Mercer

Government Human Services Consulting

Connecticut Substance Use Disorder Care 1115 Demonstration

Mid-point Assessment Report

Connecticut Behavioral Health Partnership

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Section 1

Executive Summary

The Connecticut Substance Use Disorder (SUD) Demonstration (Project Number 11-W-00372/1 and 21-W-00069/1) was approved on April 14, 2022, and is effective April 14, 2022, through March 31, 2027. This Demonstration supports the State's ongoing process of modernizing its Medicaid system. It is designed to address Connecticut's opioid crisis and support the State's effort to implement an enhanced comprehensive and lasting response to this epidemic as well as similar challenges with use of substances other than opioids.

Under the Demonstration, a full continuum of SUD care for HUSKY A, HUSKY B, HUSKY C, and HUSKY D is financed by Medicaid and Children's Health Insurance Program (CHIP) under a new Medicaid Rehabilitative State Plan and corresponding CHIP State Plan changes. In addition, the Judicial Branch Court Support Services Division (JB-CSSD) and the Department of Corrections (DOC) have joined with the Connecticut Behavioral Health Partnership (CT BHP) sister agencies to ensure that Medicaid eligible members receive SUD treatment when they are on probation, parole, inpatient, or otherwise eligible for services. The CT BHP is a working collaborative between the Department of Social Services (DSS), the Department of Mental Health and Addiction Services (DMHAS), and the Department of Children and Families (DCF) designed to create and provide timely access to an integrated, high quality behavioral health service system for Connecticut's Medicaid populations, including Husky A, B, C (Aged, Blind and Disabled) and D (Low Income Adults).

This Mid-point Assessment (MPA) examines the progress of planned service improvements expected as part of the Centers for Medicare & Medicaid Services (CMS) approved Implementation Plan, as well as the State's performance per CMS-defined metrics, as outlined in its SUD Monitoring Protocol.

Quarterly Implementation Plan progress reports and Monitoring Protocol metrics were examined for the first two and one-half years of the Demonstration (April 14, 2022–October 30, 2024). Mercer assessed progress in each CMS Milestone described in the Implementation Plan area by evaluating Demonstration activities and their alignment with the approved plan and timeline.

The SUD MPA includes:

- An examination of the State's progress toward meeting each Milestone and timeframe approved in the SUD Implementation Plan.
- An assessment of the State's progress toward closing the gap between baseline and targets each year in performance measures as approved in the SUD Monitoring Protocol.
- A discussion of implementation successes and challenges that affected the achievement of Milestones and closure of performance measure gaps to date.
- A consideration of factors likely to affect future performance in meeting Milestones and targets not yet met and the risk of missing those Milestones and performance targets.

In developing the SUD MPA methodology, the independent evaluator, Mercer and its subcontractor TriWest Group, collaborated with State partners, Medicaid stakeholders

(including members and advocates), and SUD treatment providers as required in the CMS-approved Demonstration Special Terms and Conditions (STCs).

Data for this report was collected from three primary sources:

Reviews of State and partner agencies documentation and reports, to include State Plan Amendments (SPAs), manuals, utilization and certification reports, and monitoring tools and reports.

Analysis of CMS-required monitoring metrics.

Stakeholder focus groups (including State agency staff, Administrative Services Organization [ASO] staff from Carelon Behavioral Health [Carelon], the certifying organization — Advanced Behavioral Health [ABH], providers, consumers and advocates).

The assessment of risk of not achieving required Milestones was conducted using the CMS-provided rubric, which is explained further in Section 3 of this MPA report.

Findings

Overall, the MPA found that the State has completed most of the expected activities and is making progress in all areas of the SUD Implementation Plan.

However, many critical metrics are not moving in the direction of State targets, indicating that at this point in the Demonstration, activities have not translated into outcomes. One Milestone was assessed to be at "low" risk, while two were assessed as "low to medium," two were assessed as "medium" risk and one did not have enough information to assess.

The table below provides an overview of SUD MPA findings.

CMS Milestone	Assessment of Risk	Key Findings
Milestone 1: Access to Critical Levels of Care (LOCs) for Opioid Use Disorder (OUDs) and SUDs	Medium	• All implementation plan actions have been completed. However, as discussed under Milestone 4, provider capacity is declining, which impacts access to care. • Connecticut is meeting its goal to increase access to two of the six identified levels of SUD treatment, as measured by the number of beneficiaries receiving that type of service. However, this is affected by the Medicaid unwinding and having fewer Medicaid individuals. • Other metrics are moving in the opposite direction of State targets. • All stakeholders expressed concerns that lack of capacity effects access across several critical LOCs.
Milestone 2:	Low	• All implementation plan actions have been completed.

CMS Milestone	Assessment of Risk	Key Findings
Use of Evidence-Based, SUD-Specific Patient Placement Criteria		• All (two of two) CMS critical metrics are moving in the direction of State targets. • Some providers expressed increasing concern around State progress on this Milestone.
Milestone 3: Use of Nationally Recognized SUD-Specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities	Low	• All implementation plan actions have been completed. • No critical metrics are required for this Milestone. • A few concerns emerged from stakeholders regarding authorizations for placement during care transitions. These seem to have a high potential for resolution.
Milestone 4: Sufficient Provider Capacity at Each Level of Care (LOC)	Medium	• The State completed initial action items from the implementation plan but has had to address the loss of bed capacity. These newer efforts are not yet showing results. • The overall number of providers, and bed capacity have decreased in the second year of the Demonstration. • Provider concerns over misalignment between rates and requirements is driving reductions in participating providers. • No progress has been made in creating capacity to serve adolescents in residential care, so access to residential LOCs is not available for this population.
Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Misuse and OUD	Low	• Activities associated with the first two requirements of this Milestone were complete at the time of application: — Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug misuse. — Expanded coverage of and access to naloxone for overdose reversal. • The State has made process on the third requirement of this Milestone: Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs. • The state has made progress on the critical metrics (4/4) for this Milestone. • Behavioral health stakeholders were not asked questions about outstanding requirements

CMS Milestone	Assessment of Risk	Key Findings
		regarding the Prescription Drug Monitoring Program (PDMP) and Health Information Exchange (HIE) progress, as this was not a data source as specified in the approved evaluation design related to any evaluation hypotheses. Other information sources were utilized to measure process on the third requirement.
Milestone 6: Improved Care Coordination and Transitions Between LOCs	Low to Medium	• All activities associated with this Milestone are complete. • The state has made progress on fewer than half (6/13) of the critical metrics for this Milestone. • Stakeholders have shared concerns about care transitions, and lack of support for people moving into outpatient treatment settings. • The State's determination that the budget cannot support targeted case management could be a missed opportunity. • New requirements for discharge planning as part of the American Society of Addiction Medicine (ASAM) LOC payment could help to improve progress on this Milestone.

Next Steps

While there is potential risk that the State may not meet some Milestones, there are significant successes in the Demonstration that can be leveraged to respond to current challenges. State partners have built close relationships and have good foundations for communications. Providers, while concerned about capacity and rates expressed willingness to work with the State and appreciated State efforts to work with them on training, technical assistance and in communication around changes being made to improve the Demonstration.

Recommendations to build on these successes include:

- Continue to work with providers to explore Flex Bed options and rate adjustments to facilitate increased capacity for level 3.1 and 3.5 LOCs.
- Increase focus on providing early intervention and outpatient services, including more widespread screening for SUD across all age groups to avoid costs associated with higher LOCs. Consider reimbursing outpatient providers for early intervention screenings without treatment services, including Screening, Brief Intervention, and Referral to Treatment (SBIRT). This may include making sure that all Medicaid providers have access to payment for screens and consider providing additional education in primary care settings for the SBIRT model.
- Build on the existing foundation of open and productive communication by increasing reporting of data regarding Demonstration outcomes and progress, particularly the

monitoring metrics, to all stakeholders, including providers. Consider regular meetings with State agencies and providers that move beyond policy and procedure updates and that focus on problem-solving discussions for metrics that are not meeting Demonstration targets.

- Continue bi-directional, problem-focused communications with providers and ASOs around managing care transitions across LOCs when bed capacity is limited. The State should prioritize provider concerns that ASAM LOCs have been used as cost-control mechanisms rather than a focus on individualized treatment planning.
- Provide more specific communication when provider reviews find areas of concern around quality of care (e.g., insufficient treatment dosage) and use those opportunities to improve the interventions delivered by providers.
- Consider the following options to improve retention and continuity in care:
  - A Targeted Case Management (TCM) pilot with an SUD-only population with acute treatment needs that could help the State to determine whether costs for those services might be offset by savings in reduced returns to SUD treatment after 30 days, emergency department (ED) utilization, transitions to higher, rather than lower LOCs, etc.
  - Creating access to additional Recovery Housing options for individuals receiving ambulatory care.
  - Enhanced access to ASAM 3.1 to improve transitions to lower LOCs.

Section 2

SUD Demonstration Background

The Connecticut SUD Demonstration (Project Number 11-W-00372/1 and 21-W-00069/1) was approved on April 14, 2022, and is effective April 14, 2022, through March 31, 2027. This Demonstration supports the State's ongoing process of modernizing its Medicaid system. In keeping with this goal, Connecticut Department of Social Services (DSS), in collaboration with its sister State agencies, the Connecticut Department of Mental Health and Addiction Services (DMHAS) and the Connecticut Department of Children and Families (DCF), known as the CT BHP, has implemented a comprehensive SUD benefit package of services provided by a statewide network of SUD treatment service providers for Medicaid beneficiaries. Except as otherwise specified, references to Medicaid throughout this MPA Report also include CHIP.

The 1115 SUD Waiver Demonstration is designed to address Connecticut's opioid crisis and support the State's effort to implement an enhanced comprehensive and lasting response to this epidemic as well as similar challenges with use of substances other than opioids. Connecticut is experiencing one of the most significant public health crises in its history. The striking escalation of opioid use and misuse over the last five years is impacting individuals, families, and communities throughout the State.

Data collected for this MPA generally includes information from the first two and one-half years of the Demonstration (April 14, 2022–October 14, 2024), although data for the quantitative monitoring metrics was only available from April 1, 2022, through March 31, 2024 for this report (two full Demonstration years). See further details regarding the MPA methodology in Section 3 of this report.

Description of the Demonstration's Policy Goals

Connecticut uses the Demonstration authority to finance a full continuum of SUD care for HUSKY A, HUSKY B, HUSKY C, and HUSKY D by Medicaid under a new Medicaid Rehabilitative State Plan. The continuum Medicaid eligible members receiving SUD treatment when they are on probation, parole, inpatient, or otherwise eligible for services includes through the collaboration of the JB-CSSD and the DOC with the CT BHP sister agencies.

SUD Treatment in Connecticut

The following services were the covered Medicaid SUD behavioral benefits and services prior to the Demonstration:

- SBIRT Services
- Outpatient Services
- Methadone Maintenance
- Medication for Addiction Treatment (MAT)
- Intensive Outpatient Services (IOP)

- Partial Hospitalization Program (PHP)
- Ambulatory Withdrawal Management
- Inpatient Hospital Substance Use Withdrawal Management
- Residential Treatment Center for Children through DCF
- TCM for Ages 19 and under
- TCM for Adults with Serious Mental Illness and Co-Occurring SUD

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

In addition, the State is actively working to recruit providers within the State's border to provide adolescent services. To meet Demonstration requirements of accessibility to ASAM residential services for all Medicaid eligible populations, the Demonstration implementation contained a specific focus on treatment for adolescent girls. However, the provider for boys' residential services has since closed, resulting in the State looking for new providers across all adolescent populations.

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

Specifically, the Demonstration application sought to improve outcomes for Medicaid members diagnosed with SUD by providing critical access to SUD treatment services, including inpatient and residential SUD treatment in IMDs, as part of a full continuum of treatment services that follow ASAM LOCs. Under the new SUD SPA, which was associated with this Demonstration, Connecticut implemented a comprehensive, integrated SUD benefit that included residential treatment settings. Pre-waiver IMD limitations in fee-for-service (FFS) had created barriers to ensuring members can access SUD treatment at a LOC appropriate to their needs using the ASAM criteria. Connecticut, under the Demonstration authority removed Federal Medicaid restrictions on IMDs as SUD treatment settings in FFS. The new Medicaid SUD treatment continuum enhances critical access to the full ASAM SUD treatment continuum. Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, anticipated that this Demonstration will accomplish the following goals, which make up our Demonstration hypothesis. This waiver Demonstration will:

- Increase rates of identification, initiation, and engagement in treatment for OUD and other SUDs.
- Increase adherence to and retention in treatment for OUD and other SUDs.
- Reduce overdose deaths, particularly those due to opioids.

- Reduce utilization of EDs and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.
- Lead to fewer readmissions to the same or higher LOC where readmissions are preventable or medically inappropriate for OUD and other SUDs.
- Improve access to care for physical health conditions among beneficiaries with OUD or other SUDs.
- The Demonstration Implementation Plan addresses system reforms and activities needed to achieve the following CMS Milestones:
  - Access to critical LOCs for OUD and other SUDs.
  - Widespread use of evidence-based, SUD-specific patient placement criteria.
  - Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications.
  - Sufficient provider capacity at each LOC, including MAT.
  - Implementation of comprehensive treatment and prevention strategies to address opioid misuse and Connecticut Substance Use Disorder Section 1115(a) Medicaid Demonstration OUD.
  - Improved care coordination and transitions between LOCs.

This Demonstration did not change the current delivery system structure. All Medicaid services continue to be delivered through a FFS delivery system. However, the State made various improvements to the SUD service system statewide, including aligning with ASAM 3rd edition criteria, analyzing care management initiatives that are available and improving coordination of care, and improving transitions of care. Overall, while continuing to use a FFS delivery system structure, the Demonstration streamlines, clarifies, and improves the content of each LOC and improve transitions in the care management system.

Medicaid eligibility requirements do not differ from the approved Medicaid State Plan and all Medicaid members with an assessed SUD treatment need are impacted by the Demonstration.

Section 3
Methodology

This Evaluation Design, previously approved by CMS, represents a comprehensive and independent evaluation of the original Connecticut 1115 SUD Waiver Demonstration, as described above, that complies fully with STCs 34 through 45. The evaluation examines whether the Connecticut Medicaid SUD treatment system is more effective through a provision of a complete coordinated continuum of care using ASAM placement criteria and standards, including SUD residential treatment services. The delivery system reforms are particularly important to address the needs of the Medicaid expansion population, which has historically been underserved.

As part of the Demonstration, Connecticut submitted an SUD Implementation Plan that was approved by CMS. The Implementation Plan outlines State-specific steps to achieve CMS defined Milestones for SUD treatment. This required MPA of progress in meeting SUD Implementation Plan goals and its performance is based on CMS-identified metrics. The SUD MPA includes:

- An examination of the State's progress toward meeting each Milestone and timeframe approved in the SUD Implementation Plan.
- An assessment of the State's progress toward closing the gap between baseline and targets each year in performance measures as approved in the SUD Monitoring Protocol.
- A discussion of implementation successes and challenges that affected the achievement of Milestones and closure of performance measure gaps to date.
- A consideration of factors likely to affect future performance in meeting Milestones and targets not yet met and the risk of missing those Milestones and performance targets.
- In developing the SUD MPA methodology, the independent evaluator, Mercer and its subcontractor TriWest Group, collaborated with State partners, Medicaid stakeholders (including members and advocates), and SUD treatment providers as required in the STCs.

