DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

November 5, 2026

Andrea Barton Reeves
Commissioner, Office of the Commissioner
Connecticut Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Dear Commissioner Barton Reeves,

The Centers for Medicare & Medicaid Services (CMS) is approving Connecticut's request to renew and amend its section 1115(a) demonstration, "Connecticut Substance Use Disorder (SUD) Demonstration" (Project No. 11-W-00372/1 and 21-W-00069/1), in accordance with section 1115(a) of the Social Security Act ("the Act"). This approval is effective April 1, 2027, through March 31, 2032, upon which date, unless renewed or otherwise temporarily extended, all authorities granted to operate this demonstration will expire.

CMS has determined that the Connecticut SUD Demonstration is likely to assist in promoting the objectives of the Medicaid and the Children's Health Insurance Program (CHIP) statute by assisting Connecticut in increasing adherence to, and retention in, SUD treatment programs and in reducing inappropriate or preventable utilization of emergency departments and inpatient settings through improved access to a continuum of care. This approval is in alignment with State Medicaid Director Letter (SMDL) #17-003[1] RE: Strategies to Address the Opioid Epidemic and will continue the SUD demonstration authorities without changes.

Additionally, CMS is amending this demonstration to include the Reentry Demonstration Opportunity. CMS has determined that the addition of the Reentry Initiative is likely to assist in promoting the objectives of the Medicaid and CHIP statute by increasing access to high-quality, clinically appropriate services and improving care transitions for certain individuals leaving incarceration and entering back into a community setting.

CMS's approval of this section 1115(a) demonstration is subject to the limitations specified in the attached waiver authorities, expenditure authorities, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid and CHIP state plan requirements only to the extent those requirements have been specifically listed as not applicable to expenditures under the demonstration.

Extent and Scope of Demonstration Renewal

SUD Renewal

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

With this renewal approval, under the demonstration, Connecticut will continue to provide authority for SUD treatment services to individuals who are short-term residents in residential treatment facilities that meet the definition of an institution for mental diseases (IMD) and assures that CHIP beneficiaries diagnosed with a SUD are able to access SUD services furnished in IMDs. The renewal of this Title XXI expenditure authority will ensure that children, whom otherwise would be ineligible for CHIP because they reside in IMDs, will be able to maintain or gain coverage and receive SUD treatment.

Under the renewal of this demonstration, all beneficiaries will continue to receive a full state plan Medicaid benefit package and have access to high-quality, evidence-based treatment services for opioid use disorder (OUD) and SUD across a comprehensive continuum of care.

Reentry-Pre-Release Medicaid Services for Justice-Involved Individuals

Approval of this demonstration will enable the state to provide coverage for a targeted set of services furnished to certain incarcerated individuals for up to 60 days for jails and prisons immediately prior to the individual's expected release date in jails and prisons, and for up to 90 days for youth correctional facilities prior to the individual's expected date of release from a youth correctional facility. The state's proposed approach closely aligns with CMS's "Reentry Demonstration Opportunity" as described in State Medicaid Director Letter (SMDL) #23-003[2], released on April 17, 2023, and the recently released Frequently Asked Questions document[3].

CMS has conducted additional scrutiny of Reentry Demonstration policy to ensure the program is based on evidence and appropriate stewardship of taxpayer dollars. Through evaluation of published research, consultation with the state and reentry policy stakeholders, and collaboration with federal partners, CMS has identified specific refinements and enhancements, described below, that will improve transparency, sustainability, and program integrity for these newly approved reentry demonstrations.

CMS expects to release further updated reentry demonstration guidance in the next year describing these policy changes, updated monitoring, additional oversight, and strengthened financial requirements to ensure transparency and robust program integrity.

Eligible Individuals

Connecticut will cover a set of pre-release benefits for certain individuals who are inmates residing in jails, prisons, and youth correctional facilities, (hereinafter "correctional facility") and who are adults aged 21 or older who meet 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. Connecticut will also provide pre-release benefits for children under age 21 and former foster youth under age 26 who reside in jails, prisons, or youth correctional facilities without any health-related criteria for eligibility. To qualify for services covered under the demonstration approval, individuals residing in a correctional facility must have been determined eligible for Medicaid, or CHIP, or would have been determined eligible for CHIP except for their

[2] http://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf
[3] https://www.medicaid.gov/federal-policy-guidance/downloads/reentry-faqs-090920264015.pdf

incarceration status pursuant to an application filed before or during incarceration and have an expected release date within 60 days from correctional facilities, and within 90 days from youth correctional facilities.

Medicaid and CHIP Eligibility and Enrollment
CMS is requiring, as a condition of approval of this demonstration amendment, that the state make pre-release outreach, along with eligibility and enrollment support, available to all individuals incarcerated in the correctional facilities where the pre-release coverage of demonstration services will be available.

For a Medicaid covered individual entering a correctional facility, the state will not terminate Medicaid coverage, but will suspend the individual's coverage. In the case of a child or pregnant woman currently enrolled in CHIP, the state cannot terminate coverage during a continuous eligibility period or at renewal solely because of their incarceration status. The state may suspend CHIP coverage during periods of incarceration. For individuals not enrolled in Medicaid or CHIP upon entering a correctional facility, the state will ensure the individual receives assistance with completing and submitting a Medicaid or CHIP application sufficiently prior to their anticipated release date such that the individual can receive the full duration of pre-release services, unless the individual voluntarily refuses such assistance or chooses to decline enrollment.

Scope of Pre-Release Benefit Package
The pre-release benefit package is designed to improve care transitions of incarcerated individuals back to the community, including by promoting continuity of coverage, service receipt, and quality of care, as well as the proactive identification of physical, behavioral, and other health-related needs. It is designed to address these overarching demonstration goals, while aiming to ensure that participating correctional facilities can feasibly provide all pre-release benefits to qualifying incarcerated individuals.

CMS is authorizing Connecticut to provide coverage for the following services, defined in Attachment C to the demonstration's STCs:

- Case management to assess and address physical and behavioral health needs, and social determinants of health;
- Medication-assisted treatment (MAT) services for all types of substance use disorders (SUD) as clinically appropriate, including coverage for medications in combination with accompanying counseling/behavioral therapies;
- A 30-day supply of all prescription medications, as clinically appropriate, that have been prescribed for the individual at the time of release, provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid or CHIP state plan coverage authority and policy;
- Practitioner office visit (e.g., physical exam; wellness exam; evaluation and management visit; mental health or substance use disorder treatment, therapy, or counseling; or other);
- Diagnostic services, including laboratory and radiology services;
- Prescribed drugs (in addition to MAT and the 30-day supply of prescription medications) and medication administration;
- Treatment for Hepatitis C;

- Medical equipment and supplies;
- Family planning services and supplies;
- Rehabilitative or preventative services; and
- Other licensed practitioner services and behavioral health under clinic services.

Under no circumstances should the provision of these services or related policies, procedures, or processes developed to support implementation of this demonstration result in a delay of an individual's release from incarceration or lead to increased involvement in the juvenile or adult justice systems.

Duration of Pre-Release Coverage
Connecticut requested 90 days of pre-release coverage for all eligible beneficiaries. CMS has determined that up to 60 days of pre-release coverage is appropriate for individuals in prisons and jails. Available data demonstrate that providing access to services such as MAT in the 60 days leading up to release reduces the risk of overdose, supporting the provision of pre-release coverage for up to 60 days. [4,5,6,7,8,9] Furthermore, 60 days of pre-release coverage helps ensure that incarcerated individuals are stabilized and receive adequate case management and other pre-release services under the demonstration and is likely sufficient to test whether pre-release services improve transitions of care for individuals in adult facilities. Based on ongoing monitoring and rapid cycle reports with approved and pending the states, CMS understands that it would be unduly burdensome to offer different lengths of pre-release coverage to individuals incarcerated in the same facility due to significant administrative complexity, and CMS's forthcoming Rapid Cycle Report findings indicate that key state and carceral stakeholders identified reducing complexity in operational and administrative burdens as a key facilitator to success. As such, CMS is approving coverage of these services for up to 60 days for individuals in jails or prisons. CMS continues to approve up to 90 days of pre-release services for individuals in youth correctional facilities.

Implementation and Reinvestment Plans
As described in the STCs, as a condition of demonstration approval, Connecticut is required to submit a Reentry Initiative Implementation Plan (here called Implementation Plan) to document how the state will operationalize coverage and provision of pre-release services. The Implementation Plan must be submitted to CMS on a timeline consistent with the STCs, and must describe the milestones and associated actions being addressed under this demonstration

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[4] Burns, et al. (2022). Duration of Medication Treatment for Opioid-Use Disorder and Risk of Overdose among Medicaid Enrollees in Eleven States: A Retrospective Cohort Study. *Addiction*. https://pmc.ncbi.nlm.nih.gov/articles/PMC10683938/
[5] Volkow, N. D., & Wargo, E. M. (2018). Overdose prevention through medical treatment of opioid use disorders. *Annals of Internal Medicine, 169*(3), 190–192. https://doi.org/10.7326/M18-1397
[6] Au, V. Y. O., Rosic, T., Sanger, N., Hillmer, A., Chawar, C., Worster, A., Marsh, D. C., Thabane, L., & Samaan, Z. (2021). Factors associated with opioid overdose during medication-assisted treatment: How can we identify individuals at risk? *Harm Reduction Journal, 18*, Article 71. https://doi.org/10.1186/s12954-021-00521-4
[7] Hayes et al. (2026). Evaluating the optimal duration of medication treatment for opioid use disorder. *Study for the Society of Addiction.* https://onlinelibrary.wiley.com/doi/10.1111/add.70211
[8] Friedmann, P.D., et al. (2025). Medications for Opioid Use Disorder in County Jails—Outcomes After Release. *The New England Journal of Medicine*. https://www.nejm.org/doi/full/10.1056/NEJMsa2415987
[9] Martin, R.A., et al. (2022). Post-incarceration outcomes of a comprehensive statewide correctional MOUD program: a retrospective cohort study. *Lancet Regional Health*. https://pmc.ncbi.nlm.nih.gov/articles/PMC9950664/

approval and provide operational details not captured in the STCs regarding implementation of those demonstration policies. At a minimum, the Implementation Plan will include definitions and parameters related to the implementation of the reentry authorities, and describe the state's strategic approach for making significant improvements on the milestones and actions, as well as associated timelines for meeting them, for both program policy implementation and investments in transitional nonservice elements, as applicable. The Implementation Plan will also outline any potential operational challenges that the state anticipates and the state's intended approach to resolving these and other challenges the state may encounter in implementing the reentry demonstration initiative. The section 5121 operational plan requirement in sections 1902(a)(84)(D) or 2102(d)(2) of the Act is satisfied by the state's Implementation Plan. The state is still required to provide coverage and otherwise meet state plan requirements with respect to any population or service specified in sections 1902(a)(84)(D) or 2102(d)(2) of the Act that is not covered under this demonstration.

Connecticut is also required to submit a Reentry Demonstration Initiative Reinvestment Plan (here called Reinvestment Plan) as a condition of demonstration approval. The reentry demonstration initiative is not intended to shift current correctional facility health care costs to the Medicaid and CHIP programs. Section 5032(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) (P.L. 115-271) makes clear that the purpose of the demonstration opportunity contemplated under that statute is "to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and who are otherwise eligible to receive medical assistance under title XIX." Furthermore, demonstration projects under section 1115 of the Act must be likely to promote the objectives of titles XIX and XXI, which includes the inmate payment exclusion and inmate eligibility exclusion, respectively, in recognition that the correctional authority bears the costs for health care furnished to incarcerated individuals. This demonstration does not absolve correctional authorities in Connecticut of their Constitutional obligation to ensure needed health care is furnished to inmates in their custody and is not intended as a means to transfer the financial burden of that obligation from a tribal, state, or local correctional authority to the Medicaid or CHIP programs.

To the extent that the reentry demonstration initiative newly covers services that are the responsibility of and were previously provided or paid for by the correctional facility with custody of qualifying individuals, Connecticut agrees to reinvest all new federal dollars, equivalent to the amount of federal financial participation expended for such previously existing services, into allowable justice-related activities or initiatives that increase access to or improve the quality of health care services for individuals who are incarcerated (including individuals who are soon-to-be released) or were recently released from incarceration, or for physical and behavioral health needs that may help prevent or reduce the likelihood of criminal justice system involvement. Consistent with this requirement and the STCs, Connecticut will develop and submit a Reinvestment Plan to CMS that documents an estimated calculation of the amount of federal dollars the state will receive over the course of the demonstration period, a detailed description of the state's plans to reinvest the required funds into allowable activities, and an assessment of the impact of reinvested funds on privately-owned or -operated carceral facilities and associated safeguards to prevent increasing profit or operating margins for such facilities. In order to ensure state accountability for this requirement, the state must submit annual progress updates on their reinvestment as part of the state's annual monitoring report. The state will also

be required to submit a Final Reinvestment Assessment detailing the total amount of FFP received over the demonstration period, the total amount reinvested, and the outcome of those activities.

Interaction between a State's Reentry Demonstration and the CAA, 2023 Mandate
Section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328) amends section 1902(a)(84) of the Social Security Act (the Act) and adds a new section 2102(d)(2) to describe a mandatory population of targeted low-income children in CHIP and eligible juveniles in Medicaid who are incarcerated in a public institution post adjudication of charges[10]) who are to receive a set of pre-release and post-release services. Section 5122 of the CAA, 2023 amends section 1905(a) and adds new section 2110(b)(7) of the Act to give the state the option to receive federal financial participation (FFP) for the full range of coverable services for eligible individuals who are incarcerated in a public institution while pending disposition of charges[11]. The requirements of section 5121 of the CAA, 2023 have a statutory effective date of January 1, 2025. Every state is required to submit a Medicaid and CHIP State Plan Amendment assuring compliance with these requirements.[12]

To the extent there is overlap between the services required to be covered under sections 1902(a)(84)(D) and 2102(d)(2) of the Act and coverage under this demonstration, CMS understands that it would be administratively burdensome for a state to identify whether each individual service is furnished to a beneficiary under the state plan or demonstration authority. Accordingly, to eliminate unnecessary administrative burden and ease implementation of statutorily required coverage and in this demonstration, CMS is approving a waiver of the otherwise mandatory state plan coverage requirements to permit the state instead to claim for at least the same pre-release services for the same beneficiaries under this demonstration.[13] This approach will ease implementation, administration, and claiming, and provide a more coherent approach to monitoring and evaluation of the state's reentry coverage under the demonstration. The state will provide pre-release coverage under the reentry demonstration initiative to eligible juveniles described in section 1902(nn) of the Act in alignment with sections 1902(a)(84)(D) and 2102(d)(2) of the Act, as applicable, at a level equal to or greater than otherwise would be covered under the state plan. Compliance and state plan submission requirements under section 5121 of the CAA, 2023 will remain unchanged. Any required services that are not provided through the demonstration during the pre-release period as well as any post-release services will continue to be covered under the state plan. Additionally, coverage of the population and benefits identified in sections 1902(a)(84)(D) and 2102(d)(2) of the Act, as applicable, will automatically revert to state plan coverage in the event that this demonstration ends or eliminates

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[10] Section 1902(nn) of the Act defines "eligible juvenile" as an individual under age 21 determined eligible in any eligibility group or an individual described in section 1902(a)(10)(A)(i)(IX) of the Act (the mandatory former foster care children group, which includes former foster care children between 18 and 26 years old).
[11] For CHIP, section 2110(b)(7) creates an optional exception to the CHIP eligibility exclusion for inmates of a public institution under section 2110(b)(2)(A) so incarcerated youth who are pending disposition of charges are not excluded from the definition of targeted low-income child.
[12] SHO# 24-004, RE: Provision of Medicaid and CHIP Services to Incarcerated Youth. https://www.medicaid.gov/federal-policy-guidance/downloads/sho24004.pdf
[13] Section 5122 of the CAA, 2023 gives a state the option to cover the full breadth of otherwise-covered Medicaid and CHIP services for eligible juveniles who are incarcerated pending disposition of charges. We have not yet approved this claiming flexibility for Section 5122 services and we are not providing this claiming flexibility in this approval.

coverage of beneficiaries and/or services specified in those provisions. To effectuate this approach, CMS is adding a new waiver of sections 1902(a)(84)(D) and 2102(d)(2) of the Act.

Requests Not Being Approved at this Time

Connecticut requested to provide services that address social determinants of health (SDOH), including post-release housing supports, for the justice involved population transitioning from correctional centers and institutions. CMS continues to review this request and is not approving these services at this time.

Connecticut also requested transitional non-service expenditures to support implementation of the demonstration. CMS is working with Connecticut on pathways to otherwise allowable administrative claiming such as Implementation Advance Planning Documents to support implementation costs associated with the reentry demonstration. As a result, we do not anticipate approving the state's request for transitional non-service expenditures as proposed and will no longer consider this an active request.

Budget Neutrality

This demonstration project is approved using CMS's current approach to determining budget neutrality as described in CMS SMDL #24-003.[14] However, CMS acknowledges that section 71118 of subchapter C of chapter 1 of subtitle B of title VII of Public Law 119-21 the Working Families Tax Cuts (WFTC) legislation adds a new subsection (g) to section 1115 of the Act with budget neutrality requirements that will apply beginning January 1, 2027 to CMS approvals of section 1115 Medicaid demonstration project applications, renewals, or amendments.[15] CMS issued SMDL #26-003 on June 11, 2026 to provide states with early notice regarding the changes to budget neutrality that CMS intends to propose to implement subsection 1115(g) of the Act, and expects to provide additional guidance to states on implementation of this provision.

Under SMDL #24-003, issued August 22, 2024, as a condition of demonstration approval, demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs likely would have been in that state absent the demonstration.[16] The demonstration renewal is projected to be budget neutral to the federal government. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the "without waiver" [WOW] costs). The state will be held to the budget neutrality monitoring and general financial requirements as outlined in the STCs.

Rebasing Without Waiver Baselines

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[14] https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf
[15] https://www.congress.gov/bill/119th-congress/house-bill/1/text
[16] https://www.medicaid.gov/medicaid/section-1115-demonstrations/budget-neutrality

Under this demonstration, for existing MEGs that were implemented, CMS calculated the WOW baseline by using a weighted average of the state's historical WOW per-member-per-month (PMPM) baseline and its recent actual PMPM costs. The projected demonstration expenditures associated with each MEG in the WOW baseline have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period. Using the President's Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

Hypothetical Budget Neutrality Treatment

Under its current approach to budget neutrality, CMS generally treats expenditures for populations or services which could have otherwise been covered via the Medicaid state plan, or other title XIX authority, such as a section 1915 waiver, as "hypothetical" for the purposes of budget neutrality. In these cases, CMS adjusts budget neutrality to account for the spending which the state could have hypothetically provided through the Medicaid state plan or other title XIX authority. CMS does not, however, currently allow for budget neutrality savings accrual as a result of including hypothetical populations or services in section 1115 demonstration projects. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent budget neutrality "supplemental test" for hypothetical expenditures. These supplemental budget neutrality tests subject the hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state's "with waiver" (WW) hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending with savings elsewhere in the demonstration or to refund the FFP to CMS.

There is one new Medicaid Expenditure Groups (MEGs) in the demonstration, which will be treated as hypothetical for budget neutrality purposes. For that MEG, CMS calculated the WOW baseline (which refers to the projected expenditures that could have occurred absent the demonstration and which is the basis for the budget neutrality expenditure limit for each approval period). The projected demonstration expenditures associated with each of these MEGs in the WOW baseline have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period. Using the President's Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

Reentry- Pre-Release Medicaid Services for Justice Involved

The Medicaid expenditures for pre-release services furnished to incarcerated beneficiaries under the reentry demonstration initiative include coverage of services that the state can and do cover through Medicaid state plan or other title XIX authority, for beneficiaries who are not subject to the inmate payment exclusion. CMS considers these expenditures to be "hypothetical" because the pre-release services would be coverable under the Medicaid state plan or other title XIX authority if furnished to a beneficiary outside a carceral site, similar to how CMS treats expenditures for services furnished to certain beneficiaries who are short-term residents in an institution for mental diseases primarily to receive treatment for SUD, or SMI or serious emotional disturbance (SED), under the SUD and SMI/SED section 1115 demonstration opportunities. Any population identified in section 1902(a)(84)(D) of the Act and covered

instead under this demonstration will be included in the reentry services Medicaid Expenditure Groups (MEG).

Mid-Course Correction

CMS has included a mid-course corrections STC in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration. This update identifies, a list of circumstances under which a state's baseline may be adjusted based on actual expenditure data to accommodate circumstances that are either out of the state's control (for example, if expensive new drugs that the state is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration (for example, unexpected costs due to a public health emergency); and/or the new expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (for example, a legislated increase in provider rates). CMS also explains in the STCs what data and other information the state should submit to support a potentially approvable request for an adjustment.

CHIP Allotment Neutrality

The state will be subject to a limit on the amount of federal title XXI funding that the state may receive on allowable demonstration expenditures during the demonstration period. CMS has long required, as a condition of demonstration approval, that demonstrations be "allotment neutral," meaning the federal title XXI funds for the state's CHIP program are restricted to the state's available allotment and reallocated funds. The state is eligible to receive title XXI funds for the demonstration population, up to the amount of its title XXI allotment. Title XXI funds must be first used to fully fund costs associated with CHIP state plan populations. The demonstration expenditures are limited to remaining funds.

Monitoring and Evaluation

Consistent with the demonstration STCs, the state submitted its Interim Evaluation Report (IER) with the renewal application. The IER covered the period from April 14, 2022, through December 31, 2024. Based on the findings of the IER and the Mid-Point Assessment (MPA)[17] which covered the period from April 14, 2022, through October 30, 2024, CMS determined that the state achieved mixed progress towards its demonstration goals.

The evaluation findings demonstrated improved progress in access to and utilization of treatment services, quality of care, and population health outcomes. Specifically, the MPA showed the number of Medication-Assisted Treatment (MAT) providers increased from 53 to 58, which represents an increase of over nine percentage points. The MPA also showed a 30.1 percent increase (4,525 to 5,887) in the utilization of residential and inpatient substance use disorder (SUD) treatment services, and a 27.9 percent increase (6,281 to 8,032) in the number of Medicaid beneficiaries treated in an institution for mental disease (IMD) post implementation. The IER reinforced the positive trends. It documented an increase of over nine percent (61 to 67) in the number of enrolled MAT providers; a 39 percent increase (5,797 to 8,032) in the

[17] The Mid-Point Assessment is available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ct-sud-mid-pnt-asesmnt-05292025.pdf.

number of Medicaid beneficiaries treated in an IMD, and a 302 percent increase (4.4 to 17.7) in the average length of stay at an IMD for Medicaid individuals between the baseline period and demonstration year (DY) 2. The IER also reported a 15 percent decline (0.45 to 0.38) in overdose death rates when comparing the baseline period with DY2.

