Clinical Practice-Related Issues. It was reviewed by Carelon QOCC committee and given a determination of Unable to be Determined following a review of the record set. An Unable to be

Determined designation indicates that there was not enough information available to give either a Founded or Unfounded determination.

The table below outlines the rate of SUD appeals relative to all behavioral health grievances for SUD appeals in DY1 through to DY3. The rate of SUD from DY1 (25%) to DY2 (44%) and again in DY3 (53.4%). The large number of appeals is due to the transition of the Medicaid system to American Society of Addiction Medicine (ASAM) requirements and a tightening of prior authorization in DY2 as providers learned to utilize the ASAM patient placement criteria (Milestone 2).

Table D.15. Reported SUD Appeals

	DY1	DY2	DY3	% Change DY2 to DY3
Numerator: SUD	8	11	47	327%
Denominator: All Behavioral Health	32	25	88	252%
Metric	**25%**	**44%**	**53.40%**	**21%**

There were eight total SUD related appeals in DY1, representing 25.0% of all behavioral health appeals in the same time period. All of the eight appeals were Medical Necessity Provider Level 1 Appeals. The eight Provider Level 1 appeals were related to five different providers. Of the eight appeals, six were related to three providers with appeals for the medically monitored intensive inpatient services (3.7) level of care. Of these, five denial decisions were overturned, and one was upheld. There was one appeal for the clinically managed high intensity residential services (3.5) and the denial decision was overturned, and one appeal for inpatient withdrawal management (4.0) and the denial decision was upheld.

There were 11 total SUD related appeals in DY2, representing 44% of all behavioral health appeals in the same time period. The 11 appeals included Member Level 1, Provider Level 1, and Provider Level 2 appeals. The 11 appeals related to six different providers. There was no particular trend identified and an increase of three, from eight in DY1 to 11 in DY2. One appeal was a Medical Necessity Member Level 1 Appeal. This appeal related to a 3.7 level of care and the denial decision was upheld. Eight appeals were Medical Necessity Provider Level 1 Appeals. Two appeals were related to a 3.5 level of care; one denial decision was overturned, and one was upheld. Three appeals were related to a 3.7 level of care, two denial decisions were overturned, and one was upheld. Two appeals were related to a 3.7E level of care; one denial decision was overturned, and one was upheld. Lastly, one appeal was related to the Inpatient Withdrawal Management level of care and the denial decision was overturned. Two appeals were Medical Necessity Provider Level 2 Appeals. One was related to a 3.5 level of care, and one was related to a 3.7 level of care. In both instances, the denial decision was upheld.

There were 47 total SUD related provider appeals in DY3, representing 53.4% of all behavioral health appeals in the same time period. This was an increase compared to DY2, which had 11 total SUD related appeals, representing 44.0% of all behavioral health appeals. The increase may be due to the transition of the Medicaid system to ASAM requirements and a tightening of prior authorization as providers learned to utilize the ASAM patient placement criteria. However, this should also be understood in the context of the overall low volume and the limitation of only three years' worth of data. The 47 appeals included Provider Level 1 and Provider Level 2 appeals, there were no member appeals in DY3.

SUD Provider Appeals

Forty-two of the 47 appeals in DY3 were Medical Necessity Provider Level 1 appeals. Those appeals were requested following denial of care by a physician during a peer-advisory review process where clinical presentation did not support the level of care being requested

- Twenty-eight were related to medically monitored intensive inpatient services (ASAM 3.7); of these, **25 denial decisions were upheld and three were overturned**.
- Ten were related to inpatient withdrawal management; of these, **nine denial decisions were upheld, and one was modified**.
- Two appeals were related to residential rehabilitation clinically managed high intensity residential services (ASAM 3.5) and **both denial decisions were upheld**.
- One appeal was related to medically monitored intensive inpatient co-occurring enhanced (ASAM 3.7E) and **the denial decision was upheld.**
- One appeal was related to residential rehabilitation clinically managed population focused high intensity (ASAM 3.3) **and the denial decision was overturned.**

Provider Level 1 Appeals by Level of Care and Outcome DY3

Five of the 47 appeals in DY3 were Medical Necessity Provider Level 2 appeals. These Level 2 appeals were requested after a second physician, conducting the Medical Necessity Level 1 appeal, upheld the decision of denying authorization of care because the clinical presentation did not support the ASAM level of care being requested. Three were related to medically monitored intensive inpatient services (ASAM 3.7) level of care and all denial decisions were upheld. Two were related to inpatient withdrawal management and both denial decisions were upheld.

Appendix E: Budget Neutrality Language and Worksheets

Hypothetical Budget Neutrality Test 1: SUD Services (see Expenditure Authority #1). The table below identifies the Medicaid Eligibility Groups (MEGs) that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated *WOW Only* or *Both* are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as *WW Only* or *Both*. MEGs that are indicated as *WW Only* or *Both* are counted as expenditures against this budget neutrality expenditure limit. Any expenditures over the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table E.1: Original Approved Budget Neutrality with Actual With Waiver Expenditures

Without-Waiver Total Expenditures								
MEG		**Trend**	**DY1**	**DY2**	**DY3**	**DY4Q1**	**Projection DY4**	**Projection DY5**
Hypothetical Per Capita BN Test 1								
SUD HUSKY A	Eligible Member Months	1.00%	1,816	2,044	2,109	404	2,243	3,020
	PMPM Cost	4.50%	$5,562.82	$5,813.15	$6,074.74	$6,348.10	$6,348.10	$6,633.76
	Total Expenditure	5.55%	$10,102,081	$11,882,079	$12,811,627	$2,564,632	$14,235,614	$20,033,955
SUD HUSKY C	Eligible Member Months	1.00%	652	895	933	191	1,927	2,595
	PMPM Cost	3.90%	$13,532.81	$14,060.59	$14,608.95	$15,178.70	$15,178.70	$15,770.67
	Total Expenditure	4.94%	$8,823,392	$12,584,228	$13,630,150	$2,899,132	$29,245,560	$40,924,889
SUD HUSKY D	Eligible Member Months	1.00%	15,479	18,849	17,665	3,492	15,286	20,585
	PMPM Cost	5.70%	$9,602.90	$10,150.27	$10,728.84	$11,340.38	$11,340.38	$11,986.78
	Total Expenditure	6.76%	$148,643,289	$191,322,439	$189,524,959	$39,600,607	$173,346,214	$246,747,866
TOTAL			**$167,568,762**	**$215,788,746**	**$215,966,736**	**$45,064,371**	**$216,827,388**	**$307,706,710**

With-Waiver Total Expenditures								
MEG		**Trend**	**DY1**	**DY2**	**DY3**	**DY4Q1**	**Projection DY4**	**Projection DY5**
Hypothetical Per Capita BN Test 1								
SUD HUSKY A	Total Expenditure		$9,831,162	$14,466,649	$16,154,924	$4,370,299	$14,235,614	$20,033,955
SUD HUSKY C	Total Expenditure		$3,817,448	$5,988,245	$6,196,675	$2,013,577	$29,245,560	$40,924,889
SUD HUSKY D	Total Expenditure		$82,828,298	$135,274,827	$134,676,815	$40,223,501	$173,346,214	$246,747,866
TOTAL			**$96,476,908**	**$155,729,721**	**$157,028,414**	**$46,607,377**	**$216,827,388**	**$307,706,710**

Table E.2. Extension Proposed with Five Additional Years for SUD

Without-Waiver Total Expenditures							
MEG		Trend	Projection DY6	Projection DY7	Projection DY8	Projection DY9	Projection DY10
Hypothetical Per Capita BN Test 1							
SUD HUSKY A	Eligible Member Months	1.00%	2,173	2,195	2,217	2,239	2,261
	PMPM Cost	4.50%	$ 12,009.67	$ 12,550.10	$ 13,114.86	$ 13,705.03	$ 14,321.75
	Total Expenditure	5.55%	$ 26,097,007	$ 27,547,475	$ 29,075,638	$ 30,685,552	$ 32,381,480
SUD HUSKY C	Eligible Member Months	1.00%	2,621	2,647	2,673	2,700	2,727
	PMPM Cost	3.90%	$ 16,385.73	$ 17,024.77	$ 17,688.74	$ 18,378.60	$ 19,095.36
	Total Expenditure	4.94%	$ 42,946,988	$ 45,064,565	$ 47,281,990	$ 49,622,210	$ 52,073,051
SUD HUSKY D	Eligible Member Months	1.00%	20,791	20,999	21,209	21,421	21,635
	PMPM Cost	5.70%	$ 12,670.03	$ 13,392.22	$ 14,155.57	$ 14,962.44	$ 15,815.30
	Total Expenditure	6.76%	$263,422,520	$281,223,185	$300,225,577	$320,510,473	$342,164,044
Total			**$332,466,515**	**$353,835,224**	**$376,583,205**	**$400,818,235**	**$426,618,575**

With-Waiver Total Expenditures							
MEG		Trend	Projection DY6	Projection DY7	Projection DY8	Projection DY9	Projection DY10
Hypothetical Per Capita BN Test 1							
SUD HUSKY A	Total Expenditure		$ 26,097,007	$27,547,475	$29,075,638	$30,685,552	$32,381,480
SUD HUSKY C	Total Expenditure		$ 42,946,988	$45,064,565	$47,281,990	$49,622,210	$52,073,051
SUD HUSKY D	Total Expenditure		$263,422,520	$281,223,185	$300,225,577	$320,510,473	$342,164,044
Total			**$332,466,515**	**$353,835,224**	**$376,583,205**	**$400,818,235**	**$426,618,575**