Data Sources

Primary data sources for the MPA were Demonstration documents and reports (including submitted quarterly monitoring reports), CMS-required monitoring metrics and focus groups conducted with multiple stakeholder groups, described later in this section.

The table on the following page contains a description of the implementation activities associated with each Milestone and the data sources used to assess each.

Milestone	Implementation Activities	Data Sources
Milestone 1 Access to Critical LOCs for OUD and Other SUDs	Coverage of the following services through a new SPA: • Outpatient services • Intensive outpatient services • Medication-Assisted Treatment (MAT) • Intensive LOCs in residential and inpatient settings • Medically supervised withdrawal management	• Required CMS metrics • Quarterly monitoring reports • ASO reports • Provider review results • Stakeholder focus groups (all)
Milestone 2 Use of Evidence-Based, SUD-Specific Patient Placement Criteria	Connecticut will ensure that: • Providers assess treatment needs based on ASAM assessment tools • Utilization management approaches are implemented that align with ASAM criteria • There is an independent process for reviewing placement in residential treatment settings	• Required CMS metrics • Provider certification reports • Utilization review tools and reports • Training and TA logs • ASO websites • Stakeholder focus groups (CT BHP, State partners, ASO, providers)
Milestone 3 Use of Nationally Recognized SUD-Specific Program Standards	Connecticut will ensure that the following criteria are met: • Implementation of residential treatment provider qualifications that meet the ASAM criteria • Implementation of a State process for reviewing residential treatment providers to assure compliance with these standards • Implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off site	• Provider qualification requirements • SPA • Provider certification reports • Stakeholder focus groups (CT BHP, state partners, ASO, providers)
Milestone 4 Sufficient Provider Capacity at Each LOC	Connecticut completed an initial assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical LOCs listed in Milestone 1	• Required CMS metrics • Provider certification reports • Stakeholder focus groups (all)
Milestone 5 Implementation of Comprehensive	• Implementation of opioid prescribing guidelines (completed prior to the Demonstration and not analyzed	• Required CMS metrics • Quarterly monitoring reports

Milestone	Implementation Activities	Data Sources
Treatment and Prevention Strategies to Address Opioid Misuse and OUD	through Stakeholder focus groups) • Expanded coverage of and access to naloxone (completed prior to the Demonstration and not analyzed through Stakeholder focus groups) • Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs	
Milestone 6 Improved Care Coordination and Transitions Between LOCs	Connecticut's implementation plan includes actions that will support and facilitate residential and inpatient facilities as they link beneficiaries, especially those with OUD and other SUDs, with community-based services and supports following stays in these facilities	• Required CMS metrics • Quarterly monitoring reports • Stakeholder focus groups (State agencies, providers, ASO)

Analytic Methods

Multiple analytic techniques are used for this MPA, depending on the type of data for the measure and the use of the measure in the Evaluation Design (e.g., process measure versus outcome measures). The analysis conducted for this MPA focuses on descriptive analyses, since the goal here is to illustrate State progress on each Milestone and describe potential risks to achieving the Demonstration's goals (rather than inferring causal links between activities and outcomes).

Reviews of State and Partner Documentation and Reports

In assessing the State's progress in meeting SUD Implementation Plan Milestones, the evaluation team examined the following policy, rule, and contract documents and reports:

- SPAs
- Provider manuals and bulletins
- Narratives from Carelon quarterly utilization reports
- Provider certification and LOCs lists
- Provider monitoring tools and reports
- Quarterly monitoring reports
- Training and technical assistance logs

These documents were reviewed using content analysis techniques to document various aspects of the implementation plan and confirm information reported in the quarterly monitoring reports. In some cases, frequencies (counts, percents) are also derived from these reports (specifically, monitoring reports and confirmation of provider counts).

CMS-Required Monitoring Metrics

The CT SUD Monitoring Protocol was approved in the first quarter of Demonstration Year 2 (DY2) (June 23, 2023) with no deviations from the CMS technical specification manual. All results required are reviewed and summarized here. Metrics related to quarterly utilization were examined for the first two years of the Demonstration period with April-June 2022 serving as the first quarter of the Demonstration and July-September 2024 as the mid-point. Connecticut reports all metrics with a consistent three-month lag, after the dates of services. Using the first of the following month for the "as of" date allows for consistency. The metrics are then calculated in the six months following that end data and reported to CMS nine months following the end of each quarter. Annual metrics were compared for DY1 and CY22 (baseline) and DY2 and CY23 (mid-point) for the Demonstration year metrics. The following table provides the baseline and mid-point assessment measurement periods for quarterly, demonstration year (DY) and calendar year (CY) metrics.

Measurement Period	Critical Metrics	Baseline	Mid-point
Quarterly Measures (monthly metrics are summed up and reported for each quarter)	**#3, 6, 7, 8, 9, 10, 11, 12, and 23**	April 1, 2022*–June 30, 2022	July 1, 2022 – September 30, 2024
DY	**# 4, 5, 13, 14, 25 and 36**	DY1 April 1, 2022*–March 31, 2023	DY2 April 1, 2023–March 31, 2024
CY	**# 15, 17(1), 17(2), 18, 21, 22, and 27**	CY2022	CY2023

*While the Demonstration was not approved until April 14, 2022, all metrics are calculated from April 1, 2022, to have a complete month's data.

The team also assessed the State's performance on measures identified by CMS as "critical." To assess progress across time (baseline and mid-point), metrics submitted as monthly counts were converted to a quarterly count for the two and one-half years. Metrics calculated annually provided only two data points for comparison, with the first years (DY1 and CY22) considered baseline for the mid-point[1].

Critical Milestone Metrics for Assessing Progress	
Milestone 1: Access to critical LOCs for OUD and other SUDs	
	#7 Early Intervention
	#8 Outpatient Services
	#9 Intensive Outpatient and Partial Hospitalization Services
	#10 Residential and Inpatient Services

[1] The State will have data prior to the Demonstration for the Interim Evaluation.

Critical Milestone Metrics for Assessing Progress
#11 Withdrawal Management
#12 Medication-Assisted Treatment
#22 Continuity of Pharmacotherapy for OUD
#3 Medicaid Beneficiaries with SUD Diagnosis (monthly)
#4 Medicaid Beneficiaries with SUD Diagnosis (annually)
#6 Any SUD Treatment
Milestone 2: Use of evidence-based, SUD-specific patient placement criteria
#5 Medicaid Beneficiaries Treated in an IMD for a SUD
#36 Average Length of Stay in IMDs
Milestone 3: Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities
There are no CMS-required performance metrics for this Milestone
Milestone 4: Sufficient provider capacity at each LOC
#13 Provider Availability
#14 Provider Availability — MAT
Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Misuse OUD
#18 Use of Opioids at High Dosage in Persons Without Cancer
#21 Concurrent Use of Opioids and Benzodiazepines
#23 Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries
#27 Overdose Deaths (rate)
Milestone 6: Improved Care Coordination and Transitions Between LOCs
#15 Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)
#17 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
#25 Readmissions Among Beneficiaries with SUD: Total number of inpatient discharges per 1,000 beneficiaries in the measurement period

The absolute change and percent change from baseline were calculated for each Milestone metric designated by CMS as critical. When the change from baseline was one point or less, performance was deemed to be consistent. Other metrics that were aligned with each Milestone, as assigned by CMS, also were examined as part of the overall MPA. In

accordance with CMS guidance, the evaluation team utilized the criteria for Milestone risk assessment published in the CMS guidance document, as reprinted below.

Stakeholder Focus Groups

Evaluators conducted five stakeholder focus groups/listening sessions between December 2024 and February 2025 with the following groups:

- Connecticut DSS.
- Other State partners — the Connecticut DMHAS and the Connecticut DCF JB-CSSD and the DOC.
- Advanced Behavioral Health, Inc. — the entity contracted by DMHAS and DCF to conduct the provider certification processes for the Connecticut 1115 SUD Demonstration Waiver.
- Carelon Behavioral Health — the ASO — the entity contracted to determine medical necessity and approve service authorizations and payments and perform independent reviews of residential admissions.
- State SUD providers.
- Consumers and advocates.

Each session included a facilitated discussion, ranging from 25 to 90 minutes regarding the State's current successes and challenges in making progress to the six Demonstration Milestones. Each group was attended by a facilitator and one to two note takers. All notes were consolidated and summarized by the focus group facilitator using narrative analysis. Note taker participants then reviewed summaries to confirm common themes, primary recommendations and to check for any missing discussions around specific State successes or challenges.

Assessing Performance and Risk

The SUD MPA examines the progress of planned enhancements outlined in the SUD Implementation Plan. The Mercer evaluation team assessed progress in each Implementation Plan area by evaluating Demonstration activities to-date and their alignment with the approved plan and timeline. The table below is reproduced exactly from the CMS guidance and represents the considerations made within this report when assessing progress and risk of not achieving each Milestone.

For each Milestone, Mercer first presents the findings from each of the data sources listed and then summarizes the Milestone progress in a table that follows these guidelines.

CMS Guidance: Considerations for assessing risk of not achieving each Demonstration Milestone[2]

[2] Reproduced exactly from the State Demonstrations Group (SDG), Center for Medicaid and CHIP Services (CMCS), Centers for Medicare and Medicaid Services (CMS). October 2021. Medicaid Section 1115 Substance Use Disorder (SUD) and Serious Mental Illness and Serious Emotional Disturbance (SMI/SED) Demonstrations: Mid-Point Assessment Technical Assistance. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/1115-sud-smised-mid-point-assessment-ta.pdf on November 1, 2024.

		Overall risk of not meeting milestone		
Data source	**Considerations**	**Low**	**Medium**	**High**
Critical metrics (required)	For each metric associated with the milestone, is the state moving in the direction of the state's annual goal and overall demonstration target?	All or nearly all (e.g., more than 75 percent) of the critical metrics trending in the expected direction	Some (e.g., 25-75 percent) of the critical metrics and other monitoring metrics trending in the expected direction	Few (e.g., less than 25 percent) of the critical metrics and other monitoring metrics trending in the expected direction
Implementation plan action items	Has the state completed each action item associated with the milestone as scheduled to date?	All or nearly all (e.g., more than 75 percent) of the action items Completed	Some (e.g., 25-75 percent) of the action items completed	Few (e.g., less than 25 percent) of the action items completed
Stakeholder feedback	Did key stakeholders identify risks related to meeting the milestone?	Few stakeholders identified risks; risks can be easily addressed within the planned timeframe	Multiple stakeholders identified risks that may cause challenges meeting milestone	Stakeholders identified significant risks that may cause challenges meeting milestone
Provider availability assessment data	For SUD: Does the state have or expect to have adequate provider availability at critical levels of care? For SMI/SED: Is the state moving in the expected direction as outlined in the demonstration goals and milestones and as described in the state's implementation plan for availability assessment data	For SUD: Availability is adequate For SMI/SED: All or nearly all (e.g., more than 75 percent) of the availability assessment data indicate expected progression	For SUD: Availability is not yet adequate but is moving in expected direction For SMI/SED: Some (e.g., 25-75 percent) of the availability assessment data indicate expected progression	For SUD: Availability is not yet adequate and not moving in expected direction For SMI/SED: Few (e.g., less than 25 percent) of the availability assessment data indicate expected progression

Limitations

This MPA is descriptive in nature and is designed to present a summary of implementation progress in the first two and one-half years of the Demonstration. The primary limitation of this MPA is the lack of more than two annual data points for the annual CMS-required metrics.

The report relies heavily on qualitative data, in the form of document reviews and stakeholder focus groups. Stakeholders may be biased in their perspective or have an incomplete understanding of all implementation activities. Further, document reviews are subject to interpretation by the person summarizing the documents. To address this latter limitation, summaries of document reviews and stakeholder groups have been reviewed by members of the Mercer team who have a close understanding of the Demonstration in order to verify accuracy of reports and provide additional perspectives.

Section 4

Mid-point Assessment Findings

This section presents findings for each of the six Milestones. Each Milestone MPA includes a description of the State's progress in 1) meeting its action steps and timelines outlined in the SUD Implementation Plan, 2) a descriptive analysis of progress on performance metrics, and 3) a summary of stakeholder input regarding State progress on the Milestone as required by the Evaluation Design for activities not already completed prior to the Demonstration.

Milestone 1: Access to Critical Levels of Care for OUDs and SUDs

Milestone 1 Implementation Plan

Connecticut's Implementation Plan outlines steps to 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, recognizing that each beneficiary needs a type and LOC that aligns with their individual clinical needs. To meet this Milestone, Connecticut planned to provide coverage of the following services:

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

The following two approved SPAs describe activities listed in Milestone 1.

- **SPA 22-0020** — This SPA establishes coverage and reimbursement for SUD services provided in outpatient and residential settings within the rehabilitative services benefit category. For applicable LOCs, this SPA implements and is consistent with the State's approved SUD Section 1115 Demonstration waiver.
- **SPA 22-0021** — This SPA updates the Alternative Benefit Plan (ABP) to add coverage for SUD services under the rehabilitative services benefit category for services provided in outpatient and residential settings.

The following table outlines a summary of Milestone 1 planned activities. As shown, the State has completed all activities associated with this Milestone.

Milestone Requirements	Actions Outlined in Implementation Plan	Completed
Coverage of outpatient services	Rehabilitative services benefit SPA, update State standards to be consistent with ASAM 3rd edition[3]	Complete
Coverage of intensive outpatient services	Rehabilitative services benefit SPA (same as above)	Complete
Coverage of MAT	Rehabilitative services benefit SPA (same as above)	Complete
Coverage of intensive LOCs in residential and inpatient settings	Rehabilitative services benefit SPA (same as above)	Complete
Coverage of medically supervised withdrawal management	Rehabilitative services benefit SPA (same as above)	Complete

Milestone 1 Performance Metrics

The following **critical** performance metrics, as defined in the SUD Monitoring Protocol, were considered in assessing the Demonstrations progress on improving access to SUD treatment.

