

Extension Request

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

Extension Request for the “Connecticut Substance Use Disorder” Demonstration

Demonstration include all pending amendments

**State of Connecticut
Pending Submission: March 31, 2026
Draft to Connecticut Legislature
February 4, 2026**

Section 1115 Extension Request

Connecticut Application Certification Statement — Section 1115(a) Extension

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

Type of Request (*select one only*):

☐ **Section 1115(a) extension with no program changes but with all pending amendments included**

☒ **Section 1115(a) extension with minor program changes**

☐ **Section 1115(a) extension with major program changes**

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

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

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

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

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

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

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

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

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

Signature:  Andrea Barton Reeves, J.D. Commissioner
[Governor or Commissioner of DSS]

Date: 12/05/2025

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

Renewal Appendices

Connecticut 1115 Demonstration Extension Appendix Documentation

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

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

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

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

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

No Authority Change Requested Except Minor Budget Neutral Technical Update

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

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

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

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

Programmatic Description of Waiver and Expenditure Authorities

Expenditure Authority Requested

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

Title XIX Expenditure Authority:

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

Title XXI Expenditure Authority:

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

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

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

Appendix A

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

American Society of Addiction Medicine Implementation Update Including Demonstration Impact

The State of Connecticut (Connecticut or State) Department of Social Services (DSS), Connecticut's single State Medicaid and Children's Health Insurance Program (CHIP) agency, requested a Demonstration Waiver pursuant to section 1115 of the Social Security Act from the Centers for Medicare and Medicaid Services (CMS) for substance use disorder (SUD) inpatient and residential treatment for adults and children under a fee-for-service (FFS) structure (Demonstration). Except as otherwise specified below, references to Medicaid in this Demonstration document also include CHIP. Connecticut also requested this Demonstration cover a complete array of American Society of Addiction Medicine (ASAM) levels of care (LOCs) as a component of an essential continuum of care for Medicaid-enrolled individuals with opioid addiction or other SUDs. Connecticut requested that the Demonstration be effective immediately upon approval to use Institutions for Mental Diseases (IMDs) as a Medicaid-covered setting.

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

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

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

History of the Demonstration

Introduction

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

Connecticut Medicaid covered all ambulatory ASAM LOCs 0.5 through 2.5, as well as medication-assisted treatment (MAT) and inpatient withdrawal management (ASAM level 4-WM) prior to the Demonstration. After the Demonstration's approval, Connecticut submitted a Medicaid State Plan Amendment (SPA) in conjunction with the Demonstration to cover residential and inpatient treatment, as well as all levels of withdrawal management (ASAM levels 1-WM, 2-WM, 3.1, 3.2-WM, 3.3, 3.5, 3.7, 3.7-WM, and 4). The Demonstration permitted DSS to provide critical access to medically necessary SUD treatment services in the most appropriate setting for the member as part of a comprehensive continuum of SUD treatment services.

The Demonstration also permitted DSS, through the FFS delivery system, to provide medically necessary medical and BH care (including co-occurring mental health [MH] and SUD treatment services) in the most appropriate setting for individuals receiving residential and inpatient SUD treatment services. This approach addressed the Demonstration goals, including improving health care outcomes for individuals with SUD (reducing hospital emergency department use and inpatient admissions, reducing hospital readmissions, and improving the rates of initiation, engagement, and retention in treatment).

Medicaid SUD Coverage Prior to the Demonstration

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

From calendar year 2012 through 2018, the rate of unintentional drug-related overdose deaths in Connecticut grew from 12.2 per 100,000 to 29.9 per 100,000,¹ and continued to climb. In calendar years 2019 and 2020, fatal drug overdose deaths in Connecticut rose 16.7% and 14.3% respectively from the previous year. The majority (82%) of overdose deaths in 2019 were related to fentanyl or fentanyl analogs.² The Demonstration was needed to address critical unmet needs for residential SUD treatment that continued to exist despite significant improvements to the publicly-funded treatment delivery system outside of Medicaid. Under the Department of Mental Health and Addiction Services (DMHAS) and Department of Children and Families (DCF), State-only funds and federal Substance Abuse and Mental Health Services

¹ Centers for Disease Control and Prevention, National Center for Health Statistics (2020). Underlying Cause of Death 1999-2018 on CDC WONDER Online Database. Data are from the Multiple Cause of Death Files, 1999-2018, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on May 13, 2020.

² Connecticut Office of the Chief Medical Examiner, per CDC-SUDORS grant guidelines (April 19, 2021) as published in the CT Department of Public Health Drug Overdose Monthly Report, March 2021.

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

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

Residential SUD Treatment in Connecticut Prior to the Demonstration

In 2006, DCF, which oversees BH for children in the State and DSS, in conjunction with a legislatively mandated oversight council, formed the Connecticut Behavioral Health Partnership (CT BHP), authorized pursuant to State statute (section 17a–22h of the Connecticut General Statutes), with ValueOptions (Carelon)³ serving as the Administrative Services Organization (ASO). CT BHP is a reform initiative designed to help children and parents with serious behavioral challenges remain in their homes and communities through the use of targeted, individualized clinical and support services. The ultimate goal under the initiative was to allow children and parents to function independently, restore or maintain family integrity, improve family functioning, achieve a better quality of life, and avoid unnecessary hospital and institutional care.

In 2010, DMHAS joined the CT BHP (and the authorizing statute was amended accordingly) and, collectively, a request for proposal for an ASO vendor for the expanded CT BHP was issued. ValueOptions bid on, and was awarded, the contract to be the ASO for the expanded CT BHP. The new contract went live on April 1, 2011, when more than 200,000 additional Medicaid members, primarily adults, but also a small number of youth, were added. That change brought the total membership included under the CT BHP to more than 600,000 members at that time.

While the goals of the original CT BHP described above remained in place, ValueOptions as the ASO was described in the new contract as being *the primary vehicle for organizing and integrating clinical management processes across the payer streams, supporting access to community-based services, assuring the delivery of quality services and preventing unnecessary institutional care*. Additionally, ValueOptions was expected to enhance communication and collaboration within the BH delivery system, assess network adequacy on an ongoing basis, improve the overall delivery system, and provide integrated services supporting health and recovery by working with the Departments (DSS, DCF, and DMHAS) to recruit and retain both traditional and non-traditional providers.

Effective January 1, 2012, DSS transitioned from three managed care organizations (MCOs) managing the physical health care of a large portion of the State's Medicaid population to a managed FFS structure with a single ASO for physical health, similar to the model in place for BH with ValueOptions. ValueOptions partnered with the MCO that ultimately won the bid for this contract, Community Health Network of Connecticut (CHNCT). While this contract did not increase membership, it did result in increased responsibility for ValueOptions to coordinate care provided to Medicaid members. The new contract, which went live in 2012, embedded

³ As a result of the 2014 merger between ValueOptions, Inc. and Beacon Health Strategies, LLC, ValueOptions, Inc. officially changed its name to Beacon Health Options on December 9, 2015. On March 1, 2023, Beacon changed its name to Carelon Behavioral Health (Carelon) as part of a broader rebranding effort by Elevance Health. This report will refer to this entity as Beacon.

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

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

The HUSKY D benefits under the ABP are aligned with the underlying Medicaid State Plan benefits. Although Connecticut Medicaid did not reimburse for residential SUD services prior to the Demonstration, there was a State-funded benefit for HUSKY D Medicaid beneficiaries using a former edition of ASAM. See the following table for a summary of the State-funded SUD residential benefits roughly aligned with the second edition of the ASAM criteria available prior to the Demonstration.

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

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

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

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

Demonstration Implementation

Under the Demonstration and its corresponding Medicaid SPA, Connecticut expanded services to provide a complete array of services, including residential SUD services, using placement criteria and program standards consistent with the latest edition of ASAM. The new Demonstration benefit service package included residential SUD services included under the Medicaid State Plan with an effective date of June 1, 2022. This comprehensive restructuring of the SUD benefit package and the transition to Medicaid reimbursement of residential and

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

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

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

Specific Interventions Under the Demonstration

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

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

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

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

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

Table A.3. Milestone 1 Activities under the Demonstration

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

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

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

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

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

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

Table A.5. Milestone 2 Activities under the Demonstration

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

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

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

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

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

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

Implementation Plan	Summary of Actions in Implementation Plan	Status and Date/Location of Support
	Demonstration by October 1, 2023.	July 2025 to: • Review and enhance the documentation for medical necessity to ensure the guidance and process are clear. • Establish a process for supporting providers through TA and/or training.
Implementation of a utilization management approach such that (c) there is an independent process for reviewing placement in residential treatment setting	DSS will direct the Medicaid BH ASO to use the most recent ASAM edition for utilization review, prior authorization, and to update the website, provider information and internal documentation within 24 months of Demonstration approval by April 1, 2024.	Complete Carelton's website has been updated to only reference third edition ASAM requirements. The State's ASO, Carelon began conducting an independent review process in July of 2022. Carelton resources: CT specific manuals can be found at: Providers CTBHP Providers https://www.ctbhp.com/ctbhp/en/home https://providers.ctbhp.com/providers/ Substance Use Disorder (SUD) Treatment Resources under the 1115 Demonstration Waiver CTBHP Providers https://providers.ctbhp.com/substance-use-disorder-treatment-resources-1115/ The State's ASO, Carelon, utilizes ASAM third edition when assessing medical necessity for admission to all SUD levels of care. Carelon produces a monthly report for residential levels of care that highlight the percentage of initial and concurrent authorization requests.

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

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

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

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

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

Table A.7. Milestone 3 Activities under the Demonstration

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

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

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

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

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

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

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

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

Table A.9. Milestone 4 Activities under the Demonstration

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

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

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

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

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

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

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

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

Table A.11. Milestone 5 Activities under the Demonstration

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table A.14. Milestone 6 Activities under the Demonstration

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

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

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

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

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

Evaluation Design

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

Monitoring Protocol

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

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

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

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

Drug overdose deaths continue to be a leading cause of injury-related deaths in the United States⁵, and despite Demonstration efforts, the number of SUD deaths in Connecticut continues to remain high. Deaths within Connecticut due to drug misuse, alcohol, or suicide outpace the country as a whole. According to the Centers for Disease Control and Prevention (CDC), the 2022 Connecticut age-adjusted rate for unintentional drug-induced mortality was 38.3 per 100,000 population compared to the 2022 national rate of 30.1.⁶ In Connecticut, residents are more likely to die from unintentional drug overdose than a motor vehicle crash. The majority of these deaths are linked to overdose of illicit opioids.⁷

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

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

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

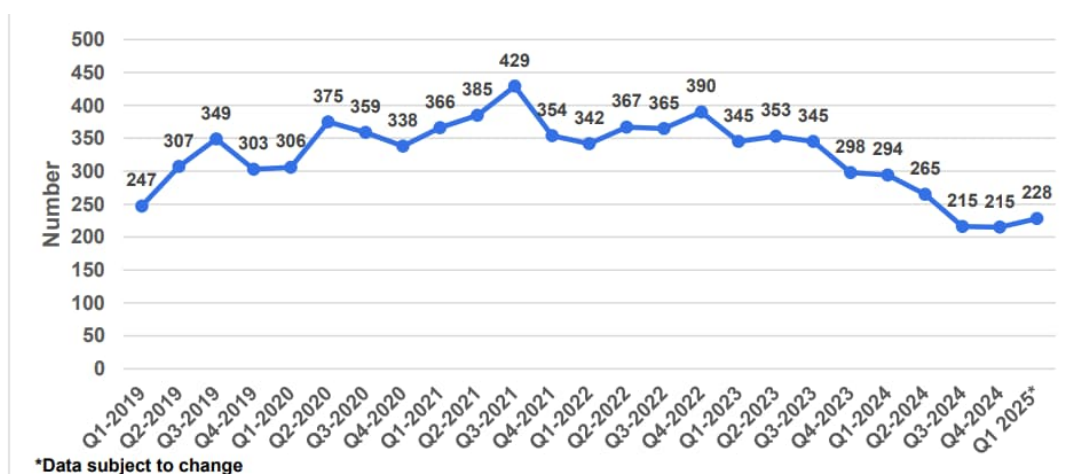
⁶ Centers for Disease Control and Prevention. (n.d.). Opioid and drug overdose statistics. Connecticut Department of Public Health. <https://portal.ct.gov/dph/health-education-management-surveillance/the-office-of-injury-prevention/opioid-and-drug-overdose-statistics>

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

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

In 2024, according to SUDORS, there were 349 less deaths, a 26.1% decrease, compared to 2023 (N=1,338). A decreasing trend in drug overdose deaths has been seen consecutively for the last three years from 2021–2024.⁹ The chart below represents the counts of confirmed drug overdose deaths by quarter (Figure A.16). Quarterly drug overdose data (Figure A.16) show that for the years 2019, 2020, and 2022, Quarter 1 had the lowest number of unintentional and undetermined intent drug overdose deaths within each specific year. Between 2019–2024, Quarter 4 of 2024 had the lowest number. The data from 2025 are preliminary and subject to change due to pending cases.¹⁰

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



Source: Data source: Office of the Chief Medical Examiner and SUDORS

https://portal.ct.gov/-/media/dph/injury-and-violence-prevention/opioid-overdose-data/monthly-death-reports/2019-june-2025_drug-overdose-deaths-monthly-report_connecticut_7-22-2025-final.pdf *Data are subject to change

Drug Overdose Death Demographics

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

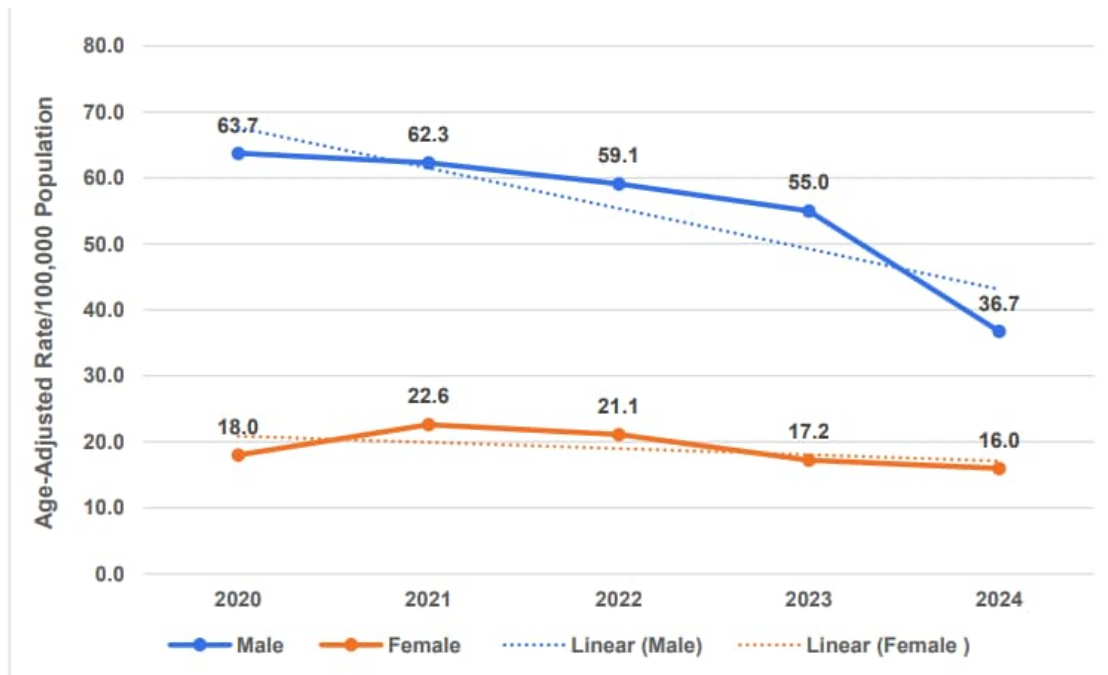
Age-adjusted drug overdose death rates were higher in males compared to females during 2020 through 2024. The line graph below (Figure A.17) represents the age-adjusted rates of drug overdose death by gender during 2020 through 2024. Overall linear trends from 2020 to 2024 show that the age-adjusted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

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

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

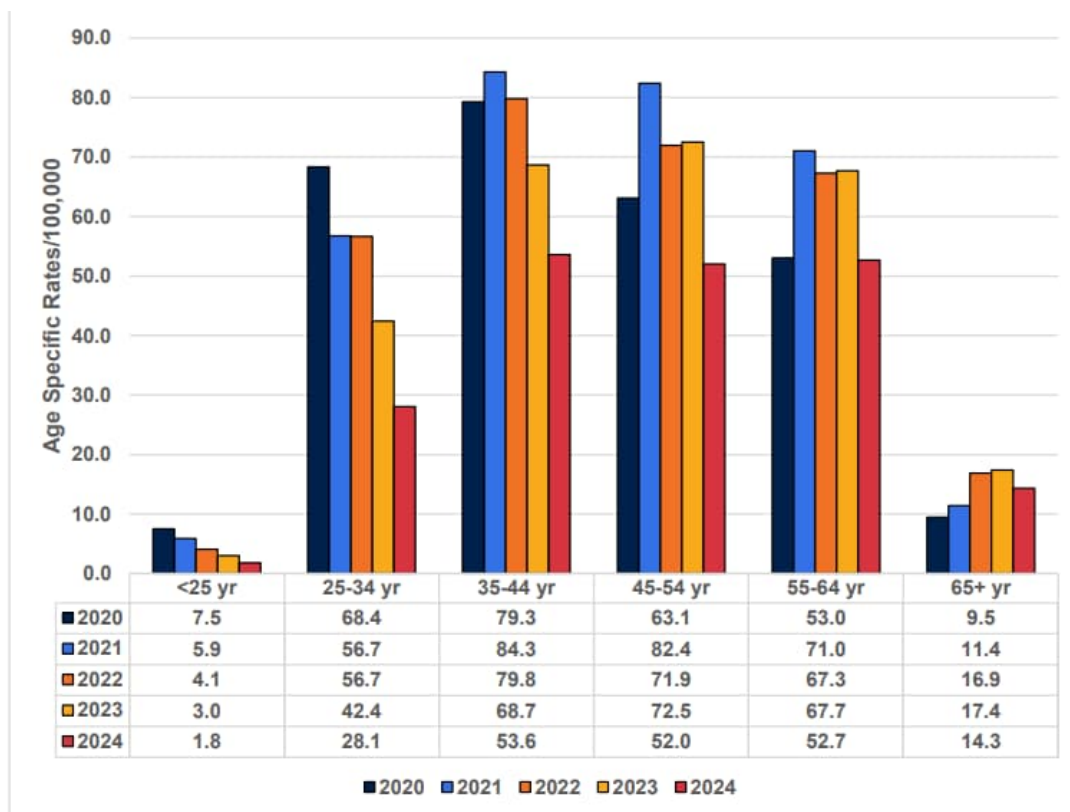
¹⁰ Connecticut Department of Public Health. (2025). 2019-June 2025 Drug Overdose Deaths Monthly Report. Retrieved from <https://portal.ct.gov/dph/health-education-management--surveillance/the-office-of-injury-prevention/opioid-and-drug-overdose-statistics>

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



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

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



Future Goals of the Program

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

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

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

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

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

Appendix B

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

Analysis of Current Demonstration for SUD

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

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

Table B.1: Master MEG Chart

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

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

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

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

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

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

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

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

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

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

Table B.4 Detailed Hypothetical Budget Neutrality Test 1

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

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

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

HUSKY A Budget Neutrality Issues

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

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

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

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

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

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

Background

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

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

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

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

HUSKY A Data Availability

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

However, with Medicaid now covering IMDs, actual HUSKY A utilization data is available for IMDs and non-IMD services. As discussed with CMS in the summer of 2024 and show in Table B.6 and Table B.7 below, HUSKY A IMD/SUD actual calendar year 2023 (CY23) costs were a little higher than projections (\$4,273 projected compared to \$4,998. actual), which would be accounted for in the higher utilization of ASAM 3 and 3.7-WM levels of care than expected in this population. However, it is the actual HUSKY A non-IMD expenditures that were not anticipated: The actual PMPM of \$2,167 PMPM, was considerably higher than the projected HUSKY A non-IMD costs of \$548 PMPM. In particular, Mercer believes that the non-IMD expenditures for pregnant women (i.e., prenatal care) in the HUSKY A MEG were not well represented by the HUSKY D projections. As the Demonstration has been implemented and early intervention with pregnant women has increased, more pregnant women are receiving earlier and more complete prenatal care at a higher cost in addition to their SUD treatment.