E.3. Extension Request for JI Reentry Portion of the Demonstration

Without-Waiver Total Expenditures										
MEG		**Trend**	**PC or Agg**	**Projection DY4**	**Projection DY5**	**Projection DY6**	**Projection DY7**	**Projection DY8**	**Projection DY9**	**Projection DY10**
JI Services	Eligible Member Months	1.00%		53,455	53,833	54,371	54,915	55,464	56,019	56,579
	PMPM Cost	6.90%	PC	$1,318.36	$1,382.17	$1,477.54	$1,579.49	$1,688.47	$1,804.98	$1,929.52
	Total Expenditure	7.97%		$70,472,562	$74,405,821	$80,335,204	$86,737,574	$93,649,438	$101,113,011	$109,170,341
JI Non-Services	Total Expenditure	0.00%	Agg	$46,443,183	$46,443,183	$46,443,183	$46,443,183	$46,443,183	$46,443,183	$46,443,183
Total				**$116,915,746**	**$120,849,004**	**$126,778,387**	**$133,180,757**	**$140,092,621**	**$147,556,195**	**$155,613,524**

With-Waiver Total Expenditures										
MEG		**Trend**		**Projection DY4**	**Projection DY5**	**Projection DY6**	**Projection DY7**	**Projection DY8**	**Projection DY9**	**Projection DY10**
Hypothetical Budget Neutrality Test 2										
JI Services	Eligible Member Months	1.00%		53,455	53,833	54,371	54,915	55,464	56,019	56,579
	PMPM Cost	6.90%	PC	$1,318.36	$1,382.17	$1,477.54	$1,579.49	$1,688.47	$1,804.98	$1,929.52
	Total Expenditure	7.97%		$70,472,562	$74,405,821	$80,335,204	$86,737,574	$93,649,438	$101,113,011	$109,170,341
JI Non-Services	Total Expenditure	0.00%	Agg	$46,443,183	$46,443,183	$46,443,183	$46,443,183	$46,443,183	$46,443,183	$46,443,183
Total				**$116,915,746**	**$120,849,004**	**$126,778,387**	**$133,180,757**	**$140,092,621**	**$147,556,195**	**$155,613,524**

E.4. Extension Request for SDOH

Without-Waiver Total Expenditures									
MEG		**Trend through DY6**	**Projection DY4**	**Projection DY5**	**Projection DY6**	**Projection DY7**	**Projection DY8**	**Projection DY9**	**Projection DY10**
Capped Hypothetical Test 3									
JI SDOH	Eligible Member Months	1.00%	31,476	31,791	32,109	32,109	32,109	32,109	32,109
	PMPM Cost	0.00%	$ 1,557.00	$ 1,557.00	$ 1,557.00	$ 1,557.00	$ 1,557.00	$ 1,557.00	$ 1,557.00
	Total Expenditure	1.00%	$ 49,008,132	$ 49,498,587	$ 49,993,713	$ 49,993,713	$ 49,993,713	$ 49,993,713	$ 49,993,713
JI SDOH Infrastructure	Total Expenditure	1.00%	$ 8,648,494	$ 8,735,045	$ 8,822,420	$ 8,822,420	$ 8,822,420	$ 8,822,420	$ 8,822,420
Total			**$ 57,656,626**	**$ 58,233,632**	**$ 58,816,133**	**$ 58,816,133**	**$ 58,816,133**	**$ 58,816,133**	**$ 58,816,133**

With-Waiver Total Expenditures									
MEG		**Trend through DY6**	**Projection DY4**	**Projection DY5**	**Projection DY6**	**Projection DY7**	**Projection DY8**	**Projection DY9**	**Projection DY10**
Capped Hypothetical Test 3									
JI SDOH	Eligible Member Months	1.00%	31,476	31,791	32,109	32,109	32,109	32,109	32,109
	PMPM Cost	0.00%	$ 1,557.00	$ 1,557.00	$ 1,557.00	$ 1,557.00	$ 1,557.00	$ 1,557.00	$ 1,557.00
	Total Expenditure	1.00%	$ 49,008,132	$ 49,498,587	$ 49,993,713	$ 49,993,713	$ 49,993,713	$ 49,993,713	$ 49,993,713
JI SDOH Infrastructure	Total Expenditure	1.00%	$ 8,648,494	$ 8,735,045	$ 8,822,420	$ 8,822,420	$ 8,822,420	$ 8,822,420	$ 8,822,420
Total			**$ 57,656,626**	**$ 58,233,632**	**$ 58,816,133**	**$ 58,816,133**	**$ 58,816,133**	**$ 58,816,133**	**$ 58,816,133**

E.5. Extension Proposed with an Additional Year (DY6) at a No Trend Increase for all Pending Amendments

Without-Waiver Total Expenditures									
MEG		Trend	Projection DY5	Projection DY6	Projection DY7	Projection DY8	Projection DY9	Projection DY10	Projection DY11
Hypothetical Per Capita BN Test 1									
SUD HUSKY A	Eligible Member Months	1.00%	3,020	3,050	2,195	2,217	2,239	2,261	2,284
	PMPM Cost	4.50%	$ 6,633.76	$ 6,633.76	$ 12,550.10	$ 13,114.86	$ 13,705.03	$ 14,321.75	$ 14,966.23
	Total Expenditure	5.55%	$ 20,033,955	$ 20,232,968	$ 27,547,475	$ 29,075,638	$ 30,685,552	$ 32,381,480	$ 34,182,870
SUD HUSKY C	Eligible Member Months	1.00%	2,595	2,621	2,647	2,673	2,700	2,727	2,754
	PMPM Cost	3.90%	$ 15,770.67	$ 15,770.67	$ 16,385.73	$ 17,024.77	$ 17,688.74	$ 18,378.60	$ 19,095.36
	Total Expenditure	4.94%	$ 40,924,889	$ 41,334,926	$ 43,373,017	$ 45,507,209	$ 47,759,586	$ 50,118,432	$ 52,588,625
SUD HUSKY D	Eligible Member Months	1.00%	20,585	20,791	20,999	21,209	21,421	21,635	21,851
	PMPM Cost	5.70%	$ 11,986.78	$ 11,986.78	$ 12,670.03	$ 13,392.22	$ 14,155.57	$ 14,962.44	$ 15,815.30
	Total Expenditure	6.76%	$ 246,747,866	$ 249,217,143	$ 266,057,886	$ 284,035,551	$ 303,226,559	$ 323,712,436	$ 345,580,149
Hypothetical BN Test 2									
JI Services (Per Capita)	Eligible Member Months	1.00%	53,833	54,371	54,915	55,464	56,019	56,579	57,145
	PMPM Cost	6.90%	$ 1,382.17	$ 1,382.17	$ 1,477.54	$ 1,579.49	$ 1,688.47	$ 1,804.98	$ 1,929.52
	Total Expenditure	7.97%	$ 74,405,821	$ 75,149,863	$ 81,138,984	$ 87,604,713	$ 94,586,540	$ 102,123,799	$ 110,262,449
JI Non-Services (Aggregate)	Total Expenditure	0.00%	$ 46,443,183	$ 46,443,183	$ 46,443,183	$ 46,443,183	$ 46,443,183	$ 46,443,183	$ 46,443,183
Capped Hypothetical BN Test 3									
JI SDOH	Eligible Member Months	1.00%	31,791	32,109	32,109	32,109	32,109	32,109	32,109
	PMPM Cost	0.00%	$ 1,557.00	$ 1,557.00	$ 1,557.00	$ 1,557.00	$ 1,557.00	$ 1,557.00	$ 1,557.00
	Total Expenditure	1.00%	$ 49,498,587	$ 49,993,713	$ 49,993,713	$ 49,993,713	$ 49,993,713	$ 49,993,713	$ 49,993,713
JI SDOH Infrastructure	Total Expenditure	1.00%	$ 8,735,045	$ 8,822,420	$ 8,822,420	$ 8,822,420	$ 8,822,420	$ 8,822,420	$ 8,822,420
TOTAL			**$ 486,789,346**	**$ 491,194,216**	**$ 523,376,678**	**$ 551,482,427**	**$ 581,517,553**	**$ 613,595,463**	**$ 647,873,411**

With-Waiver Total Expenditures									
MEG		Trend	Projection DY5	Projection DY6	Projection DY7	Projection DY8	Projection DY9	Projection DY10	Projection DY11
Hypothetical Per Capita BN Test 1									
SUD HUSKY A	Total Expenditure		$ 20,033,955	$ 20,232,968	$ 27,547,475	$ 29,075,638	$ 30,685,552	$ 32,381,480	$ 34,182,870
SUD HUSKY C	Total Expenditure		$ 40,924,889	$ 41,334,926	$ 43,373,017	$ 45,507,209	$ 47,759,586	$ 50,118,432	$ 52,588,625
SUD HUSKY D	Total Expenditure		$ 246,747,866	$ 249,217,143	$ 266,057,886	$ 284,035,551	$ 303,226,559	$ 323,712,436	$ 345,580,149
Hypothetical BN Test 2									
JI Services (Per Capita)	Eligible Member Months	1.00%	53,833	54,371	54,915	55,464	56,019	56,579	57,145
	PMPM Cost	6.90%	$ 1,382.17	$ 1,382.17	$ 1,477.54	$ 1,579.49	$ 1,688.47	$ 1,804.98	$ 1,929.52
	Total Expenditure	7.97%	$ 74,405,821	$ 75,149,863	$ 81,138,984	$ 87,604,713	$ 94,586,540	$ 102,123,799	$ 110,262,449
JI Non-Services (Aggregate)	Total Expenditure	0.00%	$ 46,443,183	$ 46,443,183	$ 46,443,183	$ 46,443,183	$ 46,443,183	$ 46,443,183	$ 46,443,183
Capped Hypothetical BN Test 3									
JI SDOH	Eligible Member Months	1.00%	31,791	32,109	32,109	32,109	32,109	32,109	32,109
	PMPM Cost	0.00%	$ 1,557.00	$ 1,557.00	$ 1,557.00	$ 1,557.00	$ 1,557.00	$ 1,557.00	$ 1,557.00
	Total Expenditure	1.00%	$ 49,498,587	$ 49,993,713	$ 49,993,713	$ 49,993,713	$ 49,993,713	$ 49,993,713	$ 49,993,713
JI SDOH Infrastructure	Total Expenditure	1.00%	$ 8,735,045	$ 8,822,420	$ 8,822,420	$ 8,822,420	$ 8,822,420	$ 8,822,420	$ 8,822,420
TOTAL			**$ 486,789,346**	**$ 491,194,216**	**$ 523,376,678**	**$ 551,482,427**	**$ 581,517,553**	**$ 613,595,463**	**$ 647,873,411**

Appendix F

On March 27, 2024, the State submitted an amendment application requesting authority for a reentry initiative and SDoH, and it is currently pending with CMS.[15] The state is seeking the authorities detailed in the amendment application as a part of this extension. The Re-entry Initiative is intended to be effective on or after July 1, 2026, upon CMS approval, with a renewal under this Extension from April 1, 2027, though March 31, 2032.