Despite the positive progress, the evaluation identified opportunities for continued improvement. For example, the IER identified a persistent shortage of providers serving adolescents. Based on focus group findings and provider certification documentation, there were no Medicaid-enrolled residential treatment providers for adolescent girls in the state. In addition, the number of adolescents receiving residential treatment remained too small for the evaluators to conduct a reliable interrupted time series analysis. Additionally, the MPA noted that the state experienced a 5.9 percent increase (22.4 to 23.7) in hospital readmission rates among Medicaid beneficiaries with a SUD diagnosis.

The state is currently working to make improvements as noted in the MPA. For example, to expand access to care, the state added two Screening, Brief Intervention, and Referral to Treatment (SBIRT) billing codes to capture all screenings and incentivize providers to conduct and report all screening services. To improve provider capacity at critical levels of care (LOCs), including MAT for opioid use disorder, the state implemented a new rate structure to address provider concerns regarding payment adequacy. The state will continue to monitor provider capacity, continuity of care, and the number of MAT providers through monthly oversight meetings with state partners. Monitoring reports from early 2025 indicate that the state modified its reimbursement rates and added two LOCs to improve access to residential treatment services for adolescents. To improve care coordination and transitions between LOCs, the state continues to monitor provider performance while offering technical assistance and care coordination training to enhance case management for individuals with high-acuity needs.

The state is required to continue conducting systematic monitoring and evaluation of the demonstration, consistent with the requirements of the STCs and applicable CMS guidance, inclusive of the reentry demonstration component. An Annual Monitoring Report capturing key metrics and narrative updates will be due to CMS 180 days after the end of each demonstration year. The state must also conduct a Reentry Early Implementation Rapid Cycle Report to assess implementation planning of the demonstration, including operational progress, barriers and facilitators, program integrity, and financial oversight, and to provide timely, actionable insights to support program refinement during the initial implementation phase.

The state must conduct an independent mid-point assessment of the SUD demonstration initiatives, to support identifying risks and vulnerabilities and subsequent mitigation strategies. In addition, the state is required to conduct an evaluation of the demonstration to support a comprehensive assessment of whether the demonstration components are effective in producing the desired outcomes for its beneficiaries and providers, as well as the state's overall Medicaid program. The state is required to develop a robust Evaluation Design with well-crafted hypotheses and research questions for all key demonstration policy components, as described in the STCs. Evaluation of the reentry demonstration initiative must align with the requirements detailed in the STCs, including examining impacts on Medicaid and CHIP coverage, continuity of care, access to and quality and efficiency of care, utilization of services, health outcomes, and carceral and community coordination in service provision, among others.

The state plan requirements for eligible juveniles under section 1902(a)(84)(D) of the Act for Medicaid and targeted low-income children under section 2102(d)(2) of the Act for CHIP, are included under this reentry demonstration initiative and must be included in applicable monitoring and evaluation activities.

Consideration of Public Comments

Reentry Amendment
CMS posted the amendment application on Medicaid.gov for a 30-day federal public comment period from April 12, 2024, through May 13, 2024. CMS received nine public comments, eight of which were relevant to the demonstration and one that was not related to the demonstration request. All eight relevant commenters were supportive of the state's request for reentry pre-release services. Several commenters highlighted recommendations related to expanding access and offering additional covered pre-release services. Some commenters also raised considerations around evaluation criteria and partnership with external organizations. CMS has carefully considered all comments.

SUD Renewal
CMS posted the demonstration application on Medicaid.gov for a 30-day federal public comment period from April 15, 2026, through May 15, 2026. CMS received 5 comments, all of which were related to the demonstration. All five commenters were supportive of the state's request for the renewal of SUD services. Additionally, two commenters reiterated their support of the state's reentry amendment request.

CMS has concluded that approval of the Connecticut SUD Demonstration is likely to promote the objectives of Medicaid and CHIP.

Program Integrity

States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid and CHIP funds and must fully comply with all applicable Medicaid and CHIP statutes and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in title XIX and title XXI of the Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity including processes to identify, investigate, and refer suspected fraud, and methods to receive complaints and identify questionable practices. The state must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid and CHIP services, including referrals to law enforcement when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a program integrity oversight plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this

demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

Other Information

CMS's approval of this demonstration renewal is conditioned upon compliance with the enclosed set of waivers, expenditure authorities, and STCs defining the nature, character and extent of anticipated federal involvement in the demonstration. The award is subject to CMS receiving written acceptance of this award within 30 days of the date of this approval letter. Your project officer for this demonstration is Tavi Wolfwood, who is available to answer any questions concerning your section 1115 demonstration and their contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
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Baltimore, MD 21244-1850
Email: Tavi.Wolfwood@cms.hhs.gov

If you have questions regarding this approval, please contact Sarah Aker, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at Sarah.Aker@cms.hhs.gov.



Dr. Mehmet Oz

Enclosure

cc: Marie Dimartino, State Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITY

NUMBERS: 11-W-00372/1 and 21-W-00069/1

TITLE: Connecticut Substance Use Disorder Demonstration

AWARDEE: Connecticut Department of Social Services

Under the authority of the section 1115(a)(1) of the Social Security Act ("the Act"), the following waivers are granted to enable the State of Connecticut (referred to herein as the state) to operate the Connecticut Substance Use Disorder Demonstration. These waivers are effective beginning on April 1, 2027, through March 31, 2032, and are limited to the extent necessary to achieve the objectives below. These waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs) set forth in the accompanying document.

As discussed in the Centers for Medicare & Medicaid Services' (CMS) approval letter, the Secretary of Health and Human Services has determined that the Connecticut Substance Use Disorder Demonstration, including the granting of the waivers described below, is likely to assist in promoting the objectives of titles XIX and XXI of the Act.

1. Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 90 Days Prior to Release Section 1902(a)(84)(D)

To enable the state not to provide coverage of the screening, diagnostic, and targeted case management services identified in section 1902(a)(84)(D) of the Act for eligible juveniles described in section 1902(nn)(2) of the Act as a state plan benefit in the 90 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the state instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The state will provide coverage to eligible juveniles described in section 1902(nn)(2) of the Act in alignment with section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.

2. Coverage of Certain Screening, Diagnostic, Referral, and Case Management Services for Targeted Low-Income Children in the 30 Days Prior to Release Section 2102(d)(2)

To enable the state not to provide coverage of the screening, diagnostic, referral, and case management services identified in section 2102(d)(2) of the Act for a targeted low-income child as a state plan benefit in the 30 days prior to the release of such targeted low-income child from a public institution, to the extent and for the period that the state instead provides such coverage to such targeted low-income children under the approved expenditure authorities under this demonstration. The state will provide coverage to targeted low-income children in alignment with section 2102(d)(2) of the Act at a level equal to or greater than would be required under the state plan.

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: 11-W-00372/1 and 21-W-00069/1

TITLE: Connecticut Substance Use Disorder Demonstration

AWARDEE: Connecticut Department of Social Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Connecticut for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, must be regarded as matchable expenditures under the state's Title XIX or XXI plan, unless otherwise specified, provided however that these expenditures are further limited by the special terms and conditions (STCs) for the Substance Use Disorder (SUD) section 1115 Demonstration. Expenditures associated with the demonstration are approved from April 1, 2027, through March 31, 2032.

The Secretary of Health and Human Services (HHS) has determined that the Connecticut Substance Use Disorder Demonstration, including the granting of the expenditure authorities described below, is likely to assist in promoting the objectives of title XIX of the Act.

The following expenditure authorities shall enable Connecticut to operate this section 1115(a) demonstration.

1. **Residential and Inpatient Treatment for Individuals with Substance Use Disorder.** Expenditures for Medicaid state plan services that are furnished to otherwise eligible individuals who are primarily receiving treatment and/or withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

2. **Expenditures for Pre-Release Services**. Expenditures for pre-release services, as described in these STCs, provided to qualifying Medicaid beneficiaries for up to 90 days immediately prior to the expected date of release in youth correctional facilities participating in the reentry demonstration initiative. Expenditures for pre-release services, as described in these STCs, for up to 60 days immediately prior to the expected date of release in jails and prisons participating in the reentry demonstration initiative.

Title XIX Requirements Not Applicable to the Medicaid Expenditure Authority for Pre-Release Services:

1. **Amount, Duration, and Scope of Services and Comparability Section 1902(a)(10)(B)**

To enable the state to provide only a limited set of pre-release services, as specified in these STCs, to qualifying individuals that is different than the services available to all other individuals outside of correctional facility settings in the same eligibility groups authorized under the state plan or demonstration authority.

2. **Freedom of Choice** **Section 1902(a)(23)(A)**

To enable the state to require qualifying individuals to receive pre-release services, as authorized under this demonstration, through only certain providers.

3. **Statewideness** **Section 1902(a)(1)**

To enable the state to provide pre-release services, as authorized under this demonstration, to qualifying individuals on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.

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 state's available allotment under section 2104 of the Act, be regarded as match-able 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).

2. **Expenditures Related to Pre-Release Services.** Expenditures for pre-release services, as described in these STCs, provided to qualifying CHIP beneficiaries for up to 90 days immediately prior to the expected date of release in youth correctional facilities participating in the reentry demonstration initiative. Expenditures for pre-release services, as described in these STCs, for up to 60 days immediately prior to the expected date of release in jails and prisons participating in the reentry demonstration initiative

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00372/1 and 21-W-00069/1

TITLE: Connecticut Substance Use Disorder Demonstration

AWARDEE: Connecticut Department of Social Services

1. PREFACE

The following are the Special Terms and Conditions (STCs) for the "Connecticut Substance Use Disorder Demonstration" section 1115(a) Medicaid demonstration (hereinafter "demonstration"), to enable the State of Connecticut (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid (CMS) has granted a waiver of certain requirements under section 1902(a) of the Social Security Act (Act) and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those waiver and expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs related to the programs for those populations affected by the demonstration are effective from April 1, 2027 through March 31, 2032, unless otherwise specified.

The STCs have been arranged into the following subject areas:

1	Preface
2	Program Description and Objectives
3	General Program Requirements
4	Eligibility and Enrollment
5	Substance Use Disorder (SUD) Programs and Benefits
6	Reentry Demonstration Initiative
7	Cost Sharing
8	Delivery System
9	Monitoring and Reporting Requirements
10	Evaluation of the Demonstration
11	General Financial Requirements
12	Monitoring Budget Neutrality for the Demonstration
13	Monitoring Allotment Neutrality for the Demonstration
14	Schedule of State Deliverables for the Demonstration

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A	SUD Implementation Plan and SUD Health IT Plan
Attachment B	Reentry Demonstration Initiative Qualifying Conditions
Attachment C	Reentry Demonstration Initiative Services
Attachment D	Reserved for Reentry Demonstration Initiative Implementation Plan
Attachment E	Reserved for Reentry Demonstration Initiative Reinvestment Plan
Attachment F	Reentry Demonstration Initiative Final Reinvestments
Attachment G	Reserved for the Evaluation Design

2. PROGRAM DESCRIPTION AND OBJECTIVES

The Connecticut Substance Use Disorder (SUD) demonstration was initially approved April 14, 2022, permitting the state to provide clinically appropriate treatment to individuals diagnosed with a SUD while they are short term residents in treatment facilities that qualify as institutions for mental disease (IMDs). In this demonstration, the state maintains and enhances access to SUD services, opioid use disorder (OUD) and other SUD services, and continues delivery system improvements for these services to provide more coordinated and comprehensive treatment for Medicaid beneficiaries with SUD. This demonstration provides the state with authority to provide high-quality, clinically appropriate treatment to beneficiaries with SUD while they are short-term residents in residential and inpatient treatment settings that qualify as an IMD. It also supports state efforts to enhance provider capacity, improve the availability of Medication Assisted Treatment (MAT) and improve access to a continuum of SUD evidence-based services at varied levels of intensity, including withdrawal management services.

The demonstration is approved for a five-year renewal, effective April 1, 2027. During the demonstration renewal period, the state seeks to achieve the following goals:

SUD Goals:

1	Increase rates of identification, initiation, and engagement in treatment for SUD
2	Increase adherence to and retention in treatment
3	Reduce overdose deaths, particularly those due to opioids
4	Reduce utilization of emergency departments 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	Improve access to care for physical health conditions among beneficiaries with SUD

In addition to the SUD demonstration renewal, the state is also receiving authority to provide certain physical and behavioral health services coverage for eligible individuals preceding their release from incarceration. Together these two components of the demonstration expand access to SUD treatment for Medicaid and CHIP beneficiaries.

3. GENERAL PROGRAM REQUIREMENTS

3.1. Compliance with Federal Non-discrimination Statutes. The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

3.2. Compliance with Medicaid and CHIP Law, Regulation, and Policy. All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.3. Changes in Medicaid and CHIP Law, Regulation, and Policy. The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state thirty (30) business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

3.4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.5. State Plan Amendments. The state will not be required to submit title XIX or XXI state plan amendments (SPA) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

3.6. Changes Subject to the Amendment Process. Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary of Health & Human Services (HHS) in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3.

3.7. Amendment Process. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis that identifies the specific "with-waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with-waiver" and "without-waiver" status on both a summary and detailed level through the current approval period using the most recent actual

expenditures, as well as summary and detailed projections of the change in the "with-waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary;

e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and monitoring reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. Extension of the Demonstration. States that intend to request an extension of the demonstration must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 CFR 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 3.9.

3.9. Demonstration Phase-Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. **Notification of Suspension or Termination.** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. **Transition and Phase-out Plan Requirements.** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. **Transition and Phase-out Plan Approval.** The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. **Transition and Phase-out Procedures.** The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(d)(1). For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable advance notice requirements and fair hearing rights described at 42 CFR 431, Subpart E. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

e. **Exemption from Public Notice Procedures 42 CFR Section 431.416(g).** CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. **Enrollment Limitation during Demonstration Phase-Out.** If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. **Federal Financial Participation.** If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.10. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

3.11. Adequacy of Infrastructure. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

3.12. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with

the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 3.7 or extension, are proposed by the state.

3.13. Federal Financial Participation. No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.14. Administrative Authority. When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, managed care organizations (MCOs), and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.15. Common Rule Exemption. The state must ensure the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program—including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration, as represented in these approved STCs, meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

4. ELIGIBILITY AND ENROLLMENT

4.1. Eligibility Groups Affected by the Demonstration. Under the SUD component of the demonstration, there is no change to Medicaid eligibility and affected groups derive their eligibility through the Medicaid state plan. Standards and methodologies for eligibility remain set forth under the state plan.

Under the demonstration, an individual eligible for CHIP, except for if the individual is residing in an IMD for diagnoses of SUD at the time of application or renewal, will continue to be eligible for CHIP. All other standards and methodologies for eligibility remain as set forth under the state plan.

4.2. Applicability of title XXI Maintenance of Effort to Demonstration Populations. The maintenance of effort provision at section 2105(d)(3)(A) of the Act applies to title XXI eligible

children enrolled in this demonstration. This provision requires that, with certain exceptions, as a condition of receiving FFP for Medicaid, states must maintain CHIP "eligibility standards, methodologies, and procedures" for children that are no more restrictive than those in effect on March 23, 2010. See STCs 13.4 and 13.5 related to the title XXI funding limits and shortfalls.

5. SUBSTANCE USE DISORDER PROGRAMS AND BENEFITS

5.1. SUD Program Benefits. The demonstration benefit package for Medicaid beneficiaries will include SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. The state is eligible to receive FFP for Medicaid beneficiaries who are short-term residents in IMDs under the terms of this demonstration for coverage of medical assistance, including SUD services, that would otherwise be matchable if the beneficiary were not residing in an IMD. The state will aim for a statewide average length of stay of 30 days or less in residential treatment settings to be monitored pursuant to STC 9.5, to ensure short-term residential stays.

Under this demonstration beneficiaries will have access to high quality, evidence-based SUD treatment services across a comprehensive continuum of care, ranging from residential and inpatient treatment to ongoing care for these conditions in cost-effective community-based settings.

5.2. SUD Implementation Plan and Health IT Plan: The state's SUD Implementation Plan, initially approved for the period from April 14, 2022, through March 31, 2027, remains in effect for the approval period from April 1, 2027, through March 31, 2032, and is affixed to the STCs as Attachment A. Any future modifications to the approved Implementation Plan will require CMS approval. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 9.2. The approved SUD Implementation Plan describes the strategic approach and a detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of this SUD project:

a. Access to Critical Levels of Care for OUD and other SUDs. Coverage of SUD treatment services across a comprehensive continuum of care including: outpatient; intensive outpatient; medication assisted treatment (medication as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state); intensive levels of care in residential and inpatient settings; and medically supervised withdrawal management;

b. Use of Evidence-based SUD-specific Patient Placement Criteria.

    i. Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society

of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines;

ii. *Utilization Management.* Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings;

c. Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities.

i. Implementation of residential treatment provider qualifications. Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in the provider manual at: https://portal.ct.gov/dss/-/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?rev=985f8232141a47dc9915a39a57e3ee38&hash=837D2FD3EC091F2BC14A28D90755895F.

The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that 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;

ii. Standards of Care. Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings;

iii. Availability of MAT. Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site;

d. Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for SUD/OUD. An assessment of the availability of providers in the critical levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT;

e. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OUD.

i. Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse;

ii. Expand coverage of and access to naloxone for overdose reversal;

iii. Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

f. Improved Care Coordination and Transitions between Levels of Care. Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities;

g. SUD Health IT Plan. Implementation of a Substance Use Disorder Health Information Technology Plan which describes technology that will support the aims of the demonstration. Further information which describes milestones and metrics are detailed in STC 5.3 and Attachment A.

5.3. SUD Health Information Technology Plan ("Health IT Plan"). The SUD Health IT plan applies to all states where the Health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #17-003, states must submit to CMS the applicable Health IT Plan(s), to be included as a section(s) of the associated Implementation Plan(s) (see STC 5.2.g.), to develop infrastructure and capabilities consistent with the requirements outlined in each demonstration-type.

The Health IT Plan describes how technology can support outcomes through care coordination; linkages to public health and prescription drug monitoring programs; establish data and reporting structure to monitor outcomes and support data driven interventions. Such technology should, per 42 CFR 433.112(b), use open interfaces and exposed application programming interfaces and ensure alignment with, and incorporation of, standards adopted by the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health IT (ASTP/ONC) in accordance with 45 CFR part 170, subpart B.

The state's Health IT Plan, initially approved for the period from April 14, 2022, through March 31, 2027 remains in effect for the approval period from April 1, 2027, through March 31, 2032, and is affixed to the STCs as Attachment A.

a. The state must monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS within its Annual Report (see STC 9.5).

b. As applicable, the state should advance HHS adopted standards in 45 CFR 170 Subpart B in developing and implementing the state's SUD Health IT policies and in all related

applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.[1]

c. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds to acquire, upgrade, or implement health IT that can be supported by standards referenced in 45 CFR 170 Subpart B, the state should use the federally recognized standards.

d. Where there are opportunities at the state- and provider-level to leverage federal funds to acquire, upgrade, or implement health IT that cannot be supported using a standard in 45 CFR 170 Subpart B, the state should seek to use other non-proprietary standards and implementation specifications developed by consensus-based standards development organizations. This may include standards identified in the ASTP/ONC Interoperability Standards Advisory (ISA).[2]

e. Specific components of the Health IT Plan are listed below:

   i. The Health IT Plan must describe the state's alignment with Section 5042 of the SUPPORT Act requiring Medicaid providers to query a Qualified Prescription Drug Monitoring Program (PDMP)[3].

   ii. The Health IT Plan must address how the state's Qualified PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[4] States should favor procurement strategies that incorporate Qualified PDMP data into electronic health records as discrete data without added interface costs to Medicaid providers, leveraging existing federal investments in open interfaces and exposed application program interfaces.

   iii. The Health IT Plan will describe how technology will support substance use disorder prevention and treatment outcomes described by the demonstration.

5.4. Unallowable Expenditures Under the SUD Expenditure Authority. The state may not receive FFP for room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

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[1] Where the plan involves health IT that is acquired, upgraded, or implemented by health care providers that have been eligible for CMS incentives to adopt health IT certified under the ONC Health IT Certification Program, states should advance the use of certified health IT, as applicable. Certified health IT incorporates the standards in 45 CFR 170 Subpart B.

[2] https://www.healthit.gov/isp/

[3] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.

[4] *Ibid.*

6. REENTRY DEMONSTRATION INITIATIVE PROGRAM

6.1. Overview of Pre-Release Services and Program Objectives.

This demonstration will provide coverage for pre-release services up to 90 days immediately prior to the expected date of release to certain individuals who are inmates residing in youth correctional facilities. This component will also provide coverage for pre-release services up to 60 days immediately prior to the expected date of release in jails and prisons participating in the reentry demonstration initiative. All facilities defined in STC 6.5 will hereinafter be called "correctional facilities." To qualify for services covered under this demonstration, individuals residing in correctional facilities must be eligible for Medicaid or CHIP as determined pursuant to an application filed before or during incarceration and must have an expected release date specified in STC 6.3 below.

6.2. The objective of this component of the demonstration is to facilitate individuals' access to certain healthcare services and case management, provided by Medicaid and CHIP participating providers, while individuals are incarcerated and allow them to establish relationships with community-based providers from whom they can receive services upon reentry to their communities. This bridge to coverage begins within a short time prior to release and is expected to promote continuity of coverage and care and improve health outcomes for justice-involved individuals. The reentry demonstration initiative provides short-term Medicaid and CHIP enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of medication-assisted treatment (MAT) and other substance use disorder (SUD) and behavioral health treatments, as appropriate for the individual.

During the demonstration, the state seeks to achieve the following goals:

e. Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in correctional facility settings prior to release;

f. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry;

g. Improve coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans (as applicable), and community-based providers;

h. Increase additional investments in health care and related services, aimed at improving the quality of care for individuals in correctional facility settings, and in the community to maximize successful reentry post-release;

i. Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs, and social determinants of health

f. Reduce all-cause deaths in the near-term post-release;

g. Reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid and CHIP individuals through increased receipt of preventive and routine physical and behavioral health care;

h. Provide interventions for certain behavioral health conditions, including use of stabilizing medications like long-acting injectable antipsychotics and medication for addiction treatment for SUDs where appropriate, with the goal of reducing overdose and overdose-related death in the near-term post-release.