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

Medicaid Eligibility Group (MEG)	Estimated Total Expenditures for SUD Medical Assistance Provided in an IMD	Estimated Total Expenditures for All Other non-SUD/IMD Title XIX State Plan Medical Assistance	Estimated Eligible Member Months for All Medical Assistance Provided in an IMD	Estimated SUD PMPM Cost	Estimated Non-SUD PMPM Cost	Estimated PMPM Cost
HUSKY A	\$ 12,007,533.00	\$ 1,540,416.67	\$ 2,810.00	\$ 4,273.00	\$ 548.00	\$ 4,821.00

Table B.7: HUSKY A: Actual Experience

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

Actual Incidence of SUD IMD Utilization

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

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

HUSKY A MEG Update Needed

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

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

Budget Neutrality — Caseload and Expenditure Estimates Waiver Period 2

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

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

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

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

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

Table B.8. Demonstration Extension Periods

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

Current Demonstration Period

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

Renewal Period Demonstration Proposals

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

Table B.9. Demonstration Proposals and Effective Dates

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

Caseload and Total Computable Expenditure Projections DY6 to DY10

SUD-IMD Renewal

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

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

Table B.10. SUD-IMD Renewal Projections

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

Justice Involved Reentry Renewal

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

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

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

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

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

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

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

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

SDOH Renewal

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

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

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

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

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

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

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

Appendix C

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

Substance Use Disorder 1115 Demonstration

Interim Evaluation Report

State of Connecticut

January 28, 2026

Contents

1. Executive Summary.....	1
• Substance Use Disorder Demonstration Information.....	1
• Evaluation Questions and Hypotheses	2
• Methodology	2
• Evaluation Conclusions	3
• Evaluation Recommendations.....	3
2. Substance Use Disorder Demonstration Information	5
• Description of the Demonstration's Policy Goals	5
3. Evaluation Questions and Hypotheses	8
• Targets for Improvement	8
• Driver Diagrams, Research Questions, and Hypotheses.....	9
• Midpoint Assessment Findings.....	12
4. Methodology.....	15
• Evaluation Design.....	15
• Target and Comparison Populations.....	15
• Evaluation Period	16
• Evaluation Measures and Data Sources	16
• Analytic Methods	16
5. Methodological Limitations	18
6. Results	20
• Connecticut Goal 1.....	20
• Primary Driver.....	20
• Primary Driver.....	42

• Primary Driver.....	44
• Primary Driver.....	49
• Primary Driver.....	52
7. Conclusions.....	68
• Connecticut Goal 1.....	68
• Primary Driver 1.....	68
• Primary Driver 2.....	73
• Connecticut Goal 2.....	74
• Primary Driver.....	74
• Primary Driver.....	75
• Connecticut Goal 3.....	75
• Primary Driver.....	75
• Primary Driver.....	76
• Connecticut Goal 4.....	77
• Primary Driver.....	77
Appendix A: CMS-Approved Evaluation Design.....	83
Appendix B: All ITS Charts and Tables	84

Section 1

Executive Summary

Substance Use Disorder Demonstration Information

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 by implementing a comprehensive SUD benefit package of services.

Data collected for this interim evaluation report includes quantitative information from the first two years and eight months of the Demonstration (April 14, 2022–December 31, 2024) and includes qualitative data from stakeholders and documents through July 2025.

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 individuals diagnosed with SUD by providing critical access to SUD treatment services, including inpatient and residential SUD treatment in Institutions for Mental Diseases, as part of a full continuum of treatment services that follow American Society of Addiction Medicine (ASAM) levels of care (LOCs). Under the new SUD State Plan Amendments, which were associated with this Demonstration, Connecticut implemented a comprehensive, integrated SUD benefit that included residential treatment settings. In addition, the State is actively working to recruit providers within the State's borders 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 State's only provider for boys' residential services has since closed, resulting in the State looking for new providers across all adolescent populations.

The national SUD Demonstrations have six goals as listed in the State's Standard Terms and Conditions:

- Increase rates of identification, initiation, and engagement in treatment for opioid use disorder (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 emergency departments (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 individuals with OUD or other SUDs.

Evaluation Questions and Hypotheses

State targets for improvement include increases in utilization across all critical ASAM LOCs, increased provider capacity, and improved care coordination and transitions, including discharges to lower LOCs.

Driver Diagrams, Research Questions, and Hypotheses

The four Connecticut-specific Goals (Connecticut Goals) under the Evaluation Design (increase enrollee access to and use of appropriate SUD services, improve quality of care and population health outcomes, improve care coordination and transitions, and maintain or reduce Medicaid costs of individuals with SUD) represent the ultimate intentions of the waiver. The primary drivers are strategic improvements necessary to achieve the Demonstration's goals. The secondary drivers describe the targeted interventions (milestones) to achieve these strategic improvements. These connections are shown in the Driver Diagrams section of the full report.

This report builds on the findings of the midpoint assessment (MPA) report, most recently revised in May 2025. Overall, the MPA found that the State has completed most of the expected activities and is making progress in almost all areas of the SUD Implementation Plan. However, many critical metrics were not moving in the direction of State targets, indicating that at the midpoint of the Demonstration, activities had not yet translated into outcomes.

The State has proposed 15 hypotheses, organized by the six primary drivers described in program driver diagrams. This report organizes findings by hypothesis and subsequent evaluation research questions posed to test each hypothesis, as described in the Methodology section of the full report.

Methodology

The evaluation of the Connecticut SUD Demonstration uses a mixed-methods Evaluation Design with three main objectives:

1. Describe the progress made on specific Demonstration-supported activities (process/implementation evaluation).
2. Demonstrate change/accomplishments in each of the Demonstration milestones (short-term outcomes).
3. Demonstrate progress in meeting the overall project goals/Connecticut Goals.

We use pre-post data where it is available to examine changes made after Demonstration implementation. While no comparison group is available, the evaluation does incorporate interrupted time series analysis where there are enough data points available to use a time-based predictive regression model to establish the counter-factual normally established with a control or comparison group. The approved Evaluation Design is included as Appendix A in this report.

Evaluation Conclusions

While the State has completed most activities in its implementation plan, it has been difficult to translate these activities into meeting Demonstration Goals. The primary challenge remains the recruitment of new providers and expansion of existing provider capacity into new ASAM LOCs.

Despite these challenges, there has been a significant increase in utilization rates for residential, inpatient, and withdrawal management services, as well as overall admissions and lengths of stays for SUD. This has driven increases in SUD spending costs. Also, while the Demonstration has yet to see expected outcomes for people receiving services in terms of reductions in ED utilization and hospitalizations, the State has seen a statistically significant reduction in overdose deaths since the start of the Demonstration.

Several care coordination challenges emerged in this evaluation. First, transitions across different LOCs can be complicated due to lack of capacity and the needed LOC. For example, a person who is clinically ready to step down from a 3.5 to a 3.1 level of care may not have a 3.1 bed available. Providers are unable to receive continued authorization at 3.5 if it is not indicated by ASAM placement criteria, even if there are no alternatives. Despite being permitted to obtain provider certification for lower levels of care, in many cases, providers have not obtained that certification and continue to request to provide the higher level of care not needed by the individual and not reimbursed, which creates stress on the provider's ability to continue participating in the program. While there are operational challenges to implement multiple levels of care in a single facility, other states such as New York have worked with providers to retain individuals with continuity of care throughout the ASAM continuum in a single facility. It also puts the client at risk of being discharged to outpatient care with fewer supports. This is exacerbated by a lack of stable housing for people transitioning from residential care to outpatient services.

While the State has enhanced discharge planning at all ASAM levels of care, the State did not invest in targeted case management under the Demonstration. As seen in these evaluation findings, connections to primary/ambulatory care and follow-up after ED visits or hospital stays have declined under the Demonstration, underscoring the importance of improving care coordination efforts. Please note that the Department of Social Services, through the Connecticut Behavioral Health Partnership, has recently engaged in a contract with the Behavioral Health Administrative Services Organization (ASO) to offer proactive and targeted case management inclusive of individuals living with and recovering from SUDs. The new program was implemented October 1, 2025.

Evaluation Recommendations

Recommendations for the State, carried over from the midpoint assessment include:

- Continue to work with providers to explore flex-bed options to facilitate increased capacity for level 3.1 and level 3.5 LOCs. Continue to publicize and implement the residential rate adjustments made July 1, 2025.
- 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. Continue to publicize and implement the new Screening, Brief Intervention, and Referral to Treatment (SBIRT) coding and payments made July 1, 2025. Consider providing education in primary care settings for the new SBIRT coding and reimbursement.

- 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 enhancing regular meetings with State agencies and providers to move beyond policy and procedure updates and instead focus on problem-solving discussions for metrics that are not meeting Demonstration targets.
- Enhance bi-directional, problem-focused communications with providers and ASOs around managing care transitions across LOCs when bed capacity is limited. The State should ensure that ASAM LOCs focus on individualized treatment planning and not cost-control mechanisms.
- Communicate more information to providers when provider on-site reviews find areas of concern around quality of care (e.g., insufficient daily treatment dosage received by individuals) and use those opportunities to improve individualized care.
- Consider the following options to improve retention and continuity in care:
 - A targeted case management 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.

Section 2

Substance Use Disorder Demonstration Information

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. In keeping with this goal, the Connecticut Department of Social Services, in collaboration with its sister State agencies, the Connecticut Department of Mental Health and Addiction Services and the Connecticut Department of Children and Families, known as the Connecticut Behavioral Health Partnership (CT BHP), has implemented a comprehensive SUD benefit package of services provided by a statewide network of SUD treatment service providers for Medicaid individuals. Except as otherwise specified, references to Medicaid throughout this Interim Evaluation Report also include the Children's Health Insurance Program (CHIP).

The 1115 SUD Waiver Demonstration (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 in the years leading up to the Demonstration impacts individuals, families, and communities throughout the State. Data collected for this Interim Evaluation Report includes quantitative information from the first two years and eight months of the Demonstration (April 14, 2022–December 31, 2024) and includes qualitative information from stakeholders and document review through July 2025.

Description of the Demonstration's Policy Goals

Connecticut uses the Demonstration authority to finance a full continuum of SUD care for Medicaid (HUSKY A, HUSKY C, and HUSKY D) and CHIP (HUSKY B) individuals under new Rehabilitative and Alternative Benefit Package Medicaid State Plans. The continuum includes Medicaid eligible individuals receiving SUD treatment when they are on probation, parole, inpatient, or otherwise eligible for services through the collaboration of the Judicial Branch Court Support Services Division and the Department of Correction with the CT BHP sister agencies.

SUD Treatment in Connecticut

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

- Screening, Brief Intervention, and Referral to Treatment Services.
- Outpatient Services.
- Methadone Maintenance.
- Medication for Addiction Treatment (MAT).

- Intensive Outpatient Services.
- Partial Hospitalization Program.
- Ambulatory Withdrawal Management.
- Inpatient Hospital Substance Use Withdrawal Management.
- Targeted Case Management (TCM) for Ages 19 Years Old and Under.
- TCM for Adults with Serious Mental Illness and Co-Occurring SUD.

Connecticut requested the Demonstration to enable Federal Financial Participation under Medicaid and CHIP for SUD residential treatment and other health care services provided in accordance with the latest edition of American Society of Addiction Medicine (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 individuals have access to the entire continuum of SUD services as defined by ASAM levels of care (LOCs).

In addition, the State is actively working to recruit providers within the State's borders to provide adolescent services including increasing residential rates on July 1, 2025. 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 State's only 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 sought to improve outcomes for Medicaid individuals 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 State Plan Amendments, which were 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 individuals could 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 would accomplish the following national Demonstration goals, which make up the Demonstration hypothesis:

- Increase rates of identification, initiation, and engagement in treatment for opioid use disorder (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 emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.
- 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 individuals with OUD or other SUDs.

The Demonstration Implementation Plan addresses system reforms and activities needed to achieve the following Centers for Medicare & Medicaid Services 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 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 the FFS delivery system. However, the State made various improvements to the SUD service system statewide, including aligning with ASAM third edition criteria, analyzing care management initiatives that are available and improving coordination of care, and improving transitions of care. Overall, while continuing to use the FFS delivery system structure, the Demonstration streamlines, clarifies, and improves the content of each LOC and improves transitions in the care management system.

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

Section 3

Evaluation Questions and Hypotheses

Targets for Improvement

The table below outlines the targets for improvement of the Demonstration, organized by Primary Drivers of change.

Primary Drivers	Targets
Improved access to the most beneficial level of care (LOC) via a full continuum of available substance use disorder (SUD) services.	- Increased use of evidence-based treatment criteria. - Ensure sufficient provider capacity.
Increase rates of identification, initiation, engagement, and retention in treatment.	- Increased access to critical levels of care (LOCs) for opioid use disorder (OUD) and other SUDs. - Improved access for youth through early intervention and SUD treatment in ambulatory American Society of Addiction Medicine (ASAM) LOC.
Reduced utilization of emergency departments (EDs) and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate.	- Increased use of evidence-based SUD-specific patient placement criteria. - Increased provider capacity at each LOC, including medication assisted treatment (MAT) for SUD/OUD.
Reduced readmissions to the same or higher LOC where the readmission is preventable or medically inappropriate.	- Increased use of evidence-based SUD-specific patient placement criteria. - Increased use of comprehensive treatment and prevention strategies to address opioid misuse and OUD.
Improved access to care coordination among individuals, including improved discharge planning and transitions.	- Improved care coordination and transitions between LOCs for physical care. - Improved discharge planning and continuity of care between providers.
Maintain or reduce Medicaid costs for individuals with SUD, where possible.	The Demonstration will remain budget neutral to the Federal government after adjusting for residential services and any other new SUD treatment services, including care coordination, developed under this Demonstration.

Driver Diagrams, Research Questions, and Hypotheses

The four Connecticut Goals represent the ultimate intentions of the waiver. The primary drivers are strategic improvements necessary to achieve the Connecticut Goals. The secondary drivers describe the targeted interventions (milestones) to achieve these strategic improvements.

These primary and secondary drivers of change are based on the March 2017 CMS letter to State Medical Directors, which outlined the interest of Centers for Medicare & Medicaid Services (CMS) to work with the states *to provide a full continuum of care for people struggling with addiction, and in hearing state-proposed solutions that focus on improving quality, accessibility, and outcomes in the most cost-effective manner*. The letter offered states the flexibility to design 1115 demonstrations aimed at making significant improvements over the course of a five-year period on the following six goals and six milestones specific to opioid use disorder or other substances.¹

Goals and Primary Driver Relationship

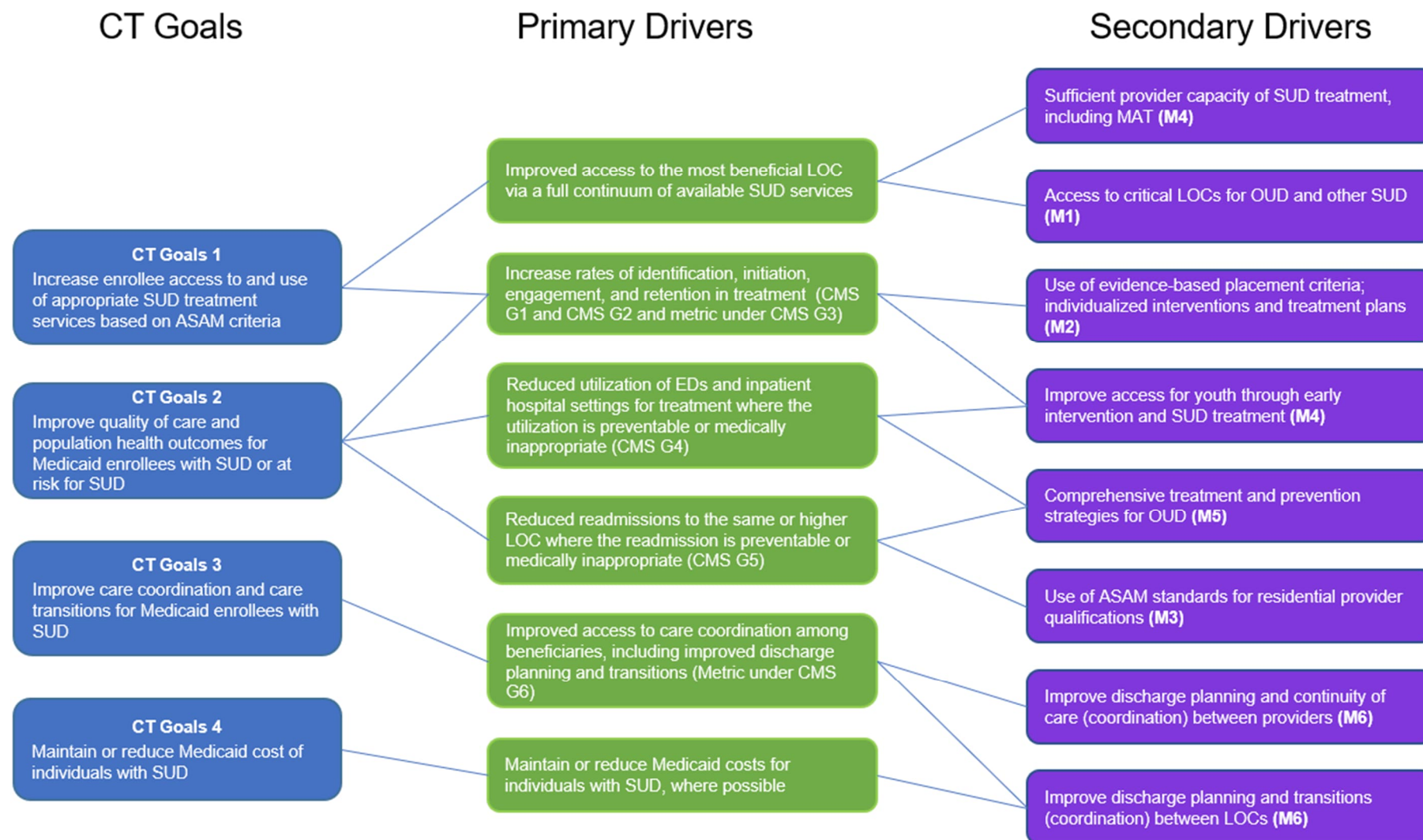
- Increased rates of identification, initiation, and engagement in treatment. (Primary Driver 2)
- Increased adherence to and retention in treatment. (Primary Driver 2)
- Reductions in overdose deaths, particularly those due to opioids. (Metric under Primary Driver 2)
- Reduced utilization of EDs and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services. (Primary Driver 3)
- Fewer readmissions to the same or higher LOC where the readmission is preventable or medically inappropriate. (Primary Driver 4)
- Improved access to care for physical health conditions among individuals. (Metric under Primary Driver 5)

¹ State Medicaid Director Letter #17-0003, U.S. Centers for Medicare & Medicaid Services, 2017, <https://www.medicare.gov/sites/default/files/federal-policy-guidance/downloads/smd17003.pdf>.

Milestones (Secondary Driver)

- Access to critical LOCs for OUD and other SUDs. (Milestone [M] 1)
- Widespread use of evidence-based, SUD-specific patient placement criteria. (M2)
- Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications. (M3)
- Sufficient provider capacity at each LOC. (M4)
- Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD. (M5)
- Improved care coordination and transitions between LOCs. (M6)

Figure 3.1: High-Level Driver Diagram



Measuring Effects on the Four Connecticut Goals

For the outcome evaluation, select performance measures were used to demonstrate observed changes in outcomes, using an interrupted time-series design where sufficient pre-Demonstration data is available, or with pre-post comparisons or comparisons to national benchmarks where sufficient pre-Demonstration data is not available. Additional performance measures were collected to monitor progress on meeting the milestones and project goals. These performance measures are grouped and described under the related primary drivers.

The research design table in Section 4 (Methodology) outlines the hypotheses and research questions of the evaluation, organized by each primary driver.

Midpoint Assessment Findings

The State submitted a midpoint assessment (MPA) report to CMS on May 29, 2025. Overall, the MPA found that the State has completed most of the expected activities and is making progress in almost all areas of the SUD Implementation Plan.

However, many critical metrics were not moving in the direction of State targets, indicating that at the midpoint of the Demonstration, activities had not yet 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.

This report builds on those findings by examining six additional months of quantitative data as well as a year's worth of quantitative data prior to the beginning of the Demonstration, applying more rigorous statistical tests to determine the degree to which changes are occurring due to Demonstration activities and updating qualitative data through additional focus groups with key Demonstration stakeholders and additional document review.

The following hypotheses of this Demonstration promote the objectives of Title XIX and Title XXI by expanding access to SUD treatment, an important component of comprehensive medical services for those who cannot otherwise afford health care.

Hypotheses About Demonstration Outcomes

The following evaluation hypotheses were designed to describe how the State intends to achieve the Demonstration's goals, as depicted in the driver diagrams above.

Connecticut Goal 1

Increase enrollee access to and use of appropriate SUD treatment services based on ASAM criteria.

Primary Driver: Improved access to care via a full continuum of available SUD services.

- Hypothesis 1: The Demonstration will increase the availability of critical LOCs for Medicaid individuals.
- Hypothesis 2: The Demonstration will increase the use of residential, MAT, withdrawal management, early intervention, and ambulatory care available by Medicaid individuals.

- Hypothesis 3: The Demonstration will lead to use of the most recent version of the ASAM placement criteria by all providers.
- Hypothesis 4: The Demonstration will increase provider capacity for SUD treatment at critical LOCs for individuals in the State.
- Hypothesis 5: The Demonstration will improve access and develop capacity for adolescent girls needing SUD residential treatment.
- Hypothesis 6: More adolescent SUD treatment services will be provided at the ambulatory ASAM LOCs.

Primary Driver: Increase rates of identification, initiation, engagement, and retention in treatment.

- Hypothesis 7: The Demonstration will improve rates of identification, initiation, and engagement in treatment.
- Hypothesis 8: The Demonstration will improve access and develop capacity for adolescent girls needing SUD residential treatment.

Connecticut Goal 2

Improve quality of care and population health outcomes for Medicaid enrollees with SUD.

Primary Driver: Reduced utilization of EDs and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate.

- Hypothesis 9: The 1115 SUD Demonstration will decrease the rate of ED and hospital use among Medicaid individuals with SUD.
- Hypothesis 10: The 1115 SUD Demonstration will lead to lower hospitalization readmission rates for individuals with SUD.

Primary Driver: Increase rates of identification, initiation, engagement, and retention in treatment.

- Hypothesis 11: Individuals with SUD will have fewer opioid-related overdose deaths.

Connecticut Goal 3

Improve care coordination and care transitions for Medicaid individuals with SUD.

Primary Driver: Improved access to care coordination among individuals, including improved discharge planning and transitions.

- Hypothesis 12: The 1115 SUD Demonstration will increase the rate of Medicaid individuals with SUD-related conditions who are also receiving primary/ambulatory care.

Primary Driver: Increase rates of identification, initiation, engagement, and retention in treatment.

- Hypothesis 13: Medicaid Institution for Mental Disease providers will demonstrate consistency in program design and discharge planning policies.

Connecticut Goal 4

Maintain or reduce Medicaid cost of individuals with SUD.

Primary Driver: Maintain or reduce Medicaid costs for individuals with SUD, where possible.

- Hypothesis 14: The Demonstration will be budget neutral to the federal government.
- Hypothesis 15: Total Medicaid SUD spending during the measurement period will remain constant after adjustment for the new residential services and any other new SUD treatment services, including care coordination, developed under this Demonstration.