Summary of the March 27, 2024, Pending 1115 Amendment to be Incorporated into the Extension

The Department of Social Services (DSS) is seeking an amendment to the Substance Use Disorder (SUD) 1115 Demonstration (Demonstration) to authorize:

1. **Reentry services** for individuals transitioning to the community from correctional facilities.
2. **Services to Address Social Determinants of Health (SDOH)** for the justice-involved (JI) Reentry population transitioning from correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile and community residential centers throughout the State.

Reentry Initiative

DSS is seeking to implement the Reentry Initiative amendment by July 1, 2026. This Reentry Initiative is the result of a collaborative effort among various State agencies and other partners, including DSS, Connecticut's single State agency for Medicaid and Children's Health Insurance Program (CHIP); the Department of Correction, the single State agency for the administration of carceral facilities; the Judicial Branch, the Department of Developmental Disabilities, the Department of Children and Families, the Department of Housing, and the Department of Mental Health and Addiction Services, the lead State agency for adult behavioral health.

The Reentry Initiative is intended to be effective upon the Centers for Medicare & Medicaid Services (CMS) approval, on or after November 1, 2025. The State requested to operate the Reentry Initiative through the end of the current SUD Demonstration approval period, which is March 31, 2027. Once Demonstration authority and implementation documents are approved, the Reentry Initiative will enable Medicaid coverage and federal financial participation (FFP) using Medicaid and CHIP matching funds for adults incarcerated in correctional centers (jails and courthouses) and correctional institutions (prisons), and youth detained in juvenile and community residential centers throughout the State receiving a targeted benefit package that would ordinarily not be covered under federal law. This Reentry Initiative will ensure a continuum of care strategy that enables robust coordination, service provision, and community connections after release.

The Reentry Initiative implements the CMS' guidance for Reentry 1115 Demonstration waivers, set forth in CMS State Medicaid Director Letter (SMD) # 23-003, Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated, posted on the CMS website at this link: https://www.medicaid.gov/sites/default/files/2023-04/smd23003.pdf.

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[15] The pending amendment may be accessed on the CMS website at: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/110976

Objectives and Goals

Reentry Initiative

The program description, goals, and objectives to be implemented or extended under the Reentry Initiative, including a description of the current or new beneficiaries who will be impacted by the Demonstration.

Program Description

Connecticut is requesting this authority to design and implement a *Reentry Initiative* that provides:

1. Medicaid Coverage for eligible inmates in the State's correctional system, including all correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile and community residential centers throughout the State. Eligible individuals include those with behavioral health needs, including mental health disorders and SUD, certain other health conditions, and detained youth.
2. A Targeted Benefit Package for these individuals, including case management services, medication-assisted treatment for SUD, a 30-day supply of medications upon release, and certain other supportive services.
3. A Coverage Period of up to 90 days immediately prior to the release of the eligible individual from the correctional system.
4. Services to Address SDOH for the JI population transitioning from correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile and community residential centers throughout the State.

This suite of coverage provisions and services will be implemented across Connecticut, creating and strengthening connections between carceral settings, government agencies, health and social service entities, and many others collaborating to better support individuals' Reentry into the community while maintaining their health and wellbeing.

Goals/Objectives

Consistent with the CMS goals as outlined in SMD#23-003, Connecticut's specific goals for the Reentry Initiative are to:

1. Increase coverage, continuity of coverage, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release;
2. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during Reentry;
3. Improve coordination and communication between correctional systems, Medicaid systems, administrative service organizations, and community-based providers;
4. Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful Reentry post-release;
5. Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and social determinants of health;
6. Reduce all-cause deaths in the near-term post-release; and
7. Reduce the number of emergency department (ED) visits and inpatient hospitalizations among recently incarcerated Medicaid beneficiaries through increased receipt of preventive and routine physical and behavioral health care.

Consistent with CMS guidance on SDOH, and other guidance on January 7, 2021, at this link: https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf, the State also intends to address unmet needs related to a lack of adequate housing support. These conditions contribute to poor health for individuals transitioning from correctional centers (jails and courthouses), correctional institutions (prisons), and juvenile and community residential centers throughout the State, and addressing them is key to successful Reentry. Connecticut requests authority to claim FFP in SDOH infrastructure investments in order to support the development and implementation of JI SDOH services, not to exceed 15% of the total JI SDOH spend.

Current and New Beneficiaries Impacted by the Re-Entry Initiative

To receive services under the Reentry Initiative, a beneficiary will need to meet all of the following qualifying criteria:

- Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a State correctional system, including all correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile and community residential centers; and
- Be enrolled in Medicaid or otherwise eligible for CHIP if not for their incarceration status; and
- Identified as expected to be released in the next 90 days and identified for participation in the Demonstration; and
- Have one of the following conditions:
  - Is an individual incarcerated in a juvenile and/or community residential center; or
  - Is an adult and meets one or more of the following diagnosis or population requirements:
    - Mental illness (MI);
    - SUD;
    - Co-occurring MI/SUD;
    - Chronic condition or significant non-chronic clinical condition;
    - Intellectual disability;
    - Acquired brain injury, including traumatic brain injury;
    - Positive test or diagnosis of HIV/AIDS; or
    - Currently pregnant or within a 12-month postpartum period.

Individuals deemed a *qualified inmate* will have eligibility determined for the appropriate Medicaid program for which they meet eligibility requirements. For example, if a *qualified inmate* meets the eligibility criteria for the Adult Expansion Medicaid program, then they would be enrolled in that specific Medicaid program.

A *qualified inmate* must meet general Medicaid program requirements. These include:

1. Must be a Connecticut resident;
2. Must be a US Citizen or qualified alien; and
3. Must meet the income and asset standards for the applicable Medicaid program.

Possible Medicaid programs include, but are not limited to:

1. Temporary Assistance for Needy Families or related child and adult caretaker groups (HUSKY A).
2. CHIP (HUSKY B).
3. Aged, Blind, or Disabled Medicaid or related groups (HUSKY C).
4. Adult Expansion Medicaid (HUSKY D).

Medicaid and CHIP Requirements

This Reentry Initiative will not change the underlying Medicaid program or CHIP; in particular, it will not change the current Connecticut fee-for-service delivery system, eligibility requirements, covered services, or cost-sharing. This Reentry Initiative will allow for the provision of certain approved services within carceral settings in the 90 days prior to release and designate new entities able to coordinate and provide those services.

Cost Sharing

There are no proposed changes to cost sharing under this amendment. Cost-sharing requirements will not differ from those provided under the State Plan for either Medicaid or CHIP.

Delivery System

No changes to Connecticut's delivery system are proposed under this amendment. Benefits will continue to be delivered in a FFS delivery system.

Eligibility

There are no proposed changes to Medicaid or CHIP eligibility requirements.

Benefit Coverage

The Demonstration will allow for the provision of certain covered benefits to incarcerated individuals and will enable FFP to the State for the federal share of these services. Per CMS guidance, DSS will develop and submit a required Implementation Plan to describe service provision and reinvestment plans for federal dollars received for services currently funded by the State.

The pre-release services authorized under the Reentry Initiative include the provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth. The State may begin

claiming FFP for services covered through the initiative, expected to begin on or after November 1, 2025, once the implementation plan is approved by CMS.

All facilities must implement service level one which includes the minimum CMS benefits plus medications and medication assistance, screening for common conditions, and diagnosis and treatment for Hepatitis C. Service level one is structured to include:

- Reentry transitional case management services to assess and address physical and behavioral health needs and SDOH;
- MAT, for all Food and Drug Administration-approved medications, including coverage for counseling; and
- Covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid State Plan) provided to the individual immediately upon release from the correctional facility;
- Medications and medication administration;
- Screening for common health conditions within the incarcerated population, such as blood pressure, diabetes, hepatitis C, and HIV/AIDS; and
- Diagnosis and treatment for hepatitis C.

A facility must implement all the services within its chosen service level as outlined in the State's implementation plan. Participating facilities' plans for service level selection and movement will be captured in the implementation plan, including a timeline for initial implementation and any additional service levels. As applicable, additional service levels may be phased in by facilities (e.g., facilities implementing only service level one initially may later implement service level two).

Additional service levels may include the following services currently covered under the Connecticut Medicaid and CHIP State Plans:

- Physical and behavioral health clinical consultation services provided through telehealth or in-person, as needed, to diagnose health conditions, provide treatment, as appropriate, and support pre-release case managers' development of a post-release treatment plan and discharge planning;
- Laboratory and radiology services;
- Services provided by community health workers to the extent covered under the Medicaid State Plan including those with lived experience;
- Family planning services;
- Rehabilitative or preventive services to the extent covered under the Medicaid State Plan, including those provided by community health workers, as applicable; and
- Provision of durable medical equipment (DME) and/or supplies.