6.3. Qualifying Criteria for Pre-Release Services. To qualify or receive services under this component of the demonstration, an individual must meet the following criteria:

a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a correctional facility specified in STC 6.5; and

b. Have been determined eligible for Medicaid, or CHIP, if not for their incarceration status; and

c. Meet one of the following two criteria to receive the described length of pre-release services:

i. Be an individual in a jail or prison with an expected release date within 60 days to receive up to 60 days of pre-release services, or

ii. Be an individual in a youth correctional facility with an expected release date within 90 days to receive up to 90 days of pre-release services.

d. Meets at least one of the health-related criteria described below and further defined in Attachment B titled "Reentry Demonstration Initiative Qualifying Conditions." Meeting such health-related criteria may be indicated by an individual, found at an initial screening conducted by the correctional facility upon intake, determined during an individual's incarceration, or found during assessment in the process of pre-release planning.

i. Adults who meet at least one of the health criteria described below and further defined in Attachment B titled "Reentry Demonstration Initiative Qualifying Conditions". Meeting such health related criteria may be indicated by an individual, found at an initial screening conducted by the correctional facility upon intake, determined during an individual's incarceration, or found during assessment in the process of pre-release planning.

A. Mental illness (MI);

B. Substance-use disorder (SUD);

C. Co-occurring MI/SUD;

D. Chronic condition or significant non-chronic clinical condition;

E. Intellectual disability;

F. Acquired brain injury, including traumatic brain injury;

G. Positive test or diagnosis of HIV/AIDS; or

H. Currently pregnant or within a 12-month post-partum period.

ii. Children under age 21 and former foster youth under 26 are not required to meet these health-related criteria and are eligible without additional health or other criteria.

e. Have a status of pre-adjudication or post-adjudication.

6.4. Scope of Pre-Release Services. The pre-release services authorized under the reentry demonstration initiative are the following services, which are described in Attachment C, Reentry Demonstration Initiative Services.

a. The covered pre-release services are:

i. Case management to assess and address physical and behavioral health needs, and social determinants of health; and

ii. MAT for all types of SUDs as clinically appropriate, including coverage for medications in combination with counseling/behavioral therapies.

iii. A 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate), provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid or CHIP state plan coverage authority and policy

iv. Practitioner office visit (e.g., physical exam; evaluation and management visit; mental health or substance use disorder treatment, therapy, or counseling; or other);

v. Diagnostic services, including laboratory and radiology services;

vi. Prescribed drugs (in addition to MAT and the 30-day supply of prescription medications) and medication administration;

vii. Treatment for Hepatitis C;

viii. Medical equipment and supplies;

ix. Family planning services and supplies;

x. Rehabilitative or preventative services; and

xi. Other licensed practitioner services and behavioral health under clinic services.

b. The expenditure authority for pre-release services through this initiative constitutes a limited exception to the federal claiming prohibition for medical assistance furnished to inmates of a public institution at clause (A) following section 1905(a) of the Act ("inmate exclusion rule"). Similarly, for CHIP, the expenditure authority for pre-release services constitutes a limited exception to the general exclusion of children who are inmates of a public institution from the definition of a targeted low-income child under section 2110(b)(2)(A) of the Act ("child exclusion rule"). Benefits and services for inmates of a public institution that are not approved in the reentry demonstration initiative as described in these STCs and accompanying protocols, and not otherwise covered under the inpatient exception to the inmate exclusion rule [or an exception in section 2110(b)(7) of the Act to the child exclusion rule remain subject to the inmate exclusion rule or the child exclusion rule, as applicable]. Accordingly, other benefits and services covered under the Connecticut Medicaid or CHIP State Plans, as relevant, that are not included in the above-described pre-release services (e.g., EPSDT treatment services for qualifying Medicaid beneficiaries under age 21) are not available to qualifying individuals through the reentry demonstration initiative.

6.5. Participating Correctional Facilities. The pre-release services will be provided at jails, prisons, and youth correctional facilities, or outside of the correctional facilities, with appropriate transportation and security oversight provided by the correctional facility, subject to Connecticut's Department of Social Services approval of a facility's readiness, according to the implementation timeline described in STC 6.11. States must be mindful of and ensure the policies, procedures, and processes developed to support implementation of these provisions do not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems. Correctional facilities that are also institutions for mental diseases (IMDs) are not allowed to participate in the reentry demonstration initiative.

6.6. Participating Providers.

a. Licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under Connecticut scope of practice statutes shall provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws and must be enrolled as Medicaid or CHIP providers.

b. Participating providers eligible to deliver services under the reentry demonstration initiative may be either community-based or correctional facility-based providers.

c. All participating providers and provider staff, including correctional providers, shall have necessary experience and receive appropriate training, as applicable to a given correctional facility, prior to furnishing demonstration-covered pre-release services under the reentry demonstration initiative.

d. Participating providers of reentry case management services may be community-based or correctional providers who have expertise and/or training working with justice-involved individuals.

e. Connecticut must develop processes and policies to ensure that case managers coordinate with providers of pre-release services and community-based providers (if they are different providers) and facilitate connections to community-based providers pre-release for timely access to services upon reentry in order to provide continuity of care.

f. Connecticut must develop processes to facilitate coordination between case managers and community-based providers in communities where individuals will be living upon release or ensure individuals have the skills and resources to inform themselves about such providers for communities with which they are unfamiliar.

g. Connecticut must develop policies so that case managers are engaged and have the necessary time needed to respond effectively to individuals who are incarcerated and transitioning back into the community.

6.7. Suspension of Coverage. Upon entry of a Medicaid-enrolled or CHIP individual into a correctional facility, Connecticut Department of Social Services must not terminate and generally shall suspend their Medicaid coverage or CHIP eligibility, in accordance with sections 1902(a)(84)(A) and 2102(d)(1)(A) of the Act.

a. If an individual is not enrolled in Medicaid or CHIP when entering a correctional facility, the state must ensure that such an individual receives outreach and assistance with completing and submitting an application for Medicaid or CHIP, unless the individual declines such assistance or wants to decline enrollment.

6.8. Opportunity to Enroll in Medicaid or CHIP. Any Medicaid or CHIP-eligible person who is incarcerated at a participating facility but not yet enrolled must be afforded the opportunity to apply for Medicaid or CHIP in the most feasible and efficient manner and must be offered assistance with the Medicaid application process in accordance with 42 CFR 435.906, 435.908, and 457.340(a). The state must accept an application submitted via any of the methods described at 42 CFR 435.907 and 457.330.

a. All individuals who are incarcerated at a participating facility must be allowed to access and complete a Medicaid or CHIP application and must be assisted in this process, including by providing information about where to complete the Medicaid or CHIP application for another state (e.g., relevant state Medicaid agency website), if the person plans to live in a different state after release.

b. All individuals enrolled in Medicaid or CHIP during their incarceration must be provided with a Medicaid, CHIP, or managed care plan card or some other Medicaid, CHIP, or managed care enrollment documentation upon release, along with information on how to use their coverage.

6.9. Managed Care Contract Requirements. If Connecticut elects to implement the demonstration through managed care, managed care plan contracts must reflect clear requirements and processes for transfer of a member's relevant health information upon release to another managed care plan or, if applicable, state Medicaid agency (e.g., if the beneficiary is moving to region of the state served by a different managed care plan or to another state after release) to ensure continuity of coverage and care.

6.10. Interaction with Mandatory State Plan Benefits for Eligible Juveniles and Targeted Low-Income Children. To the extent Connecticut includes coverage in the reentry demonstration initiative that is otherwise required to be provided under sections 1902(a)(84)(D) and 2102(d)(2) of the Act, and may include this coverage in the base expenditures used to determine the budget neutrality or allotment neutrality expenditure limit, the state may claim for these expenditures under this demonstration as well as include this coverage in the monitoring and evaluation of this demonstration.

6.11. Reentry Demonstration Initiative Implementation Timeline. Delivery of pre-release services under this demonstration will be implemented as described below. All participating correctional facilities must demonstrate readiness, as specified below, prior to participating in this initiative (FFP will not be available in expenditures for services furnished to qualifying individuals who are inmates in a facility before the facility meets the below readiness criteria for participation in this initiative). Connecticut Department of Social Services will determine that each applicable facility is ready to participate in the reentry demonstration initiative under this demonstration based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

a. 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;

b. The screening process to determine an individual's qualification for pre-release services, per the eligibility requirements described in STC 6.3;

c. The provision or facilitation of pre-release services for a period of time immediately prior to the expected date of release, as described in STC 6.1 and 6.3, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth, as applicable;

d. If Connecticut optionally elects to phase in pre-release services, Connecticut will require participating facilities to select a Service Level for implementation. Service Level One consists of the minimum benefit package pre-release services identified in STC 6.4.a.i-iii. and must be the first Service Level category that is implemented. The state may define additional Service Level categories in its Implementation Plan. As applicable, additional service levels may be phased-in by facilities in any order, e.g., Service Level Two would not be a prerequisite for phasing-in Service Level Three, except that no facility may be a participating correctional facility that does not at least achieve and maintain provision of Service Level One. A facility must demonstrate to the

state that it is prepared to implement all the services in Service Level One and within any chosen Service Level, if applicable.

e. Coordination amongst partners with a role in furnishing health care services to individuals who qualify for pre-release services, including, but not limited to, physical and behavioral health community-based providers, and social service departments.

f. Appropriate reentry planning, pre-release case management, and assistance with care transitions to the community, including connecting individuals to physical and behavioral health providers and their managed care plan (as applicable), and making referrals to case management and community supports providers that take place throughout the up to 60-day pre-release period for jails and prisons and up to 90-day pre-release period for the youth correctional facilities, as described in STC 6.3.c., and providing individuals with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply of the medications as clinically appropriate) upon release, consistent with approved Medicaid or CHIP state plan coverage authority and policy;

g. 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 demonstration initiative;

h. A data exchange process to support the care coordination and transition activities described in (e), (f), and (g) of this subsection subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

i. Reporting of data requested by the Connecticut to support program monitoring, evaluation, and oversight; and

j. A staffing and project management approach for supporting all aspects of the facility's participation in the reentry demonstration initiative, including information on qualifications of the providers with whom the correctional facilities will partner for the provision of pre-release services.

6.12. Reentry Demonstration Initiative Implementation Plan. The state is required to submit a Reentry Demonstration Initiative Implementation Plan for CMS approval that will identify for each milestone, as well as each associated action, what the state anticipates to be the key implementation challenges and the state's specific plans to address these challenges. This will include any plans to phase in demonstration components over the lifecycle of the demonstration.

The state must submit the draft Implementation Plan to CMS no later than 120 calendar days after approval of the reentry demonstration initiative. The state must submit any required clarifications or revisions to its draft Implementation Plan no later than 60 calendar days after receipt of CMS feedback. The finalized Implementation Plan, subject to CMS approval, will be

incorporated into the STCs as Attachment D titled "Reentry Demonstration Initiative Implementation Plan."

CMS will provide the state with a template to support developing the Implementation Plan.

6.13. Reentry Demonstration Initiative Reinvestment Plan. To the extent that the reentry demonstration initiative newly covers services that are the responsibility of and were previously provided or paid for by the correctional facility with custody of qualifying individuals, the state must reinvest all new federal dollars, equivalent to the amount of FFP expended for such previously existing service(s), into allowable justice-related activities defined below. FFP projected to be expended for new services covered under the reentry demonstration initiative or state plan services required under this demonstration to meet the requirements of sections 1902(a)(84)(D) or section 2102(d)(2) of the Act are not required to be reinvested pursuant to this STC. New services are defined as 1) services not previously provided or paid by the correctional facility or carceral authority with custody of qualifying individuals prior to the facility's implementation of the reentry demonstration initiative or 2) any additional increases in expenditures for existing services that have been expanded, augmented, or enhanced to meet the requirements of the reentry demonstration initiative. For services that were previously provided prior to the demonstration and now, under the demonstration, have been expanded, augmented, or enhanced, the state must calculate the proportion of FFP attributed to existing services, and reinvest an amount equivalent to the amount of FFP.

a. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, must be made over the course of the demonstration period. Allowable reinvestments may only include:

    i. The state share of funding associated with new services covered under the reentry demonstration initiative, as specified in this STC;

    ii. Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing the needs of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions;

    iii. Improved access to or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the reentry demonstration initiative opportunity;

    iv. Improved health information technology (IT) and data sharing subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

v. Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, justice-involved individuals or individuals at risk of justice involvement;

vi. Expanded or enhanced community-based services and supports, including services and supports to meet the needs of the justice-involved population; and

vii. Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the justice-involved population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.

b. Within 180 days of approval of the reentry demonstration initiative, the state will submit a reentry demonstration initiative Reinvestment Plan Attachment E for CMS approval that memorializes the state's reinvestment approach. The Reinvestment Plan must include:

i. An assessment of each authorized pre-release service, the extent to which it is a new or existing service, and a calculation of the projected amount of FFP required to be reinvested for each existing service per year;

ii. A description of the allowable activities described below above in which the state plans to reinvest the required dollars, a timeline of when those reinvestments will occur, and the goals and outcomes for those activities. The state cannot use reinvested funds to build new or conduct capital improvements for existing correctional facilities.

iii. An assessment of whether privately-owned or -operated carceral facilities would receive any of the reinvested funds and, if so, the safeguards the state proposes to ensure that such funds are used for the intended purpose and do not have the effect of increasing profit or operating margins for privately-owned or -operated carceral facilities.

c. The state will be required to include updates on reinvestment as part of the annual monitoring report. The state must describe the actual amount of required reinvestment based on actual FFP received, the amount the state has already reinvested and into what activities. The state must also include outcomes from the activities the state reinvested in.

d. No later than one year after the expiration of the demonstration period, the state will submit to CMS a Final Reinvestment Assessment Attachment F that will fully describe the final amount of required reinvestment based on actual FFP received, the amount the state reinvested and into what activities, and the outcomes of those activities.

7. COST SHARING

7.1. Cost Sharing. Cost sharing imposed upon individuals in the demonstration is consistent with the provisions of the approved state plan.

8. DELIVERY SYSTEM

8.1. Delivery System. The services provided under the Connecticut Reentry Services Demonstration will be in addition to the services provided through the Medicaid and CHIP state plans. All demonstration beneficiaries will continue to receive services through the same delivery system arrangements as currently authorized in the state. Pre-release services approved through this demonstration will primarily be delivered through a fee-for-service delivery system. Some pre-release services may be provided through managed care in scenarios where individuals enter a facility already assigned to a managed care plan and are incarcerated for a short period of time, with details to be specified in the Reentry Demonstration Initiative Implementation Plan (Attachment C).

All demonstration beneficiaries will continue to receive services through the same delivery system arrangements as currently authorized in the state for the SUD Program.

9. MONITORING AND REPORTING REQUIREMENTS

9.1. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: (1) 30 calendar days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or (2) 30 calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable. The extension request must explain the reason why the required deliverable was not submitted, the steps the state has taken to address such issue,

and the state's anticipated date of submission. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

9.2. Deferral of Federal Financial Participation from IMD Claiming for Insufficient Progress Toward Milestones. Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones as evidenced by reporting on the milestones in the Annual Monitoring Report. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar year and each calendar year thereafter until CMS has determined sufficient progress has been made.

9.3. Submission of Post-Approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs unless CMS and the state mutually agree to another timeline.

9.4. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional section 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all section 1115 demonstration, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

9.5. Monitoring Reports. The state must submit one Annual Monitoring Report each demonstration year (DY) that is due no later than 180 calendar days after the end of the DY. The state must submit a revised Annual Monitoring Report within 60 calendar days after receipt of CMS' comments, if any. CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. CMS will make on-going determinations about reporting frequency under the demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. See 42 CFR 431.420(d)(1)-(2).

The Annual Monitoring Report will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Annual Monitoring Report must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and must be provided in a structured manner that supports federal tracking and analysis.

a. **Operational Updates.** Per 42 CFR 431.428, the Annual Monitoring Report must document any policy or administrative difficulties in operating the demonstration. The Annual Monitoring Report must provide sufficient information to document key operational and other challenges, underlying causes of challenges, and how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Annual Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. **Performance Metrics**. The performance metrics will provide data to demonstrate the state's progress towards meeting the demonstration's goals and any applicable milestones. Per 42 CFR 431.428, the Annual Monitoring Report must document the impact of the demonstration on beneficiaries' outcomes of care, quality and overall cost of care, and access to care as applicable. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals. The Annual Monitoring Report must provide detailed information about deviations from CMS's applicable metrics technical specifications, relevant methodology, plans for phasing in metrics, and data or reporting issues for applicable metrics, in alignment with CMS guidance and technical assistance.

The state and CMS will work collaboratively to finalize the list of metrics to be reported on in the Annual Monitoring Report. The demonstration's monitoring metrics must cover categories to include, but not be limited to, eligibility, utilization of services, quality of care and health outcomes, and grievances and appeals. The state must report these metrics for all demonstration populations. Demonstration monitoring reporting does not duplicate or replace reporting

requirements for other authorities, such as Home and Community Based Services and Managed Care authorities.

In addition, the state is expected to report monitoring metrics for the following demonstration initiative(s), as described below per applicable CMS guidance:

i. For the SUD and/or SMI/SED component(s), the state's monitoring must cover metrics in alignment with CMS guidance and the demonstration's milestones as outlined in the SUD State Medicaid Director Letter (SMDL) dated November 1, 2017 (SMD #17–003) and/or the SMI/SED SMDL dated November 13, 2018 (SMDL #18-011).

ii. For the reentry demonstration initiative, the state must report on metrics that track implementation progress and milestones. CMS expects such metrics to include, but not be limited to: administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services as defined in STC 6.4, provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating correctional facility settings. In addition, the state is expected to monitor the number of individuals served and types of services rendered under the demonstration. Also, in alignment with the state's Reentry Initiative Implementation Plan, the state must also provide in the Annual Monitoring Report narrative details outlining its progress with implementing the initiative, including any challenges encountered and how the state has addressed them or plans to address them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology.

The reporting of these monitoring metrics may also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography) and by demonstration component, as appropriate. Subpopulation reporting can support identifying any gaps in quality of care and health outcomes, and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population.

c. **Evaluation Activities and Interim Findings.** Per 42 CFR 431.428, the Annual Monitoring Report must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

d. **SUD Mid-Point Assessment.** The state must contract with an independent entity (herein referred to as the Independent Assessor) to conduct an independent Mid-Point Assessment and submit to CMS by March 31, 2030. This timeline will allow for the Mid-Point Assessment to capture approximately the first two and a half years of program data, accounting for data run-out and data completeness. In addition, if applicable, the

state should use the prior approval period experiences as context, and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning and execution of the Mid-Point Assessment, the state must require that the Independent Assessor consult with key stakeholders such as, representatives of MCOs, health care providers, beneficiaries, community groups, and other key partners.

e. The state must require that the assessor provide a Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. If requested, the state must brief CMS on the Mid-Point Assessment. The state must submit a revised Mid-Point Assessment within 60 calendar days after receipt of CMS' comments, if any.

f. Elements of the Mid-Point Assessment must include:

    i. An examination of progress toward meeting each milestone and timeframe approved in the Implementation Plan;

    ii. A determination of factors that affected achievement on the milestones and performance metric gap closures to date;

    iii. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

    iv. For milestones or targets identified by the Independent Assessor as at medium to high risk of not being met, recommendations for adjustments in the state's Implementation Plan, or to pertinent factors that the state can influence that will support improvement.

g. **Corrective Action Plan Related to Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS might withdraw an authority, as described in STC 3.10, if metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action, and the circumstances described in STC 3.10 are met. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

9.6. Close-Out Report. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim or Summative Evaluation Reports stipulated in STC 10.8 and STC 10.9 respectively.

c. The state will present to and participate in a discussion with CMS on the Close-Out Report.

d. The state must take into consideration CMS' comments for incorporation into the final Close-Out Report.

e. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS' comments.

f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 9.1.

9.7. Monitoring Calls. CMS will convene, no less frequently than quarterly monitoring calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operations, and implementation which align with the state's demonstration monitoring reports including (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, eligibility and access, and progress on evaluation activities.

b. These calls will follow the structure of and focus on the topics in the Annual Monitoring Report.
c. CMS will provide updates on any pending actions as well as federal policies and issues that may affect any aspect of the demonstration.

d. The state and CMS will jointly develop the agenda for the calls.

9.8. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the

most recent Annual Monitoring Report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the public comments in the Annual Monitoring Report associated with the year in which the forum was held.

10. EVALUATION OF THE DEMONSTRATION

10.1. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f). This may also include the state's participation – including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable – in a federal learning collaborative aimed at cross-state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 9.1.

10.2. Independent Evaluator. The state must use an independent entity (herein referred to as the Independent Evaluator) to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The Independent Evaluator must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

10.3. Evaluation Design. The state must submit, for CMS comment and approval, an Evaluation Design with implementation timeline, no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be developed in accordance with the STCs and any applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations.

The state is strongly encouraged to use the expertise of the Independent Evaluator in the development of the Evaluation Design. The Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 10.8 and 10.9.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component, unless otherwise agreed upon by the state and CMS. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. The amendment components of the Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

10.4. Evaluation Design Approval and Updates. The state must submit to CMS a revised Evaluation Design within 60 calendar days after receipt of CMS' comments, if any. Upon CMS approval of the Evaluation Design, the document will be posted to Medicaid.gov. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each Annual Monitoring Report. Once CMS approves the Evaluation Design, if the state wishes to make changes and the changes are substantial in scope, the state must submit a revised Evaluation Design to CMS for approval; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in an Annual Monitoring Report.

10.5. Evaluation Questions and Hypotheses. Consistent with the STCs and applicable CMS guidance, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding of the demonstration's impact and its effectiveness in achieving the demonstration's goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as eligibility and various measures of access, utilization, costs, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. The evaluation is expected to use applicable demonstration monitoring and other data on the provision of and beneficiary utilization of demonstration and other applicable services. Proposed measures should be selected from nationally recognized sources and national measures sets, where possible. Measures sets could include the Consumer Assessment of Health Care Providers and Systems (CAHPS), the Medicaid and CHIP Core Sets of Health Care Quality measures, commonly referred to as the Child and Adult Core Sets, the Behavioral Risk Factor Surveillance System (BRFSS) survey, and/or measures endorsed by National Quality Forum (NQF).