Section 4

Methodology

The Evaluation Design, previously approved by Centers for Medicare & Medicaid Services (CMS), represents a comprehensive and independent evaluation of the original Connecticut 1115 Substance Use Disorder (SUD) Waiver Demonstration, as described above, that complies fully with Special Terms and Conditions 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 American Society of Addiction Medicine 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.

Evaluation Design

The evaluation of the Demonstration uses a mixed-methods Evaluation Design with three main objectives:

1. Describe the progress made on specific Demonstration-supported activities (process/implementation evaluation).
2. Demonstrate change/accomplishments in each of the Demonstration milestones (short-term outcomes).
3. Demonstrate progress in meeting the overall project goals/Connecticut Goals.

Mercer uses pre-post data where it is available to examine changes made after Demonstration implementation. While no comparison group is available, the evaluation does incorporate interrupted time series (ITS) analysis where there are enough data points available to use a time-based predictive regression model to establish the counter-factual normally established with a control or comparison group. The approved Evaluation Design is included as Appendix A in this report.

Target and Comparison Populations

As mentioned previously, there is no comparison population available for the evaluation. The target population includes non-expansion and expansion adult and adolescent Medicaid and Children's Health Insurance Program individuals with a SUD diagnosis. Based on Demonstration goals and activities, we do not anticipate that the Demonstration will have intentional differential impacts on specific subgroups, except for adolescents, and adolescent girls. However, to account for known long-term disparities in access to care, engagement, and outcomes, we will use some demographic categories as covariates in our analyses. Additionally, some covariates based on opioid use disorder diagnosis will be used in examining changes in specific SUD utilization metrics. Other specified subpopulations (e.g., dual eligible, pregnant women, and the criminal justice population) will likely have insufficient data to provide reliable analysis. All individuals who are eligible for and/or receive services will be included in the evaluation.

Evaluation Period

The evaluation period for the Draft Interim Evaluation, being submitted with the State's extension application, is April 1, 2022 through December 31, 2024. All quantitative metrics are included through this date. Qualitative data in the form of focus groups and document reviews, as described below, were conducted through July 2025 to ensure the most recent perspectives as possible.

Evaluation Measures and Data Sources

The Evaluation Design and evaluation measures are based on sources that provide valid and reliable data that will be readily available throughout the Demonstration and final evaluation. To determine that the data used for the evaluation are complete and accurate, the independent evaluator reviewed the quality and completeness of data sources (including, but not limited to, claims for pharmacy, professional, and facility services as well as eligibility data). This included, for example, frequency reports, valid values, missing values, date and numerical distributions, and duplicates (part of adjustment logic). In examining spending data, some inconsistencies were noted in billings, particularly related to Institution for Mental Diseases services. These are noted, as appropriate, where they occur in the Results section of this report.

As often as possible, measures in the evaluation have been selected from nationally recognized measure stewards for which there are strict data collection processes and audited results. The primary source of quantitative data is claims data, and the evaluation relies heavily on required metrics reported to CMS. This ensures that the data used have been examined by several parties repeatedly prior to being used to establish whether the Demonstration is meeting its goals.

The primary source of qualitative data for the evaluation are documents provided by the State and its implementation partners, as well as focus groups conducted with key Demonstration stakeholders. The Evaluation Design tables starting on page 18 of the Evaluation Design in Appendix A contain full details on all data sources used for this report.

Analytic Methods

Multiple analytic techniques are used in this report, 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). Descriptive, narrative content analysis is used to present data related to process evaluation measures gathered from document reviews, key informant interviews, etc., as discussed previously. Narrative analysis is used to identify common themes across interviews and documents.

Descriptive statistics including frequency distributions and time series (presentation of rates over time) are used for quantitative process measures in order to describe the output of specific waiver activities. These analysis techniques are also used for some short-term outcome measures in cases where the role of the measure is to describe changes in the population, but not to show specific effects of the Demonstration. Where pre-Demonstration and post-Demonstration rates are comparable, pre-post distributional tests (e.g., Chi-Square and Analysis of Variance or t-tests) are made to quantify statistical differences in process measures before and after the Demonstration.

An ITS is used to describe the effects of waiver implementation in metrics that are measured on a monthly or quarterly basis. To present results easier for the reader to understand, we show the results of a Wald test² for significance of both the level and slope change of the measure, along with estimated effect sizes.

The ITS design uses historical data to forecast the *counterfactual* of the evaluation, that is to say, what would happen if the Demonstration did not occur? We use basic time series linear modeling to forecast these *counterfactual* rates for the years following the Demonstration implementation.³ ITS models are commonly used in situations where a contemporary comparison group is not available.⁴ The State has considered options for a contemporary comparison group. Because the Demonstration will target all adult and adolescent non-expansion and expansion Medicaid individuals in need of SUD services, the only viable groups for comparison within the State would be those covered with private insurance, which would include a very different non-comparable demographic population.

Pre-Demonstration data from January 1, 2021 to March 30, 2022 were calculated using the monthly, quarterly, or annual period of time as specified in the CMS technical specifications for each metric. Trends in these data for each measure will be used to predict the counterfactual (what would have happened without the Demonstration).

Outcomes measures were calculated beginning April 1, 2022 through the end of this evaluation period (December 31, 2024).

Outcome measures with yearly measurement periods that are expressed as averages or proportions are analyzed with pre-post tests. While two or three pre-Demonstration measurement periods for yearly metrics may not be enough information to establish a trend for the ITS analysis, pre-post analyses may reveal differences in outcomes before and after the Demonstration. One-way analysis of covariance, or t-tests are used to compare pre-Demonstration averages with post-Demonstration averages, and Chi-Square tests will be used to compare proportions.

Qualitative analysis utilizes data collected from three main sources: 1) focus groups with State staff working on implementation efforts, Administrative Services Organization representatives, providers, and consumers/consumer advocates, 2) key process documentation (e.g., policy and procedure manuals, guidance documents), and 3) provider addendums.

² Cruz M, Gillen DL, Bender M, Ombao H. (2019). Assessing health care interventions via an interrupted time series model: Study power and design considerations. *Statistics in Medicine*. 38(10):1734-1752. <https://doi.org/10.1002/sim.8067>.

³ E Kontopantelis (2015). Regression based quasi-experimental approach when randomisation is not an option: interrupted time series analysis. *British Medical Journal (BMJ)*. <https://www.bmj.com/content/350/bmj.h2750>.

⁴ Ibid.

Section 5

Methodological Limitations

This analysis is limited by the quality of the data provided for the analysis. Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, has done validity and reliability checks and has been previously reporting the data in the form of metric monitoring reports. One known issue with the data is related to provider billing delay issues for the Institution for Mental Disease claims data during three early months of the Demonstration. This is noted in the cost analysis portion of the Results section of this report.

Another important point about the data is that it is only available to the evaluator in aggregated form, either at the monthly or annual level. Mercer considered using individual member-level data to enable more precise estimates and adjustments for confounding factors. However, at the current moment, data is only available in the aggregated form. While we recognize that this approach limits the ability of models to capture individual-level variation and reduces statistical power. Nonetheless, the evaluator believes that the results will still provide meaningful population-level outcomes associated with the SUD demonstration. The evaluator will acknowledge these limitations in the subsequent evaluation reports, along with considerations for interpreting the results. Furthermore, the evaluator will also utilize qualitative data gathered from focus groups to contextualize the quantitative findings to provide a more comprehensive understanding of Connecticut's demonstration impacts.

Additionally, no data was available for the criminal justice subpopulation prior to the start of the Demonstration. As a result, this group is not included in the interrupted time series (ITS) analysis results presented here.

Another limitation is related to the design itself because this evaluation plan relies heavily on descriptive, time series analysis, and qualitative data, this evaluation will describe what happened after the Demonstration was implemented. This makes it difficult to isolate why changes occurred. In other words, it is difficult to directly attribute changes after waiver implementation to the activities undertaken as part of the waiver. We address this by using an ITS method where possible, but this is not possible for all measures.

While the ITS design is the strongest available research method, in the absence of a randomized trial or matched control group, there are some threats to the validity of results in the design. The primary threat is that of history, or other changes over time happening during the waiver period. This ITS design is only valid to the extent that the Demonstration was the only thing that changed during the evaluation period. Where appropriate, sensitivity analyses for ITS were conducted by modeling the outcome measures as count data (see Appendix B). Other changes to policies or programs could affect the outcomes being measured under the Demonstration. Mercer has attempted to control this threat by considering other policy and program changes happening concurrent to the waiver period interventions. We use qualitative methods, in the form of key informant interviews, to identify other initiatives or events may have occurred during the Demonstration that might influence Demonstration effects. Based on stakeholder reports, the primary confounding factors are not associated with a specific point in time, but are instead part of ongoing workforce shortages and a lack of providers across some levels of care and for adolescent populations.

Mercer anticipated a statistically significant impact of the COVID-19 public health emergency on most metrics. However, all of the pre-Demonstration period occurred during COVID-19, meaning that there is no pre-COVID-19 data point to use to control for in the pre-analysis. However, we did run all ITS analysis using a with COVID-19 and without COVID-19 co-variate in post-Demonstration trends. In about half of the cases, variables controlling for the COVID-19 period are statistically significant. However, the 95% confidence interval of the effect size of the intervention with and without COVID-19 overlap for nearly all variables. In the case of only one subgroup analysis for one variable (Children, Metric 8) does controlling for COVID-19 have a statistically significant effect of the intervention. Decreases in trends of the number of individuals receiving services are likely due at least in part to the decrease in Medicaid individuals during the unwinding of COVID-19 era Medicaid rosters. However, this is largely controlled for by focusing on rates of treatment that include the number of individuals in the denominator.

A related threat to the validity of this evaluation is external (history). Because we have not identified a comparison group (a group of Medicaid individuals who would be eligible for the waiver interventions, but who will not receive them and/or for whom data will not be collected), it is difficult to attribute causality. However, the ITS design controls for this threat to some degree, by linking what would have likely happened (e.g., forecasting the trajectory of counts and rates over time) without any program changes and comparing this forecast to actual changes over time. We have worked to limit this threat to validity by triangulating our data. Key stakeholder focus groups were used to inform the quantitative findings and explain the degree to which individuals are seeing Demonstration impacts. In the summative evaluation, we will also attempt to seek out national and other State data for benchmarking, that will allow us to determine whether Connecticut is performing in a similar fashion to other demonstration states, non-demonstration states, or national benchmarks overall.

Section 6

Results

The following section details the results of our quantitative and qualitative analyses, sorted by each of the six Demonstration primary drivers/goals. For each hypothesis, we list results of analysis of each measure presented in the Evaluation Design table, presented in its entirety in the Evaluation Design Plan starting on page 18 in Appendix A of this report. To allow the reader to find each measure, we list results in the order they appear in the design table and include the details on the measure definitions, steward, subgroup analysis, and analytic methods.

Interrupted time series (ITS) and descriptive time series analyses were conducted using both counts (number of people) utilizing a service as well as the rate of utilization (per 1,000 Medicaid individuals). Because rates control for changes in Medicaid enrollment and in substance use disorder (SUD) diagnosis, charts are provided for rates primarily. However, count analysis and charts are also included when they differ from, or are more illustrative of the trend, than the rates. A listing of all plots and results tables for all metrics, including subgroups, analyzed using ITS is included in Appendix B of this document.

Connecticut Goal 1

Increase Individual Access To and Use of Appropriate SUD Treatment Services Based on American Society of Addiction Medicine Criteria

Primary Driver

Improved Access to Care Via a Full Continuum of Available SUD Services

Overview of Driver Progress

Overall, the State has completed its implementation plan and is beginning to make progress in recruiting more providers across each level of care (LOC). However, progress has been slow and these gains have not yet translated into greater utilization or better access to services across all levels of care. Stakeholders agreed that developing provider capacity is a lengthy process and things are moving in the right direction.

The State is seeing some increases in utilization in intensive levels of care (Partial Hospitalization Program [PHP]/Intensive Outpatient Services [IOP], residential/inpatient, Institutions of Mental Diseases [IMDs], and withdrawal management), which may be indicative of the significant needs of the population at the start of the Demonstration. To better meet the needs of Medicaid individuals and serve individuals at the most appropriate and least restrictive levels of care, it would be beneficial to begin to see decreases in utilization at these higher levels of care and increases in ambulatory utilization, particularly for young people in the State.

Securing residential treatment options for adolescents in the State remains a challenge. Recent actions, including increasing reimbursement rates on July 1, 2025, for care may help to increase treatment accessibility by adding new providers.

Table 6.1: Improved Access to Care Driver — Progress Table

Hypothesis Summary	Findings
Hypothesis 1: The Demonstration will increase the availability of critical LOCs for Medicaid individuals.	- The State has used reinvestment funds to change rate structures and increase rates; this has increased provider interest, but has not yet translated to better availability. - Some providers are piloting the use of flex-beds to accommodate an expanded continuum of LOCs. - At the start of the Demonstration, the State lost 90 adult residential beds. It has since replaced 28 of those adult residential beds. - Advocates and family individuals of people in need of treatment did not see any increases in access to care, largely because Medicaid individuals are not aware of what is available or how to access services.
Hypothesis 2: The Demonstration will increase the use of residential, medication assisted treatment (MAT), withdrawal management, early intervention, and ambulatory care available by Medicaid individuals.	- Results for this hypothesis were mixed. - Utilization rates for PHP/IOP increased significantly for most groups, but not for children, older adults, or dual-eligible subgroups. - Utilization rates for residential and inpatient services increased significantly for nearly all subgroups. However, service utilization for children/adolescents declined. - Utilization rates for Withdrawal Management services increased significantly for the total population and for all subgroups except for pregnant women and children. - Early intervention, outpatient, and MAT services did not increase because of the Demonstration. However, the Demonstration does appear to have slowed declines in these service areas that would have happened without implementation. - The number of individuals served in an IMD for SUD and the length of stay (LOS) for those stays both increased under the Demonstration.
Hypothesis 3: The Demonstration will lead to use of the most recent version of the American Society of Addiction Medicine (ASAM) placement criteria by all providers.	- Results for this hypothesis were mixed. - Stakeholders generally reported that implementation of the ASAM placement criteria has gone well and that training and technical assistance have supported providers during the transition. - The State continues to struggle to expand capacity at the residential levels of care and has lost some outpatient providers. While providers are using

Hypothesis Summary	Findings
	placement criteria, it is not translating to greater access to care (see below).
Hypothesis 4: The Demonstration will increase provider capacity for SUD treatment at critical LOCs for individuals in the State.	- Stakeholders report that the onboarding of new providers remains challenging. - Overall, there has been a decrease overall in the number of SUD providers and an increase in the number of providers providing MAT services.
Hypothesis 5: The Demonstration will improve access and develop capacity for adolescent girls needing SUD residential treatment.	The State has not yet been successful in developing any capacity for residential/inpatient treatment for adolescent girls.
Hypothesis 6: More adolescent SUD treatment services will be provided at the ambulatory ASAM LOCs.	- No adolescents reported to be screened positively using Screening, Brief Intervention, and Referral to Treatment (SBIRT) and receiving services in primary care. Data under the new SBIRT coding and rates effective July 1, 2025 is not yet available. <i>Stakeholders reported that there were over 1,300 SUD screens conducted by behavioral health providers on youth that are not included in the coding of the metric. Of those youth, 418 received referrals for service or care coordination.</i> - The rate of child/adolescent outpatient SUD services has stayed the same throughout the Demonstration. However, the trend prior to implementation was a declining rate of services, indicating that the Demonstration has likely prevented further service utilization decreases.

Hypothesis 1

The Demonstration will increase the availability of critical LOCs for Medicaid individuals.

Table 6.2: Qualitative Metrics

Measure	Time Period	Data Sources	Analytic Method(s)
Submission of State Plan Amendments (SPAs) to include residential care and to update SUD service standards.	Cumulative from start.	Document review and focus groups. ⁵	Thematic analysis of interviews and final SPAs.

⁵ As discussed in the Methodology section, our experience with this evaluation from the mid-point assessment informed our data collection strategy to use focus groups rather than key informant interviews to allow more participation and ensure more diverse perspectives.

Measure	Time Period	Data Sources	Analytic Method(s)
Stakeholder reports of implementation and access to each ASAM critical LOC.	Cumulative from start.	Document review and focus groups. ⁶	Thematic analysis of interviews and final SPAs.

Submission of State Plan Amendments

Centers for Medicare & Medicaid Services (CMS) has approved the following two SPAs to facilitate increased availability of critical LOCs for Medicaid individuals.

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

Stakeholder Reports of Implementation

During data collection for the mid-point assessment, in early 2025, stakeholders expressed concerns that lack of capacity affected access across several critical LOCs. This has not changed over the course of this year. Providers noted that securing reimbursement mechanisms for specific levels of care is only a small part of building capacity. Adding new levels of care for a provider requires capital investments. These resources are not available through the Demonstration, and the State does not have grant funds to help providers renovate facilities or make other investments needed to add new levels of care.

There is progress being made, but it is slow. The State did revise rates structures on July 1, 2025, and this, according to State partners, has led to interest from providers in providing additional adult and youth services. Providers are also looking to expand their own continuums of care, to provide multiple LOCs within their own agency or system. The State has begun to permit providers to receive additional certifications at a single location and to provide flex-beds to encourage individuals to remain in treatment through multiple levels of care, which providers have begun to implement. Most stakeholders agreed that this, combined with rate increases, is beginning to see results in adding capacity and, therefore, access to critical levels of care for adults. In particular, Connecticut Valley Hospital increased the number of beds available to individuals under the Demonstration from 102 beds on May 1, 2022 to 152 beds on July 1, 2025.

The shortage of adolescent providers persists. Only one new IOP provider has been added since January 2024. Access for youth has remained mostly the same and there is still a need for residential providers for both genders. The State has used its reinvestment funds under the Demonstration to improve rates for adolescents and collapse the rate corridors. These rates were effective July 1, 2025. There are some developing plans for new residential

⁶ As discussed in the Methodology section, our experience with this evaluation from the mid-point assessment informed our data collection strategy to use focus groups rather than key informant interviews to allow more participation and ensure more diverse perspectives.

treatment beds. Currently, the only intensive LOCs available to adolescents are ambulatory level 2.1 and level 2.5.

Advocates and family members of people in need of treatment have not experienced any increases in access to care. They report that the main barrier to accessing care is that Medicaid enrollees are not aware of what is available or how to access services when there is a need. Advocates and family individuals cited urgent concerns that when people in the community are in a behavioral health crisis, they are not receiving an appropriate response and are not being linked to stabilization services or any long-term treatment options.

There are no quantitative metrics for this hypothesis.

Hypothesis 2

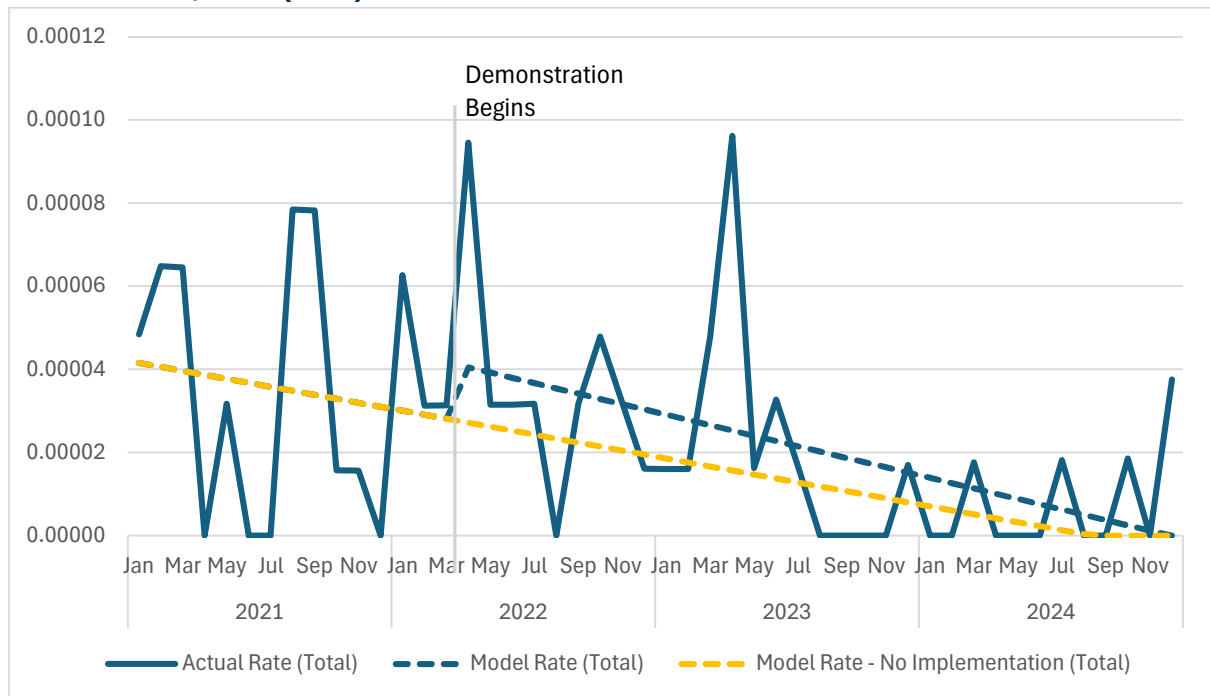
The Demonstration will increase the use of residential, MAT, withdrawal management, early intervention, and ambulatory care available by Medicaid individuals.

There are no qualitative metrics for this hypothesis.