In addition to the pre-release services, qualifying beneficiaries may also receive DME upon release, consistent with approved State Plan coverage authority and policy.

Allowable SDOH services for the JI population include:

- Rent/temporary housing for up to six months, specifically for individuals transitioning from correctional centers (jails and courthouses), correctional institutions (prisons), and youth juvenile and community residential centers throughout the State;
- Utility costs including activation expenses and back payments to secure utilities, are limited to individuals receiving rent/temporary housing as described above;
- Pre-tenancy and tenancy sustaining services, including tenant rights education and eviction prevention;
- Housing transition navigation services;
- One-time transition and moving costs (e.g., security deposit, first month's rent, utility activation fees, movers, relocation expenses, pest eradication, pantry stocking, and the purchase of household goods and furniture);
- Housing deposits to secure housing, including application and inspection fees and fees to secure needed identification;
- Medically necessary air conditioners, heaters, humidifiers, air filtration devices, generators, and refrigeration units as needed for medical treatment and prevention;
- Medically necessary home accessibility modifications and remediation services such as ventilation system repairs/improvements and mold/pest remediation.

Administrative FFP will be available for the following activities related to JI infrastructure development:

- Technology — e.g., electronic referral systems, shared data platforms, electronic health records system modifications or integrations, screening tools and/or case management systems, databases/data warehouses, data analytics and reporting, data protection and privacy, accounting and billing systems.
- Development of business or operational practices — e.g., procurement and planning, developing policies and workflows for referral management, privacy, quality improvement, trauma-informed practices, evaluation, and member navigation.
- Workforce development — e.g., cultural competency training, trauma-informed care training, traditional health worker certification, and training staff on new policies and procedures.
- Outreach, education, and stakeholder convening — e.g., design and production of outreach and education materials, translation, obtaining community input, and investments in stakeholder convening.

DSS will determine when each applicable facility is ready to participate in the Reentry Initiative based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

1. Pre-release Medicaid and CHIP application and enrollment processes for individuals who are not enrolled in Medicaid or CHIP prior to incarceration and who do not otherwise become enrolled during incarceration;
2. The screening process to determine a beneficiary's qualification for pre-release services;

3. The provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth. If a facility is not equipped to provide or facilitate the full set of pre-release services, the facility must provide a timeline of when it will be equipped to do so, including concrete steps and their anticipated completion dates that will be necessary to ensure that qualifying beneficiaries are able to receive timely any needed pre-release services;
4. Coordination among partners with a role in furnishing health care, housing, and SDOH services to beneficiaries, including, but not limited to, State agencies and State-contracted providers, as well as administrative services organizations, other behavioral health agencies, and community-based providers, including federally qualified health centers;
5. Appropriate Reentry planning, pre-release care management, and assistance with care transitions to the community, including connecting beneficiaries to physical and behavioral health providers and the administrative services organizations, and making referrals to care management and community support providers that take place throughout the 90-day pre-release period, and providing beneficiaries with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid State Plan);
6. Operational approaches related to implementing certain Medicaid and CHIP requirements, including, but not limited to applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the Reentry Initiative;
7. A data exchange process to support the care coordination and transition activities;
8. Reporting of requested data from DSS to support program monitoring, evaluation, and oversight; and
9. A staffing and project management approach for supporting all aspects of the facility's participation in the Reentry Initiative, including information on the qualifications of the providers that the correctional system will partner with for the provision of pre-release services.

An estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures, including historic enrollment or budgetary data, if applicable. This includes a financial analysis of any changes to the Demonstration requested by the State. Currently, Medicaid does not reimburse for medical services for adults incarcerated in correctional centers (jails and courthouses), correctional institutions (prisons), and juveniles detained in juvenile and community residential centers (except for services provided while such individuals are patients in a medical institution, as authorized under section 1905 of the Social Security Act).

Under the Demonstration, it is anticipated that there will be between 54,371 to 56,579 member months annually receiving a targeted benefit package 90 days pre-release costing between $1,477.54 to $1,939.52 per member per month. All but 750 individuals are expected to be adults. 90% of all adults are expected to be in the HUSKY D eligibility category. 10% of adults are expected to be in the HUSKY A or HUSKY C eligibility categories. The 750 distinct youth are expected to be split between HUSKY A and HUSKY C eligibility categories with very few

children anticipated to be in the HUSKY C eligibility categories. A non-material number of youth are expected to be in HUSKY B (CHIP).

Table F.1.

MEG		Total for Upcoming Waiver Period
JI Services	Eligible Member Months	277,348
	Total Expenditure	$471,005,568
JI Non-Services	Total Expenditure	$232,215,917
JI SDOH	Eligible Member Months	160,545
	Total Expenditure	$249,968,565
JI SDOH Infrastructure	Total Expenditure	$44,112,100

Estimated Impact of the Demonstration

The table below estimates the projected annual enrollment of beneficiaries (without and with the waiver) for each DY.

Table F.2. Estimated Projections of Annual Enrollment

Member Months under the Amendment*	DY6	DY7	DY8	DY9	DY10	Five-Year Renewal Total
Total Projected Member Months Without the Amendment	0	0	0	0	0	0
JI Total Projected Member Months under Renewal	54,371	54,915	55,464	56,019	56,579	277,348
JI SDOH	32,109	32,109	32,109	32,109	32,109	160,545

**Using a 1% caseload growth rate for the JI population; Re-entry Initiative effective July 1, 2026*

The table below estimates the projected annual expenditures (without and with the waiver) for each DY.

Table F.3. Estimated JI and JI SDOH Projections of Annual Expenditures

Projected Services Costs under Amendment*	DY6	DY7	DY8	DY9	CY10	Five-Year Renewal Total
Total projected costs without Amendment	0	0	0	0		
JI Services	$80,335,204	$86,737,574	$93,649,438	$101,113,011	$109,170,341	$471,005,568
JI Non-Services	$46,443,183	$46,443,183	$46,443,183	$46,443,183	$46,443,183	$232,215,917
JI SDOH	$49,993,713	$49,993,713	$49,993,713	$49,993,713	$49,993,713	$249,968,565
JI SDOH Infrastructure	$8,822,420	$8,822,420	$8,822,420	$8,822,420	$8,822,420	$44,112,100

**Using a 6.9% trend rate for the JI expenditures; Re-entry Initiative effective July 1, 2026, Amendment Submitted on March 27, 2024*

Demonstration Hypotheses and Evaluation

With the help of an independent evaluator, the State will amend the approved SUD evaluation plan for evaluating the hypotheses indicated below and analyze the outcomes related to the goals under the Demonstration articulated above. Connecticut will calculate and report all performance measures under the Demonstration. The State will submit the updated SUD evaluation plan to CMS for approval.

As detailed below, the State will conduct ongoing monitoring of this Demonstration related to the five Re-entry milestones as required in CMS guidance references above (including SMD#23-003) as well as the three SDOH tests required by the CMS SDOH guidance referenced above and will provide information regarding monitoring activities in the required quarterly and annual monitoring reports.

By providing Medicaid coverage prior to an individual's release from incarceration, the State will be able to bridge relationships between community-based Medicaid providers and JI populations prior to release, thereby improving the chances of individuals with a history of behavioral health conditions and/or chronic diseases receive stable and continuous care. The hypotheses and goals Stated below will be tested during the approval period.

Hypotheses: The full 90-day timeline will enable the State to support pre-release identification, stabilization, and management of certain serious physical and behavioral health conditions that may respond to ambulatory care and treatment (e.g., diabetes, heart failure, hypertension, schizophrenia, SUDs) which could reduce post-release acute care utilization.

By allowing early interventions to occur in the full 90-day period immediately prior to expected release, such as for certain behavioral health conditions and including stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs, Connecticut expects that it will be able to reduce decompensation, suicide-related deaths, overdoses, and overdose-related deaths in the near-term post-release.

Questions: The State will test, and comprehensively evaluate through robust hypotheses testing, the effectiveness of the extended full 90-day coverage period before the beneficiary's expected date of release on achieving the articulated goals of the initiative:

1. Increase coverage, continuity of coverage, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release;
2. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry;
3. Improve coordination and communication between correctional systems, Medicaid systems, administrative service organizations, and community-based providers;
4. Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful reentry post-release;
5. Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and SDOH;
6. Reduce all-cause deaths in the near-term post-release; and

7. Reduce the number of ED visits and inpatient hospitalizations among recently incarcerated Medicaid beneficiaries through increased receipt of preventive and routine physical and behavioral health care.

Additionally, the State will test, and comprehensively evaluate through robust hypotheses testing, the effectiveness of SDOH in achieving the articulated goals of the initiative:

1. Address unmet SDOH,
2. Reduce potentially avoidable, high-cost services (e.g., ED visits, institutional care), and/or
3. Improve physical and mental health outcomes for beneficiaries.

Data Source: Claims/encounter data.

Evaluation Design: Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons and interrupted time series analysis.

Waiver and Expenditure Authorities

The State seeks such waiver authority as necessary under the Demonstration to receive FFP on costs not otherwise matchable for services rendered to individuals who are incarcerated 90 days prior to their release. The State also requests the following proposed waivers and expenditure authority to operate the Demonstration.