- #7 Early Intervention Services
- #8 Outpatient Services
- #9 Intensive Outpatient and Partial Hospitalization Services
- #10 Residential and Inpatient Services
- #11 Withdrawal Management
- #12 MAT
- #22 Continuity of Pharmacotherapy for Opioid Use Disorder

In addition, the evaluators reviewed the following other performance measures:

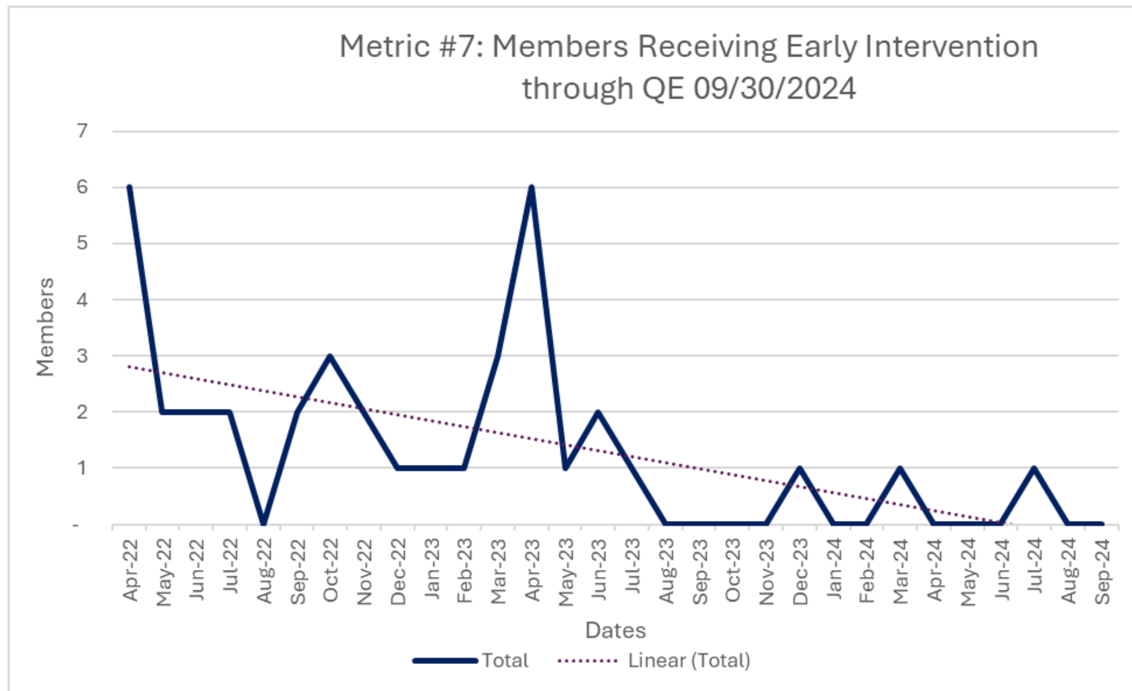
- #3 Medicaid Beneficiaries with SUD Diagnosis (monthly)
- #4 Medicaid Beneficiaries with SUD Diagnosis (annually)
- #6 Any SUD Treatment

We first look at trends over time for each of the metrics, then summarize the change for each metric between baseline (April – June 2022) and mid-point (July – September 2024),

[3] ASAM 3rd edition was the latest available as the Implementation Plan was developed and during initial implementation.

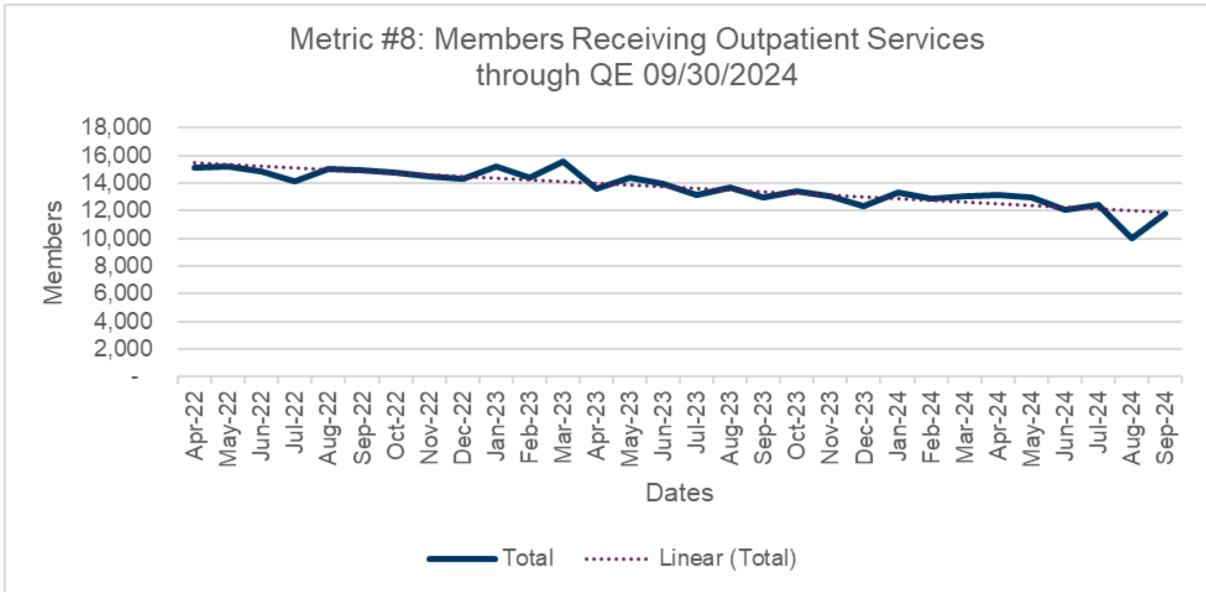
indicating whether the direction of the change (increase, decrease, stabilization, etc.) is in the direction expected by the Demonstration.

Metric #7: Early Intervention Services



Connecticut has chosen to utilize the commercial SBIRT codes for early intervention that only reimburse for SUD screens if the screen is positive and SUD treatment is provided. Other states reimburse using the Medicaid SBIRT codes that reimburse providers for any screen provided even if the screen was negative. The very small numbers of members identified as having a positive screen and receiving early intervention treatment services make the trends over time volatile. Numbers did decrease between the first month of intervention and the most recent month for which data is available. Early intervention was not a focus of the Implementation Plan but remains a critical LOC that is difficult to assess because there is not a reimbursement incentive to provide screening. As a result, early intervention does not appear to be accessible under the Demonstration given these low numbers.

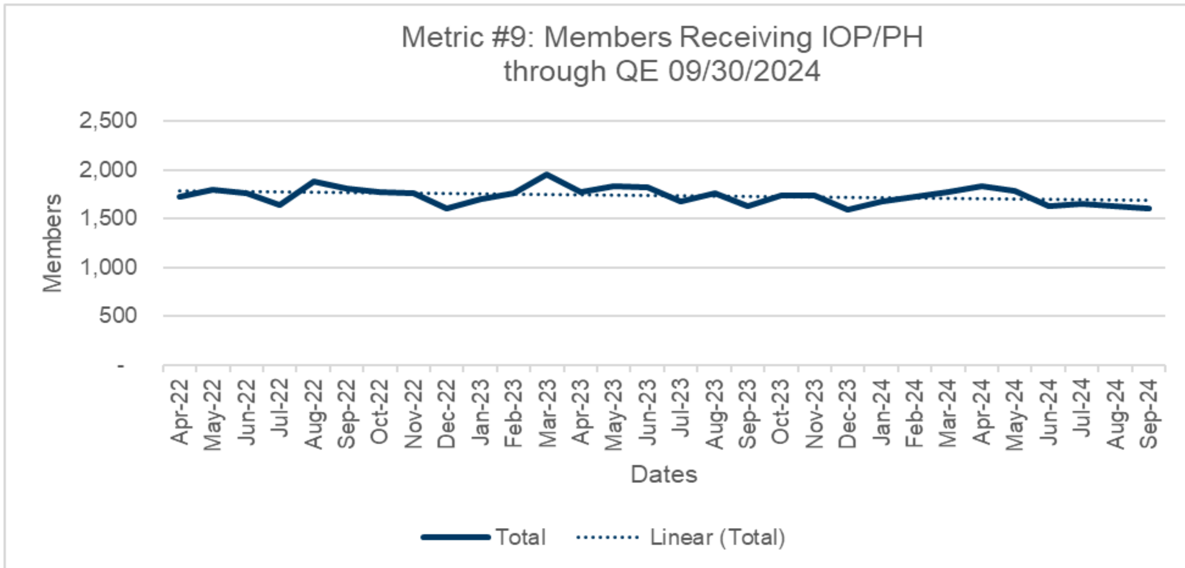
Metric #8: Outpatient Services



The number of members receiving outpatient services has been relatively stable, declining slightly over the course of the first two years of the Demonstration. This decline mirrors a decline in the number of members with an SUD diagnosis (which will be discussed in detail later in this section). The decline in the number of individuals with SUD diagnoses and receiving outpatient treatment appears to correlate with the unwinding of the public health emergency (PHE) eligibility. Connecticut's Medicaid rolls decreased by 9% from April 2023 to October 2024.[4]

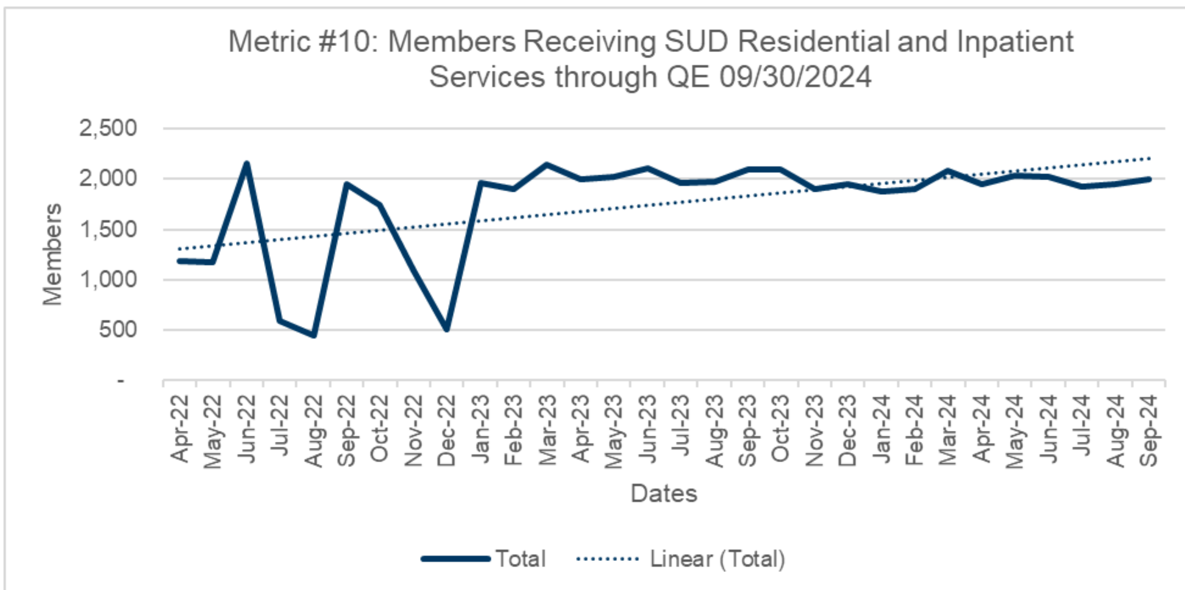
[4] Connecticut saw overall declines in enrollment during this period (July 1, 2023–June 30, 2024) due to the Public Health Emergency unwinding that could be affecting the raw counts of members receiving SUD. https://portal.ct.gov/phe/-/media/phe/ct-unwinding-data/husky-health-program-performance-dashboard-april-2023-to-april-2024.pdf In particular, October 2023 had 32,642 fewer HUSKY enrollees than July 2023. July 2023 had 62,567 fewer HUSKY enrollees than April 2023. Kaiser Family Foundation reported that from March 2023-October 2024, Connecticut lost 9% of its Medicaid and CHIP enrollment due to unwinding. www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-enrollment-data/

Metric #9 Intensive Outpatient and Partial Hospitalization Services



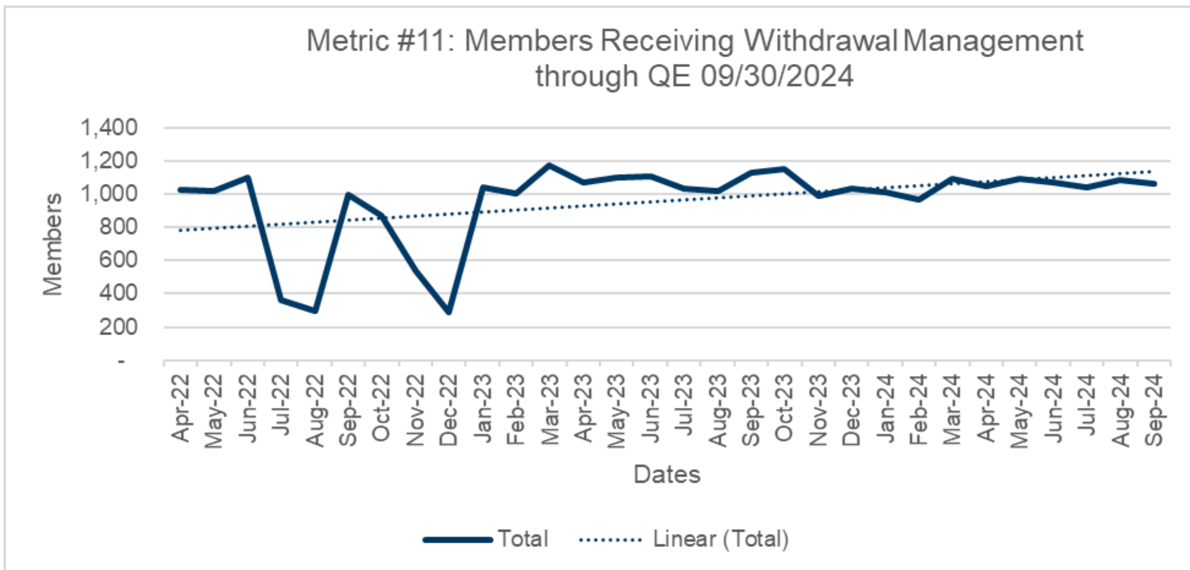
Similar to other outpatient services, the trend in the number of members receiving intensive outpatient and partial hospitalization services have remained relatively stable, showing a small increase by the time of the mid-point measurement, due to small increases in services over the last four months for which data is available. The declines from March 2023–September 2024 would appear to be related to the decline in Medicaid enrollment due to the public health unwinding.