Table 6.3: Quantitative Metrics

Measure	Time Period	Data Sources	Analytic Method(s)
Number/percent of individuals who receive prevention or early intervention services (CMS #7/CMS #3).	Monthly	Claims	ITS; with demographic subgroups
Number/percent of individuals who use outpatient services (CMS #8/ CMS #3).	Monthly	Claims	ITS; with demographic subgroups
Number/percent of individuals who use intensive outpatient and partial hospitalization services (CMS #9/ CMS #3).	Monthly	Claims	ITS; with demographic subgroups
Number/percent of individuals who use residential and/or inpatient services for SUD (CMS #10/CMS #3).	Monthly	Claims	ITS; with demographic subgroups
Number of individuals who have a claim for MAT for SUD during the measurement period (CMS #12/ CMS #3).	Monthly	Claims	ITS; with demographic subgroups
Number/percent of individuals who use withdrawal management services (CMS #11/CMS #3).	Monthly	Claims	ITS; with demographic subgroups
Number and length of IMD stays for SUD (CMS #36).	Yearly	Claims	Descriptive analysis; pre-post analysis of variance

Metric #7: Individuals Receiving Early Intervention through Quarter Ending December 31, 2024 (Rate)



Few individuals received early intervention services before the Demonstration. Since implementation, the numbers have shown a decreasing trend. The Demonstration trend (the blue dotted line) shows a similar decline to what was predicted without the Demonstration (the yellow dotted line), indicating that the Demonstration did not have any effect on early intervention utilization. Because of the large variability and small number of individuals receiving early intervention services, there is not a statistically significant trend either pre- or post-Demonstration. The ITS is unable to detect any statistically significant change ($p > .05$) from the Demonstration, as shown in the table below.

Metric 7 Rate — Total Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	5.4935447	-2	0.064
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	<0.00001	-0.00003	0.00004

An ITS analysis using the rate of individuals (as opposed to counts) revealed the same trends and similar coefficients. Numbers were so small that calculating rates result in very small numbers. There were no significant effects of the Demonstration on the percentage of Medicaid individuals receiving early intervention services.

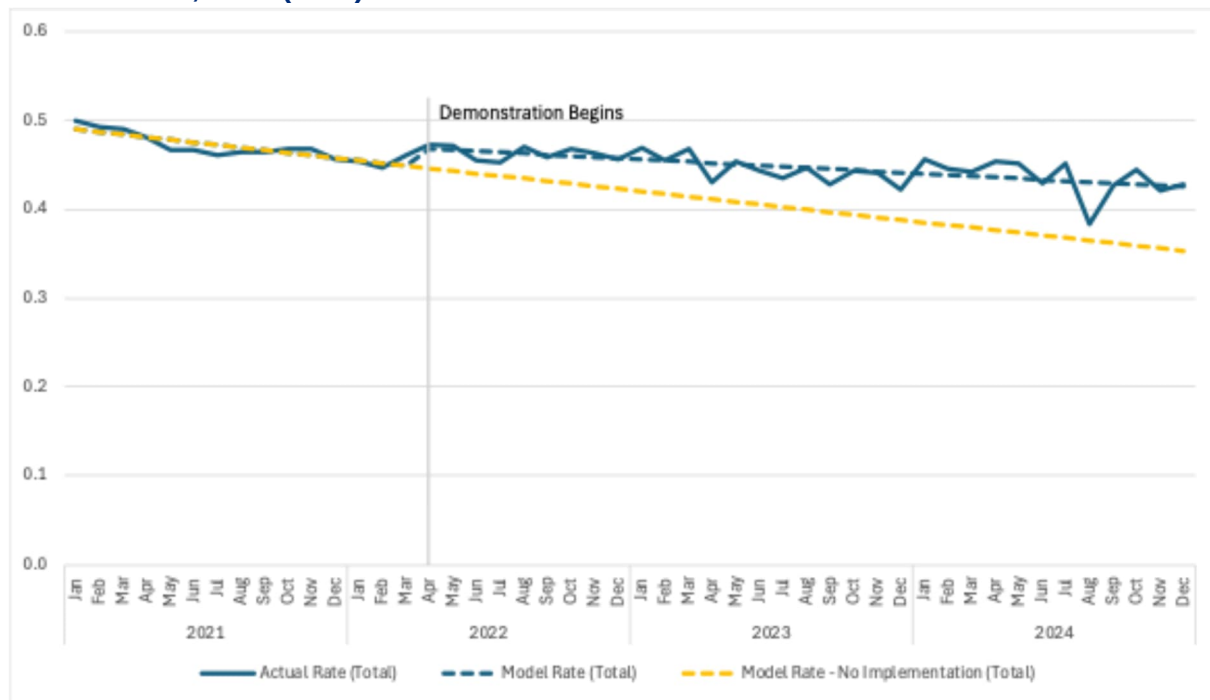
Early Intervention Services (Metric #7) for Subgroups

Trends for all subgroups were similar to the total trend, with some rising to the level of statistical significance (adults, older adults, dual-eligible, and Medicaid-only subpopulations).

Plots are nearly identical for all groups and are included in the Interim Evaluation Appendix B page 30–page 43. Graphs for the number of individuals receiving early intervention are followed by the graphs for the rate of individuals receiving Early Intervention. Note: graphs for opioid use disorder (OUD) and not pregnant individuals are also included in Appendix B. There was no data for individuals under age 18 years old, who were pregnant, or who had criminal justice involvement.

Measure Summary: This measure does not support Hypothesis 2 — that the Demonstration has increased access to critical levels of care for OUD and other SUDs. Utilization of early intervention services remains very low and appears to continue to decline. However, the Demonstration may have stemmed the overall rate of decline.

Metric #8: Individuals Receiving Outpatient Services through Quarter Ending December 31, 2024 (Rate)



The rate of individuals with an SUD diagnosis receiving outpatient SUD services (blue dotted line) declined after the start of the Demonstration, although less so than predicted by the model (yellow dotted line). The Demonstration appears to have slowed the rate of decline in outpatient service utilization that was occurring prior to its start.

Metric 8 Rate — Total Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	29.552898	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.047	0.026	0.068

The same trend holds when using counts of people receiving services, rather than the rate per 1,000 individuals with an SUD diagnosis. Post-Demonstration, outpatient service utilization continued to decline, but less steeply than was predicted by the ITS model.

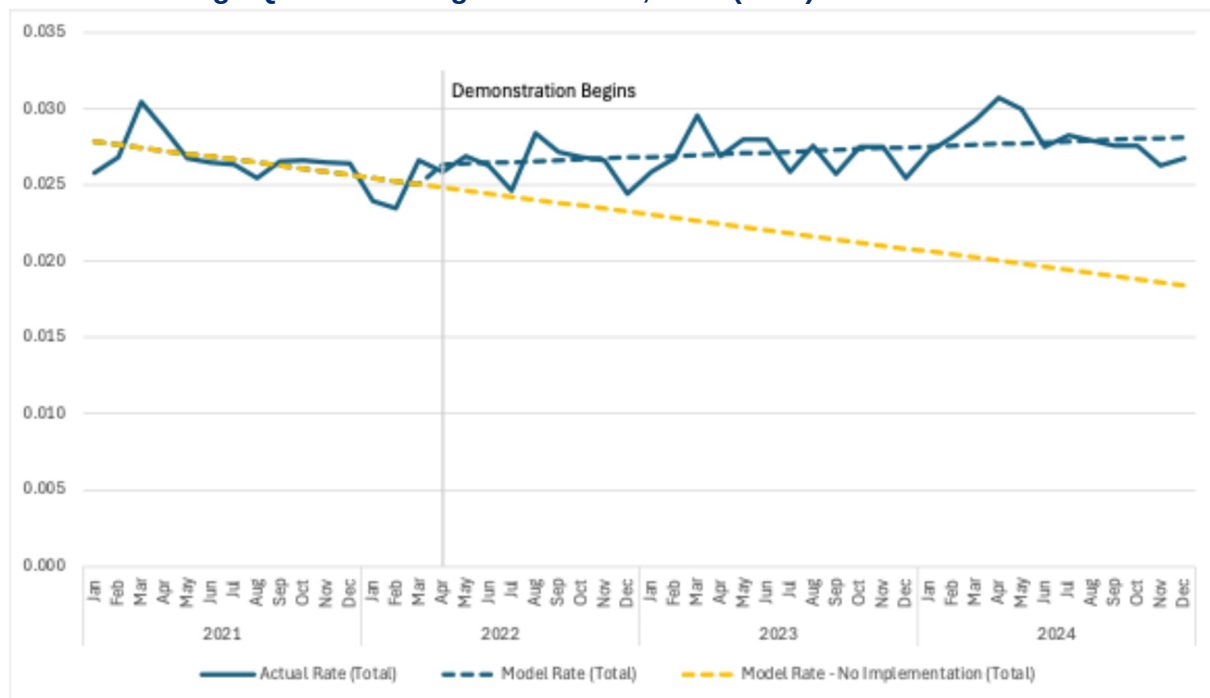
The difference in the declining outpatient services utilization rate between individuals and the model prediction was statistically significant.

Outpatient Services (Metric #8) for Subgroups

Trends in outpatient services were similar (with no significant differences) for dual-eligible, older adult, pregnant and child/youth subgroups, using both counts and rates per 1,000. See Appendix B page 44–page 61. However, when looking at rates per 1,000, the OUD subgroup declined at a statistically significant level that was less than predicted by the model. For this group only, the Demonstration appears to have slowed decreased utilization in outpatient services for individuals with an OUD diagnosis more than without the Demonstration.

Measure Summary: This measure does not support Hypothesis 2 — that the Demonstration has increased access to critical levels of care for OUD and other SUDs. It does show that the decline in outpatient services for individuals with an OUD diagnosis was lessened by the Demonstration.

Metric #9: Individuals Receiving Intensive Outpatient and Partial Hospitalization Services through Quarter Ending December 3, 2024 (Rate)



There was no overall increase in utilization of IOP and PHP services. However, because there are fewer Medicaid individuals with an SUD diagnosis, there has been a small and steady increase in the rate of utilization since the implementation of the Demonstration. This increase is statistically significant.

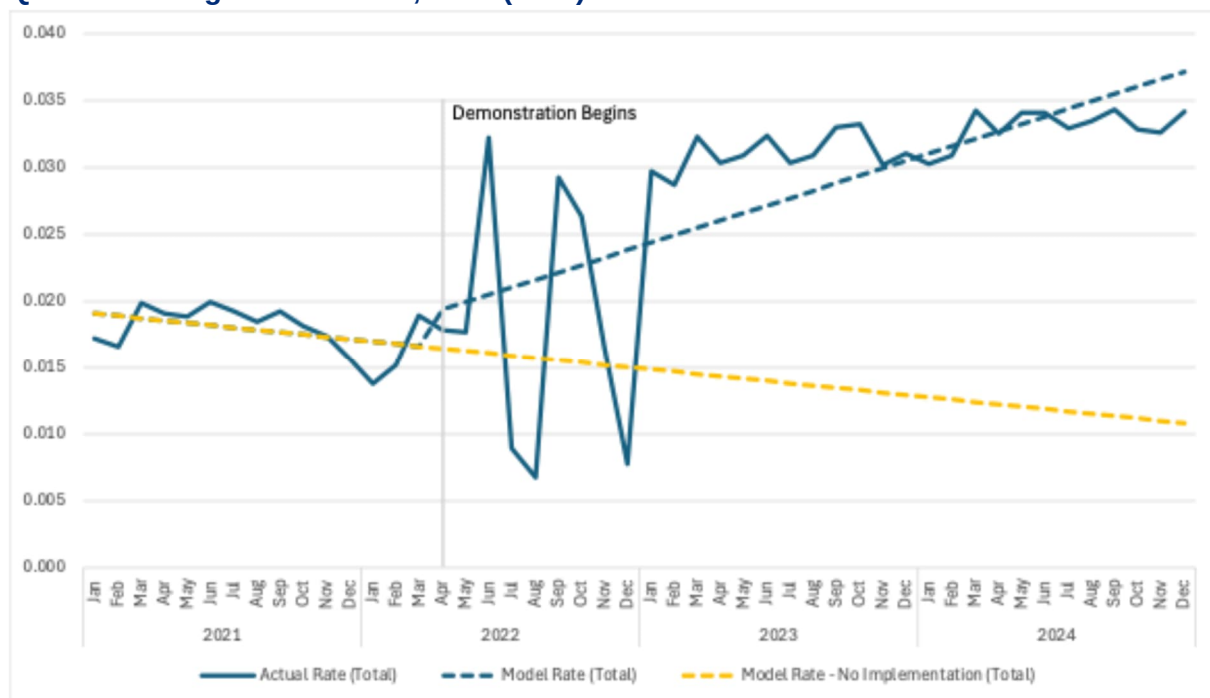
Metric 9 Rate — Total Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	30.055911	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.006	0.004	0.008

IOP and PHP Services (Metric #9) for Subgroups

There were similar, and significant, improvements in the rates of utilization of IOP and PHP services in some subgroups. However, there was not a significant change for children, older adults, or dual-eligible subgroups. Stakeholders reported that utilization of IOP and PHP for youth is obscured because youth tend to enter the behavioral health system with a mental health primary diagnosis with SUD listed as secondary diagnosis and receive co-occurring treatment in mental health programs that are not aligned with ASAM. All plots and coefficient tables are included in Appendix B page 63–page 80.

Measure Summary: This metric supports Hypothesis 2, that the Demonstration would increase access to critical LOCs. For most groups, rates of IOP and PHP utilization increased. However, rates for children/youth did not increase, which is another significant goal of the Demonstration.

Metric #10: Individuals Receiving SUD Residential and Inpatient Services through Quarter Ending December 31, 2024 (Rate)



The utilization rate for residential and inpatient services did increase significantly, both statistically significantly and by a large percentage at the start of the Demonstration.

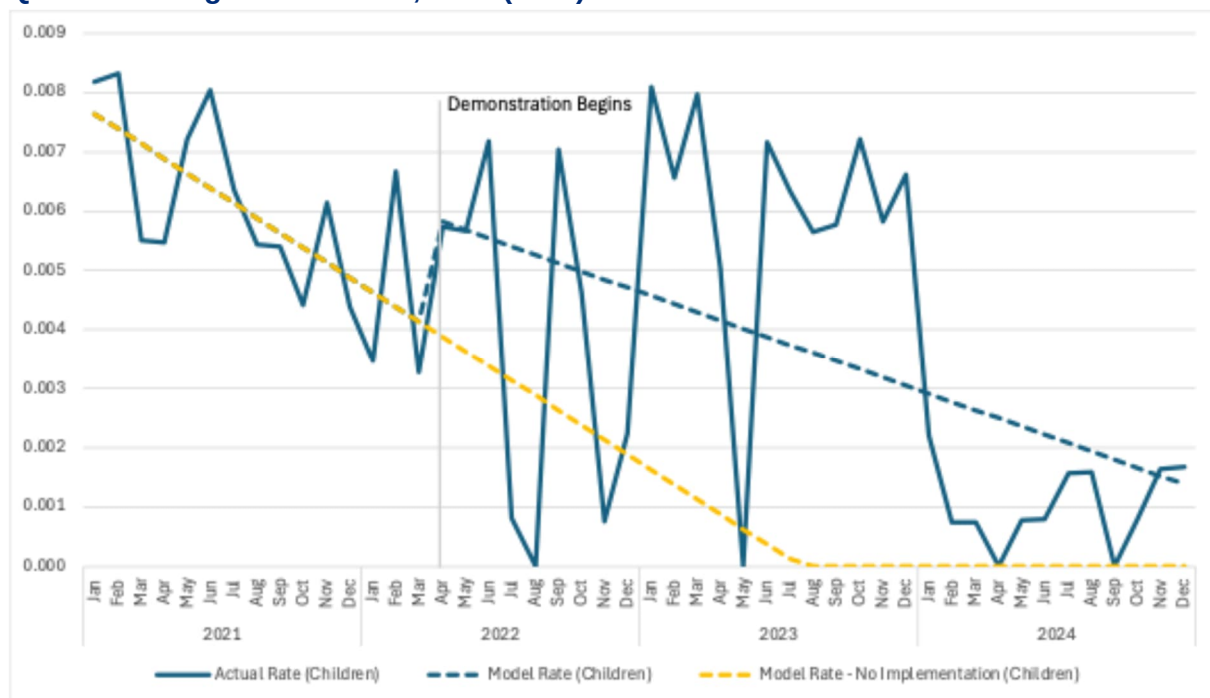
However, utilization rates were very unstable for the first eight months. Since that time, the increase has continued more modestly and steadily through the next two years.

Metric 24 Rate — Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	10.073395	-2	0.006
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.49	-0.01	1.00

Residential and Inpatient Services (Metric #10) for Subgroups

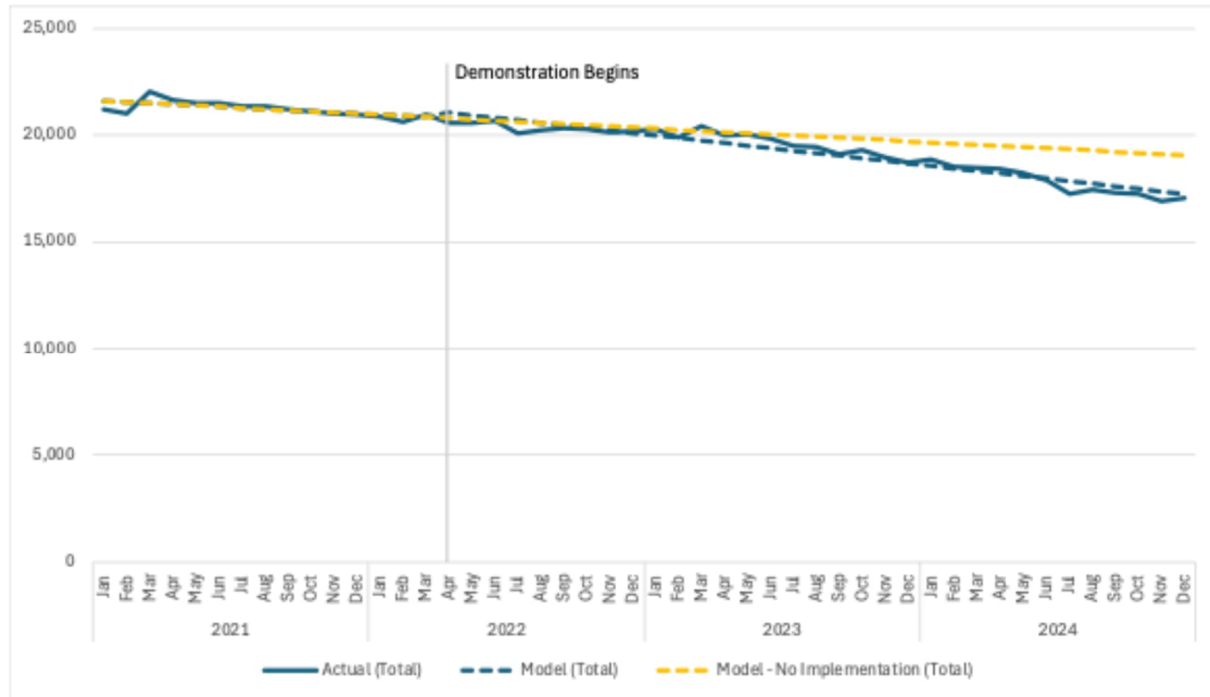
Utilization rates increased for all subgroups except for children, although changes in utilization rates for older adults were not statistically significant. See Appendix B page 81-page 98. Residential and inpatient utilization rates for children decreased significantly, likely a reflection of the closing of the boys' adolescent residential treatment facility effective January 26, 2024, leaving only inpatient and ambulatory care for adolescents. Until that closure, the pattern of utilization was very sporadic.

Metric #10: Children Receiving SUD Residential and Inpatient Services through Quarter Ending December 31, 2024 (Rate)



Measure Summary: This metric supports Hypothesis 2 — that the Demonstration would increase access to critical LOCs. For nearly all groups, rates of residential and inpatient utilization increased. However, residential and inpatient utilization rates for children/youth significantly declined.

Metric #12: Individuals Receiving MAT Services through Quarter Ending December 31, 2024 (Number)

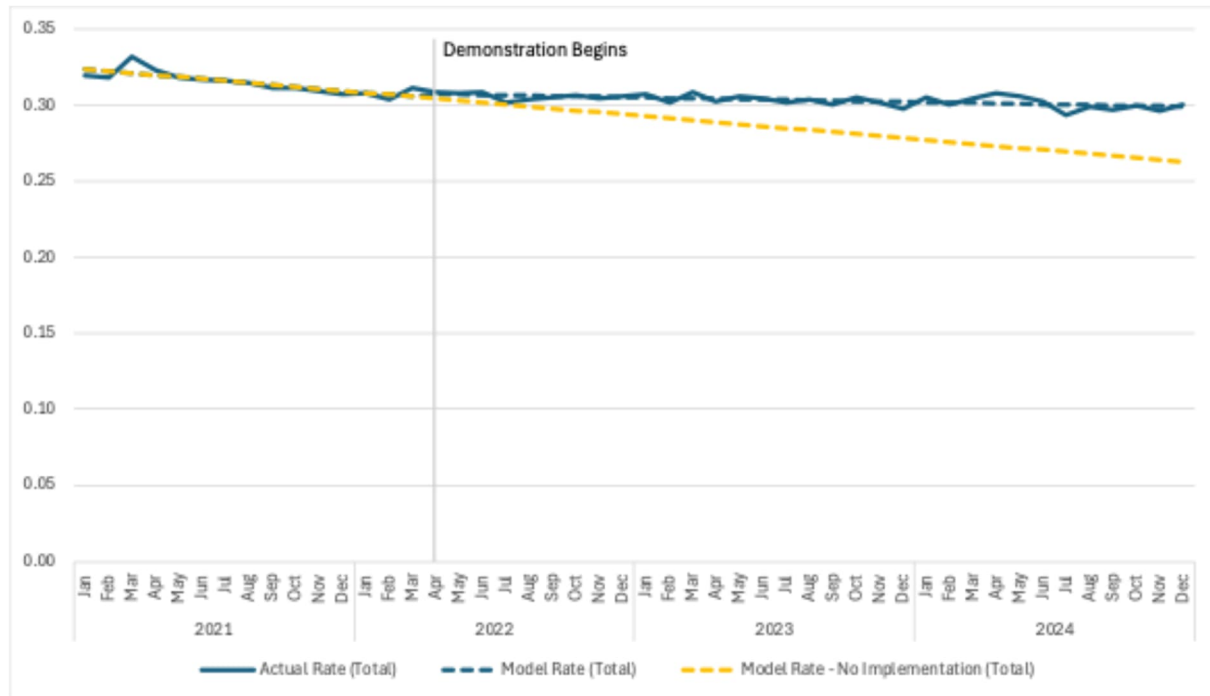


The number of individuals receiving MAT services declined after the start of the Demonstration, this decline was significantly more than predicted by the model without the Demonstration and was affected by the Public Health Emergency (PHE) unwinding.