Table F.4. Waivers Requested

Waiver Authority	Reason and Use of Waiver Authority Will Enable the State To:
Statewideness Section 1902(a)(1) 42 CFR 431.50	To enable the State to provide pre-release services, as authorized under this Demonstration, to qualifying beneficiaries on a geographically limited basis according to the Statewide implementation phase-in plan, in accordance with the Reentry Initiative implementation plan. To enable the State to cover SDOH services on a geographically limited basis during the phase-in process.
Amount, Duration, and Scope of Services and Comparability Section 1902(a)(10)(B) 1902(a)(17)	To enable the State to provide only a limited set of pre-release services, as specified in these Special Terms and Conditions (STCs), to qualifying beneficiaries that are different than the services available to all other beneficiaries outside of carceral settings in the same eligibility groups authorized under the State Plan or the Demonstration. To the extent necessary to allow the State to offer the JI SDOH services. To the extent necessary to enable the State to provide HRSN services based on service delivery systems that are not otherwise available to all beneficiaries in the same eligibility group during the phase-in process.

Waiver Authority	Reason and Use of Waiver Authority Will Enable the State To:
Freedom of Choice Section 1902(a)(23)(A) 42 CFR 431.51	To enable the State to require qualifying beneficiaries to receive pre-release services, as authorized under this Demonstration, through only certain providers.

Table F.5. Expenditure Authority Requested:

Title XIX Expenditure Authority	Expenditures
Expenditures Related to Pre-Release Services	Expenditures for pre-release services, as described in the STCs to be established by CMS, are provided to qualifying Medicaid beneficiaries and beneficiaries who would be eligible to receive Medicaid covered services if not for their incarceration status for up to 90 days immediately prior to the expected date of release from a participating State correctional system facility, including all correctional centers (jails and courthouses), correctional institutions (prisons), and juvenile detention centers.
Expenditures for Allowable Administrative Costs to Support the Implementation of Pre-Release Services	Expenditures for allowable administrative costs to support the implementation of pre-release services as outlined in April 17, 2023 SMD letter #23-003 relating to administrative information technology and transitional, non-service expenditures, including administrative costs under an approved cost allocation plan.
SDOH Services	Expenditures for approved evidence-based SDOH services not otherwise eligible for Medicaid payment furnished to individuals who meet the qualifying JI and SDOH criteria.
SDOH Services Infrastructure	Expenditures for allowable administrative costs and infrastructure not otherwise eligible for Medicaid payment, to the extent such activities are authorized as part of the approved SDOH infrastructure activities.

Appendix G

Documentation of the State's compliance with the public notice process set forth in 42 CFR §§431.408 and 431.420.

Post Award Forums

The state held an annual post-award forum for each year of the 1115 Demonstration to-date. Notice for each forum was posted 30 days in advance, per federal requirements. Forums were held on:

- October 21, 2022 (notice provided on September 21, 2022)
- October 11, 2023 (notice provided on September 11, 2023)
- September 24, 2024 (notice provided on August 19, 2024)
- September 09, 2025 (notice provided on July 30, 2025)

Details and feedback from each forum are summarized below.

First Annual Post Award Forum

Public Notice of First Annual Post Award Forum

Notice of the first Annual Post Award forum was published in the Connecticut Law Journal and posted on the DSS website on September 21, 2022, prior to 3:00 pm EDT at: Https://portal.ct.gov/-/media/departments-and-agencies/dss/health-and-home-care/substance-use-disorder-demonstration-project/post-award-forum-website-notice.pdf

Summary

The post-award forum held October 21, 2022, was attended by 69 individuals. The presentation, public comments, and State response are posted on the State's Demonstration website. Feedback was positive, noting inclusivity and collaboration with a focus on person-centered and recovery-oriented care. Treatment providers noted challenges with workforce and supported coordination with other workforce improvement efforts, and requested that training not duplicate in-house agency training. State coverage for Licensed Alcohol and Drug Counselors (LADCs) was clarified. Providers requested that the State monitor residential lengths of stay for access. Providers discussed the authorization process with interest in opportunities for a member to remain in care within one program as they transition between levels of care (LOCs). Housing needs were identified as a continued challenge for discharge planning. Providers believe two years may be insufficient to implement State standards for American Society of Addiction Medicine (ASAM) third edition.

Details

The post-award forum was held on October 21, 2022. Spanish translation was made available during the forum. The forum was attended by 69 individuals. The presentation given at the forum has been posted to the State's dedicated website for the Demonstration. Also posted are the public comments received during the forum, as well as the State's response, where applicable. Feedback on the process was positive, with providers noting inclusivity and strong collaboration while maintaining a focus on person-centered and recovery-oriented care.

Treatment providers noted continued challenges with workforce given staffing shortages in multiple disciplines. Relatedly, a request was made to not duplicate existing training offered by agencies so as to not further strain staffing resources. Clarification was provided by the State regarding the inclusion of LADCs. Advocacy was made to continue monitoring length of stay for members to ensure that there is no inadvertent impact. Providers are interested in continued support around the authorization process and expressed interest in opportunities to use a *flex bed* approach whereby members can remain in care within one program as they transition between LOCs. Housing needs were identified as a continued challenge for discharge planning when a member is ready to transition back to the community. Encouragement was offered by a participant to combine efforts of this Demonstration with other Diversity, Equity, and Inclusion (DEI) efforts to increase diversity among licensed staff and leadership. Lastly, concern was expressed that two years for implementation may not be long enough to adequately implement ASAM third edition and the State's standards.

Attendees self-report statistics:

- An individual eligible for Medicaid — one attendee.
- Five attendees were interested parties.
- 32 attendees were Medicaid enrolled providers.
- 16 attendees were State agency staff.

Attendee rating of the current Connecticut SUD treatment system:

- Excellent — four attendees.
- Good — 27 attendees.
- Fair — 31 attendees.
- Poor — two attendees.
- Of those who rated the system *excellent* — two were providers and two were State agency staff.
- Of those who rated the system *poor* — one was a provider and one was a State agency staff.

Attendee reported ability to access the current Connecticut SUD treatment system:

- I do not know how to access SUD services — two attendees.
- I know how to access SUD services — 52 attendees.
- Of those who said they did not know how to access treatment — one was a State agency staff and one was an interested party (our interpreter).

For the question *Connecticut Medicaid covers the following substance use disorder treatment services, check all that apply*:

- Outpatient services.
- Outpatient services with withdrawal management (detoxification) services.
- Medication for addiction treatment (e.g., buprenorphine, methadone, and naltrexone).
- Intensive outpatient and partial hospital treatment.

- Residential treatment.
- Residential treatment for withdrawal management (detoxification).

Of those who selected less than six, there was variation in what people knew for Medicaid covered SUD services — some included residential in their response, some did not.

- 36 people selected all six (the full continuum).
- Seven people selected five.
- Six people selected four.
- Three people selected three.
- Two people selected one — both selected *residential* for this answer, both respondents were State agency staff.

Feedback

1. Process
    a. This has been an amazingly inclusive process with lots of back and forth. We are appreciative of this. We hope that we are able to continue this process in future design processes.
    b. We wish that the intensive outpatient rate development was as inclusive as the residential rate development.
    c. Everyone has been focused on person-centered and recovery-oriented care. The opportunity to work with the State, Advanced Behavioral Health (ABH), and Beacon has been excellent. Everyone is collegial and recovery-oriented. It is much appreciated.
    d. The providers want to give credit to the State agencies on the collaboration and believe we have reached a better outcome because of it. This process should be a model of how changes to the Behavioral Health system should embark on changes. The work that happens next, we encourage continued collaboration. Inflation and workforce have affected the providers' ability to implement the ASAM, but the implementation is so far working well. Outpatient, intensive outpatient, and partial hospitalization need to have the same level of collaboration to get a good outcome.
    e. The State agency partners expressed appreciation for the openness and collaboration of the process. The Judicial Branch Court Support Services Division acknowledged that there has been lots of consideration for the judicial and corrections population. A few of the State agencies participated in a regional justice opioid initiative conference and there we heard that hiring qualified licensed staff is a concern in other States as well. We should recognize workforce issues wherever we can and work together to resolve these.
2. Workforce
    a. We underestimated how difficult it has been to hire licensed clinical staff, especially for residential staff. We are concerned with the geographical difficulties. It is hard to hire staff in both outpatient and residential settings. The lack of licensed staff will impact the ability to meet the standards and could impact future audits. The lack of staff has increased pressure on program managers. We ask that State partners be aware of this.

b. It has been extremely difficult to hire licensed clinical staff, especially for residential and outpatient settings. There is a concern about how this will impact the ability to meet the standards and future audits. This also places additional burden on the managers of the programs. There are currently vacancies for counselor positions and drug courts that require licensed staff.

c. Providers have tried numerous recruitment strategies (e.g., signing bonuses, benefit package revisions, and partnerships with universities). The struggle with hiring issues are compounding other issues. Vacant counselor positions place pressure on pre-licensure individuals as well as managers and directors.

d. Workforce recruitment remains a significant challenge because providers are facing incredible competition. It is challenging to meet guidelines and compliance with the workforce issues.

3. Length of Stay

   a. Please keep an eye on length of stay impact to make sure there is not an inadvertent impact to members and so that quality does not increase.

4. Training

   a. Training requirements should not duplicate existing training to ensure that there is no duplication of what is already required of staff.

5. Authorization

   a. Please continue to revisit the authorization process to see if once implementation has passed that processes could be streamlined to further reduce those burdens.

   b. Residential authorizations have been a challenge but are improving. Concurrent authorizations are the most challenging. Having the same expectations as commercial insurers may be more difficult in Medicaid and make access more difficult.

6. Flex beds

   a. We recommend allowing providers to flex the LOC that a bed can be certified for. Flexing the beds would allow members to remain in care where they are.

   b. Allowing for flex beds as the length of stay tightens up will keep an individual in treatment for longer periods.

7. Housing

   a. There is a need to continue building up housing options including sober living and other step-down housing.