Metric #10 Residential and Inpatient Services



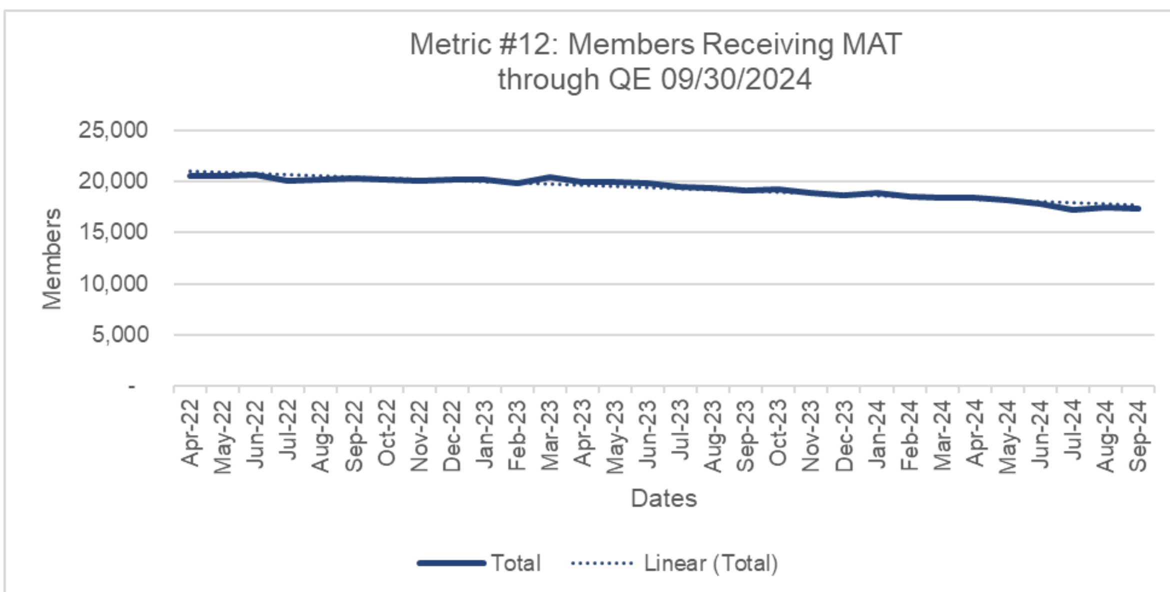
After significant fluctuation in the number of claim paid for residential and inpatient services during the first eight months of the Demonstration where due to programming challenges the claims were not submitted within three months of the date of service (the data cutoff for this metric), the trend in this metric has stabilized showing improvement from the first month, but with a small decline since January of 2023.

Metric #11 Withdrawal Management Services



Trends in the number of members receiving withdrawal management services mirror the trend of members receiving residential and inpatient services: volatile for the first eight months due to new claims programming issues, then resolving into a stable, slightly increased trend over the second year of the Demonstration.

Metric #12 Medication Assisted Treatment (MAT)



There has been a small, but consistent decline in the number of members receiving MAT since the start of the Demonstration. This is, again, consistent with the small decline in the number of members with an SUD diagnosis due to the PHE unwinding. It is also consistent with declines in dual eligible members receiving MAT under Medicaid since Medicare began covering MAT and ramp up under Medicare has increased. It is inconsistent with both the

Demonstration targets and the increasing need for SUD services expressed by the State in its waiver application.

Metric #22 Continuity of Pharmacotherapy for OUD

Metric #22 is a CY annual metric, so a monthly descriptive graphic is unavailable. Based on a comparison between CY2022 and CY2023, this metric is slightly declining so far in the Demonstration. The target was to increase this metric.

Summary of Changes in Critical Metrics

Relative to Milestone 1, CT BHP set targets to increase access to all LOCs. Mid-point results show that Connecticut is meeting its goal to increase access to two of the six identified levels of SUD treatment, as measured by the number of beneficiaries receiving that type of service.. Utilization of services has increased for residential and inpatient services (30.1%), and withdrawal management services (1.4%). MAT showed a decline (-23.3%), as did outpatient services (-24.3%) and intensive outpatient and partial hospitalization services (-7.3%). The greatest decrease was in early intervention services (-90.0%), which was less than 30 individuals. The former SBIRT code did not capture screens that were completed without a positive outcome or treatment being provided. Small numbers and volatility in this metric means that monthly changes over time cannot capture overall trends sufficiently.

Detailed results for critical metrics are presented below.

Milestone 1 Critical Metric		Results		Change at Mid-Point			State Goal	Progress
#	Name	Base-line	Mid-point	Absolute Change	Percent Change	Direction		
7	Early Intervention Services	10	1	-9	-90.0%	Decrease	Increase	No
8	Outpatient Services	45,193	34,198	-10,995	-24.3%	Decrease	Increase	No
9	Intensive Outpatient and Partial Hospitalization Services	5,282	4,897	-385	-7.3%	Decrease	Increase	No
10	Residential and Inpatient Services	4,525	5,887	1,362	30.1%	Increase	Increase	Yes
11	Withdrawal Management	3,153	3,196	43	1.4%	Increase	Increase	Yes
12	Medication-Assisted Treatment (MAT)	67,835	52,017	-15,818	-23.3%	Decrease	Increase	No

22	Continuity of Pharmacotherapy (rate), CY	0.706	0.700	-0.006	-0.8%	Decrease	Increase	No

Other Milestone 1 Metrics

In addition, the evaluators reviewed the following additional performance measures:

#3 SUD Diagnosis: The number of unique members with an SUD diagnosis during the measurement period.

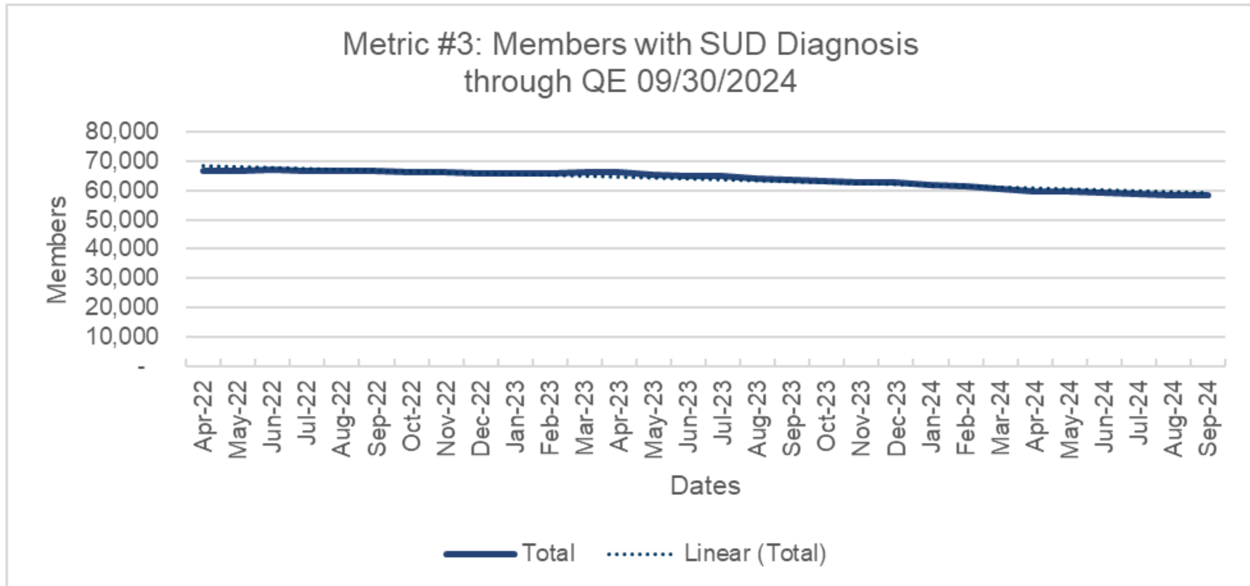
#4 SUD Diagnosis: The number of unique members with an SUD diagnosis annually

#6 Receiving SUD Treatment Services: The number of unique members receiving any SUD treatment service during the measurement period.

These additional metrics did not increase over the measurement period. Detailed results for these metrics are presented below.

Milestone 1 Other Metric		Results		Change at Mid-Point			State Goal	Progress
#	**Name**	**Base-line**	**Mid-point**	**Absolute Change**	**Percent Change**	**Direction**		
3	Members with SUD Diagnosis	200,499	175,385	-25,114	-12.53%	Decrease	Increase	No
4	Members with SUD Diagnosis (Annual)	82,857	80,364	-2,493	-3.01%	Decrease	Increase	No
6	Members Receiving SUD Treatment	96,892	81,178	-15,714	-16.22%	Decrease	Increase	No

Decreases in members with an SUD diagnosis and members receiving SUD treatment has likely been more strongly impacted by the Medicaid unwinding after the end of the COVID-19 PHE. In the interim evaluation, the interrupted time series analysis of these metrics will look at the percent of members receiving services and will control for the effect of the unwinding. Please see the graphs of Metrics #3 and #6 below.


Metric #3: Members with SUD Diagnosis through QE 09/30/2024
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
-
Members
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
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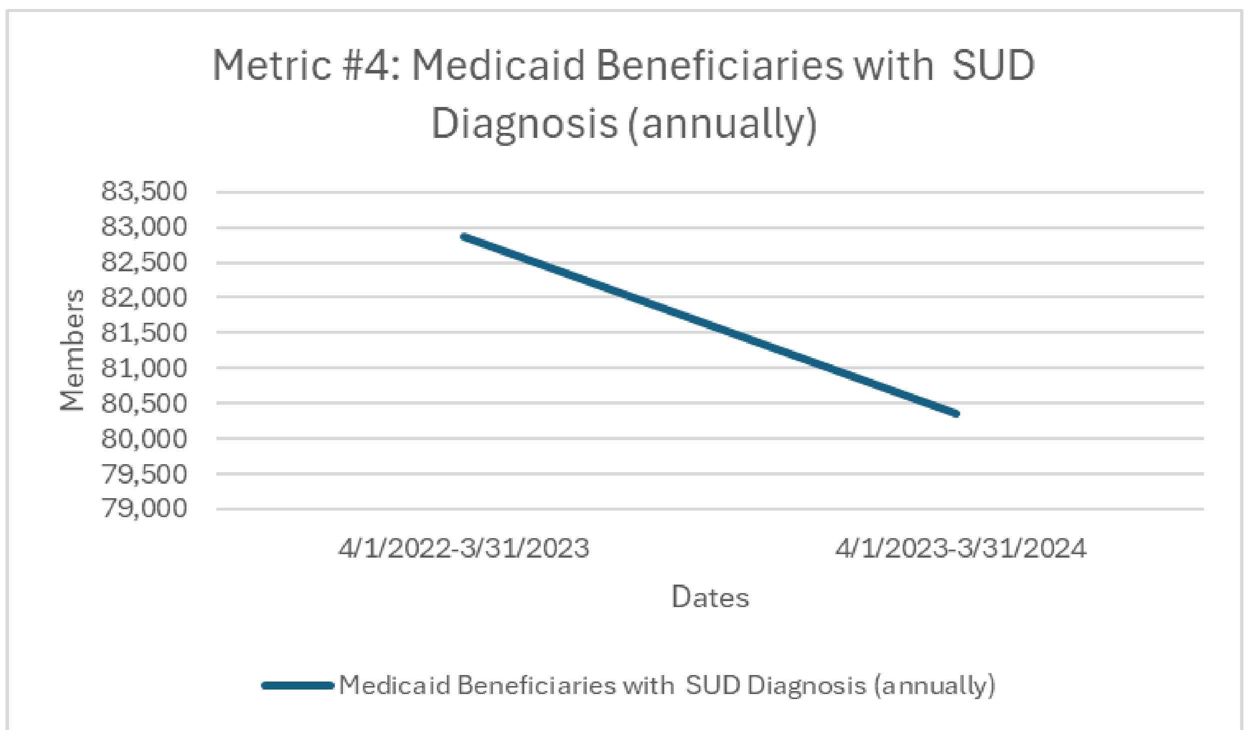
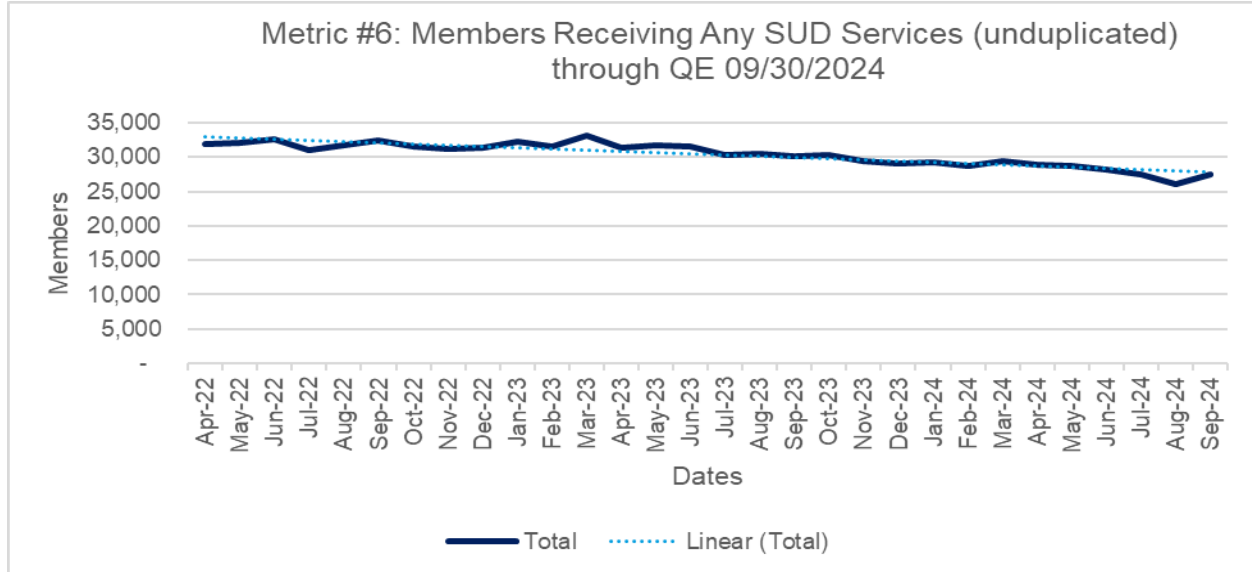
Aug-24
Sep-24
Dates
Total
Linear (Total)


Metric #4: Medicaid Beneficiaries with SUD Diagnosis (annually)
83,500
83,000
82,500
82,000
81,500
81,000
80,500
80,000
79,500
79,000
Members
4/1/2022-3/31/2023
4/1/2023-3/31/2024
Dates
Medicaid Beneficiaries with SUD Diagnosis (annually)



Milestone 1 Stakeholder Input

Providers and consumer advocates who participated in focus groups reported that access to care has not increased since the start of the Demonstration and indicated that access may be getting worse in the State. Providers described seeing more complex individuals with greater treatment needs and did report seeing more people eligible for services. However, capacity has not increased to meet the need. Providers reported ongoing waitlists for some LOCs, meaning that patients cannot be transitioned when they are ready for a lower LOC or are not progressing and need more services at higher LOC levels.

Specifically, there is very little access at ASAM level 3.1 and, to a lesser degree, at 3.5. While there is adequate availability of services at the 3.7 level, there are not available placements for individuals to step down their care appropriately. This means individuals either stay at unneeded higher LOCs or step down to a much lower LOCs (e.g., intensive outpatient) before they are ready, potentially leading to relapse.

Complicating the issue of problems for stepping down LOCs is that when a person cannot step down to a lower LOC, the ASO will not authorize continued treatment at the higher level, which is not medically necessary. Providers have to either continue to provide services, unreimbursed or discharge clients who still need significant treatment support. Providers have been offered to provide the lower LOCs but reported being reluctant to receive reduced payment for the less intense services.