Metric 12 — Total Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	10.395222	-2	0.006
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-775.49	-1,403.71	-147.26

Even though the overall number of people receiving MAT services declined, because the number of Medicaid individuals with a SUD diagnosis also declined due to the PHE unwinding, the rate of individuals with a SUD diagnosis receiving MAT stayed stable during the first nearly three years of the Demonstration. This difference between the predicted model without the Demonstration was statistically significant.

Metric #12: Individuals Receiving MAT Services through Quarter Ending December 31, 2024 (Rate)



Metric 12 Rate — Total Coefficients

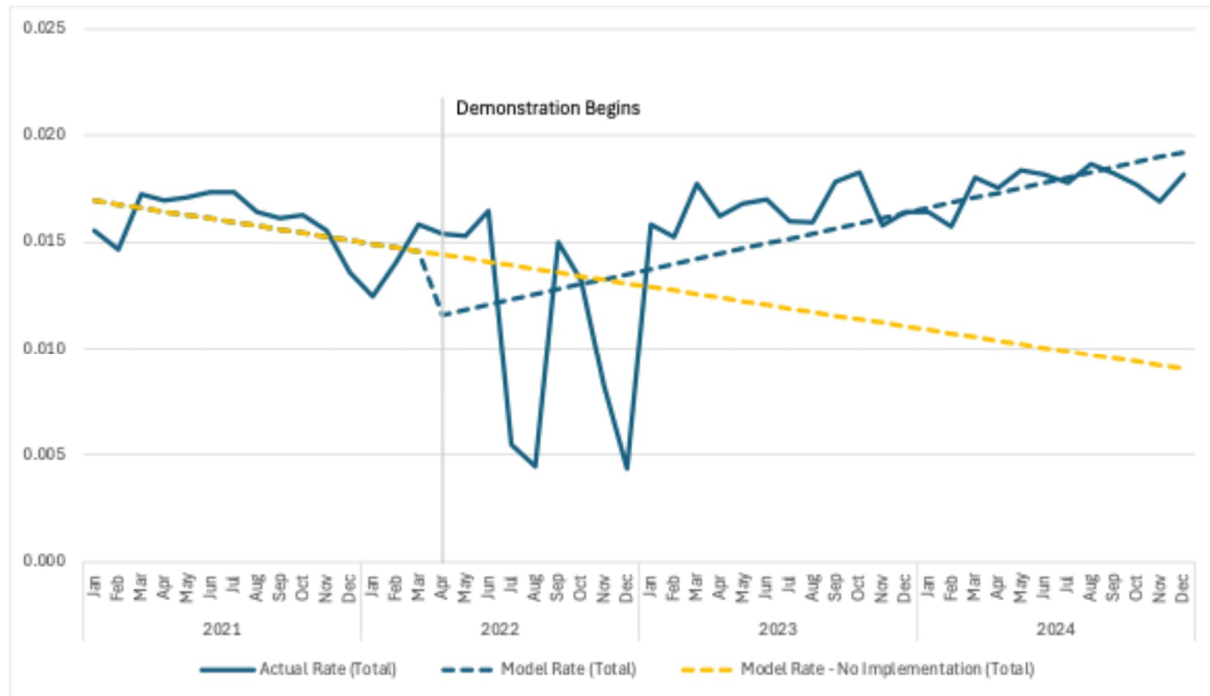
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	60.672821	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.020	0.012	0.027

MAT Services (Metric #12) for Subgroups

The Demonstration had significant effects across all subgroups except for pregnant women. For all other groups the actual trend was either stable or showed a lower rate of decline than what was predicted without the Demonstration. See Appendix B page 117–page 134.

Measure Summary: This metric only partially supports Hypothesis 2 — that the Demonstration would increase access to critical LOCs. Rates of MAT utilization did not increase as hypothesized. However, the analysis indicates that rates of utilization either stabilized or declined less than they would have absent the Demonstration for all individuals except for pregnant women.

Metric #11: Individuals Receiving Withdrawal Management Services through Quarter Ending December 31, 2024 (Rate)



After eight months of instability in utilization due to late data submission beyond the data cutoff period, the rate of individuals with an SUD diagnosis receiving Withdrawal Management (WM) services increased significantly over the next two years. This same pattern is also observed in the number of enrollees receiving WM services.

Metric 11 Rate — Total Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	24.371364	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.004	-0.0004	0.008

Withdrawal Management Services (Metric #11) for Subgroups

This trend of significant increase in WM utilization rates was similar for all subpopulations of focus except for pregnant women and children. For those two populations, rates either decreased or did not significantly change. See Appendix B page 81–page 116.

Measure Summary: This metric supports Hypothesis 2 — that the Demonstration would increase access to critical LOCs. Rates of WM utilization increased as hypothesized for total individuals and for all subgroups except for pregnant women and children.

Measure (CMS Metrics #5 and #36): Number and Average Length of IMD Stays for SUD

Measure	DY Baseline 2021–2022	DY 1 2022–2023	DY 2 2023–2024	Percentage Change
#5 Medicaid Individuals Treated in an IMD for SUD	5,797	6,281	8,032	+39%
#36 Average Length of IMD Stay for SUD	4.4	11.7	17.7	+302%

There was an increase (39%) in the number of Medicaid individuals treated in an IMD after the Demonstration was implemented. There was also a large (302%) increase in the average LOS in an IMD for Medicaid individuals between the baseline period and Demonstration Year (DY) 2.

Measure Summary: This measure supports Hypothesis 2 — that the Demonstration has increased access to critical levels of care for OUD and other SUDs. The Demonstration appears to have led to increases in both the number of individuals with an IMD stay and the average length of those stays.

Hypothesis 3

The Demonstration will lead to use the most recent version of the ASAM placement criteria by all providers.

Table 6.4: Qualitative Metrics

Measure	Time Period	Data Sources	Analytic Method(s)
Description of activities to monitor provider use of ASAM criteria for patient placement.	Cumulative from start of Demonstration.	Document review and focus groups.	Narrative analysis.
Description of training and technical assistance activities.	Cumulative from start of Demonstration.	Document review and focus groups.	Narrative analysis.

Provider Use of ASAM Criteria for Placement

The Department of Social Services 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. All implementation items associated with Milestone 2 (Use of Evidence-Based, SUD-Specific Patient Placement Criteria) have been completed by the State.

During the midpoint assessment, there was a consensus among State agency and provider stakeholder groups that providers are using the ASAM criteria to make placement decisions. There was general agreement that movement toward placement decisions and treatment episode durations 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 issue has not yet been resolved with both providers and other stakeholders acknowledging that lack of bed capacity at some levels of care may mean the placements determinations are influenced by bed availability and alternative levels of care may be pursued where possible (e.g., IOP with housing instead of ASAM 3.1). The largest consequence of this is that clients who are unable to step down to a more appropriate level of care do not have medical necessity to remain at a higher level until a bed is available and Medicaid will not reimburse for services beyond medical necessity.

Provider Training and Technical Assistance

Stakeholder groups acknowledge that adopting the ASAM criteria was initially a steep learning curve for many residential providers. The State partners and Advanced Behavioral Health (ABH) have emphasized a cooperative and supportive approach to helping providers become fully certified. The Behavioral Health Administrative Services Organization, Carelton, has also worked together with the State agencies to train, educate, and help providers adopt and incorporate the ASAM 3rd edition framework in their daily practice and clinical decision-making.

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.

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. The State should model the previous successful training and technical assistance approaches as it moves to implementation of ASAM 4th edition.

Table 6.5: Quantitative Metrics

Measure	Time Period	Data Sources	Analytic Method(s)
Number/percent of providers certified at each LOC.	Yearly	Department of Mental Health and Addiction Services (DMHAS) and Department of Children and Families certification records.	Descriptive time series; Chi-Square.

During DY 1, all providers were provisionally certified. During DY 2, monitoring, technical assistance, and integration of ASAM was the primary focus. In DY 3, certification was issued for all provider types except Behavioral Health Federally Qualified Health Centers, which was issued early in DY4.

Table 6.6: Providers Certified at each Level of Care

ASAM LOC	DY 1 Active ⁸ Programs		DY 2 Active Programs		DY 3 Active Programs	
	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent
Ambulatory Outpatient						
1-WM	33	7	33	8	3	0
2-WM	10	7	10	8	0	0
2.1	93	26	109	27	90	15
2.5	26	8	29	8	26	7
Total Outpatient	162	48	181	51	119	22
Residential Programs						
3.1	7	0	7	0	7	0
3.3	2	0	2	0	2	0
3.5	11	1	11	0	11	0
3.5PPW	5	0	5	0	5	0
3.7R	7	0	7	0	7	0
3.7Co-occurring	3	0	3	0	3	0
3.7WM	7	0	7	0	7	0
Total Residential	42	1	42	0	42	0
Total Programs	204	49	223	51	161	22

The number of outpatient providers increased between DY 1 and DY 2, but then fell in the most recent year. The decrease in DY 3 is accounted for by providers who had applied for provisional certification with intent to open programs, but some LOC were non-operational at the end of the provisional certification period and did not continue with pursuing full certification. Residential providers have stayed stable, except for the one adolescent provider that has closed since the start of the Demonstration.

As the number of providers has stayed the same, bed capacity has also shown little change. Based on DMHAS reports, there have been reductions in the number of beds available at the 3.3 and 3.5 ASAM levels, while bed capacity for 3.1 has seen virtually no change. There have also been small declines in bed capacity at all 3.7 levels, although there has been a sharp increase in bed capacity at Connecticut Valley Hospital (from 102 beds to 152 beds).

⁸ Includes providers with provisional or conditional certifications as well as those fully certified.

Measure Summary: This measure supports Hypothesis 3 — that the Demonstration will lead to use of the most recent version of the ASAM placement criteria by all providers. Stakeholders report successful training and technical assistance to the ASAM criteria, and all providers have moved from provisional certification status.

Hypothesis 4

The Demonstration will increase provider capacity for SUD treatment at critical LOCs for individuals in the State.

Table 6.7: Qualitative Metrics

Measure	Time Period	Data Sources	Analytic Method(s)
Provider capacity enrolled to deliver SUD and to deliver buprenorphine or methadone as part of MAT.	Cumulative, from start of Demonstration.	Document review and focus groups.	Content analysis of existing reports.

Provider Capacity

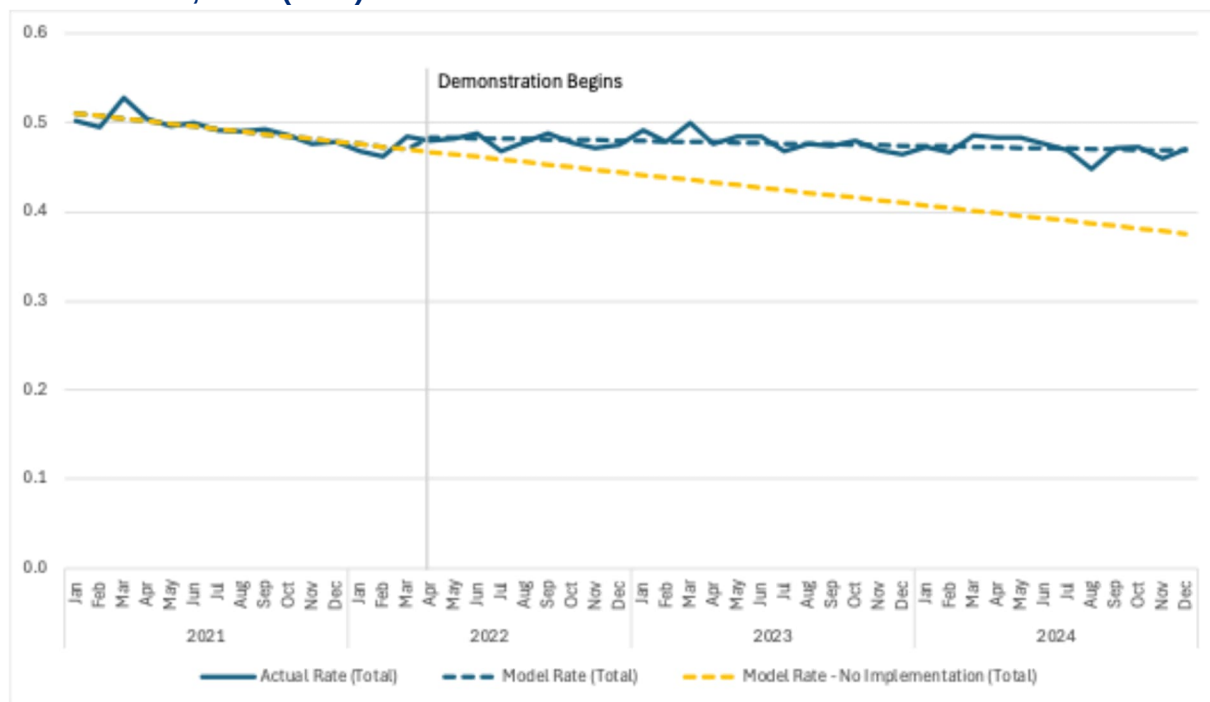
As shown in the previous table, the Demonstration has not yet resulted in increases in provider enrollment, particularly at critical residential levels of care. As the number of providers has stayed the same, bed capacity has also shown little change. Based on DMHAS reports, there have been reductions in the number of beds available at the 3.3 and 3.5 ASAM levels, while bed capacity for 3.1 has seen virtually no change. There have also been small declines in bed capacity at all 3.5 and 3.7 levels, although there has been a sharp increase in bed capacity at Connecticut Valley Hospital (from 102 to 152 beds).

ASAM Level of Care	Number of Beds May 1, 2022	Number of Beds July 1, 2025
3.1	76	74
3.3	50	24
3.5	495	464
3.5 PPW	54	48
3.7	218	200
3.7WM	172	143
CVH (3.7, 3.7WM, 4.0)	102	152
Totals	1,167	1,105

Table 6.8: Quantitative Metrics

Measure	Time Period	Data Sources	Analytic Method(s)
Number/percent of individuals receiving any SUD treatment service (CMS #6).	Monthly	Claims data.	ITS analysis.
Number of providers who were enrolled in Medicaid and qualified to deliver SUD services (CMS #13).	Yearly	Document review from partners.	Descriptive analysis.
The number of providers who were enrolled in Medicaid and qualified to deliver SUD services and who meet the standards to provide buprenorphine or methadone as part of MAT (CMS #14).	Yearly	Document review from partners.	Descriptive analysis.

Metric #6: Individuals Receiving Any SUD Services through Quarter Ending December 31, 2024 (Rate)



The rate of individuals receiving any SUD service declined slightly over the period of the Demonstration. However, the decline was less than the trend was predicted to have been had the Demonstration not occurred. The total number of unique individuals receiving services declined at a sharper rate, but because the number of individuals with an SUD diagnosis was also declining over the three-year period, the rate of decline was less sharp. The decline in both the number of individuals receiving any SUD service and the rate of service for individuals with an SUD diagnosis were statistically significant.

Metric 6 Rate — Total Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	53.372077	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.055	0.039	0.070

Any SUD Service (Metric #6) for Subgroups

This trend of a less steep decline than predicted without the Demonstration in rates of any SUD treatment for individuals with an SUD diagnosis was the same across all groups except for older adults, where an increasing trend was predicted by the model, indicating the Demonstration effect was a negative for this group. Treatment rates declined more than they would have without the Demonstration, for all other groups. The trend was the same as the total trend and the Demonstration effect for all groups was statistically significant, except for those dual-eligible for Medicaid and Medicare. In that group, the trend was the same, but the change was not significant. See Appendix B page 11–page 28.

Measure Summary: This metric does not truly support Hypothesis 4 — that the Demonstration would increase provider capacity at critical LOCs across the State (leading to more SUD treatment utilization). There were fewer enrollees receiving any SUD services than before the Demonstration and the rate of utilization for individuals with an SUD diagnosis also declined. This is likely due at least in part to decreasing provider capacity over the course of the Demonstration thus far, as discussed below.

Measure (CMS Metric #13 and Metric #14): Providers Qualified to Provide SUD Services and MAT

Measure	DY Baseline 2021–2022	DY 1 2022–2023	DY 2 2023–2024	Percentage Change
#13 Number of SUD Providers	1,779	1,797	1,735	-2.5%
#14 Number of Providers Enrolled to Provide MAT	61	63	67	+9.8%
#14 Percent of Providers Enrolled to Provide MAT	3.4%	3.5%	3.9%	+14.7%

The number of providers overall increased during DY 1, but then fell somewhat. The number of providers enrolled to provide MAT continued to increase through DY 2. Most stakeholders reported that there is not always sufficient capacity within existing treatment providers to provide needed care and adolescent providers remain scarce in the State. There was an increase in the number of providers licensed to provide MAT and, in DY 2, a small increase in the percentage of providers enrolled to provide the service.

Measure Summary: These measures do not completely support Hypothesis 4 — that the Demonstration will increase provider capacity at each level of care, including MAT, for SUD. The number of MAT providers is increasing with the implementation of the Demonstration.

Hypothesis 5

The Demonstration will improve access and develop capacity for adolescent girls needing SUD residential treatment.

Table 6.9: Qualitative Metrics

Measure	Time Period	Data Sources	Analytic Method(s)
Focus group question: Have any residential providers been certified to serve adolescent girls?	Cumulative through interim evaluation report.	Focus group with partners, State agencies, individuals.	Narrative analysis.

Stakeholder Reports of Adolescent Provider Capacity

At the start of the Demonstration, the State had one residential treatment provider for adolescent boys, but none for adolescent girls. The adolescent boy's facility closed after the start of the Demonstration on January 25, 2024, leaving no in-State residential option for adolescents, regardless of gender. Adolescents began to be served in-State ambulatory or inpatient settings only as a result.

Stakeholders previously reported that providers are reluctant to operate adolescent treatment facilities because reimbursement rates are not consistent with licensing and treatment requirements. Additionally, it is difficult to find individual providers with expertise in this population. As of July 1, 2025, the State increased adolescent residential rates and is actively recruiting providers to operate adolescent facilities, although none has begun the licensing process at this time.

Table 6.10: Quantitative Metrics

Measure	Time Period	Data Sources	Analytic Method(s)
Number/percent of adolescent girls enrolled in Medicaid who use residential and/or inpatient services for SUD (CMS #10 subgroup).	Monthly	Claims	ITS analysis

There were too few adolescents receiving any kind of residential treatment to conduct a reliable ITS analysis. Nine youth were receiving inpatient and residential treatment at the start of the Demonstration, and only two were receiving inpatient and residential treatment in December 2024, the last month for which data is available.

Measure Summary: This measure does not support Hypothesis 5 — that the Demonstration will increase the capacity and utilization of residential/inpatient treatment for adolescent girls.

Hypothesis 6

The Demonstration will result in more adolescent SUD treatment services provided at the ambulatory ASAM LOCs.

Table 6.11: Quantitative Metrics

Measure	Time Period	Data Sources	Analytic Method(s)
Number/percent of adolescent individuals who receive prevention or early intervention services (CMS #7).	Monthly	Claims	ITS analysis
Number/percent of adolescent individuals who receive outpatient services (CMS #8).	Monthly	Claims	ITS analysis

There are no qualitative metrics for this hypothesis. However, stakeholders reported that SBIRT codes used by primary care providers do not include screens conducted by behavioral health providers. Behavioral health providers receive reimbursement for screens as part of their assessment, evaluation, and/or therapy sessions. There has been significant effort under the Demonstration to increase screening for youth in outpatient behavioral health clinics. In state fiscal year 2025, behavioral health clinic staff screened over 900 youth, a subset of which screened *positive* (medium or high risk).

Training under this initiative began in the first quarter of DY 2 and implementation of screening efforts began in the second quarter of DY 2. Youth were screened using A-SBIRT in Outpatient Psychiatric Clinics for Children.