8. DEI

   a. We encourage the State to combine the SUD Waiver efforts with other DEI initiatives to ensure that providers are increasing diversity among licensed staff and leadership. Please loop together the Behavioral Health Partnership Oversight Council DEI subcommittee efforts. Heather Gates will bring that suggestion back to DEI as a participant in that committee.

9. Implementation Timelines and Flexibility

a. Providers recommended continued flexibility from the Department of Social Services (DSS) and Centers for Medicare & Medicaid Services (CMS) in this program — somewhat concerned that the two-year period may not be enough time to meet the goals of the ASAM criteria. A two-year implementation timeline may not be long enough to adequately implement ASAM. Providers wanted a commitment from DSS and CMS to hold providers harmless during this period of time should they be audited at a future date. Providers Stated that there may need to be continued flexibility from DSS and CMS after that time. The State noted that CMS and DSS require provider compliance with Medicaid requirements and that there is no grace period for Medicaid provider audits. For audits — DSS does not have the authority to waive all quality assurance components; however, the State may be able to have flexibility for some component parts.

10. LADCs

a. Will LADCs be covered?

Response: Yes, they are independent licensed practitioners who we recognize as being able to perform the clinical services within their scope of practice. LADCs are an instrumental part of the new delivery system.

Second Annual Post Award Forum

Public Notice of Second Annual Post Award Forum

Notice of the second Annual Post Award forum was posted on the Secretary of State Public Meeting Calendar and posted on the DSS website on September 11, 2023, prior to 10:00 am EDT at: Https://portal.ct.gov/dss/-/media/departments-and-agencies/dss/health-and-home-care/substance-use-disorder-demonstration-project/ct-sud-1115-waiver-public-forum-notice-and-agenda-2023.pdf?rev=b5a6753c32ad4455a81df531ed3ec1b9&hash=157DF0E6CC56EB385B4CAD18785A4F22

Summary

Fifty-nine individuals attended the post-award forum held October 11, 2023. Feedback was positive, noting inclusivity and collaboration with a focus on person-centered and recovery-oriented care. Treatment providers requested a progress update on workforce challenges and a reexamination of State requirements above the industry standards. In response to questions about review status, the State noted that providers in the first year of the Demonstration had varying abilities to meet the ASAM requirements, with the primary driver being whether electronic health records (EHRs) needed updating.

Details

The State held its second annual public forum on October 11, 2023. The forum was attended by 59 individuals of which 11 were SUD providers; 11 were contractors; two were members of the public; 24 were other State agency staff, eight were DSS staff, and one was unknown. The forum presentation was posted to the State’s dedicated website for the Demonstration along with public comments received and the State’s response, where applicable. Comments and responses are noted below and include topics on the progress of the Demonstration including access, program processes and requirements, provider certification, quality of chart audits,

provider rates, workforce challenges; concerns around streamlining the rate structure; provider certification timelines; and concern around a reduction in available beds. Actual comments and responses:

1. Access: We are concerned that the service system already appears to be constricting, with the overall bed count lower today than when the Demonstration started. There has been a myriad of changes to incentivize providers to flex their LOCs, different incentives built into the rate structures for different LOCs, and concerns about the lengths of stay and authorizations for services in certain levels of care. Without commenting in detail about each of them, we note that their collective impact of reducing available beds has happened while the funding structure still well-supports most of the LOCs and before providers are expected to be fully compliant with the new, more intensive ASAM guidelines. We are concerned that a continued reduction in available beds will lead to a serious reduction in access to these critical services.

   Response: We acknowledge the concern expressed and will continue to work internally to improve provider rates and subsequently, access.

2. Access: Generally, we've seen a shorter length of stay due based on authorization approvals. There are still gaps in availability at some LOCs and it is not uncommon that there is not an available and appropriate step down for discharge or aftercare for clients who are no longer approved at the current LOC, leaving the client in a precarious situation.

   Response: We acknowledge the concern expressed and will continue to work collaboratively to expand access and capacity and ensure alignment with the goals of the waiver.

3. Authorizations: The authorization process takes an exorbitant amount of time, although has somewhat improved and clinical rounds are helpful to this process.

   Response: Thank you for the comment, clinical rounds are an integral part of the authorization process.

4. Authorizations: The 4-hour window required for evaluation by medical doctor if using telehealth (3.7RE) and the 24-hour requirement for in-person evaluation is very challenging. Finding a psychiatrist in and of itself is next to impossible and most of them, at this stage, want to provide telemedicine services. The 1115 guideline of a significantly trimmed down window by telehealth puts us in a very difficult position to comply. Can the telehealth timeframe be expanded?

   Response: Thank you for the comment. DSS has committed to implementing ASAM, which is the industry standard for SUD residential care on page 270 of the third edition for ASAM 3.7, requires a physical examination, performed by a physician within 24 hours of admission, or a review and update by a facility physician within 24 hours of admission of the record of a physical examination conducted no more than seven days prior to admission.

5. Clinical Assessments: While the State partners have provided funding for uninsured and underinsured bed rates and treatment rates, there is no funding for the required physical exam and urine drug screens, or for needed care in the community for uninsured clients. Providers must ensure these take place but again, the cost remains on the provider. Will funding be provided for these expenses for services that are required but conducted externally to the primary treatment setting?

Response: We acknowledge your concerns; however, clinical assessments include physical exams and urine drug screens at this level of care and financial consideration for physical exams and urine drug screens were included in the treatment fees for all ASAM Levels of care.

6. Justice Involved Reentry Amendment: Received during the public hearing: Is there an update on the Justice Involved Reentry amendment to the SUD 1115?

   Response: The Amendment is in very early stages and State agencies are looking forward to gathering the public comment process once more work has been able to be accomplished when a draft is ready for public input.

7. Program Requirements: Please account for the administrative time and cost of implementing changes in Fiscal Year 2023 (FY23). Each change requires staff training, enhancements to the electronic health record, policy revisions and other operational adjustments. This is highly taxing to agency resources and wholly unaccounted for. Overall, communication regarding waiver changes seems to have lessened, but the ongoing changes are significant. Please include providers in your decision-making processes in the manner you did when the waiver was first initiated, which was collaborative and effective early on but seems to have lessened.

   Response: Thank you for the comment. The ASAM rates have included consideration for the time and cost of implementing changes including staff training, enhancements to electronic health records, policy revisions and other operational adjustments. DSS strives to ensure comprehensive collaboration with all stakeholders and hopes to provide more opportunities in the future for engagement and input.

8. Provider Certification: A two-year implementation timeline is still a challenge, particularly with the many unexpected changes along the way, including flex authorizations, flex beds and now a fee restructure.

   Response: Thank you for the comment.

9. Public Forum: We disagree with the decision not to reschedule the public comment after the technical difficulties. Feedback becomes siloed, without the opportunity for the public to hear the full range of comments. Email comments provided online are effectively static once posted.

   Response: Thank you for the comment, DSS acknowledges the technical difficulties experienced and hopes to avoid technical issues in future public forums. These questions and responses will be publicly posted and included in the formal communication with CMS so that they are publicly available.

10. Quality: Received during the public hearing: I am curious from a qualitative standpoint how things are going as providers might be moving through their first round of SUD Waiver chart audits, what are you seeing as pain points?

    Response: Providers in the first year of the Demonstration have had varying abilities to meet the ASAM requirements with the primary driver being whether the electronic health records need to be updated. To the extent that EHRs needed updating, providers' ability to meet waiver chart audit requirements has been necessarily slower.

11. Rates: While the initial fee-setting process was highly inclusive of residential provider input, the same process was not followed with intensive outpatient program (IOP) fees. Additionally, the sudden and unexpected residential fee restructure that is pending leaves providers wholly unable to budget forecast and upends the many investments, staffing and program restructures, and start-up changes providers have already made. The cost worksheet that is being used to restructure the fees also completely omits the very real returns that providers will be faced with during any Medicaid audit, as well as the administrative costs associated with implementation and ongoing monitoring.

    Response: We acknowledge the concern expressed and will continue to work internally to improve provider rates.

12. Rates: The liability of Medicaid audits is borne solely by the providers, but this expense doesn't appear to be factored into rate setting. Rate setting should incorporate a certain percentage of claims payments will be recouped during future Medicaid audits and extrapolated as a percentage. The agency must be able to set aside funds to account for this future expense. The State budget includes a line item for these takebacks. CMS and DSS require provider compliance with Medicaid requirements and there is no grace period for Medicaid provider audits.

    Response: DSS thanks you for the comment, we encourage all providers to carefully review CTDSSmap.com and federal and State regulations with respect to auditing requirements incumbent upon providers. The ASAM rates have included consideration for the time and cost of implementing changes including overhead associated with compliance.

13. Rates: Regarding the rates, we are concerned that there does not appear to be a plan for their sustainability over time. While we were pleased that the State attempted to acknowledge the rapid inflation of costs that was happening as the rates were being developed, the data upon which those rates were built is already several years old. Our economy is changing rapidly, and the market pressures related to the healthcare workforce have been significant over the last several years. The assumptions made in the rates regarding the salaries of staff are already woefully insufficient. While wage inflation has been significant, it is far from the only cost increase faced by providers. Without a plan or commitment to continue to adjust rates to account for inflation, this waiver could soon be inadequate to fund the service system it supports.

    Response: We acknowledge the concern expressed and will continue to work internally to improve provider rates.

14. Rates: It is also important to note that while some States undergo Medicaid Demonstration projects with the express policy goal of reducing the burden of services on the taxpayer, with service reduction as an accepted by-product, Connecticut approached this Demonstration differently. Our State is understandably hoping to leverage untapped federal resources by modernizing our payment structure for these services through the Medicaid program, and by doing so increase access to services. We are concerned as we see changes in the Demonstration that have the effect of reducing capacity that we are not achieving that policy goal. We encourage the State to work collaboratively with providers and each other to develop a more comprehensive system-level plan focused on how best to serve the needs of the residents of the State and to ensure that the rates and other structure.