For the first year of the Demonstration, the State's independent reviewer of residential admissions applied the ASAM placement criteria and worked with providers through education and extension of authorizations. However, as providers became certified consistent with ASAM and the implementation phase of the Demonstration completed, Carelon began enforcing ASAM placement criteria and the medical necessity required by the Demonstration's CMS mandated STCs. Providers noted the change in the State's application of ASAM requirements and reported that with the cessation of the implementation phase of the Demonstration, Carelon was not approving authorizations and claims in the same manner. Providers did not seem to understand the reasons behind Demonstration requirements, independent review of residential admissions, and application of ASAM

placement criteria. Some providers expressed a view that this could be a “crack down” to be more rigorously adherent to ASAM criteria for medical necessity, potentially linked to trying to control costs. Others thought that newer reviewers at Carelon may not have a strong enough understanding of ASAM and that more training could be needed there.

All stakeholders agreed that residential adolescent treatment access continues to be a challenge in the State. Currently, there are no in-state Medicaid providers for this LOC for youth, with most stakeholders acknowledging that the rate structures that are now in place are insufficient. There is a low overall number of adolescents who need this level of service, which means that providers cannot operate with significant capacity to offset the minimum expenditures needed to keep a facility open.

The consumer and advocacy focus group was largely focused on youth needs and this group reported a perception that “things are getting worse” in terms of access to substance use treatment. This group was unique among all of those who provided feedback in that their perspectives focused on the need for more prevention and early intervention services. This group expressed concern that there has been a large increase in marijuana use for youth and when youth need early intervention or outpatient services, it is unclear how to access them. This is consistent with very low rates of utilization of early intervention services across all age groups.

Summary of Overall Milestone 1 Progress

SUD Milestone 1 Assessment				
Assessment Area	**# Completed or Progressing**	**Key Considerations**	**Assessment of Risk**	**State Response and Intervention(s)**
Implementation Plan	5/5 (100%)	• The State submitted the SPA needed to provide these services, which was approved by CMS in the timeline expected	Low	
Critical Metrics	2/7 (28%)	• Residential and inpatient services showed the greatest increase (30.1%) over baseline, followed by small increases in withdrawal management (1.4%) early intervention, , outpatient services, intensive outpatient and partial hospitalization and MAT all decreased (-90.0%, -24.3%, -7.3%, and -23.3%, respectively). Decreases are probably related to the unwinding and coverage of fewer Medicaid individuals.	Medium	By 7/1/2025, CT will reimburse all negative and positive SUD screenings by adding two new SBIRT billing codes to incent providers to conduct screenings and to report all screenings conducted via administrative data.

SUD Milestone 1 Assessment				
Assessment Area	**# Completed or Progressing**	**Key Considerations**	**Assessment of Risk**	**State Response and Intervention(s)**
Other Metrics	0/3	• There was a similar decrease across the number of members receiving an SUD diagnosis and those receiving any SUD services. This is likely due to the discussed Medicaid unwinding, and not necessarily the Demonstration.	Low to Medium	Beginning 6/1/2025, Connecticut DSS will continue to monitor ongoing and new data as it becomes available and as part of the Interim Evaluation.
Stakeholder Input	Some stakeholders raised concerns	• Providers raised concerns about access at specific LOCs, particularly for 3.1 and described that lack of availability at some levels leads to denials because a person cannot transition to the needed LOC. • Consumer advocates did not perceive increased access to care but cited knowledge about services availability and people's readiness to seek care as primary barriers. • State agency staff discussed ensuring that individuals were placed in the right LOC. There is currently not a Residential LOC for adolescents.	Medium	Effective 7/1/2025, and pending SPA approval Connecticut DSS will implement the following interventions to address the noted concerns. • Increased adolescent treatment rates to improve access for this population and added 3.7 and 3.1 LOC to the continuum of care for adolescents. DSS collapsed the bed corridors by extending beds in 3.1, 3.3, 3,5 and 3.5 PPW from 0-13, 14-24, 25-44 to 0-24 and 25+ beds allowing the treatment rate at the lowest bed corridor to widen across higher bed numbers. • Connecticut DSS in collaboration with state partners, have increased

SUD Milestone 1 Assessment				
Assessment Area	# Completed or Progressing	Key Considerations	Assessment of Risk	State Response and Intervention(s)
				engagement efforts with providers for the adult and adolescent populations meeting with providers during site visits to share program details and requirements and address any questions or concerns related to potential enrollment; "Implemented a Provider Collaborative" quarterly meeting series to engage with providers, share program updates, provide Technical Assistance (TA) and hear and address provider concerns. The meeting series is ongoing and will continue on a quarterly cadence. • Conducted a webinar series on all aspects of ASAM to provide Technical Assistance to providers. The trainings are posted to the state SUD 1115 Demonstration website for

SUD Milestone 1 Assessment				
Assessment Area	**# Completed or Progressing**	**Key Considerations**	**Assessment of Risk**	**State Response and Intervention(s)**
				providers to access and there is planning underway to continue the series. • State partners revised staffing ratios by extending the number of clients to staff where clinical treatment and oversight would not be impacted. By 7/01/2025, DSS will convene a workgroup with the ASO to collaborate on: • Reviewing and enhancing the documentation for medical necessity to ensure the guidance and process are clear. • Establish a process for supporting providers through technical assistance and/or training.

As illustrated in the table above, the State seems to be at medium risk for meeting Milestone 1. Having access to all critical LOCs and for the entire Medicaid population (including adolescents) is the largest challenge currently faced by the State.

Milestone 2: Use of Evidence-Based, SUD-Specific Patient Placement Criteria

Milestone 2 Implementation Plan

Under this Milestone, Connecticut has implemented ASAM 3.0, which was the latest ASAM edition at the start of the implementation. ASAM is a set of evidence-based, SUD-specific patient placement criteria with the corresponding interventions and qualifications to be provided at each LOC. To meet this Milestone, Connecticut will ensure that:

- Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, linked to the ASAM Criteria.
- Utilization management approaches are implemented to ensure that:
  - Beneficiaries have access to SUD services at the appropriate LOC.
  - Interventions are appropriate for the diagnosis and LOC.
  - There is an independent process for reviewing placement in residential treatment settings.

DSS has completed provider manuals and a series of provider bulletins containing guidance related to the Demonstration. Provider bulletins can be found on the ctdssmap.com webpage. ASAM training has been made available to all providers.

The following table outlines a summary of Milestone 2 planned activities.

Milestone Requirements	Actions Outlined in Implementation Plan	Completed
Providers assess treatment needs that are SUD-specific and multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines.	DMHAS and DCF will ensure providers training necessary to implement the provider training portion of the Demonstration on behalf of DSS and the Medicaid program.	Initially Complete, Ongoing
	The Medicaid SPA and related Medicaid provider manuals will establish the ASAM as requirements for providers to assess treatment needs and develop recommendations for placement in appropriate LOCs with the effective date of the Rehabilitative SPA compliant with the most recent edition of ASAM.	Complete
Implementation of a utilization management approach such that (a) beneficiaries have	The State phased in each LOC for: Hospital, Residential, Hospital Outpatient, Ambulatory, OTPs, FQHCs, Behavioral Health Clinics,	Complete

Milestone Requirements	Actions Outlined in Implementation Plan	Completed
access to SUD services at the appropriate LOC.	Enhanced Care Clinics, and Outpatient Drug and Alcohol Abuse Centers.	
	The behavioral health ASO (Carelon) has completed a website with a provider search function for Medicaid beneficiaries and providers. The behavioral health ASO has been directed to update the website to the most recent ASAM edition and provider information.	Progressing (all completed except for Carelon website update)
Implementation of a utilization management approach such that (b) interventions are appropriate for the diagnosis and LOC.	Provider resources including ASAM standards by LOC have been completed and are available online. Providers | CTBHP Providers	Complete
	The State's ASO, Advanced Behavioral Health, implemented ASAM training for SUD residential providers statewide. Certification processes are complete for all requirements, with only Ambulatory services still ongoing.	Progressing (Ambulatory services certification ongoing)
Implementation of a utilization management approach such that (c) there is an independent process for reviewing placement in residential treatment setting.	DSS has directed the Medicaid behavioral health ASO to use the most recent ASAM edition for utilization review, prior authorization, and to update the website, provider information and internal documentation. Carelon utilizes ASAM 3rd edition when assessing medical necessity for admission to all SUD LOCs, produces a monthly report for residential LOCs, and provides technical support to providers.	Progressing (all completed except for Carelon website update)

Milestone 2 Performance Metrics

The following critical performance metrics, as defined in the SUD Monitoring Protocol, were considered in assessing the Demonstration's progress on improving access to SUD treatment.

- #5 Medicaid Beneficiaries Treated in an IMD for SUD

- #36 Average Length of Stay in IMDs

In April 2023 DSS and its ASO finalized utilization management processes for residential and other treatment programs. The process is expected to support clinically appropriate lengths of stay based on medical necessity and ASAM LOC assessment tools.

Milestone 2 Critical Metric		Results		Change at Mid-Point			State Goal	Progress
#	Name	Base-line	Mid-point	Absolute Change	Percent Change	Direction		
5	Medicaid Beneficiaries Treated in an IMD for SUD	6,281	8,032	1,751	27.9%	Increase	Increase	Yes
36	Average Length of Stay in IMDs	10.89	17.65	6.76	62.1%	Increase	Decrease/ No more than 30 days	Yes (under 30 days)

Milestone 2 Stakeholder Input

There was a consensus among State agency and provider stakeholder groups that providers are using the ASAM criteria to make placement decisions. While there was general agreement that movement toward placement decisions and timing based on medical necessity (rather than fixed program lengths) was a positive direction for the State. In general, placements based on ASAM criteria should result in people who need services getting the right LOC for their individual needs. Providers reported that a lack of capacity at specific LOCs mean that real-world transitions in LOCs are frequently driven by bed availability rather than medical necessity, without sufficient alternative options.

This could be addressed by moving toward more flexibility in the LOCs provided within a single facility or agency. The State has begun moving in this direction. However, many providers expressed an unwillingness to provide lower LOCs (particularly, 3.1) because the rate paid for the lower LOCs was not sufficient to keep higher LOC capacity open. This is further complicated by authorization reviewers adhering to standards to facilitate transitions in care as required under the Demonstration. One participant provided an example where a person was approved for a lower LOC with a bed opening the following day, but with an additional night needed at the higher LOC. The ASO reviewer required a discharge because medical necessity was not met for the transition day. Other providers agreed with the assessment that Carelon' s current focus seems to lean toward the strict adherence to ASAM levels as required under the Demonstration for federal Medicaid funding instead of individualized care and coordinating transitions across LOCs.

A similar concern was voiced around intensive outpatient services when individuals were not progressing in treatment. Carelon may move to discharge individuals if the providers do not provide treatment alternatives to reengage individuals, especially when individual willingness to engage with treatment is causing challenges. The consumer focus group pointed to

individual willingness to engage and participate as being one of the biggest barriers to accessing care.

SUD Milestone 2 Assessment				
Assessment Area	**# Completed or Progressing**	**Key Considerations**	**Assessment of Risk**	**State Response and Intervention(s)**
Implementation Plan	7/7 (100%)	• The State has completed or is progressing in activities to align provider certification and utilization management reviews to align with ASAM 3rd edition criteria. The only activities that continue in progress are updates to website language to reflect the 3rd edition and completion of Ambulatory services provider certification.	Low	
Critical Metrics	2/2 (100%)	• The number of members receiving treatment for a SUD in an IMD has increased since the start of the Demonstration, but the length of stay is increasing. However, the LOC increase could be due to a need for longer LOC to receive the	Low	

SUD Milestone 2 Assessment				
Assessment Area	**# Completed or Progressing**	**Key Considerations**	**Assessment of Risk**	**State Response and Intervention(s)**
		appropriate levels of treatment. The Demonstration's target regarding IMD LOC is less than 30 days, which has been met.		
Stakeholder Input	Some increasing stakeholder concerns	• Providers expressed concerns over treatment authorizations, largely due to placement decisions made during care transitions; no similar concerns were expressed by State agency staff. Carelon is complying with Demonstration mandates to provide an independent review of all residential admissions to ensure medical necessity and compliance with ASAM placement criteria.	Low to Medium	February 2025 and on-going: DSS began and continues to monitor and review monthly, metrics related to authorizations, placement decisions and care transitions with state partner agencies and together determine training and technical assistance would be beneficial to mitigate concerns shared by providers. Connecticut is committed to ensuring providers understand the requirements of ASAM with respect to treatment authorizations and placement decisions. • DSS provided technical assistance to providers during the February 2025 Provider Collaborative and through the 2024/2025 webinar series. • The DSS ASO, Carelon, meets with providers upon request if an authorization request is denied clarifying the rational for the denial and offering TA with the authorization documentation process.

Overall, the State seems to be at low risk of not meeting this Milestone. However, the challenges seem to at least originate from previously discussed challenges around lack of capacity at some LOCs. However, there appears to be concern from providers, based on those participating in our focus group, that the ASAM placement criteria and individualized care is not sustainable. Increased communications with providers and problem solving around managing care transitions when bed capacity is limited will be an important part of ensuring that this Milestone is fully met.

Milestone 3: Use of Nationally Recognized SUD-Specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Milestone 3 Implementation Plan

Through this Demonstration, Connecticut receives federal financial participation (FFP) for a continuum of SUD services, including services provided to Medicaid enrollees residing in residential treatment facilities that qualify as IMDs. To meet this Milestone, Connecticut's Implementation Plan outlines activities that will ensure that the following criteria are met:

- Implementation of residential treatment provider qualifications (in licensure requirements, policy manuals, managed care contracts [in Connecticut, this reference refers to the ASO contracts], or other guidance) that meet the ASAM criteria or other nationally recognized, SUD-specific program standards regarding the types of services, hours of clinical care and credentials of staff for residential treatment settings.
- Implementation of a State process for reviewing residential treatment providers to assure compliance with these standards.
- Implementation of a requirement that residential treatment facilities offer MAT onsite or facilitate access off-site.

The following table outlines a summary of Milestone 3 planned activities.

Milestone Requirements	Actions Outlined in Implementation Plan	Completed
Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, contracts, or other guidance.	MMIS coding, rates and billing guidance for residential providers have been completed and distributed in Provider Bulletins.	Completed
	Provider Bulletins include guidance on POS 55 requirements for residential treatment facilities, reimbursement for SUD inpatient treatment at state-operated and private hospitals, and CHIP reimbursement for SUD treatment at free-standing residential facilities.	Completed

Milestone Requirements	Actions Outlined in Implementation Plan	Completed
Implementation of a State process for reviewing residential treatment providers to ensure compliance with these standards.	Connecticut established a four-phase monitoring process at the beginning of the 1115 SUD Demonstration. DMHAS and Advanced Behavioral Health continued intensive ASAM certification monitoring by completing Phase 4 of monitoring with residential SUD programs. This phase focused on assessing the deficiencies identified in Phase 3 and helping where needed to meet full certification. At the end of the two-year provisional certification period 42 residential SUD programs met full certification under the Demonstration. Additional technical assistance and site monitoring is planned for three programs in need of additional support.	Completed
Implementation of requirement that residential treatment facilities offer MAT onsite or facilitate access off-site.	No action needed; criteria met at time of application.	Complete (at application) It was reported that some facilities including ASAM 3.1 and sober houses have methadone limit dosages. The reason for this is unclear and may be a holdover from abstinence philosophy.