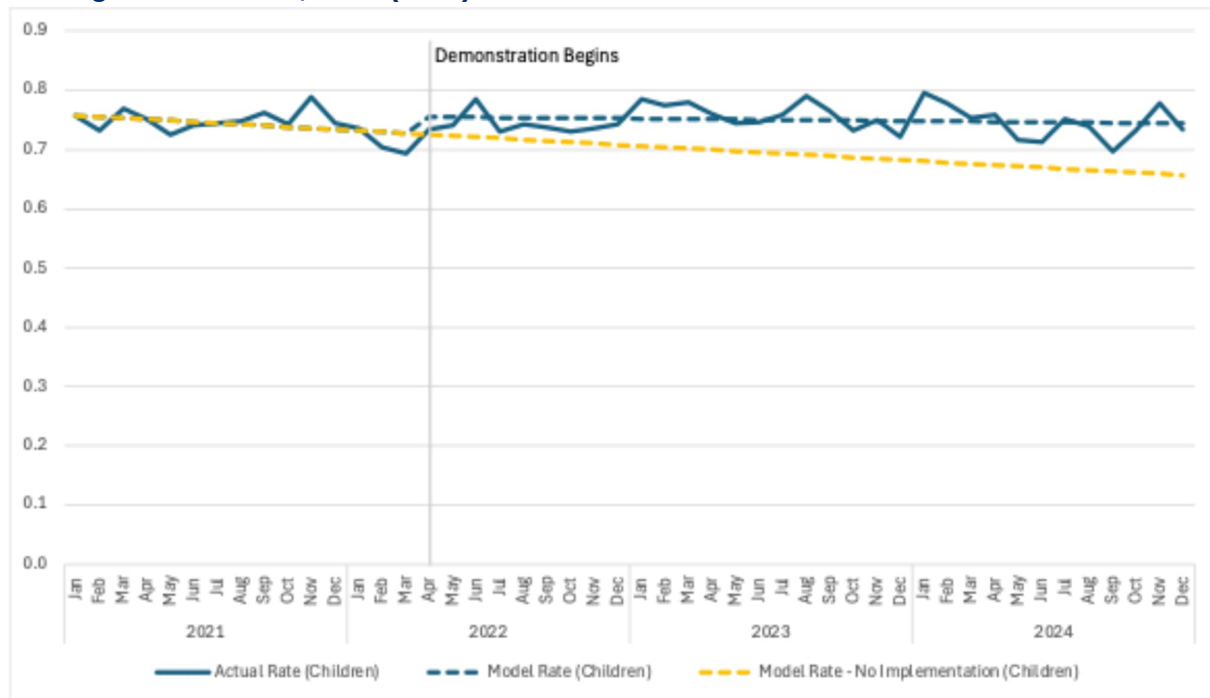
- From July 2023–March 2024, 346 youth were screened. Of which, 124 screened *positive* at medium or high risk. 128 referrals to services were made during this same time period (youth may receive a referral to more than one program). Additionally, 112 youth with identified substance use from A-SBIRT received service coordination services.
- From April 2024–March 2025, 822 youth screened. Of which, 240 screened *positive* at medium or high risk. 485 referrals to services were made during this same time period. Additionally, 265 youth with identified substance use from A-SBIRT received service coordination services.
- From April 2025–June 2025, 216 youth screened. Of which, 54 screened *positive* at medium or high risk. 118 referrals to services were made during this same time period. Additionally, 37 youth with identified substance use from A-SBIRT received service coordination services.
- Starting July, 2025, four new behavioral health providers are joining this project.

Metric #7: Children/Adolescents Receiving Early Intervention through Quarter Ending December 31, 2024 (Rate)

There were no children/adolescents (individuals less than 17 years old) with any recorded prevention/early intervention services in any of the months of claims data provided for this report. Therefore, no analysis was conducted.

Measure Summary: The metric did not support Hypothesis 6 — that the Demonstration will result in more adolescent SUD treatment services being provided at the ambulatory ASAM LOCs. However, additional information provided by stakeholders found that prevention/early intervention services were recorded as provided to youth due intensive SBIRT adolescent provider training and SBIRT services.

Metric #8: Children/Adolescents Receiving Outpatient Services through Quarter Ending December 31, 2024 (Rate)



The rate of children/adolescent individuals with an SUD diagnosis receiving outpatient SUD services has stayed stable over the course of the Demonstration so far. However, the ITS model predicted that these services would decline if the Demonstration had not been implemented. The effect of the Demonstration on these rates was statistically significant.

Metric 8 Rate — Children Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	8.6948488	-2	0.013
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.058	0.001	0.116

Measure Summary: The outpatient measure somewhat supports Hypothesis 6 — that the Demonstration will increase utilization of adolescent SUD treatment at the ambulatory ASAM LOC. While Metric #7 did not have adolescents reported to be screened positively using SBIRT and receiving services in primary care, initiatives launched by behavioral health providers resulted in screening over 1,300 youth and the referral of 418 youth who screened positively to services Data under the new SBIRT coding and rates effective July 1, 2025 is not yet available. The rate of child/adolescent outpatient SUD services has stayed the same throughout the Demonstration. However, the trend prior to implementation was a declining rate of services, indicating that the Demonstration has likely prevented further service utilization decreases.

Primary Driver

Increase Rates of Identification, Initiation, Engagement, and Retention in Treatment

Overview of Driver Progress

Overall, the State has not made significant progress towards this goal. Most Demonstration efforts reported by stakeholders involved transitioning providers to ASAM and providing training, technical assistance, and review. Now that providers are more established and the State has better experience with the provider onboarding process, efforts may need to more thoroughly turn identifying substance use risks and concerns and engaging individuals in treatment when indicated. Based on stakeholder reports that most Medicaid individuals are unaware of available services or how to access them, this represents an important opportunity for the State to increase rates of identification, initiation, engagement, and retention (IER) in treatment. The State should consider this as it transitions to the new ASAM 4.0, which will take a considerable amount of State resources, and could distract from the need to improve IER across the Medicaid program.

Increased Rates of IER in Treatment — Progress Table

Hypothesis Summary	Findings
Hypothesis 7: The Demonstration will improve rates of identification, initiation, and engagement in treatment.	Results for this hypothesis were mixed. There were some small improvements in initiation of treatment, while the percentage of individuals engaged in treatment decreased.
Hypothesis 8: The Demonstration will improve access and develop capacity for adolescent girls needing SUD residential treatment.	The State has not yet successfully recruited and certified any SUD residential providers for adolescent girls.

Hypothesis 7

The Demonstration will improve rates of identification, initiation, and engagement in treatment.

Quantitative Metrics

Measure	Time Period	Data Sources	Analytic Method(s)
Initiation of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET-AD) (CMS #15).	Yearly	Claims; all Dx and Tx (alcohol, opioid, and other).	Descriptive analysis.
Engagement of AOD Abuse or Dependence Treatment (IET-AD) (CMS #15).	Yearly	Claims; all Dx and Tx (alcohol, opioid, and other).	Descriptive analysis.

There were no qualitative metrics for this hypothesis.

Measure (CMS Metric #15): Increase in Treatment Initiation and Engagement

Metric #15 Measure	CY 2021	CY 2022	CY 2023	Percentage of Change
#15(a) Initiation of AOD Treatment.	27.9%	28.3%	28.9%	3.6%
#15(b) Engagement in AOD Treatment.	67.3%	66.6%	63.8%	-5.2%

The Demonstration did have a very small, statistically significant effect on the increase in individuals initiating alcohol or other drug treatment after the Demonstration began (Chi-Square=4.95; $p<.05$; effect size=.01).

The rate of the individuals engagement in treatment fell each year following implementation. There was a 5.2% decrease in this measure that was statistically significant at $p<0.001$.

Measure Summary: This measure only partially supports Hypothesis 7 — the Demonstration will improve rates of identification, initiation, and engagement in treatment. There were some small improvements in initiation of treatment, but the percentage of enrollees engaged in treatment decreased.

Hypothesis 8

The Demonstration will improve access and develop capacity for adolescent girls needing SUD residential treatment.

Measure	Time Period	Data Sources	Analytic Method(s)
Any residential providers certified to serve adolescent girls.	Cumulative from start of Demonstration.	Focus groups and provider documentation review.	Narrative analysis.

Thus far in the Demonstration, no new providers have been certified to provide Medicaid residential treatment for adolescent girls, meaning there are currently no providers in the state.

Quantitative Metrics

Measure	Time Period	Data Sources	Analytic Method(s)
Number/percent of adolescent female individuals who use residential and/or inpatient services for SUD (CMS #10).	Monthly	Claims	ITS Analysis

Because currently, there are no Medicaid residential providers for girls, there have been no claims for this metric to analyze.

Primary Driver

Reduced Utilization of Emergency Departments and Inpatient Hospital Settings for Treatment Where the Utilization is Preventable or Medically Inappropriate

Overview of Driver Progress

Overall, the State has made mixed progress towards this goal. While there have not been declines in rates of emergency department (ED) utilization or hospital stays because of SUD, the State has seen a decrease in overdose deaths since the start of the Demonstration.

Reduced Utilization of EDs and Inpatient Hospitalizations — Progress Table

Hypothesis Summary	Findings
Hypothesis 9: The Demonstration will decrease the rate of ED and hospital use among Medicaid individuals with SUD.	- For most Medicaid individuals, there was no positive effect of the Demonstration on measures of ED or hospital utilization for SUD. - There were some small positive effects on ED utilization for children and on hospital stays for older adults.
Hypothesis 10: The Demonstration will lead to lower hospitalization readmission rates for individuals with SUD.	There was no positive effect of the Demonstration on hospital readmission rates for individuals with a SUD. Rates increased slightly.
Hypothesis 11: Individuals with SUD will have fewer opioid-related overdose deaths.	There has been a statistically significant decline in overdose deaths compared to the calendar year before the Demonstration.

Hypothesis 9

The Demonstration will decrease the rate of ED and hospital use among Medicaid individuals with SUD.

Quantitative Metrics

Measure	Time Period	Data Sources	Analytic Method(s)
ED Utilization for SUD per 1,000 Medicaid Individuals (CMS #23).	Monthly	Claims	ITS analysis.
Inpatient Stays for SUD per 1,000 Medicaid Individuals (CMS #24).	Monthly	Claims	ITS analysis.

Metric #23: ED Utilization for Individuals for SUD per 1,000 Medicaid Individuals (Rate per 1,000)

The counterfactual scenario is based on projecting out the pre-treatment trend. That trend is dominated by seasonality that is also apparent during the treatment period. The winter months have low rates, the summer months have high rates. The trends in both the pre- and during Demonstration periods are both downward over time, but the downward magnitude is larger during the pre-Demonstration period, as is the magnitude of the seasonal upward and downward movement around the trend. See the graph below to confirm this.

Looking at levels and not trend, the rates are higher during the pre-demonstration period, and it would make sense that the counter-factual yellow line would be above the blue demonstration period trend line. If this were the case, there would be estimated reductions in ED utilization during the Demonstration instead of our estimated increase (blue is above yellow on the diagram).

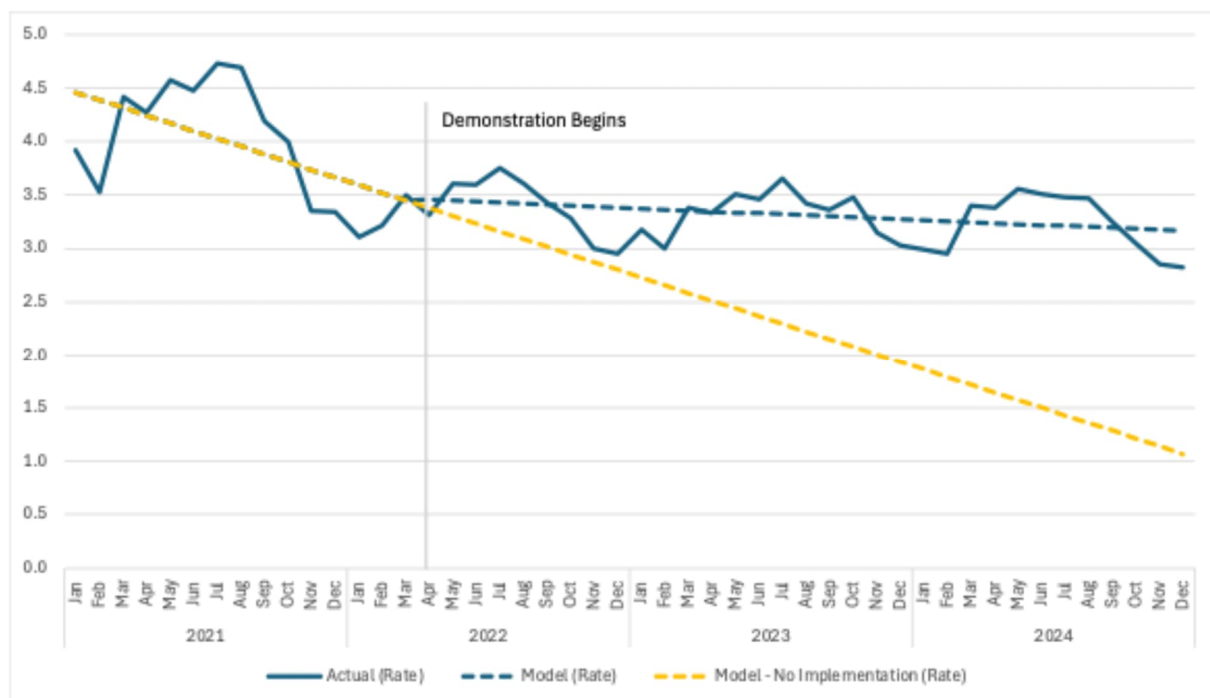
But the yellow trend line is not based on levels, but the projected trend. Because the pre-Demonstration period ends in the winter months, and the previous summer had very high ED utilization, the trend line has a very steep downward slope. If the previous January and February had lower utilization, the trend line would not be very steep, but those two data points are about as high as the treatment period highs (not lows). Again, see the diagram.

Based on this, the concern is that the projected yellow line is based on a period with large variability, and is therefore measured with imprecision. We do not show a confidence interval for the projected values, and it is certainly possible that the 95% CI for the yellow line could overlap the 95% CI for the blue line. This is the concern.

1. The statistical results for the pre-implementation period are pretty strong. The slope coefficient (-.0932) has a P-value of 0.001 using OLS standard errors, and a P-value of 0.009 using Newey-West standard errors, which are robust to autocorrelation (which exists in the series). Even using the higher P value, the line is almost certainly downward sloping and not due to sampling error. Having more data on the pre-demonstration period might change this, but we used all the data available.
2. The increase in ED utilization is not driven by the downward sloping yellow line alone, but by the difference between the blue and yellow line (both of which are downward sloping).

The change in slope from yellow to blue has a positive coefficient of 0.063 (it becomes flatter) with a p-value of 0.08 (NW). However, even this does not measure the variability between estimates of the yellow and blue lines. The issue is that there is some correlation between the change in intercept and change in slope, and that correlation increases the standard errors and P values of both coefficients. A test for whether the combined effect is different from zero is a joint significance test. I used a Wald test. That test had a P value of 0.013, so we can rule out that the combined effect of a change in intercept and change in slope is zero.

3. Estimation of the difference ED rates is slightly more complicated than this. While the Wald statistic shows that the change in slope and change in intercept are not both zero (so the blue and yellow lines are different), when I look back at the coefficients, the change in intercept is -0.93 while the change in slope is 0.063. They are moving in opposite directions. The blue line shifts down (not visible in the graph), but is flatter. To measure the net effect, I calculated the average change by month for the 33 months of demonstration period data. I used the NW standard errors, and reported the 95% CI for this average change. These results are on the tab named Effect_Summary. The average effect is 1.09, which seems consistent with the graph (the yellow line is below the blue line). But the 95% CI for the average effect is [-0.55, 2.73]. Using standard errors that are robust to autocorrelation, our estimate of the average increase in utilization during the demonstration period does include zero, and is therefore not statistically significant. But it is very close.



The rate of ED utilization for SUD-related causes declined slightly over the Demonstration period. However, this declining trend began well before the Demonstration started. While the effect of implementation over time was significant, that effect was higher rates of utilization than otherwise predicted had the Demonstration not occurred.

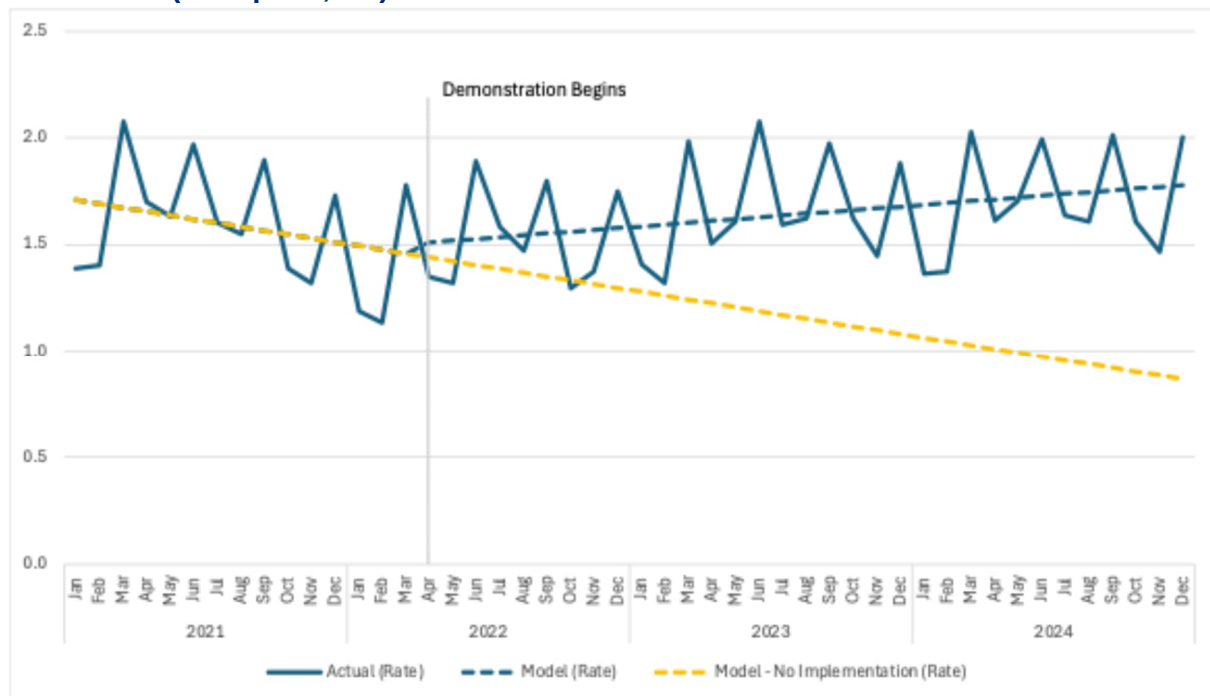
Metric 23 Rate — Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	8.7273747	-2	0.013
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	1.09	-0.55	2.73

ED Utilization for an SUD (Metric #23) for Subgroups

The trend was the same across all subgroups except for two. The declining trend rate for children was both statistically significant and was an improvement over the non-implementation model that predicted an increasing trend in ED utilization for children, indicating some benefit of the Demonstration to this group only. The overall trend line was the same for older adults, but it was not statistically significant. See Appendix B page 135-page 139.

Measure Summary: This metric supports a positive effect of the Demonstration for children, but does not support Hypothesis 9 — that the Demonstration would decrease ED utilization overall for SUD for Medicaid individuals.

Metric #24: Inpatient Hospital Stays for Individuals for SUD per 1,000 Medicaid Individuals (Rate per 1,000)



The rate of hospital stays related to SUD increased slightly over the Demonstration period and was statistically significant.

Metric 24 Rate — Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	10.073395	-2	0.006
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.49	-0.01	1.00

Hospital Stays for an SUD (Metric #24) for Subgroups

The trend was the same across all subgroups except for older adults, who saw an initial decrease in hospital stays right after Demonstration implementation, then a much more gradual increase in stays that was predicted by the non-implementation model. See Appendix B page 140–page 144.

Measure Summary: This metric does not support Hypothesis 9 — that the Demonstration would decrease hospital use for SUD for Medicaid individuals. However, there does seem to be a small positive effect on this measure for older adults.

There were no qualitative metrics for this hypothesis.

Hypothesis 10

The Demonstration will lead to lower hospitalization readmission rates for individuals with SUD.

Quantitative Metrics

Measure	Time Period	Data Sources	Analytic Method(s)
Readmissions Among Individuals with SUD (CMS #25).	Yearly	Claims	Descriptive analysis.

Measure (CMS Metric #25): Readmissions Among Individuals with SUD

Metric #25 Measure	DY Baseline (2021–2022)	DY 1 (2022–2023)	DY 2 (2023–2024)	Percentage Change
#25 Readmissions Among Individuals with SUD.	22.7%	22.4%	23.7%	4.4%

The rates of hospital readmission for Medicaid individuals with an SUD increased slightly across the first years of the Demonstration and did not improve. This increase from Baseline to DY2 was statistically significant ($p < .01$).

Measure Summary: This measure does not support Hypothesis 10 — that the Demonstration will decrease hospital readmission rates for individuals with an SUD. Rates increased slightly over baseline.

There were no qualitative metrics for this hypothesis.

Hypothesis 11

Individuals with SUD will have fewer opioid-related overdose deaths.

Quantitative Metrics

Measure	Time Period	Data Sources	Analytic Method(s)
Overdose Deaths (rate) (CMS#27).	Yearly	State data on cause of death.	Descriptive time series.

Measure (CMS Metric #27): Overdose death rate

Metric #27 Measure	Baseline (2021–2022)	DY 1 (2022–2023)	DY 2 (2023–2024)	Percentage Change
#27 Overdose death rate per 1,000 individuals.	0.45	0.42	0.38	-15%

Overdose rates have been declining since the start of the Demonstration, with a current decline of 15% over baseline. This difference was statistically significant using a Chi-Square test (Chi-Square = 20.2; $p < .001$).

Measure Summary: This measure does support Hypothesis 11 — that the Demonstration will decrease overdose death rates.

There were no qualitative metrics for this hypothesis.

Primary Driver

Improved Access to Care Coordination Among Individuals, Including Improved Discharge Planning and Transitions

Overview of Driver Progress

Overall, the State has completed its implementation related to providing training and technical assistance on care coordination, transitions, and discharges. However, the expected outcomes have not yet been realized by the State.

Improved Access to Care Coordination — Progress Table

Hypothesis Summary	Findings
Hypothesis 12: The Demonstration will increase the rate of Medicaid individuals with SUD-related conditions who are also receiving primary/ambulatory care.	The percentage of Medicaid individuals who also received primary/ambulatory care decreased from baseline. All rates of follow-up following an ED visit for either a mental health or SUD-related cause also declined from baseline.
Hypothesis 13: Medicaid IMD providers will demonstrate consistency in program design and discharge planning policies.	The State has completed training and technical assistance for IMD providers that include program design and discharge planning. Providers, overall, have

Hypothesis Summary	Findings
	been positive about training and technical assistance (TA) opportunities.

Hypothesis 12

The Demonstration will increase the rate of Medicaid individuals with SUD-related conditions who are also receiving primary/ambulatory care.