The state must develop robust evaluation questions and hypotheses related to each demonstration initiative, and per applicable CMS guidance. Specifically:

a. Hypotheses for the SUD component of the demonstration must align with the goals of the program, including increasing rates of identification and initiation of and engagement in treatment as well as adherence to and retention in treatment, reducing overdose deaths, reducing utilization of emergency departments and inpatient hospitalizations as well as readmissions to the same or higher levels of care, and improving access to care for physical health conditions.

b. Evaluation of the Reentry Demonstration Initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible individuals, and efficient high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the Reentry Demonstration Initiative in the state, the evaluation hypotheses must focus on, but not be limited to: cross-system communication and coordination; connections between correctional and community services; access to and quality of care in correctional and community settings; preventive and routine physical and behavioral health care utilization; non-emergent emergency department visits and inpatient hospitalizations; and all-cause deaths.

In instances where the state is testing services beyond the minimum benefit package or providing coverage for a period over 30 days and up to 90 days immediately prior to a beneficiary's expected release date, the state is required to incorporate additional hypotheses to describe those tests. The state must also provide a comprehensive analysis of the distribution of services rendered by type of service over the duration of up to 90-days coverage period before the individual's expected date of release—to the extent feasible—and discuss in the evaluation any relationship identified between the provision and timing of particular services with salient post-release outcomes. For example, the state could include the following: utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release. In addition, the state is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient, and effective reentry planning; enabled pre-release management and stabilization of clinical, physical, and behavioral health conditions; and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage of pre-release services.

The demonstration's evaluation efforts will be expected to include the experiences of correctional and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community. Finally, the state must conduct a comprehensive cost analysis to support developing estimates of implementing the Reentry Demonstration Initiative, including covering associated services.

As part of its evaluation efforts, the state must also conduct an overall demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation and Medicaid health services expenditures. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey or interviews to assess, for instance, beneficiary understanding of the demonstration policy components and beneficiary experiences with access to and quality of care. To better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—and barriers to—implementation, the state is strongly encouraged to undertake a robust process/implementation evaluation. The implementation evaluation can inform the state's

crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Finally, the state may collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography). Such stratified data analyses can provide a fuller understanding of gaps in access to and quality of care and health outcomes, as well as help inform how the demonstration's various policies support improving outcomes.

10.6. Evaluation Budget. A budget for the evaluations must be provided with the Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

10.7. Reentry Early Implementation Rapid Cycle Report. The state must conduct and submit a Rapid Cycle Report (RCR) to CMS as a required evaluation deliverable for this demonstration. The purpose of the RCR is to assess implementation planning of the demonstration, including operational progress, barriers and facilitators, program integrity, and financial oversight, and to provide timely, actionable insights to support program refinement during the initial implementation phase.

The state must submit the RCR no later than 180 calendar days following the onset of claiming for demonstration services ("go-live"). The state must notify CMS of the anticipated go-live date no later than 30 calendar days in advance. CMS may, at its discretion, approve an alternative submission timeline if warranted by the state's implementation schedule or operational milestones.

The RCR must use a mixed-methods approach, incorporating both qualitative and quantitative information, and must assess implementation progress and key milestones, including the status of data-sharing agreements, provider onboarding, systems readiness, and care coordination processes, as well as a comparison of planned versus actual implementation timelines and approaches for service delivery and operations, including explanations for any deviations from the approved implementation plan. The RCR must also highlight any known gaps in data needed for future evaluations and potential mitigation strategies.

The RCR must also assess early operational experiences, including successes and challenges associated with coordination across correctional facilities and community-based providers, and must identify mitigation strategies where appropriate. The RCR must further include early financial information, including expenditures and any identified claiming considerations, as feasible, and an assessment of data infrastructure, reporting capabilities, and data quality, including limitations that may affect future evaluation activities. The RCR must make the methodology clear (e.g., financial analyses, interviews, focus groups) as well as the sources of the data (e.g., carceral facilities, community providers, state staff/contractors). The RCR may also include recommendations for refining the state's CMS-approved Evaluation Design,

including identification of feasible outcome measures, data sources, and analytic approaches based on actual implementation experience.

The state must participate in discussions with CMS to review RCR findings and must identify and implement programmatic improvements, as appropriate. The state must document any changes made in response to RCR findings in subsequent monitoring reports. The state must publish the final RCR on its public website within 30 calendar days of CMS approval. The Rapid Cycle Report must incorporate structured input from key demonstration interest holders (e.g., correctional facilities, community-based providers, and other partners). The report must address core implementation questions aligned with CMS evaluation guidance.

The report must also include a structured assessment of implementation plan activities, including the status of key milestones, explanations for deviations from planned timelines, and recommended modifications to implementation strategies.

10.8. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). The draft Interim Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

a. For demonstration authority or any component within the demonstration that expires prior to the overall demonstration's expiration date, and depending on the timeline of the expiration/phase-out, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

b. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. When applying for an extension of the demonstration, the Interim Evaluation Report should be posted to the state's website with the application for public comment. If the state does not request an extension for the demonstration, the Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase-outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

c. The state must submit a revised Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report, if any.

d. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

10.9. Summative Evaluation Report. The state must submit a draft Summative Evaluation report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be

developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

a. The state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft Summative Evaluation Report, if any.

b. Once approved by CMS, the state must post the final Summative Evaluation report to the state's Medicaid website within 30 calendar days.

10.10. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

10.11. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, or the Summative Evaluation Report.

10.12. Public Access. The state shall post the final documents (e.g., Annual Monitoring Report, Close-Out Report, Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

10.13. Additional Publications and Presentations. For a period of 12 months following CMS' approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment on or review some or all of these notifications and reviews.

11. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

11.1. Allowable Expenditures. This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable

demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

11.2. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate match-able demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

11.3. Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that the non-federal share is obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that such funds must not be used to match any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, CMS reserves the right to prohibit the use of any sources of non-federal share funding that it determines impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to fund the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statute or regulations, the state must address CMS' concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

11.4. State Certification of Funding Conditions. As a condition of demonstration approval, the state certifies that the following conditions for non-federal share funding of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as

the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the state share of title XIX payments, including expenditures authorized under a section 1115 demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of the reimbursement for claimed expenditures. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

11.5. Financial Integrity for Managed Care and Other Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.

b. For non-risk-based PIHPs and PAHPs, arrangements comply with the upper payment limits specified in 42 CFR 447.362, and if payments exceed the cost of services, the state will recoup the excess and return the federal share of the excess to CMS.

11.6. Requirements for Health Care Related Taxes and Provider Donations. As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903 (w)(3)(E)(i) of the Social Security Act and 42 CFR § 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903 (w)(4) of the Social Security Act and 42 CFR 433.72.

e. All provider related-donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903 (w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

11.7. State Monitoring of Non-federal Share. If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 9.1. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

11.8. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section 12.

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability.

11.9. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit

11.10. Medicaid Expenditure Groups. Medicaid expenditure groups (MEGs) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The master MEG Chart table provides a master list of MEGs defined for this demonstration. The column titled *MEG* in the below table reflects the state's terminology for their distinct eligibility groups. The table does not include Husky B, which is the eligibility group for children enrolled in CHIP.

Table 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

Table 1: Master MEG Chart					
Husky C	Hypo 1	X		X	Aged, Blind, and Disabled
Husky D	Hypo 1	X		X	Medicaid expansion enrollees
JI Services	Hypo 2	X		X	Expenditures for pre-release services provided to qualifying beneficiaries for up to 90 days of coverage for youth correctional facilities or 60 days of coverage for jails, prisons immediately prior to release from participating facilities.
ADM	N/A				All additional administrative costs that are directly attributable to the demonstration and not described elsewhere and are not subject to budget neutrality.

11.11. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00372/1). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. To assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year

on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. Pharmacy Rebates. Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

d. Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in section 12 table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. Member Months. Using the Budget Neutrality Monitoring Tool, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 2: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date

Table 2: MEG Detail for Expenditure and Member Month Reporting								
Husky A	Children and Caretaker adults (Non-Expansion Adult Medicaid beneficiaries) diagnosed with a SUD	*See STC # 5.4*	Follow CMS 64.9 Base Category of Service Definitions	Date of service	MAP	Y	April 1, 2027	March 31, 2032
Husky C	Aged, Blind, and Disabled Medicaid beneficiaries diagnosed with a SUD	*See STC # 5.4*	Follow CMS 64.9 Base Category of Service Definitions	Date of service	MAP	Y	April 1, 2027	March 31, 2032
Husky D	Medicaid Expansion adult beneficiaries diagnosed with a SUD	*See STC # 5.4*	Follow CMS 64.9 Base Category of Service Definitions	Date of service	MAP	Y	April 1, 2027	March 31, 2032
JI Services	Report all expenditures for pre-release services provided to qualifying beneficiaries for up to 90 days of coverage for youth correctional facilities or 60 days of coverage for jails and prisons immediately prior to release from participating facilities.	*N/A*	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	April 1, 2027	March 31, 2032
ADM	Report all additional administrative costs that are directly	*N/A*	Follow standard CMS 64.10 Category of		ADM	N	April 1, 2027	March 31, 2032

Table 2: MEG Detail for Expenditure and Member Month Reporting								
	attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality		Service Definitions	Date of payment				

11.12. Demonstration Years. Demonstration years for this demonstration are defined in the Demonstration Years table below.

Table 3: Demonstration Years

Demonstration Year 6	April 1, 2027 to March 31, 2028	12 months
Demonstration Year 7	April 1, 2028 to March 31, 2029	12 months
Demonstration Year 8	April 1, 2029 to March 31, 2030	12 months
Demonstration Year 9	April 1, 2030 to March 31, 2031	12 months
Demonstration Year 10	April 1, 2031 to March 31, 2032	12 months

11.13. Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

11.14. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the

Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

11.15. Budget Neutrality Mid-Course Correction Adjustment Request. No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

11.16. Contents of Request and Process. In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 11.18. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. After acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

11.17. Types of Allowable Changes. Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

a. Provider rate increases that are anticipated to further strengthen access to care;

b. CMS or state technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

c. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

d. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

e. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

f. High-cost innovative medical treatments that states are required to cover; or,

g. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

11.18. Budget Neutrality Update. The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

a. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and

b. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

12. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

12.1. Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of one or more Hypothetical Budget Neutrality Tests, as described below. CMS' assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

12.2. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 1, Master MEG Chart and Table 2, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

12.3. Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost multiplied by the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

12.4. Main Budget Neutrality Test. This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of Hypothetical Budget Neutrality Tests. Any excess spending under the Hypothetical Budget Neutrality Tests must be returned to CMS.

12.5. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

12.6. Hypothetical Budget Neutrality Test 1: SUD Services. The table below identifies the 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.

MEG	PC or Agg*	WOW Only, WW Only, or Both	TREND	DY 6	DY 7	DY 8	DY 9	DY 10
Husky A	PC	Both	4.4%	$7,890.36	$8,237.54	$8,599.99	$8,978.39	$9,373.44
Husky C	PC	Both	4.5%	$10,227.49	$10,687.73	$11,168.68	$11,671.27	$12,196.48
Husky D	PC	Both	6.2%	$9,951.71	$10,568.72	$11,223.98	$11,919.87	$12,658.90

12.7. Hypothetical Budget Neutrality Test 2: JI Services. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. 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.

MEG	PC or Agg*	WOW Only, WW Only, or Both	TREND	DY 6	DY 7	DY 8	DY 9	DY 10
JI Services	PC	Both	7.1%	$1,900.96	$2,035.93	$2,180.48	$2,335.29	$2,501.10

12.8. Composite Federal Share. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on

Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Main or Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

12.9. Budget Neutrality Monitoring Tool and Reporting Requirements. Per 42 CFR 431.428, the state must document the financial performance of the demonstration. The state must provide quarterly budget neutrality status updates that meet all reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs (including the submission of corrected budget neutrality data upon request), using the Budget Neutrality Monitoring Tool provided through the Demonstration Evaluation Management and Oversight System (DEMOS). The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in the Monitoring Budget Neutrality for the Demonstration section. The quarterly budget neutrality status updates are due no later than 60 calendar days following the end of each demonstration quarter, while the fourth-quarter information is due no later than 90 calendar days following the end of the DY. These monitoring reports are subject to the deferral as described in STC 9.1. CMS will provide technical assistance, upon request.[5]

12.10. Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from April 1, 2027 to March 31, 2032. If at the end of the demonstration approval period the Hypothetical Budget Neutrality Test(s) has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test will be based on the time period through the termination date.

12.11. Corrective Action Plan. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

[5] Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

Table 4: Budget Neutrality Corrective Action Plan Calculations		
Demonstration Year	**Cumulative Target Definition**	**Percentage**
DY 6	Cumulative budget neutrality limit plus:	2.0 percent
DY 6 through DY 7	Cumulative budget neutrality limit plus:	1.5 percent
DY 6 through DY 8	Cumulative budget neutrality limit plus:	1.0 percent
DY 6 through DY 9	Cumulative budget neutrality limit plus:	0.5 percent
DY 6 through DY 10	Cumulative budget neutrality limit plus:	0.0 percent

13. MONITORING ALLOTMENT NEUTRALITY

13.1. Reporting Expenditures Subject to the Title XXI Allotment Neutrality Agreement. The following describes the reporting of expenditures subject to the allotment neutrality agreement for this demonstration:

a. Tracking Expenditures: In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outlined in section 2115 of the State Medicaid Manual.

b. Use of Waiver Forms: Title XXI demonstration expenditures will be reported on separate Forms designated for CHIP (i.e., Forms CMS-21 Waiver and/or CMS-21P Waiver), identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). The state must submit separate CMS-21 waiver forms for each title XXI demonstration population.

c. Premiums: Any premium contributions collected under the demonstration shall be reported to CMS on the CMS-21 Waiver form (specifically lines 1A through 1D as applicable) for each title XXI demonstration population that is subject to premiums, in order to assure that the demonstration is properly credited with the premium collections.

d. Claiming Period: All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the

state must continue to identify separately, on the Form CMS-21 Waiver, net expenditures related to dates of service during the operation of the demonstration.

13.2. Standard CHIP Funding Process. The standard CHIP funding process will be used during the demonstration. The state will continue to estimate match-able CHIP expenditures on the quarterly Form CMS-21B for CHIP. On these forms estimating expenditures for the title XXI funded demonstration populations, the state shall separately identify estimates of expenditures for each applicable title XXI demonstration population.

CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must report demonstration expenditures through Form CMS-21W and/or CMS-21P Waiver for the CHIP population. Expenditures reported on the waiver forms must be identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). CMS will reconcile expenditures reported on the CMS-21W/CMS-21P Waiver form with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

13.3. Title XXI Administrative Costs. All administrative costs (i.e., costs associated with the title XXI state plan and the title XXI funded demonstration populations identified in these STCs) are subject to the title XXI 10 percent administrative cap described in section 2105(c)(2)(A) of the Act.

13.4. Limit on Title XXI Funding. The state will be subject to a limit on the amount of federal title XXI funding that the state may receive on eligible CHIP state plan populations and the CHIP demonstration populations described in STC 16 during the demonstration period. Federal title XXI funds for the state's CHIP program (i.e., the approved title XXI state plan and the demonstration populations identified in these STCs) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with CHIP state plan populations. Demonstration expenditures are limited to remaining funds..

13.5. Exhaustion of Title XXI Funds for CHIP Population. If the state exhausts the available title XXI federal funds in a federal fiscal year during the period of the demonstration, the state must continue to provide coverage to the approved title XXI separate state plan population.

14. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION

Deliverable	Timeline	STC Reference
Reentry Demonstration Initiative Implementation	120 days after reentry demonstration approval.	STC 6.12

Plan		
Reentry Demonstration Initiative Reinvestment Plan	180 days after reentry demonstration approval.	STC 6.13
Reentry Early Implementation Rapid Cycle Report	180 days after reentry go-live.	STC 10.7
Reentry Demonstration Initiative Final Reinvestment Assessment	One year after end of demonstration period.	STC 6.13
Evaluation Design	No later than 180 calendar days after approval of the demonstration. Revised no later than 60 days after receipt of CMS comments.	STC 10.3 and 10.4
Interim Evaluation Report	One year prior to the end of the demonstration period, or when the extension application is submitted, whichever is sooner. Revised no later than 60 calendar days after receipt of CMS comments.	STC 10.8
Summative Evaluation Report	No later than 18 months after the end of the demonstration period. Revised no later than 60 calendar days after receipt of CMS comments.	STC 10.9
Annual Monitoring Report	No later than 180 calendar days after the end of each demonstration year.	STC 9.5
SUD Mid-Point Assessment	The end of the third year after approval of the demonstration.	STC 9.5 (d)
CMS-64 Quarterly Medicaid Expenditure Report	30 calendar days after the end of each quarter.	STC 11.2
Quarterly Budget Neutrality Monitoring Report	60 calendar days after the end of each demonstration quarter except the 4th quarter which is due 90 days after the end of each DY.	STC 12.9

Annual Budget Neutrality Monitoring Report	90 calendar days after the end of each demonstration year.	STC 12.9

Connecticut Department of Social Services

Implementation Plan

for

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

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

Updated March 7, 2022

OVERVIEW

This Implementation Plan is submitted in conjunction with the Connecticut Department of Social Services (DSS) submission of a substance use disorder (SUD) demonstration waiver pursuant to Section 1115 of the Social Security Act. Connecticut is committed to providing a full continuum of care for people with opioid use disorder (OUD) and other SUDs and expanding access and improving outcomes in the most cost-effective manner possible. Consistent with the state's waiver application, except as otherwise specifically provided below or as required by federal law, all references in this Implementation Plan to Medicaid also apply to the state's Children's Health Insurance Program (CHIP).

Goals:

1. Increased rates of identification, initiation and engagement in treatment for OUD and other SUDs;
2. Increased adherence to and retention in treatment for OUD and other SUDs;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where readmissions is preventable or medically inappropriate for OUD and other SUDs; and
6. Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

Milestones:

1. Access to critical levels of care for OUD and other SUDs;
2. Widespread use of evidence-based, SUD-specific patient placement criteria;
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
4. Sufficient provider capacity at each level of care, including medication assisted treatment (MAT);

5. Implementation of comprehensive treatment and prevention strategies to address opioid misuse and OUD; and
6. Improved care coordination and transitions between levels of care.

Section I – Implementation Plan Milestone Completion

This section contains information detailing Connecticut's strategies for meeting the six milestones over the course of the Demonstration. Specifically, this section:

1. Includes a summary of how, to the extent applicable, Connecticut already meets each milestone, in whole or in part, and any actions needed to meet each milestone, including the persons or entities responsible for completing actions;
2. Describes the timelines and activities that Connecticut will undertake to achieve the milestones; and
3. Provides an overview of future plans to improve beneficiary access to SUD services and promote quality and safety standards

Milestones

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;
- Medication-Assisted Treatment (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.

Below is a table that describes Connecticut's plans to meet Milestone 1, to improve access to SUD treatment services for Medicaid beneficiaries, including a variety of services at different levels of intensity across a continuum of care. This milestone will be met within 12 to 24 months of Demonstration approval.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	**Provide an overview of current SUD treatment services covered by the state in each level of care. For services currently covered in the state plan, list the benefit category and page location; for services currently covered in a Demonstration, include the program name and Special Term and Condition number.**	**Provide an overview of planned SUD treatment services to be covered by the state in each level of care: indicate whether planned services will be added to the state plan or authorized through the 1115.**	**Provide a list of action items needed to be completed to meet milestone requirements, if any. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item.**
Coverage of outpatient services	Connecticut Medicaid covers SUD outpatient treatment services under the following sections of the Medicaid State Plan[6]: • Outpatient hospital (Section 2.a of Attachment [Att.] 3.1-A, currently Att. 3.1-A Page 1 and Addendum [Add.] Page 1c to Att. 3.1-A)	Connecticut plans to submit a SUD Medicaid State Plan Amendment (SPA) updating the State's standards to be consistent with the latest edition of the American Society of Addiction	The Department of Social Services (DSS) will submit a SPA in the rehabilitative services benefit category to update the State's

[6] The CHIP State Plan substantively covers the same services listed here as covered by Medicaid, although they are reflected differently in the CHIP State Plan and EPSDT is a concept unique to federal Medicaid law that does not apply to CHIP.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	• FQHC (Section 2.c of Att. 3.1-A, currently Att. 3.1-A Page 1 and Add. Page 1d to Att. 3.1-A) • Physician services (Sec. 5 of Att. 3.1-A, currently Att. 3.1-A Page 2 and Add. Pages 2g and 3 to Att. 3.1-A) • Other licensed practitioner (OLP) Licensed Psychologist services (Sec. 6 of Att. 3.1-A, currently Att. 3.1-A Page 3 and Add. Page 4b to Att. 3.1-A) • OLP Licensed Clinical Social Worker services (Sec. 6 of Att. 3.1-A, currently Att. 3.1-A Page 3 and Add. Page 4d to Att. 3.1-A) • OLP Licensed Marital and Family Therapists services (Sec. 6 of Att. 3.1-A, currently Att. 3.1-A Page 3 and Add. Pages 4d and 4d(i) to Att. 3.1-A) • OLP Licensed Professional Counselor Services (Sec. 6 of Att. 3.1-A, currently Att. 3.1-A Page 3 and Add. Page 4e to Att. 3.1-A) • OLP Licensed Alcohol and Drug Counselor Services (Sec. 6 of Att. 3.1-A, currently Att. 3.1-A Page 3 and Add. Page 4e to Att. 3.1-A) • OLP Nurse Practitioner Services, Certified Pediatric Nurse Practitioner Services, and Family Nurse Practitioner Services (Secs. 6 and 23 of Att. 3.1-A, currently Att. 3.1-A Page 3 and Add. Pages 4c and 14 to Att. 3.1-A)	Medicine (ASAM).	standards to be consistent with the latest edition of ASAM no later than 12 months following Centers for Medicare and Medicaid Services (CMS) approval of the Demonstration (by April 1, 2023).