Milestone 3 Performance Metrics

There are no CMS-required performance metrics for this Milestone and no State-elected quantitative measures.

Milestone 3 Stakeholder Input

Stakeholder groups acknowledge that adopting the ASAM criteria was initially a steep learning curve for many residential providers. The State, Carelon, and ABH have emphasized a cooperative and supportive approach to helping providers become fully credentialed. ABH reported some specific issues with some providers, but reports show that, overall, the majority of residential providers are meeting the criteria, with few corrective actions needed and with the resolution process going smoothly.

Stakeholders (Carelon and ABH) did report two specific issues that DSS and other State partners did not seem to be aware of: 1) some providers not allowing clients with specific (high) Methadone dosages prescribed and 2) sufficiency of treatment intensity to support a person's improvement during treatment. DSS has not received any complaints with respect to the quality of care. This difference could mean that general provider quality issues are minimal and restricted to a small number or could signal a need for better communication between ABH, Carelon, and the State regarding provider qualifications and potential training or technical assistance needs. Both issues could have significant impact on treatment quality, so better communication between ABH, Carelon, and State partners seems warranted.

Providers were satisfied with the training and technical assistance they received regarding ASAM criteria, with at least one using the term "great" to describe the training received. Providers did express a desire for more in-person intensive training opportunities, as staff turnover is high. There is availability of online, self-guided training, but the consensus of providers is that the intensive in-person trainings are much better.

Milestone 3 Assessment

SUD Milestone 3 Assessment			
Assessment Area	**# Completed or Progressing**	**Key Considerations**	**Assessment of Risk**
Implementation Plan	4/4 (100%)	• The State has completed all action items from the Implementation Plan regarding residential provider qualifications.	Low
Critical Metrics	N/A	N/A	N/A
Stakeholder Input	A few specific concerns reported	• Providers had positive views of intensive training opportunities. • The State and partners have taken a collaborative approach with providers who need technical assistance to meet all ASAM criteria for residential qualifications. • The reports of some provider quality issues appear to be isolated at this time.	Low

SUD Milestone 3 Assessment			
		• Improved communication across all partners is encouraged to address emerging problems.	

The State appears on track to achieve this Milestone and to continue successes in establishing and the ongoing monitoring of residential provider qualifications. Improved communication could be an opportunity to anticipate any emerging challenges to meeting this Milestone and address them quickly.

Milestone 4: Sufficient Provider Capacity at Each Level of Care

Milestone 4 Implementation Plan

To meet this Milestone, Connecticut completed an initial assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical LOCs listed in Milestone 1. This assessment focused on 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. The State identified gaps in treatment for adolescents.

Since that initial assessment, the State has seen quarterly reductions in capacity beginning in Demonstration Year 2. To address the new gaps, the State implemented a Flex Bed model to improve capacity at a lower LOCs (3.1 and 3.5). However, provider response to the Flex Bed model was low due to the perception reported by providers, that they were not being paid to maintain the higher LOC capacity. As a result, capacity remains lacking, particularly in those areas based on stakeholder input.

The following table outlines a summary of Milestone 4 planned activities.

Milestone Requirements	Actions Outlined in Implementation Plan	Completed
Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical LOCs throughout the State including those that offer MAT.	The State has completed a capacity assessment and has created technology to continue to monitor ongoing capacity.	Completed
	The State has noted reductions in capacity since the Demonstration. While not in the original implementation plan, new actions have been identified to try to offset bed capacity reductions.	Progressing

Milestone Requirements	Actions Outlined in Implementation Plan	Completed
	The State began a Flex Bed model in May of 2023, but there have been few providers taking advantage of that model.	

Milestone 4 Performance Metrics

The following critical performance metrics, as defined in the SUD Monitoring Protocol, were considered in assessing the Demonstration's progress on improving access to SUD treatment.

- #13 SUD Provider Availability
- #14 SUD Provider Availability — MAT

Results for the identified critical metrics show that while overall SUD provider availability decreased slightly, the number of SUD providers who offer MAT services slightly increased.

Milestone 4 Critical Metric		Results		Change at Mid-Point			State Goal	Progress
#	Name	Base-line	Mid-point	Absolute Change	Percent Change	Direction		
13	SUD Provider Availability	1,796	1,735	-61	-3.4%	Decrease	Increase	No
14	SUD Provider Availability — MAT	53	58	5	9.4%	Increase	Increase	Yes

Milestone 4 Stakeholder Input

In focus groups, DSS staff discussed losing beds early in the Demonstration, due to decreased services during the COVID-19 PHE and rate structures that caused some providers to close beds at specific LOCs. These issues have been exacerbated by workforce shortages. DSS staff described fluctuations during the first two years of the Demonstration and noted that efforts to enhance rate structures and active recruitment with providers have resulted in more providers coming forward to provide services. These observations are consistent with many of the findings from analysis of metrics, with those fluctuations particularly seen in residential and inpatient treatment and withdrawal management.

Other State partners, when asked about capacity, focused more on getting people in need of services into the right LOC, but did not express any perspectives that capacity has increased. These partners explained that the first two and one-half years of implementation have focused on increasing the understanding of ASAM across the continuum. Representatives from DMHAS, DCF and judicial partners shared that State efforts have improved placement decisions, with people getting into the right services and that wait times

have recently begun to decrease due to shorter lengths of stay that are related to medical necessity guiding LOCs.

Rates are affecting provider willingness to provide 3.1 and 3.5 LOCs. The State has also not yet resolved its challenge to secure providers for adolescent residential care, largely due to overall low levels of need and the significant additional services required for this population (including staff ratios, school services, etc.). This need was supported by stakeholders from State agencies and partners.

One provider noted that the State may need to move to a co-occurring model for adolescent residential care to serve youth with both SED and SUD (and co-occurring) needs to increase the demand for services to a threshold that will support a minimum average occupancy rate to support ongoing operations.

Stakeholders did not express any concerns with provider enrollment standards, except to the degree that the enrollment standards are not aligned with rates for some LOCs. The State continues to work on the Flex Bed model, but this model has been implemented by few providers.

Milestone 4 Assessment

SUD Milestone 4 Assessment				
Assessment Area	**# Completed or Progressing**	**Key Considerations**	**Assessment of Risk**	**State Response and Interventions(s)**
Implementation Plan	1/2 (50%)	The State completed an initial capacity assessment that identified gaps in care for adolescents. Since then, however, there have been decreases in residential capacity for other populations and critical levels, potentially creating a medium risk for meeting this Milestone.	Low to Medium	
Critical Metrics	1/2 (50%)	The number of providers has decreased since the start of the Demonstration, but there has been an increase in the number of providers of MAT.	Medium	Beginning December 2023, DSS has monitored and continues to monitor the number of MAT providers through monthly oversight meetings with state partners and project team meetings to address and ensure access to

SUD Milestone 4 Assessment				
				care is available to all members that require SUD services. July 1, 2025, DSS will modify the fee schedule to have a single fee for all LOC. As noted above under milestone #1, on July 1, 2025, DSS made changes to the rate structure and added two LOCs for the adolescent population. Beginning January 1, 2025, DSS and state partners increased engagement efforts including site visits to Providers to share information about the program; through informational meetings with interested providers; through ongoing training initiatives; and Provider Collaboratives that seek to provide engagement opportunities and technical assistance. DSS plans to engage new providers to share updates on the program and changes to rates,

SUD Milestone 4 Assessment				
				eliminate barriers in program requirements that go beyond ASAM and create additional burdens on providers; continue to provide opportunities for technical assistance and engagement through provider collaboratives, training series. DSS will continue to engage in a multi-pronged approach to address access if data continues to trend in the wrong direction.
Stakeholder Input	Stakeholders reported concerns	As discussed in Milestone 1, providers report that rates for some of the lower LOCs (e.g., 3.1 and 3.5) are not sufficient to sustain capacity. The lack of capacity jeopardizes continuity of care.	Medium	Noted above in Milestone #1, beginning July 1, 2025, and pending SPA approval DSS will implement the new rate structure to address the provider concerns around rates and will continue to monitor capacity and continuity of care.

Overall, the State is at medium risk of not meeting this Milestone. The primary cause appears to be the misalignment between qualification standards at specific LOCs and the rates being paid for those services. This contributes to the already noted provider capacity challenges which is the main challenge currently facing the State.

Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Misuse and OUD

Milestone 5 Implementation Plan

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

The following table outlines a summary of Milestone 5 planned activities.

Milestone Requirements	Actions Outlined in Implementation Plan	Completed
Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug misuse.	Not needed. Met at time of application: • Prior to the Demonstration, DPH implemented prescribing guidelines to prevent opioid over use through a number of updates to Connecticut policy and law regulating prescribing of controlled substances and opioid medications. • In 2019, Connecticut amended the Medicaid State Plan to reflect the new drug utilization review provisions required in federal law under the SUPPORT Act.	Completed (at application)
Expanded coverage of and access to naloxone for overdose reversal.	Not needed. Met at time of application: • Connecticut passed a “Good Samaritan” law in 2011 that protects people, who call 911 seeking emergency medical services for an overdose, from arrest for possession of drugs/paraphernalia. • Connecticut passed a law in 2012 allowing prescribers to prescribe, dispense, or administer naloxone	Completed (at application)

Milestone Requirements	Actions Outlined in Implementation Plan	Completed
	to any person to prevent or treat a drug overdose and protects the prescriber from civil liability and criminal prosecution. • In 2014, the protection was extended to any person administering the naloxone. • In 2015, legislation permitted trained and certified pharmacist to prescribe and dispense naloxone directly. • In 2018, prescribers may develop agreements with organizations wishing to train and distribute naloxone. • Connecticut also had a State Opioid Response grant that distributed 12,000 naloxone kits prior to the Demonstration.	
Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs.	• Connecticut mandated use of the Connecticut Prescription Monitoring and Reporting System (CPMRS), the State's prescription drug monitoring program in 2015. • The Department of Consumer Protection (DCP), the prescription drug monitoring program vendor (Appriss Health), and DSS will continue to onboard new electronic health records and pharmacy dispensing vendors. • DCP in collaboration with the Office of Health Strategy (OHS) and DSS will continue to link the CPMRS with the health information exchange (HIE) consistent with the Implementation Advance Planning Document (IAPD). • DCP and DSS evaluated the feasibility of utilizing predictive analytics to forecast increased risk of long-term prescription misuse based on initial prescribing characteristics. NarxCare has	In Progress (low)

Milestone Requirements	Actions Outlined in Implementation Plan	Completed
	been included in the CPMRS system. • DCP, OHS, and DSS will continue to work to identify management across systems for better integration. • DCP, OHS, and DSS will continue to explore additional analytical tools to assist with enforcement to minimize the risk of inappropriate overprescribing. A new compliance module was implemented in 2022. • Connecticut's approach to HIE has been incremental for standing up the HIE and implementing functionality based on priorities established by the State. The base functionality has been implemented but Connecticut continues to implement additional features and functionality. Connecticut has a combined Operational Advance Planning Document (OAPD) for the Operations and IAPD for the planned development/Design, Development and Installation process (DDI) (submitted in 2024 and covers FY 2025 and 2026).	

Milestone 5 Performance Metrics

Mercer examined the following performance metrics, as defined in the SUD Monitoring Protocol, related to the implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD:

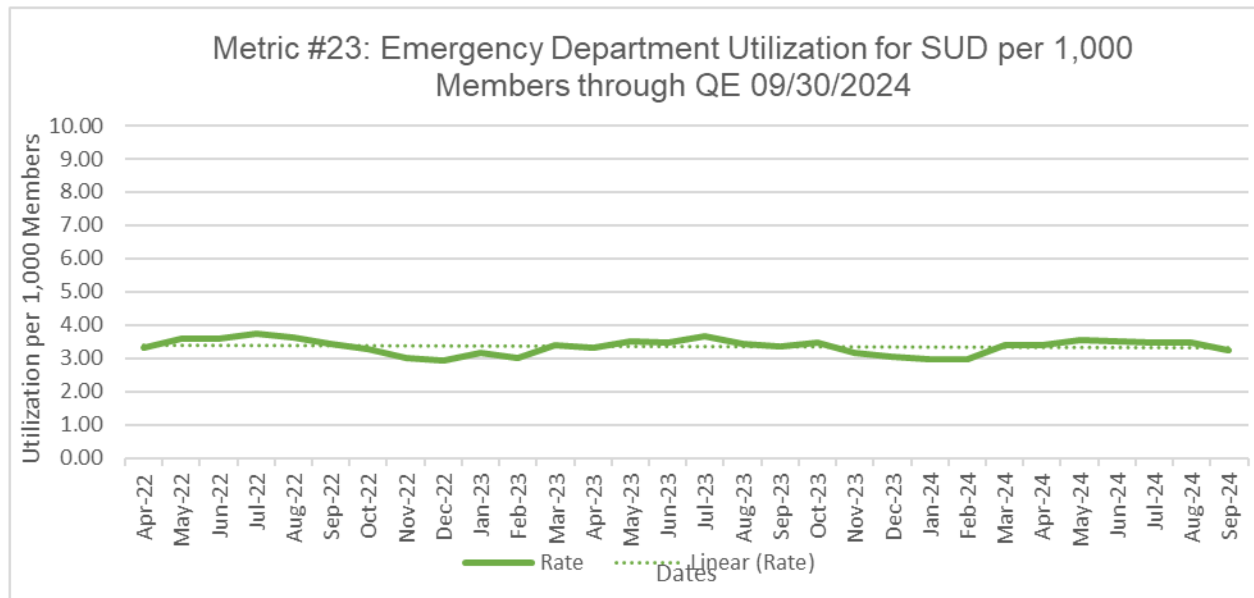
- #18 Use of Opioids at High Dosage in Persons Without Cancer: Rate per 1,000 beneficiaries included in the denominator without cancer who received prescriptions for opioids with a daily dosage greater than 120 morphine milligram equivalents for 90 consecutive days or longer.
- #21 Concurrent Use of Opioids and Benzodiazepines: Percentage of beneficiaries with concurrent use of prescription opioids and benzodiazepines.
- #23 Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries: Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period.

- #27 Overdose Deaths (rate): Rate of overdose deaths during the measurement period per 1,000 adult Medicaid beneficiaries affected by the Demonstration.

Metrics #18 and #21 both decreased from the baseline (-13.4% and -.6%) consistent with the State's goals to reduce use of opioids at high dosage in persons without cancer and concurrent use of opioids and benzodiazepines. Metric #27 overdose deaths decreased from baseline to mid-point by -9.5%. Metric #23 (emergency department utilization for SUD) decreased from baseline (April - June 2022) to mid-point (July - September 2024) by 3%. Detailed results for critical metrics are presented below.

Metric #23: Emergency Department Utilization

For metric #23, the emergency department utilization from the Baseline (April-June 2022) through Midpoint (July – September 2024) has remained relatively constant.