Quantitative Metrics

Measure	Time Period	Data Sources	Analytic Method(s)
Access to Preventive/ Ambulatory Health Services for Adult Medicaid Individuals with SUD (CMS #32).	Yearly	Claims	Descriptive time services analysis, Chi-Square tests for change pre-post Demonstration.
Follow-Up After ED Visit for AOD Abuse or Dependence (CMS #17-1).	Yearly	Claims	Descriptive time services analysis, Chi-Square tests for change pre-post Demonstration.
Follow-Up After ED Visit for Mental Illness (CMS #17-2).	Yearly	Claims	Descriptive time services analysis, Chi-Square tests for change pre-post Demonstration.

Measure (CMS Metric #32) Ambulatory Health Services

Metrics	CY 2021	CY 2022	CY 2023	Percentage Change
#32 Ambulatory Health Services for Adult Medicaid Individuals with SUD.	89.6%	88.5%	88.0%	-1.8%

Overall, the percentage of individuals with SUD who also had an ambulatory health service declined slightly between baseline and the most recent Demonstration year, but remained relatively high.

Measure Summary: This measure does not support Hypothesis 12 — that the Demonstration will increase the rate of Medicaid enrollees with SUD-related conditions who are also receiving primary/ambulatory care.

Measure (CMS Metric #17) Follow-Up After ED Visit

Metrics	DY Baseline (2021–2022)	DY 1 (2022–2023)	DY 2 (2023–2024)	Percentage Change from Baseline
#17-1 Follow-Up After ED Visit for AOD Abuse or Dependence (7 days).	15.6%	15.6%	11.9%	-23.7%
#17-1 Follow-Up After ED Visit for AOD Abuse or Dependence (30 days).	25.8%	24.9%	20.9%	-19.0%
#17-2 Follow-Up After ED Visit for Mental Illness (7 days).	30.4%	24.3%	27.2%	-10.5%
#17-2 Follow-Up After ED Visit for Mental Illness (30 days).	43.4%	36.8%	40.1%	-7.6%

There was a decline in rates of follow-up for ED visits across all measures, when compared to the baseline year. All decreases in these measures were statistically significant ($p < 0.01$).

Measure Summary: This measure does not support Hypothesis 12 — that the Demonstration will increase the rate of Medicaid individuals with SUD-related conditions who are also receiving primary/ambulatory care.

Hypothesis 13

Medicaid IMD providers will demonstrate consistency in program design and discharge planning policies.

Qualitative Metrics

Measure	Time Period	Data Sources	Analytic Method(s)
Description of training and TA activities to align providers with new ASAM standards.	Cumulative from start of Demonstration.	Document review and focus groups.	Narrative analysis.

State partners have built close relationships and have good foundations for communications. Providers, while concerned about capacity and rates, expressed a 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. Training and technical assistance activities for IMDs have included consistency in programming and transitions and discharge planning, including documentation and referral requirements.

Overall, providers spoke positively about 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.

However, there are other structural barriers currently limiting good care coordination and making transitions difficult. As noted in the midpoint assessment, the State completed a fiscal study and determined that the current budget will not support targeted case management (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. The midpoint assessment contained a recommendation that the State consider a pilot to determine how supporting TCM services could be accomplished. However, there has not been enough time elapsed since that report for the State to consider and implement this recommendation.

There were no quantitative metrics for this hypothesis.

Primary Driver

Maintain or Reduce Medicaid Cost of Individuals with SUD

Hypothesis Summary	Findings
Hypothesis 14: The Demonstration will be budget neutral to the federal government.	The Demonstration is budget neutral under Hypothetical Budget Neutrality Test 1 in each of the first three years of the Demonstration.
Hypothesis 15: Total Medicaid SUD spending during the measurement period will remain constant after adjustment for the new residential services and any other new SUD treatment services, including care coordination, developed under this Demonstration.	Costs were already beginning to increase before the start of the Demonstration and the effect of implementation was not statistically significant even before adjusting for the cost of the new residential services and other new SUD treatment services, including care coordination, required by ASAM. Connecticut invested \$152 million into its SUD treatment network to begin covering residential treatment and require ASAM standards, including care coordination at every level of care. Many providers were provisionally certified through April 2025, which was the beginning of DY 4, and expenditures to continue to come into compliance with ASAM criteria occurred through that timeframe.

Hypothesis 14

The Demonstration will be budget neutral to the federal government.

A summary of the With and Without Waiver costs for the Demonstration to date are in the table below showing that the Demonstration is budget neutral under **Hypothetical Budget Neutrality Test 1** in each of the first three years of the Demonstration.

Summary of Current Demonstration Hypothetical Budget Neutrality Test 1

	DY 1	DY 2	DY 3
Without Waiver	\$167,568,762	\$215,788,746	\$215,966,736
With Waiver	\$96,476,908	\$155,729,721	\$157,028,414
Variance	\$71,091,854	\$60,059,025	\$58,938,322

Hypothesis 15

Total Medicaid SUD spending during the measurement period will remain constant after adjustment for the new residential services and any other new SUD treatment services, including care coordination, developed under this Demonstration.

The table below utilizes the annual aggregate cost metrics under the Demonstration.

Cost Analysis 1: Annual Aggregate Costs

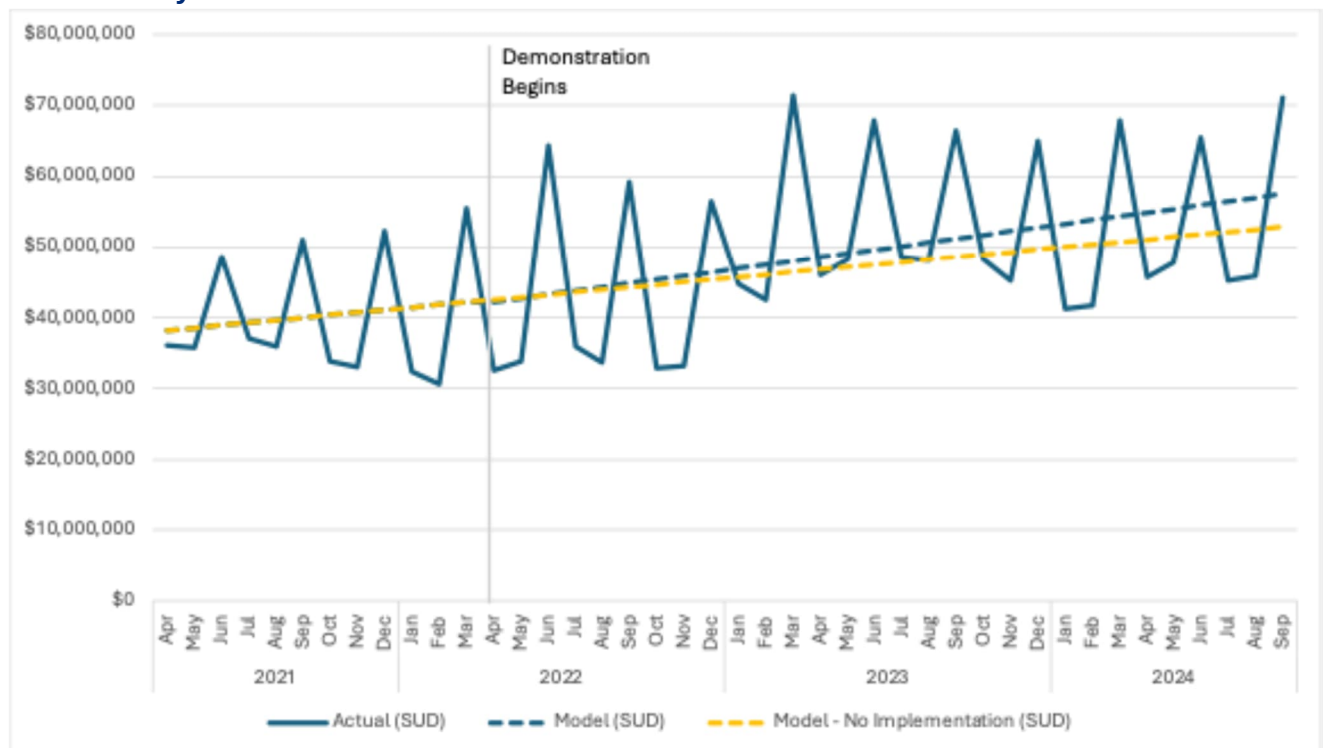
Metric	DY 0 (April 2022 to March 2022)	DY 1	DY 2	DY 3 (6 months: April–September 2024)
Total SUD Spending (CMS #28) is the sum of all Medicaid spending on SUD treatment services.	\$482,140,244	\$540,695,058	\$634,279,618	\$321,104,435
SUD Spending within IMDs (CMS #29). The sum of all Medicaid spending on inpatient/residential treatment for SUD provided within IMDs.	\$14,425,340	\$21,866,087	\$138,774,558	\$74,711,485
Per Capita SUD Spending (CMS #30). The sum of all Medicaid spending on SUD treatment services (CMS #28) divided by the annual number of unique individuals with a SUD diagnosis (CMS #4).	\$5,755	\$6,526	\$7,893	\$4,879

Metric	DY 0 (April 2022 to March 2022)	DY 1	DY 2	DY 3 (6 months: April–September 2024)
Per Capita SUD Spending within IMDs (CMS #31). The sum of all Medicaid spending on IMDs (CMS #30) divided by the annual number of individuals with a claim for inpatient residential treatment in an IMD (CMS #5).	\$2,488	\$3,481	\$17,278	\$14,786

The total SUD spending grew after the implementation of the Demonstration by \$152 million. The SUD IMD expenditures grew by \$124.3 million after the Demonstration. The per capita SUD spending under the Demonstration grew from \$5,755 to \$7,893, while the per capita spending on IMD residents grew from \$2,488 to \$17,278 in the first two Demonstration years.

Cost Analysis 2: Medicaid SUD Treatment Costs Versus Total Treatment Costs for Individuals with SUD Diagnoses

SUD Monthly Treatment Costs



The chart above shows that SUD spending increased after the beginning of the Demonstration. However, costs were already beginning to increase before the start of the Demonstration and the effect of implementation was not statistically significant even before

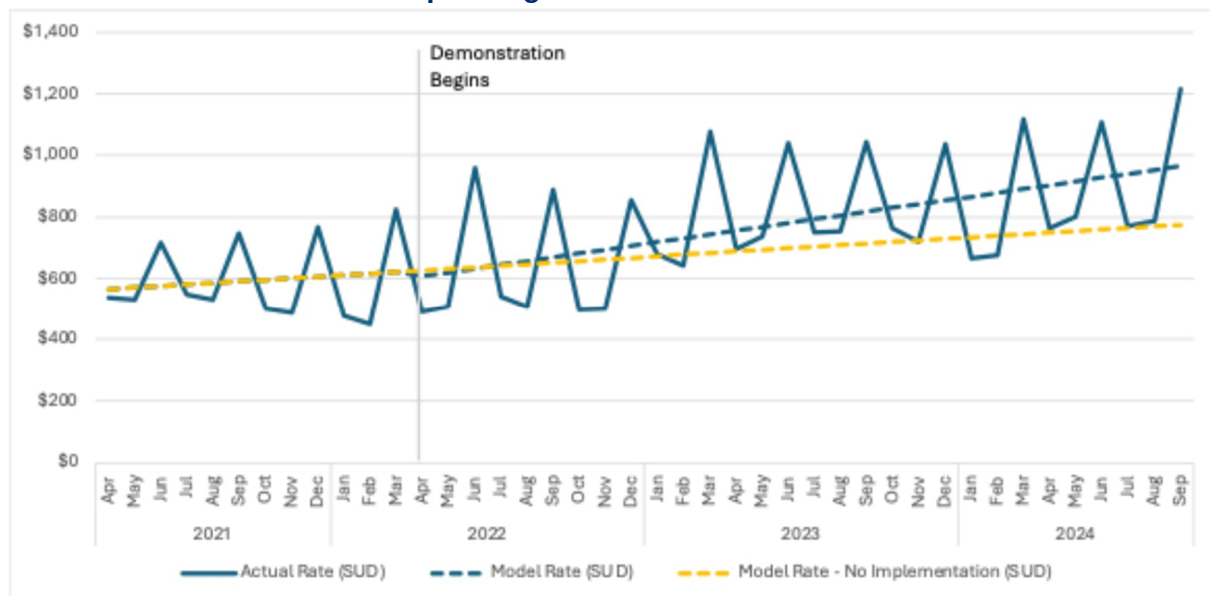
adjusting for the cost of the new residential services and other new SUD treatment services, including care coordination, required by ASAM.

Cost Analysis: SUD Spending Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	0.52321433	-2	0.76981337
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	2,174,188.67	-10,258,633.48	14,607,010.81

The Hypothesis calls for Connecticut to have total Medicaid SUD spending during the measurement period that remains constant after adjustment for the new residential services and any other new SUD treatment services, including care coordination, developed under this Demonstration. Connecticut invested \$152 million into its SUD treatment network to begin covering residential treatment and require ASAM standards, including care coordination, at every level of care. Many providers were provisionally certified through April 2025, which was the beginning of DY 3, and continuing to come into compliance with ASAM criteria as noted above. Note that there is only six months of spending data in DY 3 of the Demonstration available.

	New Residential Services and Other New SUD Treatment Costs, Including Care Coordination
New SUD Treatment Spending	\$152,139,374
New SUD IMD Spending	\$124,349,218
New SUD Non-IMD Spending	\$27,790,156

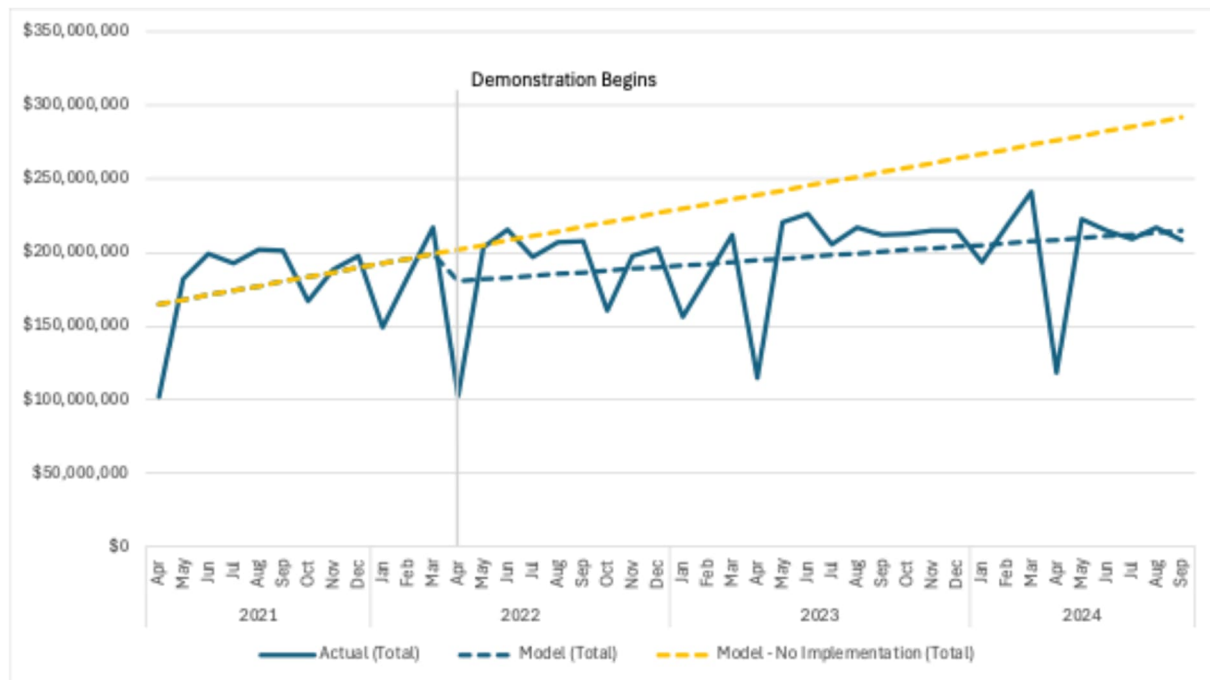
Per Member Per Month SUD Spending



The increase in per member per month (PMPM) SUD spending was similar to total monthly costs and was also not significant.

Cost Analysis: SUD Spending Rate (PMPM) Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	5.58202026	-2	0.0613592
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	85.86	-99.97	271.70

Total Treatment Costs

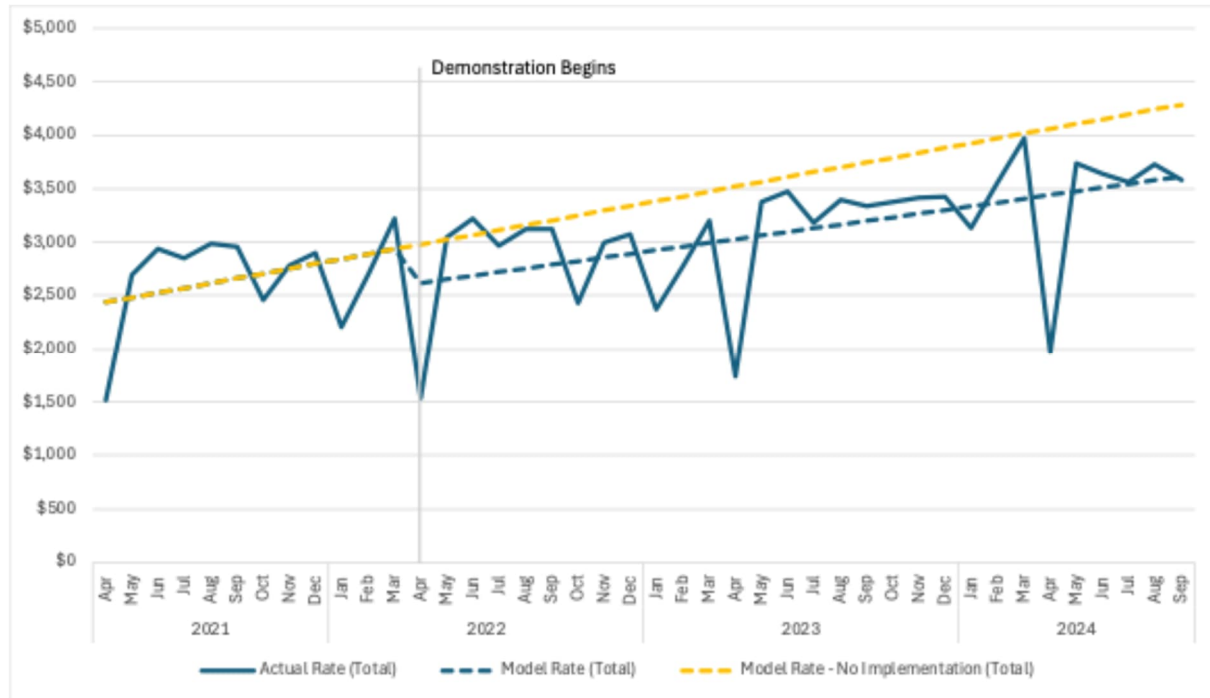


Total treatment spending increased slightly after the Demonstration, but less so than predicted by the model with no implementation. The difference, however, was not statistically significant.

Cost Analysis: Total Spending Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	3.9673293	-2	0.13756419
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-49,127,345.82	-118,159,984.43	19,905,292.79

The same trend, also not significant, was seen when examining PMPM total spending for individuals with an SUD.

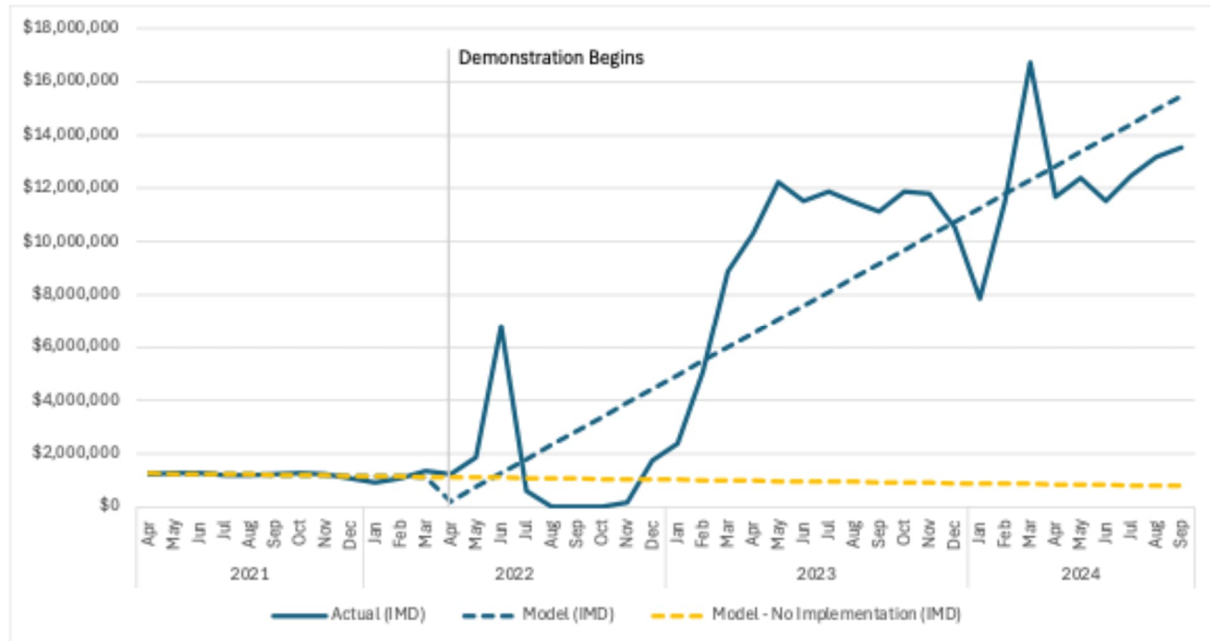
Total PMPM Spending



Cost Analysis: Total Spending Rate Coefficients

	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	5.51413018	-2	0.0634778
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-517.51	-1,516.83	481.81

IMD SUD Spending



IMD spending increased dramatically after the Demonstration began, although early spending figures are erratic due to billing issues with providers that occurred in the early part of the Demonstration⁹. These numbers have remained in the analysis, but could skew significance testing in the model.