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	• OLP Physician Assistants (Sec. 6 of Att. 3.1-A, currently Att. 3.1-A Page 3 and Add Page 4f to Att. 3.1-A) • Clinic Free-standing clinic services (non-FQHC) Methadone Clinics or Chemical Maintenance Clinics (Sec. 9 of Att. 3.1-A, currently Att. 3.1-A Page 4 and Add. Page 7 to Att. 3.1-A) • Rehabilitation Services Pursuant to EPSDT – Office-based off-site rehabilitation services (Sec. 13.d of Att. 3.1-A, currently Att. 3.1-A Page 6 and Supplement Page 2b to Add. Page 12 to Att. 3.1-A)		
Coverage of intensive outpatient services	Connecticut Medicaid covers SUD intensive outpatient treatment services, including partial hospitalization, under the following sections of the State Plan: • Outpatient hospital (Section 2.a of Attachment [Att.] 3.1-A, currently Att. 3.1-A Page 1 and Add. Page 1c to Att. 3.1-A • FQHC (Section 2.c of Att. 3.1-A, currently Att. 3.1-A Page 1 and Add. Page 1d to Att. 3.1-A) • Clinic Free-standing clinic services (non-FQHC) Behavioral Health Clinics/Mental Health and Substance Abuse Clinics (Sec. 9 of Att. 3.1-A,	Connecticut plans to submit a SUD SPA updating the State's standards to be consistent with the latest edition of ASAM.	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).

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	currently Att. 3.1-A Page 4 and Add. Page 7 to Att. 3.1-A)		
Coverage of MAT (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the State)	Connecticut Medicaid covers MAT (for non-OUD and OUD) and associated counseling/services under the following sections of the State Plan: • Physician services (Sec. 5 of Att. 3.1-A, currently Att. 3.1-A Page 2 and Add. Pages 2g and 3 to Att. 3.1-A) • Clinic Free-standing clinic services (non-FQHC) Behavioral Health Clinics/Mental Health and Substance Abuse Clinics (Sec. 9 of Att. 3.1-A, currently Att. 3.1-A Page 4 and Add. Page 7e to Att. 3.1-A) • Clinic Free-standing clinic services (non-FQHC) Methadone Clinics or Chemical Maintenance Clinics (Sec. 9 of Att. 3.1-A, currently Att. 3.1-A Page 4 and Add. Page 7g to Att. 3.1-A) • Medication-Assisted Treatment (MAT) 1905(a)(29)	Connecticut plans to submit a SUD SPA updating the State's standards to be consistent with the latest edition of ASAM.	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).

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Coverage of intensive levels of care in residential and inpatient settings	Connecticut Medicaid does not cover residential SUD in a non-hospital setting. Connecticut Medicaid covers the following inpatient SUD treatment: • Inpatient hospital services (Sec. 1 of Att. 3.1-A, currently Att. 3.1-A Page 1 and Add. Pages 1a and 1b to Att. 3.1-A) • Inpatient hospital for individuals age 65 or older in institutions for mental diseases (Sec. 14 of Att. 3.1-A, currently Att. 3.1-A page 6) • Inpatient psychiatric facility services for individuals under 22 years of age (Sec. 16 of Att. 3.1-A, currently Att. 3.1-A page 7) Connecticut reimburses providers outside of the Medicaid program using a Substance Abuse Prevention and Treatment (SAPT) block grant and State funds for residential programs.	Connecticut plans to submit a SUD SPA updating the State's standards to be consistent with the latest edition of ASAM and including residential SUD treatment for children and adults. Connecticut will reimburse SUD residential providers for children and adults in the Medicaid program in non-IMDs with the effective date of the SPA and for IMDs with the effective date of the 1115 Demonstration and SPA	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).
Coverage of medically supervised withdrawal management	Connecticut Medicaid does not cover medically supervised withdrawal management in a non-hospital setting. Connecticut Medicaid covers the following detoxification: • Inpatient detoxification in a general hospital setting (Inpatient hospital Services, Sec. 1 of Att. 3.1-A, currently Att. 3.1-A Page 1 and Add. Page 1a to Att. 3.1-A)	Connecticut plans to submit a SUD SPA updating the State's standards to be consistent with the latest edition of ASAM and including coverage of medically supervised withdrawal management in a non-hospital setting.	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

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	Connecticut Medicaid covers limited ambulatory detoxification under the following authorities: • Outpatient hospital (Sec. 2 of Att. 3.1-A, currently Att. 3.1-A Page 1 and Add. Page 1c to Att. 3.1-A) • Clinic Free-standing clinic services (non-FQHC) e. Behavioral Health Clinics/Mental Health and Substance Abuse Clinics (Sec. 9 of Att. 3.1-A, currently Att. 3.1-A Page 4 and Add. Page 7 to Att. 3.1-A) • Clinic Free-standing clinic services (non-FQHC) g. Methadone Clinics or Chemical Maintenance Clinics (Sec. 9 of Att. 3.1-A, currently Att. 3.1-A Page 4 and Add. Page 47 to Att. 3.1-A)	Connecticut reimburses providers outside of the Medicaid program using SAPT block grant and State funds for detoxification programs.	withdrawal management in a non-hospital setting no later than 12 months following CMS approval of the Demonstration (by April 1, 2023).

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; and
- Utilization management approaches are implemented to ensure that
  (a) beneficiaries have access to SUD services at the appropriate level of care,
  (b) interventions are appropriate for the diagnosis and level of care, and
  (c) there is an independent process for reviewing placement in residential treatment settings.

Below, Connecticut identifies its plan to increase the use of ASAM's evidence-based, SUD-specific placement criteria to provide treatment that reflects diverse patient needs and evidence-based clinical guidelines. This table includes current and intended actions and associated timelines needed to meet Milestone 2 (*Use of evidence-based, SUD-specific patient placement criteria)*. This milestone will be met within 12-24 months of Demonstration approval.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	Provide an overview of current state use of evidence-based, SUD-specific patient placement criteria and utilization management approach to ensure placement in appropriate level of care and receipt of services recommended for that level of care	Provide an overview of planned state implementation of requirement that providers use an evidence-based, SUD-specific patient placement criteria and use of utilization management to ensure placement in appropriate level of care and	Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item

Milestone Criteria	Current State	Future State	Summary of Actions Needed
		receipt of services recommended for that level of care.	
Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines	Connecticut providers are not required to utilize assessments that are directly tied to the ASAM criteria for treatment planning. DCF has cross-walked the GAIN (the current children's tool) to the ASAM placement criteria for children's assessment and treatment planning.	Connecticut will develop a universal training program for providers to assess treatment needs based on ASAM's multi-dimensional tools (or a tool cross-walked to ASAM criteria such as the GAIN for children) and to base treatment needs on those assessments. Connecticut will require all Medicaid SUD providers to sign an addendum to the Medicaid provider enrollment agreement that includes requirements for level of care (LOC) assessments using ASAM's most recent edition, consistent with provider training.	Department of Mental Health and Addiction (DMHAS)/Department of Children and Families (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 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

Milestone Criteria	Current State	Future State	Summary of Actions Needed
			recent ASAM edition patient placement criteria and program standards. 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.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of a utilization management approach such that (a) **beneficiaries have access to SUD services at the appropriate level of care**	Although Connecticut Medicaid's current behavioral health (BH) administrative services organization (ASO), which performs utilization management for all Medicaid BH services, including SUD services, internally uses the latest edition of ASAM patient placement criteria, the State's website is not consistent with that criteria. The state's non-Medicaid BH ASO, which reviews residential placements, utilizes an older version of the ASAM placement criteria.	Connecticut will ensure that program standards are set for beneficiaries to have access to SUD services at the appropriate LOC based on the six ASAM dimensions of care. Connecticut will update contract language (BH ASO) to reflect requirements for utilization management using ASAM's most recent edition language consistent with provider training. Connecticut will use the most recent ASAM edition for utilization review. All website, provider information and internal documentation will be consistent with the latest ASAM edition.	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 1, 2023). 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).
Implementation of a	Today, the State BH ASO utilizes the ASAM	Connecticut will develop	DMHAS/DCF have statutory

Milestone Criteria	Current State	Future State	Summary of Actions Needed
utilization management approach such that (b) **interventions are appropriate for the diagnosis and level of care**	third edition (which is the latest edition) to review utilization for ambulatory care and inpatient hospital care. However, the ASO for residential care, which is outside of the Medicaid system, utilizes an earlier version of ASAM for utilization review. State websites do not consistently refer to the latest versions of ASAM for determining that interventions are appropriate for the diagnosis and level of care.	program standards to ensure that providers' interventions are appropriate for the diagnosis and each ASAM LOC. All Medicaid websites, criteria, manuals, and provider standards will consistently refer to the latest ASAM edition.	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 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

Milestone Criteria	Current State	Future State	Summary of Actions Needed
			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 April 1, 2024.
Implementation of a utilization management approach such that (c) **there is an independent process for reviewing placement in residential**	The current Medicaid BH ASO already uses the most recent ASAM edition for inpatient utilization review. DMHAS' ASO for the non-Medicaid Behavioral Health Recovery Program (BHRP) uses an older edition of ASAM to review placements in non-hospital residential treatment settings. The residential placement criteria currently in use can be found at the following link: http://www.abhct.com/Customer-	Connecticut will use the most recent ASAM edition for utilization review of Medicaid inpatient and residential placements. All website, provider information and internal documentation will be consistent with the latest ASAM edition.	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

Milestone Criteria	Current State	Future State	Summary of Actions Needed
treatment settings	Content/WWW/CMS/files/BHRP-clinical/ABH_Clinical_Level_of_Care_Guidelines_2015.pdf	Connecticut will update contract language (BH ASO and addendum to the Medicaid provider enrollment agreement) to reflect requirements for utilization management and LOC assessments using the language in the most recent ASAM edition, consistent with provider training.	approval by April 1, 2024.

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 (FFP) for a continuum of SUD services, including services provided to Medicaid enrollees residing in residential treatment facilities that qualify as institutions for mental diseases (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 Administrative Services Organization 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; and
- Implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off site.

Below, Connecticut has outlined how it will incorporate nationally recognized, SUD-specific ASAM program standards into their provider qualifications for residential treatment facilities through their policy manuals and other guidance to meet Milestone 3 (*Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities)*. This milestone will be met within 24 months of Demonstration approval.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	Provide an overview of current provider qualifications for residential treatment facilities and how these compare to nationally recognized SUD-specific program standards, e.g., the ASAM Criteria	Provide an overview of planned use of nationally recognized SUD-specific program standards in improving provider qualifications for residential treatment facilities.	Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for

Milestone Criteria	Current State	Future State	Summary of Actions Needed
			completion of each action item
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**	Connecticut Medicaid does not currently reimburse for SUD residential treatment for adults. Residential treatment is reimbursed by non-Medicaid SAPT block grant and State funds and includes ASAM 3.1, ASAM 3.5, ASAM 3.7 and ASAM 3.7D using the second edition of ASAM. The current standards can be found in Section 3 of the manual at the following linked website: http://www.abhct.com/Customer-Content/WWW/CMS/files/BHRP_Provider_Manual_2013.pdf Medicaid SUD treatment for children is reimbursed under EPSDT and roughly corresponds to an ASAM 3.5 LOC.	Connecticut plans to submit a SUD SPA updating the State's standards to be consistent with the latest edition of ASAM and including residential SUD treatment. Connecticut is currently conducting a public process for stakeholders to provide feedback on the types of services, hours of clinical care, and credentials of staff for residential treatment settings that will be Implemented under the Medicaid State Plan.	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 Criteria	Current State	Future State	Summary of Actions Needed
staff for residential treatment settings			Milestone 2 (no later than 24 months after Demonstration approval or by April 1, 2024).
Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards	Currently SUD residential treatment providers are not enrolled in the Connecticut Medicaid program. All SUD residential providers are licensed by the Connecticut Department of Public Health (DPH). In addition: (1) SUD residential providers for children must also be licensed by DCF; and (2) SUD residential providers for adults that participate in BHRP must also be reviewed by DMHAS non-Medicaid BHRP ASO using criteria from the second edition of ASAM.	DMHAS/DCF have statutory authority for SUD service 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, 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

Milestone Criteria	Current State	Future State	Summary of Actions Needed
			recertification (by April 1, 2024).
Implementation of requirement that residential treatment facilities offer MAT onsite or facilitate access off-site	Connecticut already has in place a requirement that residential treatment facilities offer multiple versions of MAT on-site or facilitate access off-site. All but one residential treatment provider already offers multiple versions of MAT on-site or facilitates access off-site. The one facility in question does not accept residents receiving methadone, but accepts placement of residents using Buprenorphine. The State has provided education to this facility and it will be accepting methadone residents in the future consistent with ASAM criteria and the Demonstration requirements.	None needed – Connecticut currently meets criteria.	None needed – Connecticut currently meets criteria.

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 develop plans for enhancement of capacity based on assessments of provider availability

The table below summarizes the current and future actions, including associated timelines, to meet Milestone 4 (*Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment)*. 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.*

The anticipated penetration rate and geographic distributions of providers at each LOC is noted where available.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	Provide an overview of current provider capacities throughout the state to provide SUD treatment at each of the critical levels of care listed in Milestone 1.	Provide an overview of planned improvements to provider availability and capacity intended to improve Medicaid beneficiary access to treatment throughout the State at each of the critical levels of care listed in Milestone 1.	Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item

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; Medication Assisted Treatment (medications as well as counseling	For non-residential levels of care, the state's behavioral health ASO currently tracks ambulatory/outpatient providers level of care and capacity. Except for situations such as fixed prescribing limits, the ASO does not otherwise track specific slots for open-access ambulatory levels of care. In the report entitled "*Connecticut Opioid and Other Substance Use Disorder Treatment and Recovery Service Capacity and Infrastructure Planning Support Act Semiannual Report*," dated September 30, 2020, Connecticut reported on the capacity of the Medicaid SUD system. As a fee-for-service system, Connecticut Medicaid's provider network consists of direct service Medicaid providers who are each enrolled with DSS. Based on data from the State's September 2020 capacity report, in total, 7,824 providers delivered services to members with SUD during dates of service from October 1, 2019 through December 31, 2019. The majority (4,014) were providing physician services, while significant numbers were also providing outpatient hospital services including ED services (2,528 providers), inpatient services (1,560 providers), and prescription drugs (1,091	Connecticut will examine the potential to enhance access monitoring reporting under the Demonstration. This initiative will leverage the DMHAS bed monitoring and the BH ASO bed monitoring for ongoing access monitoring and recruitment and enrollment of new facilities.	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).

and other services); Intensive Care in Residential and Inpatient Settings; Medically Supervised Withdrawal Management.	prescribers of medications related to SUD, including MAT for OUD and AUD). MAT Providers Since different data sources were used to determine providers for prescription drugs (pharmacy claims) and all other service categories (medical and behavioral health claims), there is substantial overlap between the providers listed in the “prescription drugs” category and the “other” service categories. The total number of State MAT providers during dates of service from October 1, 2019 through December 31, 2019 was 711; of which, 704 appeared as prescribers of MAT in the pharmacy claims data. For other service categories, providers appeared on medical and behavioral health claims largely for distributing methadone and, to a smaller extent, non-pharmaceutical buprenorphine (i.e. injectable). The service categories with the most MAT providers, other than prescription drugs, were physician services (162), outpatient hospital services including ED services (157), clinic services (146), and home health services (129).		

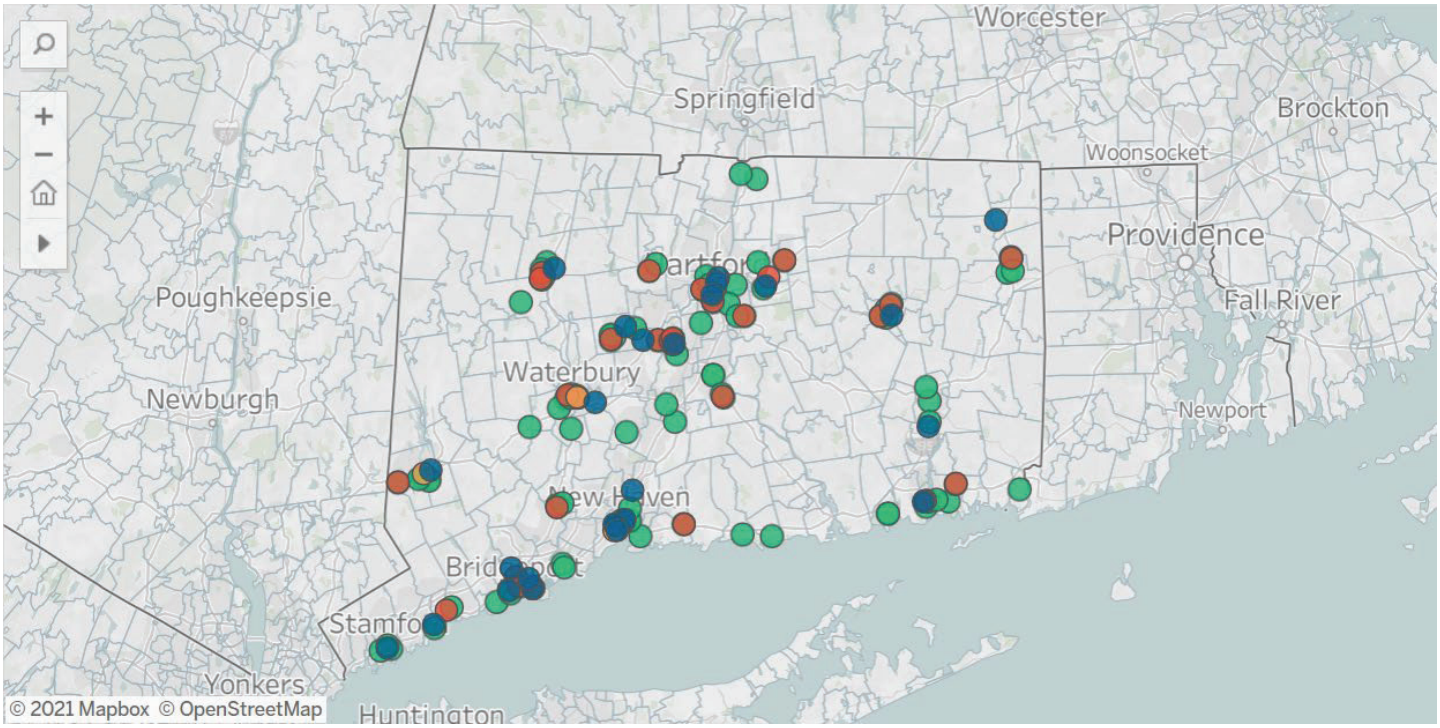
	Overall, 42,322 members with SUD received care in at least one of the service categories outlined in the guidelines. The largest number of members with SUD (23,058) received care at a clinic, which includes FQHCs and methadone clinics. Many members also received physician services (14,525) and outpatient hospital services, including ED services (10,718). DMHAS maintains a real-time website listing the open residential and inpatient SUD treatment beds for the public and providers at https://www.ctaddictionservices.com/. This current online capacity system is working with real-time access. DMHAS' BHRP ASO also maintains residential data that tracks utilization and sends weekly updates (by provider by LOC by site) – on average capacity and bed count. This information calculates the rolling average capacity by fiscal year and is provided to		

	DMHAS weekly. DDaP is the DMHAS data warehouse and is used to analyze actual utilization data. The DMHAS Evaluation Quality Metrics Improvement Division manages DDaP data. The Medicaid BH ASO maintains a search capacity for outpatient SUD treatment availability including an accessibility map for MAT. That search capacity and map can be found at the following link: https://public.tableau.com/views/CTBHPMedicaidMATProviderMap/TreatmentProviders?:embed=y&:display_count=yes&:showVizHome=no The Medicaid BH ASO SUD accessibility maps (current as of 6/16/2021) can be found below this chart. At this time, the search capacity and maps do not include an indicator of which providers are accepting new patients and must be used in combination with the DMHAS website.		