Milestone 5 Critical Metric		Results		Change at Mid-Point			State Goal	Progress
#	Name	Baseline	Mid-Point	Absolute Change	Percent Change	Direction		
18	Use of Opioids at High Dosage in Persons Without Cancer	5.2%	4.5%	-0.7%	-13.4%	Decrease	Decrease	Yes
21	Concurrent Use of Opioids and Benzodiazepines	17.3%	17.2%	-0.1%	-0.6%	Decrease	Decrease	Yes
23	Emergency Department Utilization per	10.5	10.2	-0.3	-3.0%	Decrease	Decrease	Yes

	1,000 Medicaid Enrollees							
27	Overdose deaths (rate) per 1,000 CT Population	.420	.380	-0.040	-9.5%	Decrease	Decrease	Yes

Milestone 5 Stakeholder Input

Behavioral health stakeholders were not asked questions about outstanding requirements regarding the Prescription Drug Monitoring Program (PDMP) and Health Information Exchange (HIE) progress, as this was not a data source as specified in the approved evaluation design related to any evaluation hypotheses. Other information sources were utilized to measure process on PDMP and HIE progress.

SUD Milestone 5 Assessment			
Assessment Area	**# Completed or Progressing**	**Key Considerations**	**Assessment of Risk**
Implementation Plan	100% complete	• Activities associated with the first two requirements of this Milestone were complete at the time of application: — Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug misuse. — Expanded coverage of and access to naloxone for overdose reversal. • The State has made process on the third requirement of this Milestone: Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs as listed in the Milestone 5 actions table above.	low
Critical Metrics	4/4 (100%)	• The state has made progress on the critical metrics (4/4) for this Milestone.	low
Stakeholder Input	N/A	• The approved evaluation design did not call for stakeholder input on this milestone and other data sources were utilized to monitor progress on PDMP and HIE progress, which was the only outstanding requirement.	N/A

Milestone 6: Improved Care Coordination and Transitions Between LOCs

Milestone 6 Implementation Plan

Connecticut's Implementation Plan includes actions that will support and facilitate residential and inpatient facilities as they link beneficiaries, especially those with OUD and other SUDs, with community-based services and supports following stays in these facilities. Connecticut's intent is to enhance 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.
- Current policies or plans to improve care coordination for co-occurring physical and mental health conditions.

Milestone Requirements	Actions Outlined in Implementation Plan	Completed
Additional policies to ensure coordination of care for co-occurring physical and mental health conditions.	Incorporate strong discharge planning and transition planning into the residential and ambulatory LOC at the provider level using new ASAM standards. Require service coordination in all ASAM LOCs.	Complete
	Review existing care management models reimbursed via State dollars, Medicaid administrative dollars and Medicaid FFS payments across the State and ensure care management for the SUD population.	Progressing
	Use TCM budget analysis to determine if the target population in the TCM SPA can be expanded to include SUD-only (i.e., TCM co-occurring SUD versus SUD-only).	Complete

Milestone 6 Performance Metrics

The SUD Monitoring Protocol metrics related to improved care coordination and transitions between LOCs designated by CMS as critical include thirteen metrics and sub-metrics. Of those metrics six improved (46%) and seven did not improve (54%). The results are below:

- #15 Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): total scores and sub-population breakouts reported for:

- Initiation of AOD Treatment — Percentage of beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of the diagnosis. Three of four metrics (75%) improved. The exact metric results are in the table below.
  - Initiation of AOD Treatment - Alcohol abuse or dependence (rate 1, cohort 1) Alcohol: This rate improved.
  - Initiation of AOD Treatment - Opioid abuse or dependence (rate 1, cohort 2) Opioid: This rate improved.
  - Initiation of AOD Treatment - Other drug abuse or dependence (rate 1, cohort 3) Other: This rate did not improve.
  - Initiation of AOD Treatment - Total AOD abuse of dependence (rate 1, cohort 4) Total: This rate improved.
- Engagement of AOD Treatment — The percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit. One of four metrics improved. The exact statistics are in the table below.
  - Engagement of AOD Treatment - Alcohol abuse or dependence (rate 2, cohort 1) Alcohol: This rate did not improve.
  - Engagement of AOD Treatment - Opioid abuse or dependence (rate 2, cohort 2) Opioid: This rate did not improve.
  - Engagement of AOD Treatment - Other drug abuse or dependence (rate 2, cohort 3) Other: This rate improved.

- Engagement of AOD Treatment - Total AOD abuse of dependence (rate 2, cohort 4) Total: This rate did not improve.#17 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence: Two or four results reported for four sub-groups improved with the exact statistics in the table below:
  - Percentage of ED visits for beneficiary's diagnosis of AOD abuse or dependence and who had a follow-up visit for AOD within seven days of the ED visit: This rate did not improve.
  - Percentage of ED visits for which the beneficiary received a follow-up visit for AOD within 30 days of the ED visit: This rate did not improve.
  - Percentage of ED visits for beneficiary's diagnosis of mental illness which the beneficiary received a follow-up visit for mental illness within seven days of the ED visit: This rate improved.
  - Percentage of ED visits for which the beneficiary received a follow-up visit for mental illness within 30 days of the ED visit: This rate improved
- #25 Readmissions Among Beneficiaries with SUD: Total number of inpatient discharges per 1,000 beneficiaries in the measurement period: This rate did not improve. The exact statistics are in the table below.

Overall, the state is improving the initiation of treatment but not the engagement and length of treatment. This suggests that better care coordination over time to retain individuals in care are needed. In addition, follow-up after emergency room visits are improving at 30-days post visit but not immediately following emergency room visits at the seven-day mark. This suggests that better care coordination immediately post emergency room visits are needed. Finally, the hospital readmission rates are not improving suggesting that better care coordination with community providers is needed post hospital discharge.

Detailed data for critical metrics are presented below.

Milestone 6 Critical Metric		Results		Change at Mid-Point			State Goal	Progress
#	Name	Base-line	Mid-point	Absolute Change	Percent Change	Direction		
15a	1. Initiation of AOD Treatment - Alcohol abuse or dependence (rate 1, cohort 1)	21.9%	22.2%	0.3%	1.5%	Increase	Increase	Yes
	2. Initiation of AOD Treatment - Opioid abuse or dependence (rate 1, cohort 2)	28.0%	29.3%	1.3%	4.7%	Increase	Increase	Yes
	3. Initiation of AOD Treatment - Other drug abuse or dependence (rate 1, cohort 3)	18.4%	16.2%	-2.3%	-12.3%	Decrease	Increase	No
	4. Initiation of AOD Treatment - Total AOD abuse of dependence (rate 1, cohort 4)	28.3%	28.9%	0.6%	2.1%	Increase	Increase	Yes
15b	5. Engagement of AOD Treatment - Alcohol abuse or dependence (rate 2, cohort 1)	78.8%	77.9%	-0.9%	-1.1%	Decrease	Increase	No
	6. Engagement of AOD Treatment - Opioid abuse or dependence (rate 2, cohort 2)	133.6%	124.0%	-9.6%	-7.2%	Decrease	Increase	No
	7. Engagement of AOD Treatment - Other drug abuse or dependence (rate 2, cohort 3)	72.3%	75.5%	3.2%	4.4%	Increase	Increase	Yes
	8. Engagement of AOD Treatment - Total AOD abuse of dependence (rate 2, cohort 4)	66.6%	63.8%	-2.9%	-4.3%	Decrease	Increase	No
17(1a)	Follow-up after discharge from the ED for AOD within 30 days	24.9%	20.9%	-4.0%	-16.1%	Decrease	Increase	No
17(1b)	Follow-up after discharge from the ED for AOD within 7 days	15.6%	11.9%	-3.6%	-23.3%	Decrease	Increase	No
17(2a)	Follow-up after discharge from the ED for mental health within 30 days	36.8%	40.8%	3.9%	10.7%	Increase	Increase	Yes

Milestone 6 Critical Metric		Results		Change at Mid-Point			State Goal	Progress
#	Name	Base-line	Mid-point	Absolute Change	Percent Change	Direction		
17(2b)	Follow-up after discharge from the ED for mental health within 7 days	24.3%	27.2%	2.9%	12.0%	Increase	Increase	Yes
25	Readmissions for SUD in 30 days post discharge	22.4%	23.7%	1.3%	5.9%	Increase	Decrease	No

Stakeholder Input

While the State's analysis did not support budget availability for TCM services for SUD only populations, there are opportunities to improve care coordination, particularly around transitions across different LOCs.

Also, the significant struggles when trying to move patients across different levels of residential care, combined with some comments about supporting individuals who are struggling in IOP present opportunities for improvement and suggest that finding the funds to invest in TCM or other efforts to improve recovery housing or lower LOCs such as expanded access to ASAM 3.1 may need to be a higher priority for the State. Given that the only critical measure for this Milestone, Readmissions for SUD in 30 days post discharge was increasing, combined with stakeholder input suggests that investing in TCM or other efforts to improve recovery housing or lower LOCs such as expanded access to ASAM 3.1 has a potential to have cost savings in reducing readmissions.

Milestone 6 Assessment

SUD Milestone 6 Assessment				
Assessment Area	**# Completed or Progressing**	**Key Considerations**	**Assessment of Risk**	**State Response and Interventions(s)**
Implementation Plan	3/3 (100%)	• All activities associated with this Milestone were completed as planned.	Low	
Critical Metrics	6/13 (46%)	• While treatment initiation is increasing, treatment engagement	Medium	Beginning 6/1/2025, Connecticut DSS will continue to monitor ongoing and new data as it becomes available and as part

SUD Milestone 6 Assessment				
Assessment Area	**# Completed or Progressing**	**Key Considerations**	**Assessment of Risk**	**State Response and Interventions(s)**
		is decreasing. • The State has made progress in increasing the percentage of ED follow ups occurring for mental health but not AOD.		of the Interim Evaluation.
Stakeholder Input	Stakeholders shared concerns	• Stakeholders pointed to issues during care transitions that can contribute to lack of treatment progress. • The lack of TCM as an available service is a missed opportunity to improve care.	Medium	Care transitions and Care coordination was a new component of the ASAM treatment model and included in residential rates.

Overall there is a low to medium risk to the state of accomplishing this Milestone. The State completed a fiscal study and determined that the current budget will not support TCM services. The main concern expressed by stakeholders in this report relates to transitions across LOCs and support for individuals as they move from residential to intensive outpatient services (sometimes without securing housing supports). TCM would be one opportunity for the State to begin to address these two issues. Other options would be enhancing access to Recovery Housing during ambulatory care or increasing the capacity of providers providing ASAM 3.1 LOCs.

There was a slight increase in readmissions to SUD treatment in the 30 days post-discharge, an indicator that after care and treatment services are not sufficient to sustain long-term

recovery. Stakeholders discussed perspectives that additional supports, in addition to clinical treatment, such as evidence-based treatment for mental health conditions or services that address readiness to change (such as Motivational Interviewing) or supports for social determinants of health and well-being (predominantly housing) can be large factors in treatment success. Without TCM, housing, and enhanced access at ASAM 3.1, addressing these issues will remain challenging.

Next Steps

While there is potential risk that the State may not meet some Milestones surrounding access, there are significant successes in the Demonstration that can be leveraged to respond to current challenges. State partners have built close relationships and have good foundations for communication and trust. Providers, while concerned about capacity and rates, expressed willingness to work with the State and appreciated current efforts to work with them on training, technical assistance and in communication around changes being made to improve the Demonstration.

Recommendations to build on these successes include:

- Continue to work with providers to explore Flex Bed options and rate adjustments to facilitate increased capacity for level 3.1 and 3.5 LOCs.
- Increase focus on providing early intervention and outpatient services, including more widespread screening for SUD across all age groups to avoid costs associated with higher LOCs. Consider supporting outpatient providers in early intervention services, including SBIRT. This may include making sure that all Medicaid providers have access to payment for these services and consider providing education in primary care settings for the SBIRT model.
- Build on the existing foundation of open and productive communication by increasing reporting of data regarding Demonstration outcomes and progress, particularly the monitoring metrics, to all stakeholders, including providers. Consider regular meetings with State agencies and providers that move beyond policy and procedure updates and that focus on problem-solving discussions for metrics that are not meeting Demonstration targets.
- Start bi-directional, problem-focused communications with providers and ASOs around managing care transitions across LOCs when bed capacity is limited. The State should prioritize provider concerns that ASAM LOCs might be used as cost-control mechanisms rather than a focus on individualized treatment planning.
- Communicate more when provider reviews find areas of concern around quality of care (e.g., insufficient treatment dosage) and use those opportunities to improve.
- Consider the following options to improve retention and continuity in care:
  - A TCM pilot with an SUD-only population with acute treatment needs that could help the State to determine whether costs for those services might be offset by savings in reduced returns to SUD treatment after 30 days, ED utilization, transitions to higher, rather than lower LOCs, etc.
  - Creating access to Recovery Housing for individuals receiving ambulatory care.

- Enhanced access to ASAM 3.1 to improve transitions to lower LOCs.

Attachment 1

Independent Assessor Description

Connecticut (DSS) has taken steps to ensure that Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, is free of any conflict of interest and will remain free from any such conflicts during the contract term. DSS considers it a conflict if Mercer currently 1) provides services to ASOs or health care provider doing business in Connecticut under the Health First Connecticut program; or 2) provides direct services to individuals in DSS or DMHAS-administered programs included within the scope of the technical assistance contract. If DSS discovers a conflict during the contract term, DSS may terminate the contract pursuant to the provisions in the contract.

Mercer does not have any conflicts of interest, such as providing services to any MSOs or health care providers doing business in Connecticut under the Connecticut program or to providing direct services to individual recipients. One of the byproducts of being a nationally operated group dedicated to the public sector is the ability to identify and avoid potential conflicts of interest with our firm's multitude of clients. To accomplish this, market space lines have been agreed to by our senior leadership. Mercer is the designated primary operating practice in the Medicaid space.

Before signing a contract to work in the Medicaid market, either at the state-level or otherwise, we require any Mercer entity to discuss the potential work with Mercer. If there is a potential conflict (i.e., work for a Medicaid health plan or provider), the engagement is not accepted. If there is a potential for a perceived conflict of interest, Mercer will ask our state client if they approve of this engagement, and we develop appropriate safeguards such as keeping separate teams, restricting access to files, and establish process firewalls to avoid the perception of any conflict of interest. If our client does not approve, the engagement will not be accepted. Mercer has collectively turned down a multitude of potential assignments over the years to avoid a conflict of interest.

Given that Mercer is acting as both technical assistance provider and independent evaluator for this project, DSS and Mercer have implemented measures to ensure there is no perceived conflicts of interest. This contract was awarded following a competitive bidding process that complied with all Connecticut State laws, the Mercer evaluation team (TriWest) is functionally and physically separate from the technical assistance team, and the contract does not include any performance incentives that would contribute to a perception of conflicted interests between technical assistance services and the independence of the evaluation process. As an additional firewall, the evaluation statistical analyses will be conducted by a subcontractor that has not had any interaction with the technical assistance team, using data that has been reviewed and accepted by CMS (through monitoring protocol submissions).