Response: We acknowledge the concern expressed and will continue to work collaboratively with providers and State partners to improve the waiver infrastructure to ensure alignment with the goals of the waiver.

15. Workforce: Is Connecticut making progress on the workforce crisis for licensed staff? The speaker noted that Connecticut is requiring SUD groups to be led by licensed staff which is above the industry standards.

    Response: The State will need to examine the Connecticut clinical standards without violating the standards in ASAM which are a requirement of the Demonstration.

16. Workforce: Staffing requirements around licensed clinicians, medical and nursing staff continue to underestimate the ongoing and universal staffing shortages among these provider types. The cost of not meeting these staffing requirements is carried by the provider agencies with the potential to impact future audits with significant financial penalties. It also increases the workload of existing staff leading to burnout and turnover. We are all competing for the same individuals and the State has not taken any concrete steps to address this ongoing and frequently voiced concern. Our staffing needs have also increased beyond the initially anticipated staffing plan, due to the heavy documentation and administrative burdens. Staffing shortages have not improved.

    *Response: We acknowledge the concern expressed and will continue to work collaboratively with providers and State partners to continue to evaluate program requirements such as clinical standards and staffing ratios to address workforce challenges and ensure alignment with the goals of the waiver***.**

Third Annual Post Award Forum

Public Notice of Third Annual Post Award Forum

Notice of the third Annual Post Award forum was posted on the Secretary of State Public Meeting Calendar on August 19, 2024 and the notice was posted on the DSS website on August 24, 2024, prior to 5 pm EDT at: Https://portal.ct.gov/dss/-/media/departments-and-agencies/dss/health-and-home-care/substance-use-disorder-demonstration-project/ct-sud-1115-waiver-public-forum-notice-and-agenda---09-sep-2024.pdf?rev=355776514fad45859680c72a814d8c43&hash=F786AB957DB02E4D3F91295188166F6B

Summary

The State held its annual public forum on September 24, 2024. The forum included all State agency partners (DSS, Department of Children and Families [DCF], Department of Mental Health and Addiction Services [DMHAS], Department of Correction, and Judicial Branch), State contracted Administrative Services Organization — Carelon and ABH, and 15 SUD community provider agencies**.** The presentation given at the forum has been posted to the State's dedicated website for the Demonstration. Also posted are the public comments received during the forum as well as the State's response, where applicable. Feedback on the progress of the Demonstration focused on access, program processes, and workforce challenges.

The State's third annual post award forum was held September 24, 2024. There were 83 attendees. Additional comments were accepted through September 30, 2024, including comments from the 54 attendees at the quarterly provider collaboration meeting.

1. Why did the DSS speaker mention only HUSKY A, HUSKY C, and HUSKY D in relationship to Budget Neutrality? Is HUSKY B under the Demonstration? Can those children receive services under the Demonstration, and do they still have a copayment?

   Response: HUSKY B children are under the Demonstration. However, because HUSKY B children have a higher income, CMS does require them to pay a copayment. In addition, CMS treats that particular population differently under the budget neutrality test than the HUSKY A, HUSKY C, and HUSKY D populations (i.e., more favorably) and excludes that population from the agreement.

2. Regarding the appeals, when the Carelon website for authorizations is down, why are providers being held to administrative denials. Last weekend, there was a scheduled outage on Saturday, but the authorization website was also down on Friday night. Our agency had several denials on Monday when the website was back up for that time period.

   Response: Carelon will look into this and will address this issue.

3. In June 2024, ASAM 3.7 providers were told that the National Provider Identifier of the rendering provider must be submitted on a claim, but that 3.5 and 3.1 providers did not have to do that as well. We recently had a 3.1 claim denied because there was no rendering provider. Can you help us with this?

   Response: Please forward the Internal Control Number to Alexis Mohammed and DSS will look into this issue. Lynne Ringer, Carelon BH @Yaretza Pizarro can share which program you are with so that I can follow-up.

4. We are an ASAM 3.7 RE and 3.7 provider. While the Demonstration has expanded services, it has also expanded barriers as well. Individuals coming from hospitals are pretty stable on their psychiatric medications and diabetes but are not given an appropriate length of stay. There is sometimes a 1–2 week wait to get into an ASAM 3.5 level of care.

   Response: Thank you for your comment. We will take this back.

5. We are not used to providing the additional services. Carelon expects us to see clients weekly and look into their complex medical ongoing medical conditions that is not acute during their short stay. It doesn't seem to be getting better. The stays are so short. We want to feel good about the level of care we are providing.

   Response: Thank you for your comment. We will take this back.

6. We are providing ASAM 3.7 WM, Intensive Outpatient Program (IOP)/Partial Hospitalization Program (PHP), and are applying for methadone. We are very happy that ASAM has been implemented. The use of a standard assessment and treatment planning has improved SUD care in Connecticut. It has improved consistency, and it facilitates communication with Carelon. We also like that there is now an expectation of a multidisciplinary team.

7. We provide ASAM 3.7. Similar to RNP and Rushford, we are dealing with high levels of medical acuity at ASAM 3.7. We have a client who had severe sleep apnea and could not stay away in group. We were able to get him into a sleep study and address those needs. Response: Thank you for your comment. We will take this back.

8. Further comments: Agreed! We are being asked to treat conditions that are out of our scope.

9. And will the slides be sent out after the meeting?

   Response: Yes, slides will be made available on the DSS website and via email.

10. ASAM 3.7 requires a large number of peer support individuals. Peers are not able to support members like the clinical/medical support team members. Peers aren't babysitters. We are required to have three full-time peers who cannot generate outpatient encounters. They can do groups, but we cannot utilize them effectively. DSS should lift the requirements in residential and begin to allow billing in outpatient settings.

11. Will you please share this recorded meeting with us so we can share with colleagues who were not able to attend?

Comments accepted at the September 27, 2024, Quarterly provider collaborative, which was announced as being within the post award forum comment submittal period:

1. Have all site visits occurred for the ambulatory providers awaiting final certification?

   Response: There are still three to four agencies yet to review; however, those visits have been scheduled, and the agencies know who they are. In October 2024, the State will send out certification letters in a staggered manner. Once agencies have the approval letters, they will need to be uploaded to the Medicaid Management Information System. Because the system isn't ready for upload yet, no letters have been sent.

2. Is there a way to make Department of Public Health (DPH) and Medicaid regulations more consistent? For example, Opioid Treatment Program (OTP) and Certified Alcohol and Drug Counselor (CADC) regulations differ greatly.

   Response: DSS is meeting with DPH next week and will be starting work next week on especially the OTP regulations.

3. Providers have financial vulnerability to comply with all regulations.

4. Licensed Practical Nurses are not permitted to do nursing assessments? LADCs cannot give psychiatric diagnoses. Can the 1115 waiver override these issues?

   Response: The 1115 waiver cannot override the Nurse/LADC practice act in the State. The State advocates will need to advocate for change at the legislature. Everyone should partner together to advocate for needed reforms. Please send DMHAS a copy of a blank nursing assessment.

5. 100% of staff we hire are interns. To be able to hire interns, we need to be able to pay the interns for their internships.

6. Agencies need more staff to hire. Associate licensed staff can now go into independently licensed offices. This decimated the workforce. Independent practitioners can also do telehealth. We need more workforce development.

   Response: Effective October 1, 2022, Bulletin 20-22-67 allowed Associated Licensed practitioners to be hired by independently licensed offices.

7. The 1115 reviews conflict with the Medicaid policy for outpatient care cited by DSS staff.

8. Providers have submitted recommendations about the 25% intern ratio. This waiver rule is a hindrance to the SUD operations. It is very hard to track and maintain.

   Response: State Partners are reviewing staffing ratios and are close to issuing updated guidance.

9. How will rates be looked at? Will there be a preliminary examination?

   Response: Connecticut must perform rate modeling. We have appreciated the input in the past. We will have a back-and-forth process. We value the work and input of the providers.

10. The ASAM fourth edition is out, and private insurers are requiring its use as soon as November 2024. When will Connecticut Medicaid adopt the fourth edition?

    Response: State Partners are looking at this and will roll out an update with a very long notice period to allow providers time to implement.

11. An update to the regulations is needed. There was a grandparent clause for Licensed Professional Counselors to track credentials. We wanted to see a workgroup to address this issue and to update the scopes of practice.

    Response: DPH is soliciting advice about provider input on scopes of practice. Please direct comments to Chris Anderssen, Section Chief of Professional Licensing.

12. The current standards values intern more than master's level clinicians. The State has given licensed individuals and the interns that they supervise more authority than master's level clinicians to provide SUD care.

13. Will all OTPs have different rates under the new rate system? Will all 3.7 rates be increased or just certain providers rates?

    Response: We will look at rates across the system not just for individual providers.

14. Interns performing no more than 25% of services is very hard to measure. Where did this decision come from?

    Response: State Partners are reviewing staffing ratios and are close to issuing updated guidance.

15. It would be helpful to align the DSS license and 1115 regulation.

16. Interns, Associates, and Medical Assistant (MA) licensed staff have very different training and permissions. While an associate license is pending, associates are allowed to provide clinical care with active oversight, but MA licensed staff are not.

17. IOP runs for three hours. Having a requirement like 1/3 would make more sense for the intern policy. Associate licenses are necessary for access. We are in the Southeast corner of the State. Clinics and private practices are now having a hard time finding individuals with associate licenses. In between MA level practitioners are working towards their licenses. The issue isn't the Associate licensed practitioners, it is the individuals with MA level.

18. ABH is auditing for this under the 1115 for IOP and PHP. Under the 1115 Demonstration, the MA level practitioner can't do anything.