Sample Connecticut Medicaid BH ASO accessibility maps and search function (current as of June 16, 2021) – Search for a Behavioral Health Medicaid provider offering MAT services by name, city, or medication ([http://www.ctbhp.com/medication-assisted-treatment.html)](http://www.ctbhp.com/medication-assisted-treatment.html)

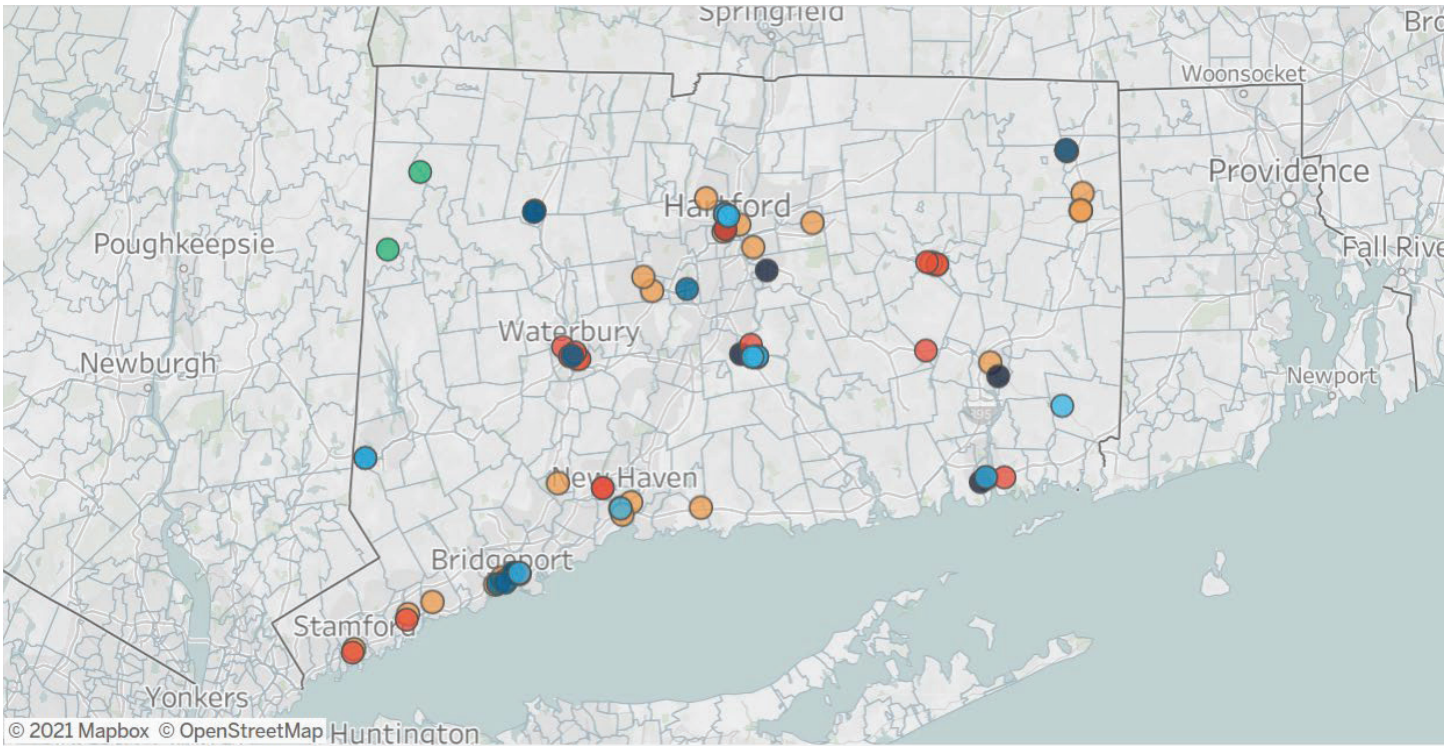
Select to Highlight (dots may be overlaid)

- Methadone Clinic
- Partial Hospital/IOP with Housing
- Intensive Outpatient (IOP)
- Behavioral Health Outpatient
- Partial Hospitalization (PHP)



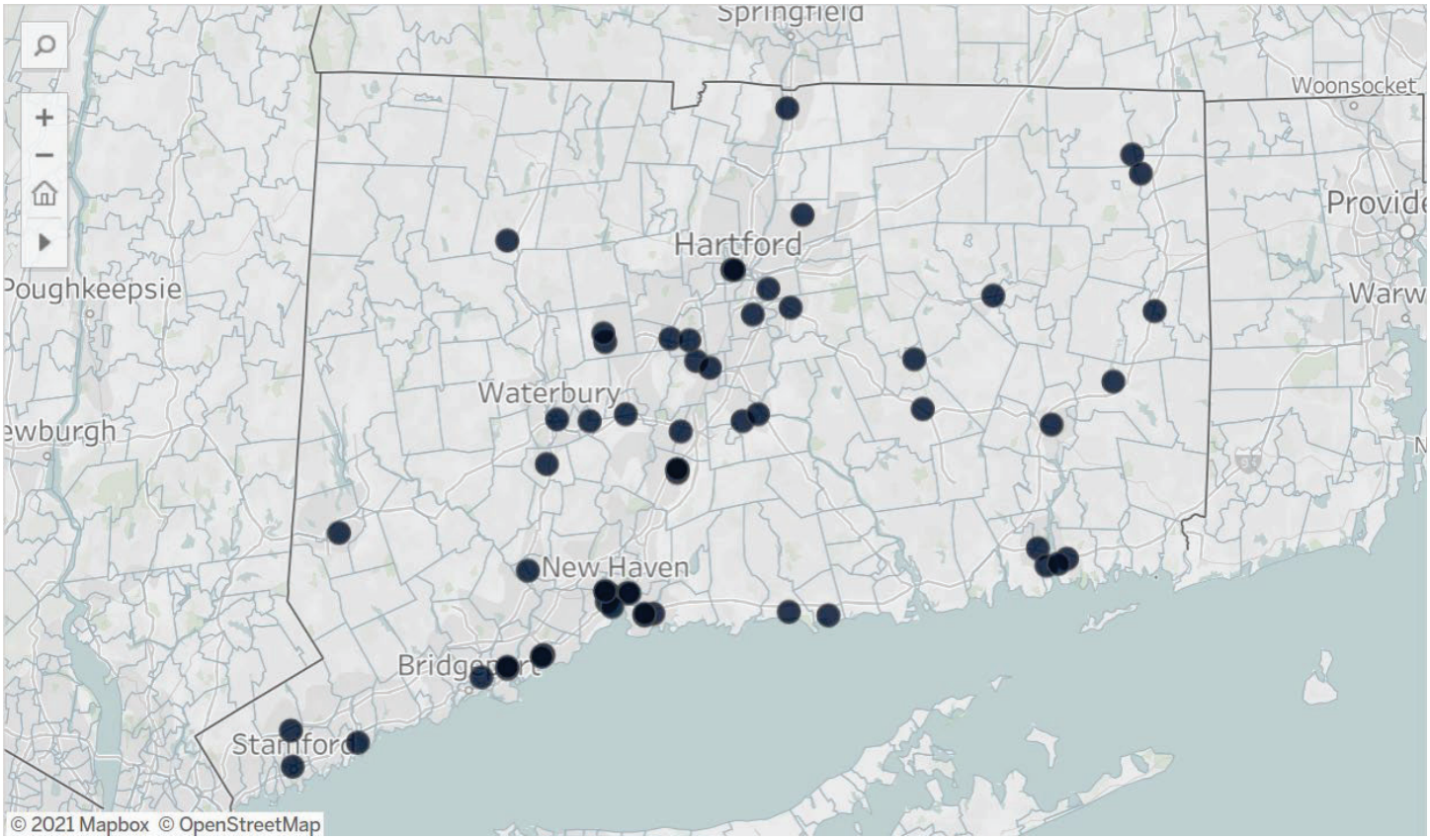
Search for other treatment services that support substance use recovery
Select to Highlight

- Freestanding or State Hospital Detoxification
- SA 3.7 - Intensive Residential Co-Occurring (30 to 45 days)
- SA 3.7 - Intensive Residential (14 to 28 days)
- SA 3.5 - Women's & Children's Programs (3 to 6 Months)
- SA 3.5 - Intermediate Treatment (1 to 3 Months)
- SA 3.3 - Long-Term Care (4 to 6 Months)
- SA 3.1R - Halfway House (3 to 4 months)
- Walk-In Access Center



Medical data is provided and maintained with accuracy/integrity under the responsibility of the Medical ASO

Search for a MEDICAL Medicaid provider offering MAT services.



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 IT infrastructure to improve its prescription drug monitoring program (PDMP).

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	Provide an overview of current treatment and prevention strategies to reduce opioid abuse and OUD in the state.	Provide an overview of planned strategies to prevent and treat opioid abuse and OUD.	Specify a list of action items needed to be completed to meet milestone requirements as detailed above. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item
Implementation of opioid prescribing guidelines along	To address the opioid and prescription medication crisis, DPH has implemented prescribing guidelines to prevent opioid	None needed – Connecticut currently meets criteria.	None needed – Connecticut currently meets criteria.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
with other interventions to prevent opioid abuse	over-use through a number of updates to Connecticut policy and law regulating the prescribing of controlled substances and opioid medications.[7] Connecticut has also collaborated with other State agencies, legislators, and various professional groups to improve the Connecticut Prescription Monitoring and Reporting System (CPMRS) – the State's PDMP. Effective October 1, 2019, Connecticut amended the Medicaid State Plan to reflect new drug utilization review provisions required in federal law (Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act [SUPPORT Act; P.L. 115-271]). These provisions are designed to reduce opioid-related overprescribing and abuse. The required provisions include the following: 136 separate opioid		

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

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	prescription claim reviews at the point of sale as well as retrospective reviews, monitoring and management of antipsychotic medication in children, and identification of processes to detect fraud and abuse. See a more complete listing below this chart.		
Expanded coverage of, and access to, naloxone for overdose reversal	Connecticut has taken a number of steps over the past eight years to make naloxone more widely available. State legislation was first introduced in 2011 in the State's General Assembly and some of the subsequent legislative sessions included new state legislation that has made naloxone more accessible over the years. A "Good Samaritan" law passed in 2011 protects people, who call 911 seeking emergency medical services for an overdose, from arrest for possession of drugs/paraphernalia. Legislation enacted in 2012, which allowed prescribers (physicians, surgeons, physician assistants, advanced practice registered nurses, dentists, and podiatrists) to prescribe, dispense, or administer naloxone to any	None needed – Connecticut currently meets criteria.	None needed – Connecticut currently meets criteria.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	person to prevent or treat a drug overdose, protects the prescriber from civil liability and criminal prosecution. Protection from civil liability and criminal prosecution was extended to the person administering the naloxone in response to an overdose in 2014. Legislation enacted in 2015 allows pharmacists, who have been trained and certified, to prescribe and dispense naloxone directly to customers requesting it. Most recently, another State law (Public Act 18-166) allows prescribers to develop agreements with organizations wishing to train and distribute naloxone. This legislation established new reporting requirements, established a framework for expanding distribution and availability of naloxone, enacted limitations on prescribing controlled substances, and commissioned a feasibility study for opioid intervention courts. All of these changes have supported efforts to make naloxone widely available. In addition, Connecticut has established other initiatives addressing OUD, including expanding availability of		

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	naloxone as outlined in the State's Implementation Plan due to receipt of federal grant funds. Additional opportunities to expand naloxone availability to the public have been met through the federal State Opioid Response grant. A total of 12,000 naloxone kits were made available for distribution in FY 2019 through DMHAS, the Department of Correction, DPH, the Connecticut Hospital Association, and the Regional Behavioral Health Action Organizations.		
Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs	Connecticut first mandated use of the CPMRS, the State's PDMP, by prescribers in 2015, with additional provisions added in 2016. CPMRS is a tool to track the dispensing of controlled prescription drugs to patients. CPMRS is designed to monitor information for suspected misuse or diversion (i.e., channeling drugs into illegal use), and can give a prescriber or pharmacist critical information regarding a patient's controlled substance prescription history. This information has helped prescribers and pharmacists identify high-risk	As of the submission of the Medicaid Implementation Advanced Planning Document (IAPD) in 2019, 31,124 practitioners have controlled substance registrations, with some practitioners having more than one registration. CPMRS data have been integrated with 6,868 EHRs, including three major health systems. This initiative will allow the State to meet the following objectives:	See Attachment A

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	patients who would benefit from early interventions. Since implementation, the use of CPMRS has grown. In 2018, CPMRS reported 1.9 million annual requests from law enforcement, pharmacists, and prescribers. This is nearly double the annual law enforcement, pharmacist, and prescriber requests from 2015 when there were one million requests. CPMRS has also documented a drop in Schedules IV and V controlled substances over time. Consistent with the overall data, the number of Medicaid-reimbursed opioid prescriptions have dropped, as well as Medicaid's percentage of payments for opioids dispensed. Public Act 15-198 mandated that practitioners review a patient's controlled substance prescription history prior to prescribing controlled substances. The	• Further reduce the number of individuals who "doctor shop;" • Provide health care providers critical information regarding a patient's controlled substance prescription history and expand the availability of other data sources to support clinical decision making; • Support clinician interventions for patients exhibiting high-risk behaviors; and • Assist providers in achieving the medication reconciliation meaningful use objective and measure.[8] An additional goal of this integration initiative is to explore providing as many avenues as possible for an authorized health care provider to access the CPMRS, including integrated	

[8] Stage 3 of meaningful use consolidates medication reconciliation into the HIE objective. The objective requires that eligible professionals provide a summary of the care record when transitioning or referring a patient to another setting of care, receive or retrieve a summary of care record upon the receipt of a transition or referral or upon the first encounter with a new patient, and incorporate summary of care information from other providers into their EHR using the functions of Certified EHR Technology. Providers must attest to all three measures and must meet the threshold for at least two measures to meet the objective.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	law also mandated that pharmacists report controlled substance dispensing on a daily basis. Connecticut also plans to continue to leverage opportunities described in State Medicaid Director Letter (SMDL) 16-003 to help professionals and hospitals eligible for the Medicaid Promoting Interoperability Program, formerly known as the Medicaid Electronic Health Record (EHR) Incentive Program connect to other Medicaid providers through the integration of CPMRS into EHRs and pharmacy dispensing systems. All hospitals and pharmacies now have the ability to have CPMRS integrated into their EHRs and pharmacy management systems.	access through Health Information Exchanges (HIEs).	

Connecticut Laws Impacting Prescribing and Practice

RODRICK MARRIOTT, PharmD, Director, Department of Consumer Protection, Drug Control Division

There have been a number of updates to Connecticut law in past years that have an impact on the prescribing community, especially in regards to controlled substances and opioid medications. All of the changes have been small steps to help combat the opioid and prescription medication crisis. The changes for practitioners were made keeping in mind the effect they may have on their day to day work.

We have worked with sister agencies, legislators, and different professional groups to ensure we're taking thoughtful steps forward, and improving the Connecticut Prescription Monitoring and Reporting System (CPMRS), sometimes known as the Prescription Drug Monitoring Program (PDMP). Here are some of the changes:

2015



- Physicians are required to take continuing education courses in risk management, in controlled substance prescribing, and pain management.
- Prescribers are required to review a patient's record on the CPMRS before prescribing any schedule II-V controlled substance meant to last more than 72 hours.
- Physicians must review patient records once every 90 days for a controlled substance prescription meant for on-going treatment.



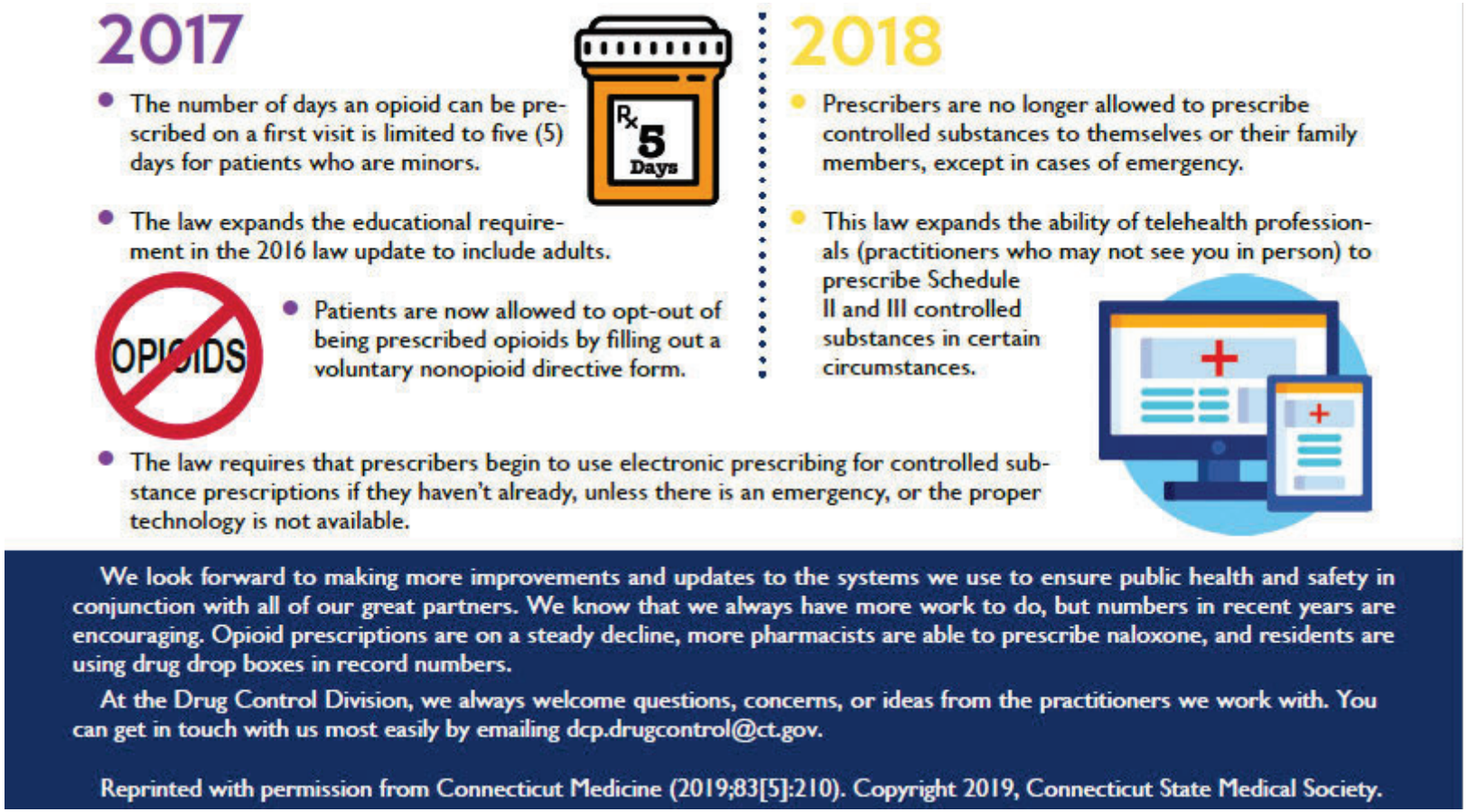
2016

- In a major change, the law mandates a 7-day supply limit on opioid prescriptions for first time outpatient use. The law maintains professional judgment of the prescribing practitioner to prescribe more than a 7-day supply for on-going use when needed.





- The law requires education for patients under 18 and their guardian regarding the risks of addiction and overdose associated with opioids, and the dangers of combining them with alcohol, benzodiazepines, and other depressants. Patients should also understand the reason for the prescription.
- Also in 2016, practitioners were allowed to delegate an authorized agent to search the CPMRS.
- Under this law, patient records now only need to be reviewed once per year for on-going prescriptions that are Schedule V controlled substances. All other schedules remain at the 90-day level.



https://portal.ct.gov/-/media/DCP/drug_control/PMP/Educational-Materials/Prescribing-Laws-2019-CM.pdf?la=en

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 to 24 months of Demonstration approval.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities.	Provide an overview of current care coordination services and transition services across levels of care.	Provide an overview of planned improvements to care coordination services and transition services across levels of care	Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Additional policies to ensure coordination of care for co-occurring physical and mental health conditions	Connecticut has multiple interventions for coordinating the care of individuals with SUD and transitioning them between LOCs, including, but not limited to, facility credentialing, discharge planning requirements, and care management initiatives at DSS, DCF and DMHAS. These include, but are not limited to: • Discharge planning; • Referral and transition requirements; and • Cross-departmental care management initiatives. Current care coordination/case management interventions include: 1. Medicaid targeted case management (TCM) for individuals with serious and chronic mental illness inclusive of individuals with SUD and co-occurring mental illness. 2. Medicaid behavioral health homes pursuant to section 1945 of the Social Security Act. 3. Non-Medicaid DMHAS intensive case management (regions 1, 2, 4 and 5) for HUSKY D Medicaid beneficiaries. Case management support priority is given to	Under the Demonstration, DSS, DCF and DMHAS will create a clear delineation of responsibility for improved coordination and transitions between LOCs to ensure that individuals receive services and supports following stays in facilities and are retained in care; this includes efforts to align activities between DSS, DCF and DMHAS.	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.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	those with a recent inpatient treatment for BH disorders with a focus on SUD diagnoses. Specific care management initiatives include an opioid antagonist treatment protocol. The model also utilizes a recovery specialist who works with the individual in the community to assist them in moving through the recovery continuum. 4. Non-Medicaid DMHAS Region 3 intensive case management under the Eastern Region Service Center (ERSC). This collaborative effort between MH and SUD agencies offers person-centered care and develops recovery plans with the consumer to facilitate employment, independent living, housing, and use of social, 12 step and other community supports. 5. Medicaid Person-Centered Medical Home Plus (PCMH+) benefit. This Medicaid State Plan benefit is an integrated care program under section 1905(a)(30) of the Social Security Act that includes primary care case management services (PCCM) as defined in section 1905(t) and offers enhanced care coordination activities in several key areas, including integrating primary care and BH care, and promoting linkages to community supports, services and natural support		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 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 TCM SPA can be expanded to include SUD-only (i.e., TCM co-occurring

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	systems. PCMH+ provider performance is measured using various quality measures and providers are encouraged to facilitate improvement in transitions of care. 6. Connecticut Behavioral Health Partnership Intensive Care Management (ICM) by the Medicaid program's BH ASO, which is a Medicaid administrative service. 7. Intensive Care Coordination (ICC) for children in Child Welfare (CW) and non-system-involved children by DCF's contractor. This Integrated Family Care and Support (IFCS) model engages families and connects them to traditional and non-traditional resources and services in their community. The model also includes a peer specialist and service delivery is coordinated through family team meetings (eight care coordinators who can serve CW families and psychiatric residential treatment facility transitions directly [staff ratio 1:8-10]). 8. State-funded, non-Medicaid routine care coordination for children (10 providers including 75 care coordinators) – wraparound process (staff ratio 1:10-12), provided by DCF and its contractor.		SUD versus SUD-only) by April 1, 2023.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	9. Intensive family care including case management by DCF and its contractor (unsubstantiated families at risk [staff ratio 1:20-25}) 10. Intensive Care Management (ICM) by the Medicaid program's medical ASO, which is a Medicaid administrative service. This program includes outreach to providers as well as direct member engagement. Primary care providers are notified when patients are filling high-dose opioid prescriptions and are provided an opioid utilization report. The ICM team conducts monthly outreach to members attributed to non-PCMH practices who have filled high-dose opioid prescriptions. Members are offered MAT or other SUD treatment. The model also uses community health workers if community resource needs are identified.		

Section II – Implementation Plan Administration

Please provide the contact information for the state's point of contact for the Implementation plan.

Name and Title: William Halsey, Director of Integrated Care, Division of Health Services, Department of Social Services
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Section III – Implementation Plan Relevant Documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.

Attachment A: Template for Substance Use Disorder Health Information Technology Plan

Attachment A Section I.

As a component of Milestone 5, Implementation of Strategies to Increase Utilization and Improve Functionality of PDMPs, in SMDL 17-003, states with approved Section 1115 Substance Use Disorder (SUD) demonstrations are generally required to submit a SUD Health Information Technology (IT) Plan as described in the Special Terms and Conditions (STCs) for these demonstrations within 90 days of demonstration approval. The SUD Health IT Plan will be a section within the state's SUD Implementation Plan Protocol and, as such, the state may not claim federal financial participation for services provided in Institute for Mental Disease until the SUD Health IT Plan has been approved by CMS.

In the event that the state believes it has already made sufficient progress with regards to the health IT programmatic goals described in the STCs (i.e., PDMP functionalities, PDMP query capabilities, supporting prescribing clinicians with using and checking the PDMPs, and master patient index and identity management), it must provide an assurance to that effect via the assessment and plan below (see Table 1, "Current State").

SUD Demonstration Milestone 5.0, Specification 3: Implementation of Strategies to Increase Utilization and Improve Functionality of PDMP.