In regard to Mercer's proposed subcontractors, all have assured Mercer there will be no conflicts and that they will take any steps required by Mercer or DSS to mitigate Substance Use Disorder 1115 Waiver Evaluation Design State of Connecticut Mercer 45 any perceived

conflict of interest. To the extent that we need to implement a conflict mitigation plan with any of our valued subcontractors, we will do so.

Mercer, through our contract with DSS, has assured that it presently has no interest and will not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services. Mercer has further assured that in the performance of this contract, it will not knowingly employ any person having such interest. Mercer additionally certified that no member of Mercer’s Board or any of its officers or directors has such an adverse interest

Attachment 2

Data Collection Tools

Connecticut 1115 Substance Use Disorder Mid-Point Assessment Preliminary Information Request

State Request

The Mid-point Assessment report is due to Centers for Medicare & Medicaid Services (CMS) on May 31, 2025. Current plans are that the draft mid-point assessment report be sent to the State on March 31, 2025, to start the clearance process. Please note additional information and data may be requested throughout the mid-point assessment process as follow-up questions arise.

From the guidance:

The mid-point assessment provides an opportunity for a state with a substance use disorder (SUD) and/or serious mental illness (SMI)/serious emotional disturbance (SED) demonstration to:

- Describe progress towards milestones and monitoring metric targets at the demonstration mid-point.
- Identify necessary adjustments to demonstration activities.
- If needed, work with CMS to develop a corrective action plan to help the state meet its demonstration requirements and milestones.

Data needs to be submitted to Mercer no later than Monday, December 2, 2024 — *Naming convention for files: Goal/Hypothesis/*

Research Question_DataName (e.g., G1H1RQ3.1_ State Plan Amendment)

Interviews and Focus Groups will need to be finished no later than February 14, 2025.

Key Informant Interviews	Questions
DSS	• RQ1.1: Has access to critical LOCs improved in Medicaid? • RQ3.1: Stakeholder reports of successful implementation and adequate access to each ASAM critical LOC. • RQ3.1: Description of activities to monitor provider use of ASAM criteria for patient placement for providers who are certified at higher LOCs, as well as non-certified providers at ASAM .5 and ASAM 1 LOCs. • RQ3.1: Description of training and technical assistance activities to align providers with new ASAM standards. • RQ4.1: The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT. • RQ5.1: Has access to SUD residential treatment improved for adolescent girls?
KII DMHAS/DCF/JB-CSSD/DOC Staff	• RQ1.1: Has access to critical LOCs improved in Medicaid? • RQ3.1: Stakeholder reports of successful implementation and adequate access to each ASAM critical LOC. • RQ3.1: Description of activities to monitor provider use of ASAM criteria for patient placement for providers who are certified at higher LOCs, as well as non-certified providers at ASAM .5 and ASAM 1 LOCs. • RQ3.1: Description of training and technical assistance activities to align providers with new ASAM standards. • RQ4.1: The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT. • RQ5.1: Has access to SUD residential treatment improved for adolescent girls?
KII Medicaid and DMHAS/DCF ASO Representatives (Carelon)	• RQ1.1: Has access to critical LOCs improved in Medicaid? • RQ1.1: Qualitative results of grievance and appeals for Demonstration year 1 and year 2. • RQ3.1: Stakeholder reports of successful implementation and adequate access to each ASAM critical LOC.

Key Informant Interviews	Questions
	• RQ3.1: Description of activities to monitor provider use of ASAM criteria for patient placement for providers who are certified at higher LOCs, as well as non-certified providers at ASAM .5 and ASAM 1 LOCs. • RQ3.1: Description of training and technical assistance activities to align providers with new ASAM standards. • RQ4.1: The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT. • RQ5.1: Has access to SUD residential treatment improved for adolescent girls?
KII Provider Certification Representatives (ABH)	• RQ1.1: Has access to critical LOCs improved in Medicaid? • RQ3.1: Description of activities to monitor provider use of ASAM criteria for patient placement for providers who are certified at higher LOCs, as well as non-certified providers at ASAM .5 and ASAM 1 LOCs. • RQ3.1: Description of training and technical assistance activities to align providers with new ASAM standards. • RQ3.1: Stakeholder reports of successful implementation and adequate access to each ASAM critical LOC. • RQ4.1: The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT. • RQ5.1: Has access to SUD residential treatment improved for adolescent girls?
Providers	• RQ13.1: Did IMD providers improve program design and discharge planning policies?
Members	TBD

Data needs to be submitted to Mercer no later than Monday, December 2, 2024.

Goal/Hypothesis/ Research Question	Data Sources (Specific Data Needed)	Type of Data
Goal 1/Hypothesis 1 (G1H1) Research Question 1.1 (RQ1.1) RQ3.1	• ASO policies and procedures. • Provider addendums and review tools. • Copy of State Plan Amendment.	• Question: Has access to critical LOCs improved in Medicaid? • Question: Qualitative results of grievance and appeals for Demonstration year 1 and year 2. • Submission of SPA to include residential care and to update SUD service standards to align with ASAM standards for each LOC. • Stakeholder reports of successful implementation and adequate access to each ASAM critical LOC. • Documents needed for document review (see list in left column).
Goal 1/H3 RQ3.1	• DMHAS and DCF certification records. • Baseline (2021) through present. • Aggregate and detailed reports from onsite provider monitoring records.	• Number/percent of providers certified **at each LOC.** • Summary reports and supporting documents (e.g., completed onsite tools with all raw data) for each provider at each LOC. • Description of activities to monitor provider use of ASAM criteria for patient placement for providers who are certified at higher LOCs, as well as non-certified providers at ASAM .5 and ASAM 1 LOCs.
	• ASO and State documentation of training and technical assistance activities.	• Description of training and technical assistance activities to align providers with new ASAM standards.

Goal/Hypothesis/ Research Question	Data Sources (Specific Data Needed)	Type of Data
Goal 1/H4 RQ4.1	• How does the State track this (Carelon and DMHAS)? Who will provide this data? • Document review from ASOs and State agency partners.	• Number/percent of Medicaid-accepting providers licensed and certified at each LOC including MAT. • Number/percent of providers with open bed capacity and availability (DMHAS) • Number/percent of ambulatory providers with open caseloads (accepting new clients) (Carelon) • The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT.
Goal 3/H13 RQ 13.1	• Description of training and technical assistance activities to align providers with new ASAM standards.	• RQ13.1: Did IMD providers improve program design and discharge planning policies? (Process Question)

Data/Information Needed from the State — State Checklist

Goal/Hypothesis/ Research Question	Type of Data	Data Sources (Specific Data Needed)	Scheduled Y/N or Sent to Mercer Y/N
Goal 1/Hypothesis 1 (G1H1) Research Question 1.1 (RQ1.1) RQ3.1	• Question: Has access to critical LOCs improved in Medicaid? • Submission of SPA to include residential care and to update SUD service standards to align with ASAM standards for each LOC. • Stakeholder reports of successful implementation and adequate access to each ASAM critical LOC. • KIIs/focus groups. • Will need to work with Connecticut to set up KIIs or focus groups (see list in next column).	• KII DSS staff.	
		• KII DMHAS/DCF/JB-CSSD/DOC staff.	
		• KII Medicaid and DMHAS/DCF ASO representatives (Carelon).	
		• KII Provider Certification representatives (ABH).	
	Documents needed for document review (see list in next column)	• ASO policies and procedures	
		• Qualitative results of grievance and appeals for Demonstration year 1 and year 2	
		• Provider addendums and review tools	
		• Copy of State Plan Amendment	
Goal 1/H3		• DMHAS and DCF certification records • Baseline (2021) through present	

Goal/Hypothesis/ Research Question	Type of Data	Data Sources (Specific Data Needed)	Scheduled Y/N or Sent to Mercer Y/N
RQ3.1	Number/percent of providers certified **at each LOC.** Summary reports and supporting documents (e.g., completed onsite tools with all raw data) for each provider at each LOC. Description of activities to monitor provider use of ASAM criteria for patient placement for providers who are certified at higher LOCs, as well as non-certified providers at ASAM .5 and ASAM 1 LOCs.	• Aggregate and detailed reports from onsite provider monitoring records (this will also be included in KIIs as described previously)	
	Description of training and technical assistance activities to align providers with new ASAM standards.	• ASO and State documentation of training and technical assistance activities (this will also be included in KIIs as described previously)	
Goal 1/H4 RQ4.1	Number/percent of Medicaid-accepting providers licensed and certified at each LOC including MAT. Number/percent of providers with open bed capacity and availability. Number/percent of ambulatory providers with open caseloads (accepting new clients).	• How does the State track this (Carelon and DMHAS) Who will provide this data? • KII and document review from ASOs and State agency partners.	

Goal/Hypothesis/ Research Question	Type of Data	Data Sources (Specific Data Needed)	Scheduled Y/N or Sent to Mercer Y/N
	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT.		
Goal 1/H5 RQ 5.1	Has access to SUD residential treatment improved for adolescent girls?	• Qualitative KII Interview — Have any residential providers been certified to serve adolescent girls?	
Goal 3/H13 RQ 13.1	RQ13.1: Did IMD providers improve program design and discharge planning policies? (Process Question)	• Description of training and technical assistance activities to align providers with new ASAM standards. • Key Informant interviews and document review with SUD providers.	

Provider Key Informant Interview/Focus Group Questions

- In your view, has access to critical LOCs improved in Medicaid?
- Can you talk about specific successes you have had around getting certified after the ASAM transition and ensuring adequate access to each ASAM critical LOC? What were some of the biggest challenges?
- In terms of using ASAM criteria for patient placement, are there particular places where things are going well? It sounds like most of you (providers) are doing well, is that your perception? Are there specific areas that could use more training or technical assistance?
- What have been some of the challenges in providing services to adolescents? Adolescent girls in particular?
- What is your perspective on communication between providers and ABH, Carelon and State partners? Are there specific successes? Do you have suggestions for improvements?

Carelon Key Informant Interview/Focus Group Questions

- In your view, has access to critical LOCs improved in Medicaid?
- Can you talk about specific successes you have had around implementation and ensuring adequate access to each ASAM critical LOC? What were some of the biggest challenges?
- In terms of activities to monitor provider use of ASAM criteria for patient placement for providers, are there particular places where things are going well? It sounds like most providers are doing well, is that your perception? Are there common areas where providers are struggling?
- Has access to SUD residential treatment improved for adolescent girls? What have been some of the challenges in enrolling adolescent providers?
- Are you seeing any trends in number of providers enrolled in Medicaid and qualified to deliver SUD services since the start of the Demonstration? Are there specific successes? What about challenges or lessons learned in provider recruitment and retention?

Connecticut State Partners Key Informant Interview/Focus Group Questions

- In your view, has access to critical LOCs improved in Medicaid?
- Can you talk about specific successes you have had around implementation and ensuring adequate access to each ASAM critical LOC? What were some of the biggest challenges?
  - Potential probe: Website updates to current ASAM edition, is everything under the 3rd edition right now? Are there plans to update to the 4th edition?
  - Potential probe: What is your biggest access to care challenges (are they related to a particular LOC or transitions, what about geography or specific populations)?
- (Confirm that DMHAS and DCF [and Carelon] have been providing the training and TA)
  - Can you share your perspective of the training and technical assistance activities that have been conducted over the past two years to align providers with new ASAM standards: Are there particular successes that you would highlight? What about challenges or "lessons learned"?
- Can you talk a little bit about the relationship across the State agencies working together on the waiver? What has been successful? What are the challenges?
- Can you talk about the provider monitoring process? How are the different oversight agencies (ABH, DCF, Carelon, DSS) been communicating about provider availability and quality of care?
- How has the implementation of new residential treatment provider qualifications, licensure requirements, policy manuals, contracts gone? Specific successes or challenges/lessons learned to highlight?
  - Probe: How has guidance on new billing gone, specifically for residential treatment providers? Particularly successes or challenges?
- Has access to SUD residential treatment improved for adolescent girls? What have been some of the challenges access for this population?
- Are you seeing any trends in number of providers enrolled in Medicaid and qualified to deliver SUD services since the start of the Demonstration? Are there specific successes? What about challenges or lessons learned in provider recruitment and retention?
  - (RQ4.1) The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT. (note, need to get this from the metrics)

Connecticut Consumer/Advocacy Key Informant Interview/Focus Group Questions

- In your view, has access to necessary SUD treatment services improved in Medicaid in the past two and one-half years?
  - What the biggest remaining unmet needs for children and youth and their caregivers?
- What are the two to three most significant barriers to obtaining care for children and youth in the State?
- What are the two to three most significant barriers to obtaining care for parents and other caregivers in the State?
- How do you view the current quality of care available for children and youth (reminder, focus on substance use services)?
  - Have you seen improvements in the quality of care over the past two and one-half years?
- How do you view the current quality of care available for parents and other caregivers (reminder, focus on substance use services)?
  - Have you seen improvements in the quality of care over the past two and one-half years?

Connecticut DSS Key Informant Interview/Focus Group Questions

- In your view, has access to critical LOCs improved in Medicaid?
- Can you talk about specific successes you have had around implementation and ensuring adequate access to each ASAM critical LOC? What were some of the biggest challenges?
  - Potential probe: Website updates to current ASAM edition, is everything under the 3rd edition right now? Are there plans to update to the 4th edition?
  - Potential probe: What is your biggest access to care challenges (are they related to a particular LOC or transitions, what about geography or specific populations)?
- (Confirm that DMHAS and DCF [and Carelon] have been providing the training and technical assistance)
  - Can you share your perspective of the training and technical assistance activities that have been conducted over the past two years to align providers with new ASAM standards: Are there particular successes that you would highlight? What about challenges or “lessons learned”?
- Can you talk about the provider monitoring process? How are the different oversight agencies (ABH, DCF, Carelon, DSS) been communicating about provider availability and quality of care?
- How has the implementation of new residential treatment provider qualifications, licensure requirements, policy manuals, contracts gone? Specific successes or challenges/lessons learned to highlight?
  - Probe: How has guidance on new billing gone, specifically for residential treatment providers? Particularly successes or challenges?
- Has access to SUD residential treatment improved for adolescent girls? What have been some of the challenges access for this population?
- Are you seeing any trends in number of providers enrolled in Medicaid and qualified to deliver SUD services since the start of the Demonstration? Are there specific successes? What about challenges or lessons learned in provider recruitment and retention?

ABH Key Informant Interview/Focus Group Questions

- In your view, has access to critical LOCs improved in Medicaid?
- Can you talk about specific successes you have had around provider certification and ensuring adequate access to each ASAM critical LOC? What were some of the biggest challenges?
- In terms of activities to monitor provider use of ASAM criteria for patient placement for providers, are there particular places where things are going well? It sounds like most providers are doing well, is that your perception? Are there common areas where providers are struggling?
- Has access to SUD residential treatment improved for adolescent girls? What have been some of the challenges in enrolling adolescent providers?
- Are you seeing any trends in number of providers enrolled in Medicaid and qualified to deliver SUD services since the start of the Demonstration? Are there specific successes? What about challenges or lessons learned in provider recruitment and retention?

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