19. We have lost experienced CADCs and had to hire interns. It is frustrating. We keep having this conversation and we need a fix.

    - General DSS response regarding Medicaid behavioral health outpatient service regulations (e.g., ASAM 1):

        – Originally group/solo practices could not hire associate or MA level practitioners. They can only bill the work that the practitioner does itself. However, the rules changed and now a group/solo practice can have an Associate level practitioner practicing if the licensed practitioner co-signs all notes and has a running log of a weekly meeting where all cases are discussed.

        – Behavioral health clinic settings can bill Connecticut Medicaid for MA level and Associate practitioners. The rate of supervision is outlined in the Medicaid regulations for unlicensed or associate licensed staff to do the work. There must be a meeting one time a week for supervision. The clinic is the billing entity with supervision from the Medicaid Director who is responsible for all care in the clinic.

20. Medicaid program does not have certification requirements for ASAM 1, only for higher more intensive level of care.

    - Certification is not required for providers only providing level of care Level 1 – Outpatient Services.

- SUD intensive ambulatory and residential providers (i.e., all levels of care other than Level 1 – Outpatient Services) serving adults must be certified by the Connecticut DMHAS or its designee.
- SUD intensive ambulatory and residential providers (i.e., all levels of care other than Level 1– Outpatient Services) serving children must be certified by DCF or its designee.

Availability of Various Waiver-Related Reports for Public: The 1115 Demonstration requires quarterly and annual reporting on the specific milestones and measures to CMS. Part of the reporting also includes a summary of the public comments received at the post award forum to be provided to CMS. DSS posts all the required information on the DSS website, including budget neutrality information.

Fourth Annual Post Award Forum

Public Notice of Fourth Annual Post Award Forum

Notice of the fourth Annual Post Award forum was posted on the Secretary of State Public Meeting Calendar on July 30, 2025, prior to 5:00 pm EDT and the notice was posted on the DSS website on July 31, 2025, prior to 5:00 pm EDT at: https://portal.ct.gov/dss/-/media/departments-and-agencies/dss/health-and-home-care/substance-use-disorder-demonstration-project/notice-of-2025-public-forum-and-agenda.pdf?rev=f5f27689f22642bea8c126b6dc9085c7&hash=1837E717C5C463BBFEC08E76793168AA

Summary

The fourth annual Connecticut SUD 1115 Post Award Forum was held on September 9, 2025, at 9:00 EDT. There were 70 attendees.

There were three questions asked during the forum.

1. Will you be sending these slides out to participants from today?
2. Will the slide deck be distributed after this meeting?
3. Can you repeat what you just said about the availability of the presentation?

Responses:

1. The slide deck will be sent out to all attendees and will be posted next week to: ct.gov/dss/SUD1115.
2. Comments will be accepted through September 16, 2025. Please email to: alexis.mohammed@ct.gov.
3. For information on the Connecticut SUD 1115 Medicaid Waiver and to sign up for alerts and updates, please go to Connecticut SUD 115 Waiver Demonstration page : ct.gov/dss/SUD1115.

After the forum concluded, the following questions were asked as follow-up:

I am concerned about the metric that used to only measure IMD hospital length of stay and now includes IMD hospital AND RES length of stay. It’s like comparing apples to oranges. Is this OK? CMS is allowing both of these categories in one metric?

I am also concerned about the decrease in follow-up care after an ED intervention. Do the State partners have a strategy or plan to address this? Same with the preventative/primary care intervention.

Response: The state is required to assess demonstration outcomes according to the CMS approved and Connecticut specific Monitoring Protocol which measures the effectiveness of its substance use disorder (SUD) program based on specific goals, milestones, and quantitative metrics. It is used to track improvements in treatment access, retention, patient outcomes, and to reduce preventable hospital and emergency department use. The monitoring is required by the Centers for Medicare & Medicaid Services (CMS) and includes both the state's internal

monitoring and an independent evaluation. The Monitoring Protocol is posted on the Section 1115 Demonstration Waiver for Substance Use Disorder (SUD) Treatment website on the 1115 Monitoring and Evaluation tab. The state recently submitted the 1115 SUD Demonstration Waiver Mid-Point Assessment to CMS. The Mid-Point Assessment measures the state's progress toward achieving its waiver goals by evaluating key metrics and implementation activities. It provides an opportunity for Connecticut and the Centers for Medicare & Medicaid Services (CMS) to evaluate the demonstration's effectiveness and address any challenges. Contained within that assessment is Connecticut’s response to the findings and plan for corrective action.

Public Notice for the Extension Request

1. Connecticut is providing an open comment period for public comments from December 17, 2025 – January 18, 2026.

2. The 30-day public comment period will begin on December 17, 2025, to January 18, 2026. Written comments at any of the public hearings or submitted by email will be accepted until 5:00 pm EST. As of close of the comment period, the following comments will be included in Attachment 5, that pertain to the 1115 Demonstration submission.

3. Connecticut published a Public Notice in the Connecticut Law Journal on December 09, 2025. The notice can be found at Attachment 1. The notice included a summary description of the Demonstration, the location and times of the public hearings, information on different ways to provide comments, and an active link to the full public notice document on the State's website.

4. The State also published on its website the full public notice[16] with information about public input process and planned hearings, the draft Demonstration renewal application, and a link to the Demonstration page on the CMS Website. Below is the link to access the public notice posting, Demonstration Extension application draft, and the full public notice.

   Connecticut's Draft 1115 Demonstration Extension and public hearing information are posted to the DSS website at this link: https://portal.ct.gov/dss/health-and-home-care/substance-use-disorder-demonstration-project?language=en_US

5. Connecticut certifies that it used an electronic mailing list to notify the public. Connecticut used the electronic mailing list that is used for the Medical Assistance Program Oversight Council (MAPOC) to email the Abbreviated Public Notice. The brief public notice was also used by all State agencies to notify stakeholders via their listservs. This Abbreviated Public Notice can be found at Attachment 3.

6. The State will conduct two public hearings on the 1115 Demonstration Extension application including one in-person hearing with remote access. These public hearings will be held on December 22, 2025, from 10:00 A.M.-12:00 P.M. via web conference, teleconference, and/or in person. and one during the **MAPOC** via web conference and teleconference on January 9, 2026, from 1:00 P.M.-3:30 P.M. Public Hearing Slides can be found in Attachment 4. Additional information regarding the public hearings is included below. Members of the public will be invited to make comments in person via the telephone or the virtual platform, Zoom as follows:.

PublicHearingwithoptionalvirtualWebinarHostedbyDSS

December 22, 2025

Time: 10:00 A.M. – 12:00 P.M.

In-person at: 55FarmingtonAvenue,FirstFloor,Room1011,Hartford,CT06105.

[16] Cornell Law School (n.d.) *Definition of 42 CFR 431.408.* https://www.law.cornell.edu/definitions/index.php

Web Conference/Teleconference:

Topic: Substance Use Disorder Demonstration Waiver Extension Public Hearing
10:00 AM Eastern Time (US and Canada) **Join Zoom Meeting**
https://us06web.zoom.us/j/86785379034?pwd=WKIMSuKbiUuDK2Dun4TXSnBB0B3r2z.1

Meeting ID: 867 8537 9034
Passcode: 988428

One tap mobile
+13017158592,,86785379034#,,,,*988428# US (Washington DC)

+13052241968,,86785379034#,,,,*988428# US

Join instructions
https://us06web.zoom.us/meetings/86785379034/invitations?signature=9yOtksi4kL1dnL-QybU-89TMqQE1JfziiQglIWNSIM8

PublicHearingConvenedbytheConnecticutGeneralAssemblyMedical AssistanceProgramOversightCouncil

January 9, 2026

Time: 1:00 P.M. – 3:30 P.M.

Join Zoom Meeting

https://zoom.us/j/97350054937?pwd=JCoO97AjaR2cbVSgXNEZjAx5IV2nt2.1

Meeting ID: 973 5005 4937

Passcode: 919295

One tap mobile:

+19292056099,,97350054937#,,,,*919295# US (New York)

+13017158592,,97350054937#,,,,*919295# US (Washington DC)

Join instructions
https://zoom.us/meetings/97350054937/invitations?signature=saH8AktJXumdvo7QBKhrk2VkzH_OLQYL9ZZxfXxE1nU

7. A **summary of public comments** and feedback from commenters received during the public comment period will be provided in Attachment 5 after the public comment period has been completed.

8. The 60-day tribal comment period will begin on December 17, 2025 – February 16, 2026. **Tribal notice** can be found at Attachment 6. Written comments or submitted by email will be accepted until 5:00 pm EST. The comments will be included in Attachment 7, that pertain to the 1115 Demonstration submission. Connecticut has two federally recognized tribes, the Mashantucket Pequot Tribal Nation and the Mohegan Tribe. The State has solicited feedback from both tribes by sending emails to the tribal representatives with a copy of the public notice, plus a copy of the budget neutrality, and waiver application (as well as a link to the DSS website with the relevant documents). This process follows the State's approved tribal consultation State Plan Amendment. Comments will be included in the Attachment 7.

9. After review of the comments and concerns, the following changes to the renewal were made TBD

Section IX. Demonstration Amendment Contact

Name and Title: William Halsey, LCSW, MBA, State Medicaid Director, Director of Medicaid and Division of Health Services, Department of Social Services

Telephone Number: 860-424-5077

Email Address: william.halsey@ct.gov

Attachment 1. Connecticut Law Journal Notice

Attachment 2. Full Public Notice

Attachment 3. Abbreviated Public Notice

Attachment 4. Public Hearing Slides

Attachment 5. Public Notice Comments

Attachment 6. Tribal Consultation

Attachment 7. Tribal Consultation Comments