The specific milestones to be achieved by developing and implementing a SUD Health IT Plan include:

- Enhancing the health IT functionality to support PDMP interoperability.
- Enhancing and/or supporting clinicians in their usage of the State's PDMP.

The State should provide CMS with an analysis of the current status of its health IT infrastructure/"ecosystem" to assess its readiness to support PDMP interoperability. Once completed, the analysis will serve as the basis for the health IT functionalities to be addressed over the course of the demonstration — or the assurance described above.

The SUD Health IT Plan should detail the current and planned future state for each functionality/capability/support — and specific actions and a timeline to be completed over the course of the demonstration — to address needed enhancements. In addition to completing the summary table below, the State may provide additional information for each Health IT/PDMP milestone criteria to further describe its plan.

Table 1. State Health IT/PDMP Assessment and Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
5. Implementation of comprehensive treatment and prevention strategies to address Opioid Abuse and Opioid Use Disorder, that is: • Enhance the State's health IT functionality to support its PDMP. • Enhance and/or support clinicians in their usage of the State's PDMP.	Provide an overview of current PDMP capabilities, health IT functionalities to support the PDMP and supports to enhance clinicians' use of the state's health IT functionality to achieve the goals of the PDMP.	Provide an overview of plans for enhancing the State's PDMP, related enhancements to its health IT functionalities and related enhancements to support clinicians' use of the health IT functionality to achieve the goals of the PDMP.	Specify a list of action items needed to be completed to meet the Health Information Technology (HIT)/PDMP milestones identified in the first column. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item
PDMP Functionalities			
Enhanced interstate data sharing in order to better track patient specific prescription data	Connecticut's PDMP, the Connecticut Prescription Monitoring and Reporting System (CPMRS), participates in Prescription Monitoring Program Interconnect (PMPI). The system allows a user to search PDMPs in other states.	Connecticut will continue to grant access to PDMP users from other states via the PMPi platform. This will depend on each state's ability to share data. Connecticut will continue to explore expanding connectivity to states not currently exchanging with CPMRS, will participate in NESCSO SUPPORT Act planning process. Connecticut has begun	As data sharing is dependent on other states (including necessary changes to state law), there are no specific actions that can be listed here.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	Currently there are 45 active and pending participants. Figure 1 illustrates that Connecticut has activated interstate data sharing with 40 states, in addition to Puerto Rico and Washington D.C., and includes all states bordering Connecticut and the northeast region. The CPMRS has not connected with all participants due to several factors, with the most common barrier being: • A state is focusing on connecting with their border states first. • A state is currently transitioning to a new PDMP system. • A state has prioritized other PDMP projects over interstate connectivity.	to use RxCheck hub to support interstate exchanges. Connecticut would like to continue to increase the number and value of the interstate data sharing agreements with other states. The proposed contract resources and existing administrative technician will work to improve the interstate data sharing relationships, as well as seek out additional state agreements to expand the value of the PDMP for Connecticut-covered providers. This activity will improve the comprehensiveness and accuracy of every PDMP query made by covered providers by ensuring that medication history located in other state PDMPs can be considered when consulting Connecticut's PDMP.	
Enhanced "ease of use" for prescribers and other State and federal stakeholders	Connecticut has been working diligently to encourage and facilitate integration of the CPMRS into EHRs. This integration puts the CPMRS	Connecticut plans to continue to leverage opportunities described in SMDL 16-003 to help professionals and hospitals eligible for Medicaid EHR Incentive Payments connect to other Medicaid providers through the	The Connecticut Department of Consumer Protection (DCP), the PDMP vendor (Appriss Health), and DSS, as the

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	data directly into the workflow of health care professionals, bypassing multiple password requirements and the need to exit their EHR to access the CPMRS from a separate web portal. As noted in the SUPPORT Act IAPD, CPMRS data have been integrated with some EHRs, including three major health systems. Connecticut is also working on the integration of the PDMP into the HIE, which is seen as a more sustainable option.	integration of CPMRS into EHRs and pharmacy dispensing systems. Hospitals and pharmacies may request to have CPMRS integrated into their EHRs and pharmacy management systems. **Effective January 1, 2021, dispensation information for insulin drugs, glucagon drugs, diabetes devices, diabetic ketoacidosis devices, gabapentin, and naloxone are required to be uploaded into the CPMRS. All listed prescriptions will be available on patient reports except for naloxone. Only CPMRS admin will have access to naloxone data for the purpose of aggregate population analytics that will help to inform public policy.** The Connecticut Prescription Monitoring Program (PMP) announced a statewide initiative to integrate the CPMRS into approved EHR/PMS using Appriss Health's PMP Gateway service in 2021. The integration will eliminate the need for providers to navigate to the CPMRS website, log in, and enter their patient's information. Instead, the EHR/PMS will	administrator of the EHR Incentive Program, will continue to onboard new EHR and pharmacy dispensing vendors.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
		automatically initiate a patient query, which will return the patient's controlled substance prescription records directly within the clinical workflow inside the EHR/PMS. • Access PMP data at the point-of-care • Streamline searches • Increase utilization of the CPMRS • Access to PMP data and NarxCare analytics within the workflow	
Enhanced connectivity between the State's PDMP and any statewide, regional or local HIE	Leveraging the HIE infrastructure would potentially allow for the most efficient pathway for practitioners and dispensers to access a complete patient profile that includes their controlled substance history. **PDMP Activities** In 2018, Congress passed the SUPPORT Act, which includes important health reforms to combat the opioid crisis by advancing treatment and	DCP has been working with Connecticut's Office of Health Strategy (OHS) for the purpose of integrating the CPMRS into the HIE. The Health Information Exchange (HIE) is working with our software vendor to integrate the Connecticut Prescription Monitoring and Reporting System (CPMRS) data. The HIE is still in its infancy in Connecticut and they are working through the technical specifications to ensure that the data shared is appropriate and auditable to ensure compliance with regulations. **The CPMRS can now be accessed through approved electronic health**	DCP, in collaboration with OHS and DSS, will continue to link the CPMRS with the HIE consistent with the IAPD.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	recovery initiatives, improving prevention, protecting communities and more. In December 2019, DSS submitted a new IAPD to CMS, *Medicaid Management Information System Support Act*, to request 100% federal funds available under Section 5042 of the *SUPPORT Act*. The IAPD application was subsequently approved in February of 2020. In July 2020, DSS submitted an updated HIT IAPD that included activities related to PDMP HIE connectivity.	**records (EHR) and pharmacy management systems (PMS) where PDMP data and NarxCare analytics will be delivered directly into practitioner workflow. The Connecticut Prescription Monitoring Program (PMP) announced a statewide initiative to integrate the CPMRS into approved EHR/PMS using Appriss Health's PMP Gateway service in 2021. For updated accessibility statistics, see Table 1 and Table 2.** The SUPPORT Act and the HIT IAPDs include activities intended to expand the capacity of the CPMRS by continuing to connect health systems and providers and by integrating CPMRS into EHRs. The work proposed within the IAPDs will continue the existing work of adding connections and integrating into additional EHRs and initiate some implementation activities as well as planning for areas where there are gaps between the current PDMP and the definition of a "qualified" PDMP, pursuant to the SUPPORT Act. Connectivity and integration to the statewide HIE ("Connie") is strategically	

Milestone Criteria	Current State	Future State	Summary of Actions Needed
		seen as a preferred solution for provider workflow integration. For EHR integrations, the HIE will connect to Appriss Health's PDMP gateway product, to the RxCheck hub or both. The HIE connection will facilitate a bi-directional data feed between the HIE and PDMP. The trigger for the query will occur during the prescribing workflow and can be automated. The diagram after this chart (Figure 2) illustrates the basic connectivity architecture with the HIE available for connections to the PDMP through the Appriss Health hub.	
Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns [9]	CPMRS data informs planning and decision making such as identification of geographical hot spots for prescribed opioids and other controlled substances, prescriber outreach and relationships between reported prescription drug use and overdose deaths. In 2016, the CPMRS introduced automated clinical notifications	Connecticut will develop additional analytical tools to address limitations in the current system and correlate long-term opioid use directly to clinician prescribing patterns. Connecticut has recently purchased the "NarxCare Enterprise"™ platform via a federal grant. NarxCare provides a comprehensive tool to assess narcotic overdose and diversion risk. NarxCare	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

[9] Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: http://dx.doi.org/10.15585/mmwr.mm6610a1. (See also "Use of PDMP" #2 below.)

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	for prescribers and dispensers to assist them with timely information about patients they are treating. In 2018, the CPMRS added the "prescriber report," which provides prescribers with individual controlled substance prescribing data to assist them in understanding how their prescribing compares against their peers. In 2016, the PDMP transitioned to a new, more robust CPMRS platform that provides a better range of analytical tools for all users and allows reports to aid with the enforcement of the mandatory registration of all Community Support Program (CSP) registrants in CPMRS. Connecticut's PDMP does not have the tools to determine compliance with uploading for dispensing practitioners and non-resident pharmacies.	aggregates and analyzes controlled substance prescription information from providers and pharmacies, and presents interactive, visual representations of that information as well as advanced analytic insights, complex risk scores and more features to aid physicians, pharmacists and care teams to increase patient safety and outcomes. The platform can also accommodate additional information sources to create more holistic risk models, assessments and alerts. NarxCare helps practitioners assess narcotic overdose and diversion risk. DCP is currently working with the vendor to implement this tool in the CPMRS.	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.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	Connecticut is currently attempting to purchase a module from Appriss Health to improve the ability to monitor all pharmacy and dispensing practitioners for uploading compliance.		
Current and Future PDMP Query Capabilities			
Facilitate the State's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e., the State's Master Patient Index [MPI] strategy with regard to PDMP query)	**Integrated Eligibility System** Implemented in August 2017, the integrated eligibility system uses a NextGate solution for patient-matching across programs. The DSS Enterprise Master Person Index (EMPI) is funded through a shared services APD and will be retained by DSS for continued use by the integrated eligibility system. **EMPI** DSS implemented the NextGate EMPI solution in January 2016 with a goal of creating a consolidated view of	**OHS and Connie** The State is developing a federated model of HIE (aka "network-of-networks"). This structure will allow both individual EHRs and existing HIE initiatives to connect and share data through secure interfaces connecting public and private HIE nodes to the statewide HIE network using national standards for point-to-point exchange or participating in a national network. In this federated HIE data model, EHR patient data will remain within the individual systems of record and be pulled or pushed from HIE services as required. Queried data will be organized and contextualized through HIE services to support identified use cases.	DCP, OHS and DSS will work to identify management across systems for better integration. As a benefit of the IAPD, we are offering a simplified system to provide enhanced data sharing within the state known as the gateway. We have onboarded a significant number of providers via integration into the electronic health record (EHR) and pharmacy dispensing software that leverage the data from

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	patient/person information across disparate source systems as well as workflow and basic reporting tools for ongoing maintenance of the system. Today, the EMPI is used by the State's eligibility and enrollment system (DSS-ImpaCT) and the State's HIE system, Access Health CT. EMPI is hosted by the State's Department of Administrative Services, Bureau of Enterprise Systems and Technology.	The roadmap has three major lanes: (i) governance, (ii) enterprise data governance, and (iii) HIE. See Figure 3. Statewide HIE Roadmap The HIE will be implemented in multiple stages to deliver functionality to the stakeholders/users in a timely and efficient manner, following an incremental delivery methodology and procurement process. The initial focus is on core foundational components: HIE services as shown in Figure 3 Statewide HIE Roadmap. These core services will focus on the installation and configuration of HIE componentry, including enhancement, transformation and alignment of data, management and auditing, technical assistance, and deploying to existing EHRs via standard protocols. Each stage will focus on the release of solution components as required to deliver the functionality captured in the prioritized use cases. The HIE services will interface with the Core Data Analytic Solution (CDAS) shared core system components, including the Informatica Master Data Management (MDM) multi-	those systems to provide searches and return PDMP data. **The CPMRS can now be accessed through approved electronic health records (EHR) and pharmacy management systems (PMS) where PDMP data and NarxCare analytics will be delivered directly into practitioner workflow. The Connecticut Prescription Monitoring Program (PMP) announced a statewide initiative to integrate the CPMRS into approved EHR/PMS using Appriss Health's PMP Gateway service in 2021. For updated accessibility statistics, see Table 1 and Table 2.**

Milestone Criteria	Current State	Future State	Summary of Actions Needed
		domain system Identity as a Service (IDaaS) The MDM component implemented includes a master person index (MPI). The HIE services will interface with the UConn CDAS MDM solution for identity and consent management. Optimizing access to Medicaid patient data and recognizing a statutory obligation for hospitals to be connected within one year of operations, the initial implementation of use cases will focus on one or two FQHCs and a large hospital. The HIE will utilize industry standard interfaces to obtain data from the FQHCs and a hospital in the format of Continuity of Care Documents and/or Quality Reporting Document Architecture Category I to the HIE. The initial implementation will focus efforts on building to match patients and providers and establish care relationships. The result is proven capability to patient matching that will ensure the success of future connections and value proposition to stakeholders. Once stable service is	

Milestone Criteria	Current State	Future State	Summary of Actions Needed
		verified, the intention is to deploy to the remaining FQHCs, hospitals and small independent provider groups to include additional EHRs, CDAS and lab information. The HIT Project Management Office (PMO) will develop and recommend a sequence of connections as the HIE scales based on readiness at care settings and priorities that will be reviewed with the HIT Advisory Council for evaluation. The State will provide a single, combined view of data regardless of the data origination point through IDaaS. This will capture a unified view of person, provider and relationship data in a manner to deliver a best instance of identity, as a service. For example, the architectural approach that we wish to achieve would allow the interface of these identity services with other master person index and provider registry systems, such as, Medicaid EMPI, and other related tools used to support their specific needs. Stakeholder outreach and feedback and the movement to interface foundational	

Milestone Criteria	Current State	Future State	Summary of Actions Needed
		services via published web services and application programming interface architectures, identifies a clear objective to provide an IDaaS for use by other stakeholders. A key component of the architecture is access controls to ensure appropriate and permitted use of data through identity management. An additional shared service will perform the transformation of data to align and normalize the data for interoperability across EHR systems. These services will provide data parsing and standardization to classify, de-duplicate and enrich clinical data and enable improved patient care and clinical informatics. Quality control and assurance capability will be used for alerts and scorecards to enable providers to better understand and improve the quality of data in their EHRs. **Master prescription history database** Statewide databases like the CPMRS and networks like Surescripts have established feasible methods of maintaining and accessing prescription medication fill data	

Milestone Criteria	Current State	Future State	Summary of Actions Needed
		and have largely addressed issues of privacy, data security, data storage and data access. The State is researching to determine if, with appropriate resources and legal empowerment, these databases might form the basis of a centralized master list of active prescription medications and medication history.	
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	Leveraging the HIE infrastructure would potentially allow for the most efficient pathway for practitioners and dispensers to access a complete patient profile that includes their controlled substance history.	PDMP has been working with OHS for the purpose of integrating the CPMRS into the HIE once the infrastructure is built. The new approved SUPPORT Act IAPD includes activities intended to expand the capacity of the CPMRS by connecting health systems and providers and integrating CPMRS into EHRs. The work proposed within this IAPD and the HIT IAPD will continue the existing work of adding connections and integrating into additional EHRs, begin some implementation activities, and begin the planning for areas where there are gaps between the current PDMP and the definition of a qualified PDMP pursuant to the SUPPORT Act. Planning for use cases dependent on PDMP participation and	Connecticut will continue to integrate the CPMRS into the HIE as the infrastructure is built consistent with the newly approved IAPDs. The CPMRS is a highly integrate tool in the EHR and pharmacy dispensing software today and looking to add the HIE. The software team at the EHR and pharmacy dispensing software get to determine where the information is displayed based on their internal development. In

Milestone Criteria	Current State	Future State	Summary of Actions Needed
		utilization is also included and Connecticut's statewide HIE will be connected to the PDMP. *Connie* is strategically seen as a preferred solution for provider workflow integration. For EHR integrations, the HIE will connect to Appriss Health's PDMP Gateway product, to the RxCheck hub, or both. The HIE connection will facilitate a bi-directional data feed between the HIE and PDMP. The trigger for the query will occur during the prescribing workflow and can be automated. The diagram (Figure 2) after this chart illustrates the basic connectivity architecture with the HIE available for connections to the PDMP, through the Appriss Health hub. The Medicaid enterprise can query the PDMP through an HIE connection. In the future, if statutory and data sharing issues are resolved to remove current restrictions, Medicaid could establish a direct connection to the PDMP if needed by a use case. Among its various funding opportunities, the *SUPPORT Act* provides resources to	2020, the CPMRS received over 19 million requests via integrated search which was a new record for the state without connection to the HIE. The technical work of integration is being managed by the staff at the HIE and our software vendor. Our software vendor has an Active Programming Interface (API) developed but will also build a custom interface if the EHR or pharmacy dispensing software requires it. **The CPMRS can now be accessed through approved electronic health records (EHR) and pharmacy management systems (PMS) where PDMP data and NarxCare analytics will be delivered directly into**

Milestone Criteria	Current State	Future State	Summary of Actions Needed
		better integrate and utilize state PDMPs or PDMP in Connecticut (CPMRS). DSS, DCP and OHS recently submitted a request to CMS to fund a planning and design process to identify specific, tangible, value-added initiatives related to CPMRS. Current collaborations include a successful three-agency workgroup focused on the SUPPORT Act. This group, composed of DSS, DCP, and OHS were successful in receiving CMS approval for SUPPORT Act funding. The three agencies are now developing plans for PDMP improvements to make sure that the PDMP will meet the qualified standard for a qualified PDMP. Other initiatives that are in the joint DSS-OHS portfolio include e-consults and e-referrals. Through the SUPPORT Act IAPD and other SUPPORT Act-funded initiatives, opportunities related to the stated purpose and goals of the Medication Reconciliation and Polypharmacy Committee are actively monitored.	**practitioner workflow. The Connecticut Prescription Monitoring Program (PMP) announced a statewide initiative to integrate the CPMRS into approved EHR/PMS using Appriss Health's PMP Gateway service in 2021. For updated accessibility statistics, see Table 1 and Table 2.**

Milestone Criteria	Current State	Future State	Summary of Actions Needed
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	Connecticut will continue to implement Appriss Health's NarxCare program.	Connecticut hopes to add to the CPMRS the NarxCare platform via a federal grant. NarxCare provides a comprehensive tool to assess narcotic overdose and diversion risk. NarxCare aggregates and analyzes controlled substance prescription information from providers and pharmacies, and presents interactive, visual representations of that information as well as advanced analytic insights, complex risk scores and more features to aid physicians, pharmacists and care teams to increase patient safety and outcomes. The platform can also accommodate additional information sources to create more holistic risk models, assessments and alerts. DCP is currently working with Appriss Health to implement this tool in the CPMRS. One large healthcare system and one national pharmacy chain have already purchased this enhanced analytic tool on their own.	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. Integration into the CPMRS continues grow and as stated earlier we had over 19 million integrated searches in 2020. There are mandatory look-up requirements for prescribers of controlled substances in the law in Connecticut. The EHR vendor and operator as well as the pharmacy dispensing software operate are permitted flexibility regarding the timing of the information being presented.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
			Currently, the state is providing NarxCare, which is an enhanced analytical tool to identify overdose risk, free as part of grants with other partners like the Department of Public Health, the Department of Mental Health and Addiction Services, the Center for Disease Control and Prevention, the Department of Justice, and the Substance Abuse and Mental Health Services Administration. The program is operational at this point.
Master Patient Index / Identity Management			
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	• The PDMP system already uses an algorithm that automatically links patient records (coming from pharmacies) based on name, date of birth, zip code and street address.	DCP and DSS will develop an approach for the CPMRS and HIE to identify management functions across both systems with a goal to improve efforts to integrate care and have better outcomes.	DCP, OHS and DSS will work to identify management across systems for better integration.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	• Appriss Health uses the prescription drug monitoring interface, AWARxE, which provides Project Management Professional staff the following capabilities to: — Authorize practitioners, their delegates and pharmacists registering for CPMRS access — Manage CPMRS accounts — Maintain a list of data submitters, from pharmacies and licensed practitioners, who dispense Schedule II, III, IV or V controlled substances — Approve data submissions from pharmacies and licensed practitioners who dispense Schedule II, III, IV or V controlled substances under federal and state law		

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	— Conduct analysis of pharmacies that have not reported or are delayed in reporting — Create dashboard announcements accessible to registered users — Consolidate patient information for patients reported to the database with differences in name, date of birth or gender — Generate patient prescription history reports — Generate dispensary activity reports — Generate alerts for practitioners and pharmacists based on thresholds for high doses, high-risk drug combinations, and potentially risky patient behavior.		
Overall Objective for Enhancing PDMP Functionality & Interoperability			

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Leverage the above functionalities/capabilities/supports (in concert with any other state health IT, technical assistance 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	Prior to 2017, there was no consistent way to track whether or not CSP/CPMRS registrants who wrote a controlled substance prescription were reviewing a patient's record when prescribing more than a three-day supply. In 2017, through a collaborative effort supported by a federal grant with DPH, DCP was able to hire a durational employee with technical expertise in data analytics to run additional reports that aggregate the number of prescribers who have never reviewed any patient's controlled substance prescription records. Appriss Health has a new analytical tool that will enable the PDMP to identify those who are not compliant with the lookup mandate. The PDMP cannot generate automated, comprehensive reports to flag prescribers who	The PDMP administrator refers issues to Drug Control Agents, who enforce the mandated lookup requirements. DSS receives reports from its medical and dental ASOs of Medicaid patients filling opioid prescriptions in amounts exceeding 100 morphine milligram equivalents (MME) per day for a minimum of 90 consecutive days. That information is utilized for outreach to providers.	Connecticut will explore additional analytical tools to assist with enforcement to minimize the risk of inappropriate overprescribing. The compliance module, which we hope to turn on by the end of the year, includes automated reports that will identify non-compliance with our law. Currently, we can do these manually and do so as required during investigations. We recently turned on an enhance tool to identify prescribers who were utilizing the CMPRS via integration without being compliant with the registration requirement and credential. These steps are dramatically improving our data and will

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	fail to follow the three-day supply mandated lookup. Because of the lack of analytical tools, enforcement has been based on individual complaints to the Drug Control Division. **e-Prescribing Support** The interChange system includes e-Prescribing functionality, which allows providers to check eligibility and medication history, access program formulary information and obtain potential drug interactions for the Medicaid program participants. Surescripts is utilized as a subcontractor to provide connectivity between the provider and the pharmacy and between the provider and the payer and to build the Medicaid portal into the State's e-Prescribing network. Transaction volume for		allow us to activate this module efficiently and reduce false positives.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	e-Prescribing has increased steadily since implementation in 2010 as more prescribers have begun utilizing the functionality. Approximately 777,500 eligibility and 424,000 medication history transactions are processed monthly.		

Attachment A Section II – Implementation HIT Administration

Please provide the contact information for the State's point of contact for the SUD Health IT Plan.

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Attachment A Section III – Relevant Documents

Please provide any additional documentation or information that the State deems relevant to successful execution of the implementation plan

Figure 1. Interstate PDMP Data Sharing

Authorized roles in the CPMRS currently have access to prescription data from 39 states, Washington DC, Puerto Rico, and the Military Health System. This includes all border states. Connecticut allow other states to connect via the PMP Interconnect (PMPi) or RxCheck, which are data sharing hubs that use end-to-end encryption to facilitate data sharing across state borders.



Source: https://portal.ct.gov/DCP/Prescription-Monitoring-Program/Prescription-Monitoring-Program, accessed on 10/25/2021.

Figure 2: PDMP Diagram with HIE

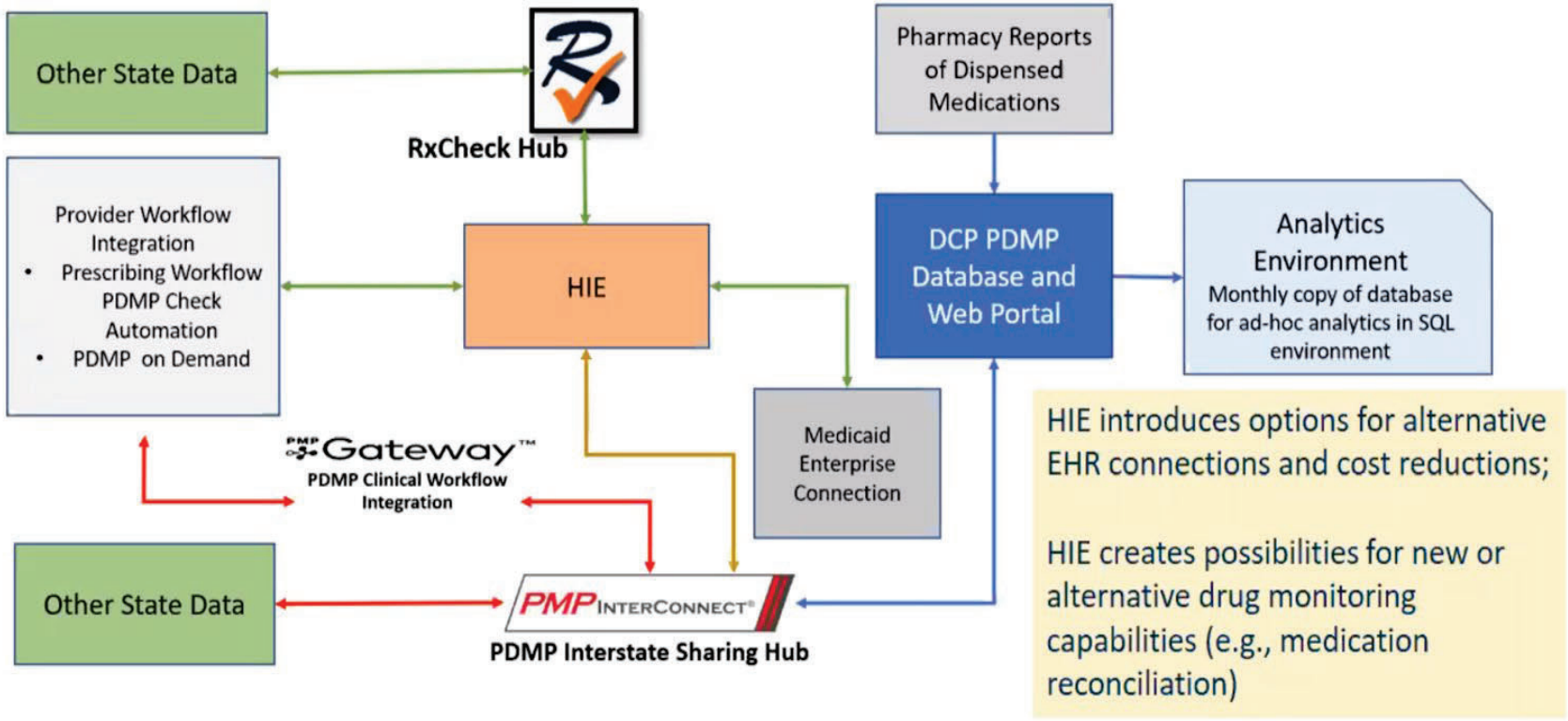

Other State Data
RxCheck Hub
Pharmacy Reports of Dispensed Medications
Provider Workflow Integration
• Prescribing Workflow PDMP Check Automation
• PDMP on Demand
HIE
DCP PDMP Database and Web Portal
Analytics Environment
Monthly copy of database for ad-hoc analytics in SQL environment
Medicaid Enterprise Connection
Gateway™
PDMP Clinical Workflow Integration
Other State Data
PMP InterConnect®
PDMP Interstate Sharing Hub
HIE introduces options for alternative EHR connections and cost reductions;
HIE creates possibilities for new or alternative drug monitoring capabilities (e.g., medication reconciliation)

Figure 3: Statewide HIE Roadmap

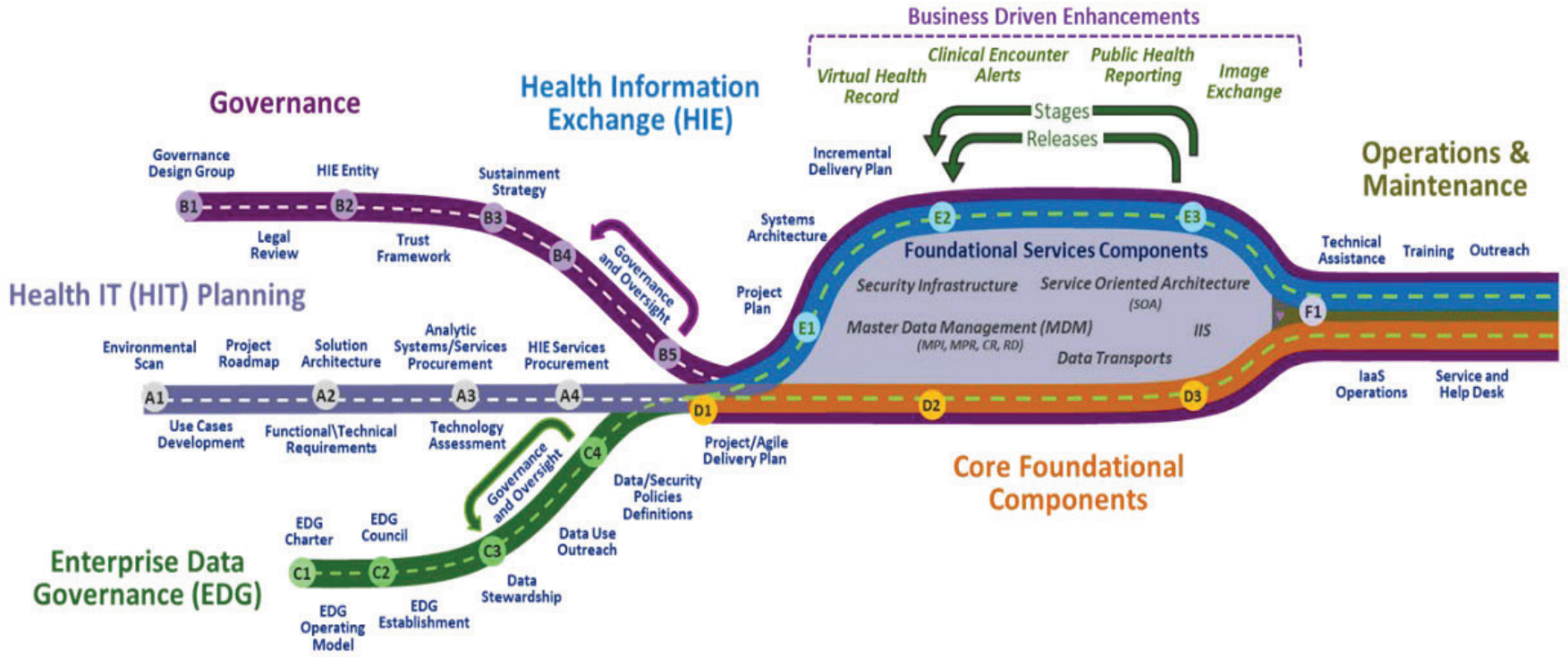


Table 1: CPMRS User Growth

	Prescribers	Prescriber Delegates	Pharmacists	Pharmacist's Delegate	Total
2016	24,068	362	2,255		26,685
2017	26,015	741	2,515		29,271
2018	28,791	1,157	2,730		32,678
2019	26,943	1,521	2,937	43	31,444
2020	29,351	1,767	3,026	68	34,212

Source: https://data.ct.gov/Health-and-Human-Services/Bar-Chart-CPMRS-Registered-Users/cx8y-d3r6

Table 2: CPMRS User Search Growth

	Law Enforcement	Pharmacist	Pharmacist's Delegate	Prescriber	Prescriber Delegate	Total
2015	5,574	465,256		484,736		955,566
2016	3,475	283,588		694,510		981,573
2017	3,924	675,926		1,130,511	142,033	1,952,394
2018	4,206	634,497		1,237,933	284,521	2,161,157
2019	3,808	611,141	3,027	1,392,390	300,580	2,310,946
2020	4,165	576,685	15,038	1,425,554	283,062	2,304,504

Source: https://data.ct.gov/Health-and-Human-Services/Bar-Chart-CPMRS-User-Searches-per-Year/i7mq-p6p2

ATTACHMENT B
Reentry Demonstration Initiative Qualifying Conditions

Qualifying Condition	Definition
Mental Illness (MI)	A person with a "mental illness" is a person who is currently receiving mental health services or medications OR meets both of the following criteria: i. The beneficiary has one or both of the following: a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities; AND/OR b. A reasonable probability of significant deterioration in an important area of life functioning; AND ii. The beneficiary's condition as described in paragraph (i) is due to either of the following: a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems, OR b. A suspected mental disorder that has not yet been diagnosed.
Substance Use Disorder (SUD)	A person with a "substance use disorder" or "SUD" is a person who either: i. Meets SUD criteria, according to the criteria of the current editions of the DSM and/or the International Statistical Classification of Diseases and Related Health Problems, OR ii. Has a suspected SUD diagnosis that is currently being assessed through either National Institute of Drug Abuse (NIDA)-modified Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), American Society of Addiction Medicine (ASAM) criteria, Global Appraisal of Individual Needs (GAIN), or other state-approved screening tool.
Co-occurring MI/SUD	A person with a "mental illness" AND a "substance use disorder" as defined above.
Chronic Condition or Significant Non-Chronic Clinical Condition	A person with a "chronic condition" or a "significant non-chronic clinical condition" has ongoing and frequent medical needs that require treatment and can include one

	or more of the following diagnoses, as indicated by the individual, and may be receiving treatment for the condition, as indicated: • Active cancer • Active coronavirus disease 2019 (COVID-19) or Long COVID-19 • Active hepatitis A, B, C, D, or E • Advanced liver disease • Advanced renal (kidney) disease • Dementia, including, but not limited to Alzheimer's disease • Autoimmune disease, including, but not limited to rheumatoid arthritis, Lupus, inflammatory bowel disease, and/or multiple sclerosis • Chronic musculoskeletal disorders that impact functionality of activities of daily living, including, but not limited to arthritis and muscular dystrophy • Chronic neurological disorder • Severe chronic pain • Congestive heart failure • Connective tissue disease • Coronary artery disease • Currently undergoing a course of treatment for any other diagnosis that will require medication management of three or more medications or one or more complex medications that requires monitoring (e.g., anticoagulation) therapy after re-entry • Cystic fibrosis and other metabolic development disorder • Epilepsy or seizures • Foot, hand, arm, or leg amputee • Hip/pelvic fracture • HIV/AIDS • Hyperlipidemia • Hypertension • Incontinence • Severe migraine or chronic headache • Moderate to severe atrial fibrillation/arrhythmia • Moderate to severe mobility or neurosensory impairment including, but not limited to spinal cord injury, multiple sclerosis, transverse myelitis, spinal canal stenosis, peripheral neuropathy • Obesity • Peripheral vascular disease

	• Pressure injury or chronic ulcers (vascular, neuropathic, moisture-related) • Previous stroke or transient ischemic attack • Active respiratory conditions, including, but not limited to severe bronchitis, chronic obstructive pulmonary disease, asthma, or emphysema • Several viral, bacterial, or fungal infections • Sickle cell disease or other hematological disorders • Significant hearing or visual impairment • Spina bifida or other congenital anomalies of the nervous system • Tuberculosis OR • Type 1 or 2 diabetes.
Intellectual Disability	A person with an "intellectual disability," is defined in section 1-1g of the Connecticut General Statutes and originates before eighteen years of age.
Acquired Brain Injury (ABI), Including Traumatic Brain Injury (TBI)	A person with an "acquired brain injury" or "ABI" includes Traumatic Brain Injury and is defined in section 17b-260a-3 of the Regulations of Connecticut State Agencies.
HIV/AIDS	A person with "HIV/AIDS" means a person who has tested positive for either human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) at any point in their life.
Pregnant or Postpartum	A person who is "pregnant" or "postpartum" is a person who is either currently pregnant or within 12 months following the end of the pregnancy.

ATTACHMENT C

Reentry Demonstration Initiative Services

Covered Service	Definition
Case Management under Targeted Case Management (1905(a)(19), 42 CFR 440.169 and 42 CFR 441.18)	Re-entry Transitional Case Management (RTCM) will be provided in the period up to 90 days immediately prior to the expected date of release and is intended to facilitate re-entry planning into the community to: 1. Support the coordination of services delivered during the pre-release period and upon re-entry; 2. Ensure smooth linkages to social services and support; and 3. Ensure the arrangement of appointments and timely access to appropriate care and pre-release services delivered in the community. Services will include: • Conducting a health risk assessment, as appropriate. • Assessing the needs of the individual to inform development, with the client, of a discharge/re-entry person-centered care plan, with input from the clinician providing consultation services and the correctional system's re-entry planning team: o While the re-entry transitional person-centered care plan is created in the pre-release period and is part of the case management pre-release service to assess and address physical and behavioral health medical needs and educational, social, or other services/needs identified, the scope of the plan extends beyond release; • Developing a person-centered care plan • Completing referrals and related activities, and monitoring and follow-up activities as described below • Obtaining informed consent, when needed, to furnish services and/or to share information with other entities to improve coordination of care; • Providing warm linkages with designated care managers (including potentially a care management

	provider. for which all individuals eligible for pre-release services will be eligible) upon re-entry; • Ensuring that necessary appointments with physical and behavioral health care providers, including, as relevant to care needs with behavioral health coordinators and providers, are arranged; • Making warm linkages to community-based services and supports including, but not limited to educational, social, pre-vocational, vocational, housing, nutritional, transportation, childcare, child development, and mutual aid support groups; • Providing a warm hand-off, as appropriate, to post-release case managers who will provide services under the Medicaid and CHIP State Plan or other waiver or Demonstration authority; • Ensuring that, as allowed under federal and state laws and through consent with the beneficiary, data are shared and, as relevant, to physical and behavioral health providers to enable timely and seamless hand-offs; • Conducting follow-up with community-based providers to ensure engagement was made with individual and community-based providers as soon as possible and no later than 30 days from release; and • Conducting follow-up with the individual to ensure engagement with community-based providers, behavioral health services, and other aspects of discharge/re-entry planning, as necessary, no later than 30 days from release.
Medication for Addiction Treatment Services under Medication Assisted Treatment (MAT) (1905(a)(29)) and Rehabilitative Services Benefit (1905(a)(13))	• MAT for Opioid Use Disorders (OUD) includes all medications approved under section 505 of the Federal Food Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Act (42 U.S.C. 262) to treat opioid use disorders as authorized by the Social Security Act Section 1905(a)(29). • MAT for Alcohol Use Disorders (AUD) and Non-Opioid Substance Use Disorders includes all FDA-approved drugs and services to treat AUD and other SUDs.

	• Psychosocial services delivered in conjunction with MAT for OUD as covered in the State Plan section 1905(a)(29) MAT benefit, and MAT for AUD and Non-Opioid Substance Use Disorders as covered in the State Plan section 1905(a)(13) rehabilitation benefit, including assessment; individual/group counseling: patient education; prescribing, administering, dispensing, ordering, monitoring, and/or managing MAT.
30-day Supply of Prescription Medications at Prescription drugs (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25)	Covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with approved Medicaid State Plan)
Practitioner Office Visit at Physician services (1905(a)(5), 42 CFR 440.50); Certified pediatric and family nurse practitioner services (1905(a)(21), 42 CFR 440.166(b) and 42 CFR 441.22); other licensed practitioner services (1905(a)(6), 42 CFR 440.60); clinic services (1905(a)(9), 42 CFR 440.90); and Other diagnostic, screening, preventive, and rehabilitative services (1905)(a)(13), 42 CFR 440.130)	Physical and behavior health clinical consultation services include targeted preventive, physical and behavioral health clinical consultation services related to the qualifying conditions. Clinical consultation services are intended to support the creation of a comprehensive, robust and successful re-entry plan including: • Conducting diagnosis, stabilization and treatment in preparation for release (including recommendations or orders for needed labs, radiology, and/or medications); • Providing recommendations or orders for needed medications and DME that will be needed upon release; and • Consulting with the pre-release care manager to help inform the pre-release care plan. Clinical consultation services are also intended to provide opportunities for clients to meet and form relationships with the community-based providers who will be caring for them upon release, including behavioral health providers, and enable information sharing and collaborative clinical care between pre-release providers and the providers who will be caring for the client after release, including behavioral health warm linkages. Services may include, but are not limited to: • Medication administration

	• Addressing service gaps that may exist in correctional facilities;
	• Diagnosing and stabilizing individuals while incarcerated, preparing them for release;
	• Providing treatment, as appropriate, to ensure control of qualifying conditions prior to release (e.g., to suggest medication changes or to prescribe appropriate DME for post-release);
	• Supporting re-entry into the community; and
	• Providing behavioral health clinical consultation which includes services covered in the State Plan rehabilitation benefit but is not limited to:
	  ○ Assessment and Individualized Plan Development,
	  ○ Health Services and Medication Management,
	  ○ Therapy,
	  ○ Skill Building and Psycho-Education, and
	  ○ Service coordination.

Diagnostic services under Laboratory and X-ray services (1905(a)(3), 42 CFR 440.30, and 42 CFR 441.17) and Other diagnostic, screening, preventive, and rehabilitative services (1905)(a)(13), 42 CFR 440.130)	Laboratory and radiology services will be provided consistent with the State Plan.
Prescribed Drugs and Medication Administration under Prescription drugs (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25)	Medications will be provided consistent with the State Plan.
Treatment for Hepatitis C at Physician services (1905(a)(5), 42 CFR 440.50); Other diagnostic, screening, preventive, and rehabilitative services (1905)(a)(13), 42 CFR 440.130); and Laboratory and X-ray	Screening, diagnosis, and treatment for hepatitis C consistent with Medicaid State Plan coverage for pharmacy, physician, laboratory, radiology, outpatient hospital.

services (1905(a)(3), 42 CFR 440.30, and 42 CFR 441.17)	
Medical Equipment and Supplies (1905(a)(7), 42 CFR 440.70(b)(3))	DME consistent with Medicaid State Plan requirements. In addition to the pre-release services, qualifying beneficiaries may also receive durable medical equipment (DME) upon release, consistent with approved State Plan coverage authority and policy.
Family Planning Services and Supplies (1905(a)(4)(C), 42 CFR 441.20)	Family planning consistent with the Medicaid State Plan requirements, including contraceptives and other birth control.
Other – Rehabilitative and Preventative Health Services	Rehabilitative and preventive health services, including the initial visits while the individual is incarcerated or detained, to transition the individual to a community provider for preventive, rehabilitative or other diagnostic and/or screening health services covered under the State Plan, including: • Other diagnostic, screening, preventive, and rehabilitative services (1905(a)(13), 42 CFR 440.130) o Other diagnostic and screening services covered under the state plan including screening for common health conditions within the incarcerated population, such as blood pressure, diabetes, hepatitis C, and HIV. o Preventive services covered under the State Plan, including the US Preventive Services Task Force A & B recommendations such as: ▪ Tobacco counseling services, ▪ Services to treat Autism Spectrum Disorders pursuant to EPSDT. o Rehabilitative Services covered under the State Plan including: ▪ All American Society of Addiction Medicine ambulatory, residential and outpatient hospital levels of care as covered under the state plan (room and board not covered) and

	▪ Services under the Connecticut EPSDT including office-based off-site rehabilitation services, home and community-based behavioral health services, multi-systemic therapy multi-dimensional family therapy, functional family therapy, intensive in-home child and adolescence psychiatric services (IlCAPS), emergency mobile psychiatric services (EMPS), extended day treatment, ▪ Rehabilitation services in a residential setting as covered in the state plan (room and board not covered) including assessment, individual treatment planning & review, individual, group, and family psychotherapy, medical/psychiatric services (medication administration and psychotropic management), rehabilitative counseling, care coordination.
Other –other licensed practitioner services (1905(a)(6), 42 CFR 440.60)	• Services under the Other Licensed Practitioner Option provided by the following practitioner types: o Psychologists o Licensed Clinical Social Worker o Licensed Marriage and Family Therapists o Licensed Professional Counselors o Licensed Drug and Alcohol Counselor Services o Physician Assistants o Nurse Practitioners
Other – Behavioral health under clinic services (1905(a)(9), 42 CFR 440.90)	• Services under the Clinic Option o Behavioral health clinics

ATTACHMENT D
Reentry Demonstration Initiative Implementation Plan [Reserved]

ATTACTMENT E
Reentry Demonstration Initiative Reinvestment Plan [Reserved]

ATTACHMENT F
Reentry Demonstration Initiative Final Reinvestments [Reserved]

ATTACHMENT G
Reserved for the Evaluation Design