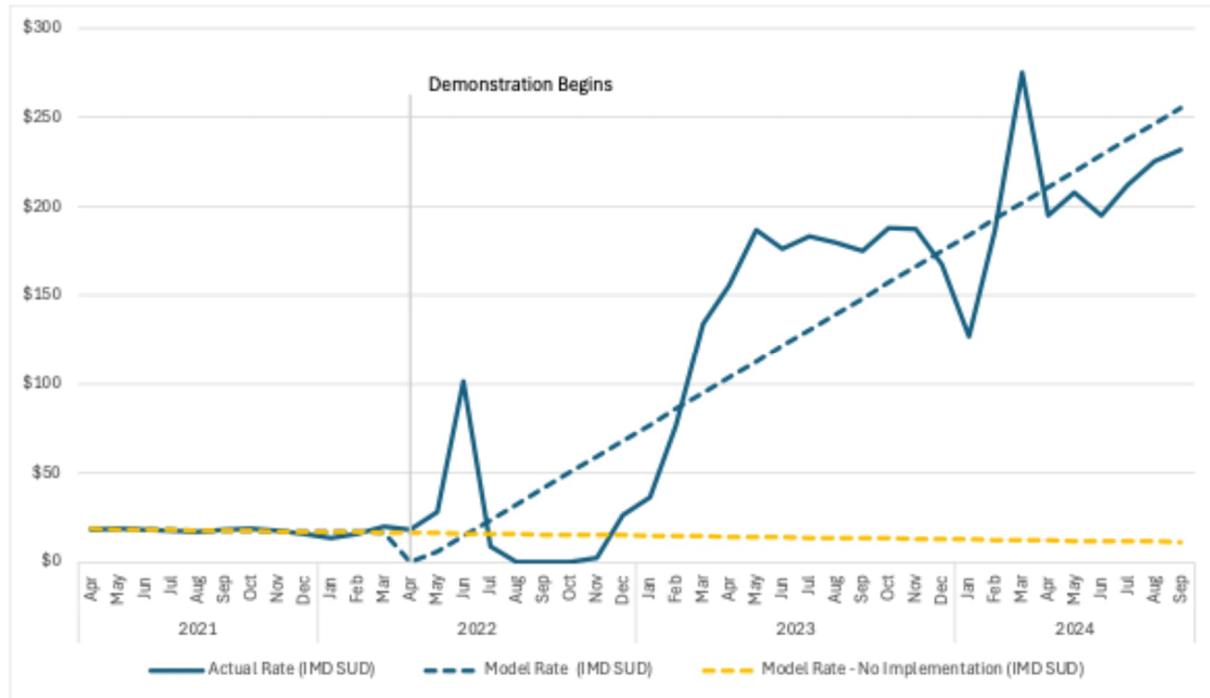
Increases in SUD spending are consistent with significant increases in both the number and length of IMD stays for SUD treatment. Prior to the Demonstration, Medicaid only reimbursed for SUD inpatient hospital stays for individuals over age 65 years old and under age 21 years old in an IMD. After the Demonstration, Medicaid began reimbursing for all Medicaid individuals to receive medically necessary SUD treatment in IMDs meeting ASAM criteria.

Cost Analysis: IMD SUD Spending Coefficients

	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	127.261797	-2	2.3198E-28
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	6,882,355.96	5,136,615.41	8,628,096.51

⁹ Because of the three month data lag cut-off, there are four months of data at the beginning of the Demonstration where the volume of claims was cut off because providers required more than three months to bill the new H2036 code. The providers could have taken 4 months–6 months to file those claims in a timely manner those months. The data is also showing a drop off in claims beginning in February/March of 2024. That could be because of enhanced utilization review required under the Demonstration rather than a claims completeness issue.

PMPM IMD SUD Spending



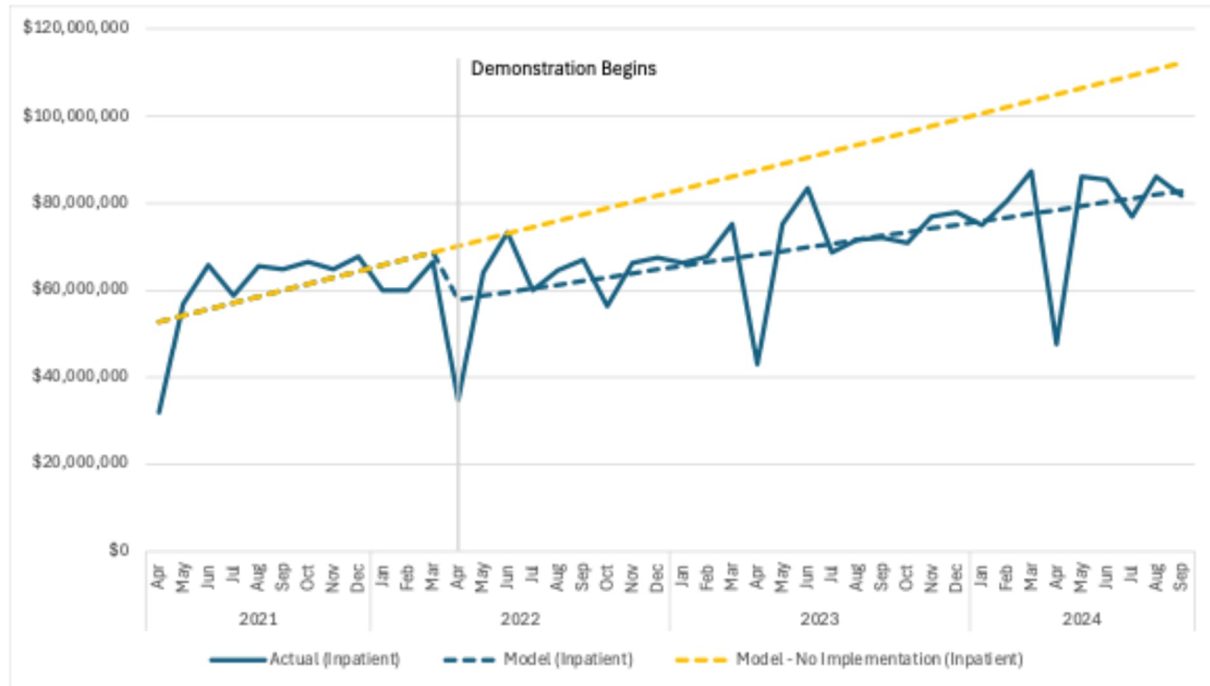
The significant increase in the total IMD SUD spending is replicated in the PMPM spending trends.

Cost Analysis: IMD SUD Spending Rate Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	196.281061	-2	2.3884E-43
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	112.11	87.86	136.35

Cost Analysis 3

Medicaid Cost Drivers for Individuals with SUD Diagnoses

Inpatient Spending

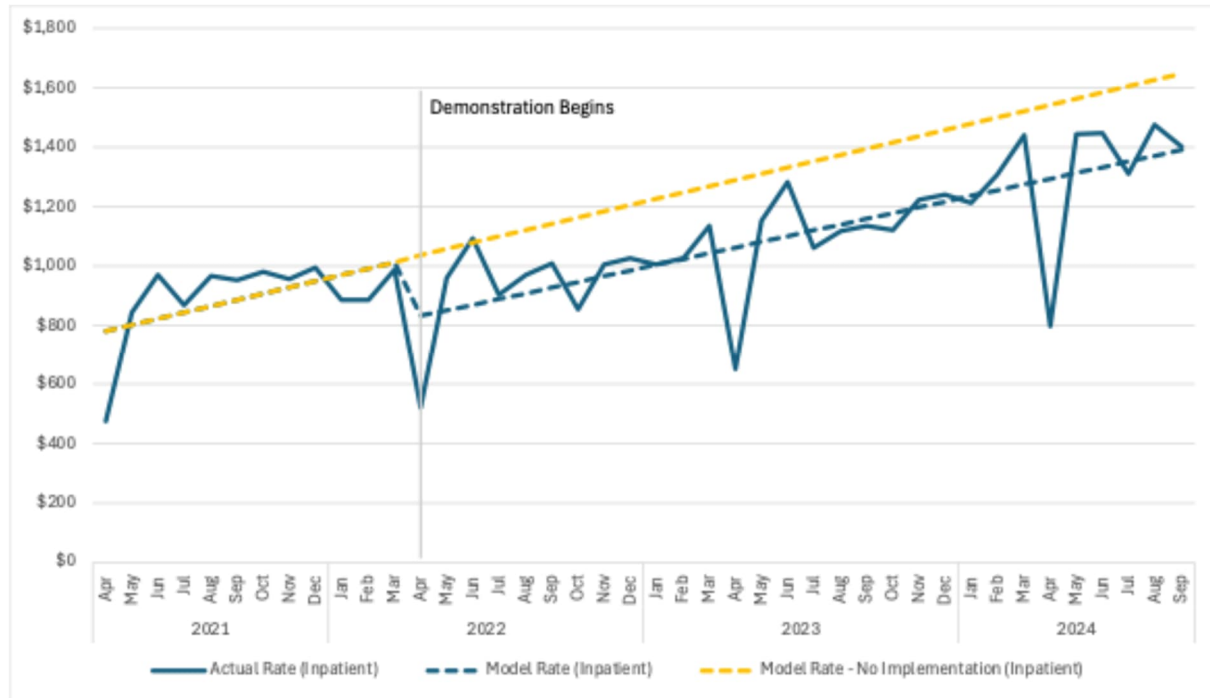


Inpatient spending increased following Demonstration implementation, but at a rate lower than predicted. This difference was statistically significant. The Demonstration appears to have reduced the increases in inpatient spending for individuals with SUD.

Cost Analysis: Inpatient Spending Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	14.0886662	-2	0.00087234
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-20,820,734.51	-49,300,707.16	7,659,238.15

The same trend is seen for PMPM spending for inpatient services.

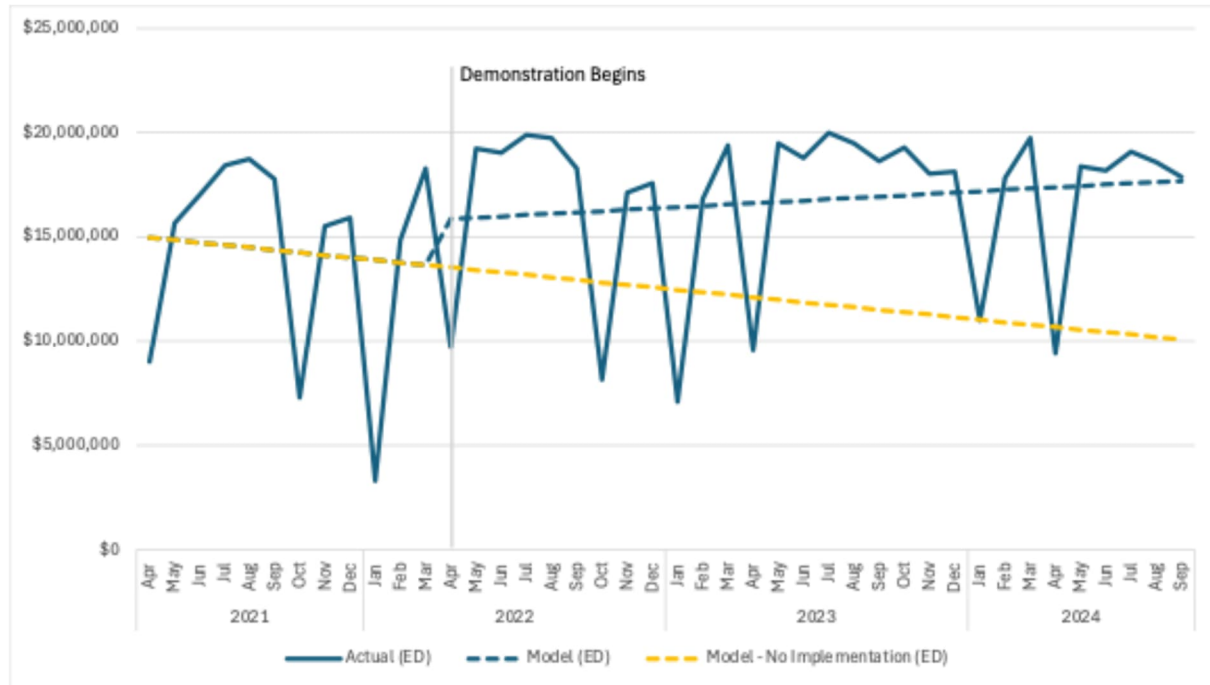
PMPM Inpatient Spending



Cost Analysis: Inpatient Spending Rate Coefficients

	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	17.8560794	-2	0.00013262
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-230.73	-643.01	181.56

ED Spending

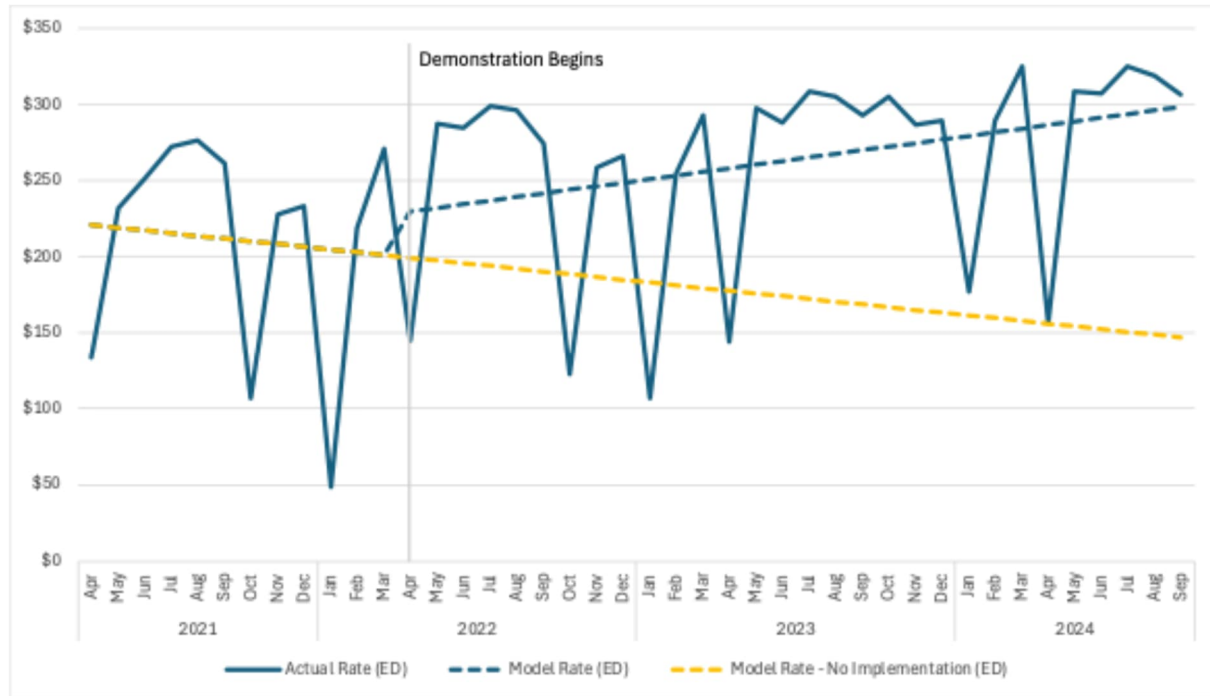


ED spending increased slightly after the start of the Demonstration, although these costs had been declining prior to implementation. However, the impact of the Demonstration on this trend is not statistically significant.

Cost Analysis: ED Spending Coefficients

	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	1.94232699	-2	0.37864223
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	4,969,460.10	-3,464,017.86	13,402,938.07

PMPM ED SUD Spending

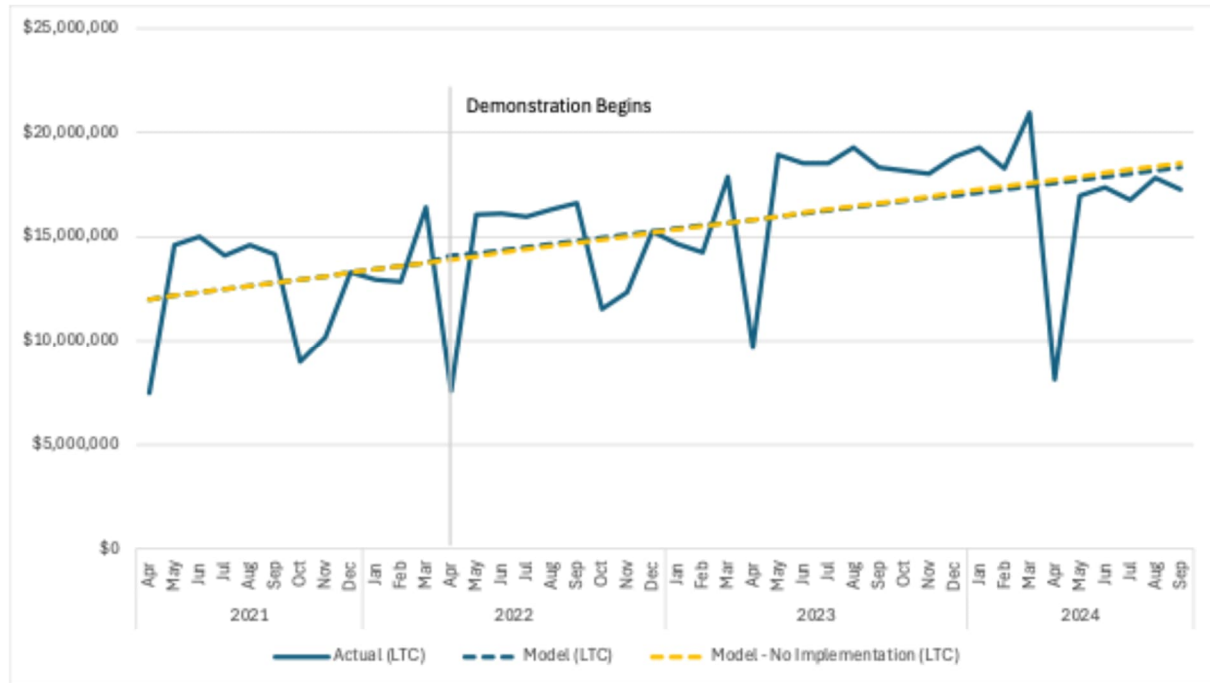


Trends in PMPM ED spending also increased, but not significantly.

Cost Analysis: ED Spending Rate Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	2.06015733	-2	0.35697888
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	90.76	-33.39	214.92

Changes in both overall long-term care (LTC) spending and PMPM LTC SUD spending were not statistically significant.

LTC SUD Spending

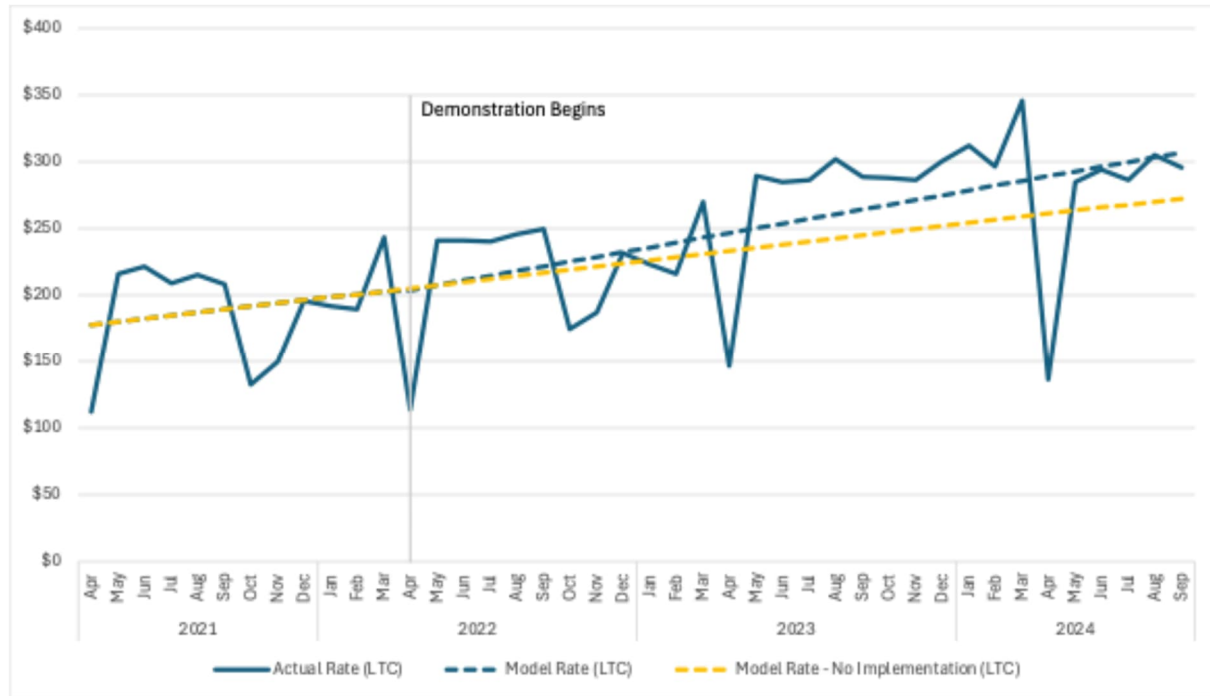


LTC spending does not appear to be affected by the Demonstration.

Cost Analysis: LTC Spending Coefficients

	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	0.05785229	-2	0.97148821
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-33,362.02	-4,856,946.96	4,790,222.92

PMPM LTC SUD Spending

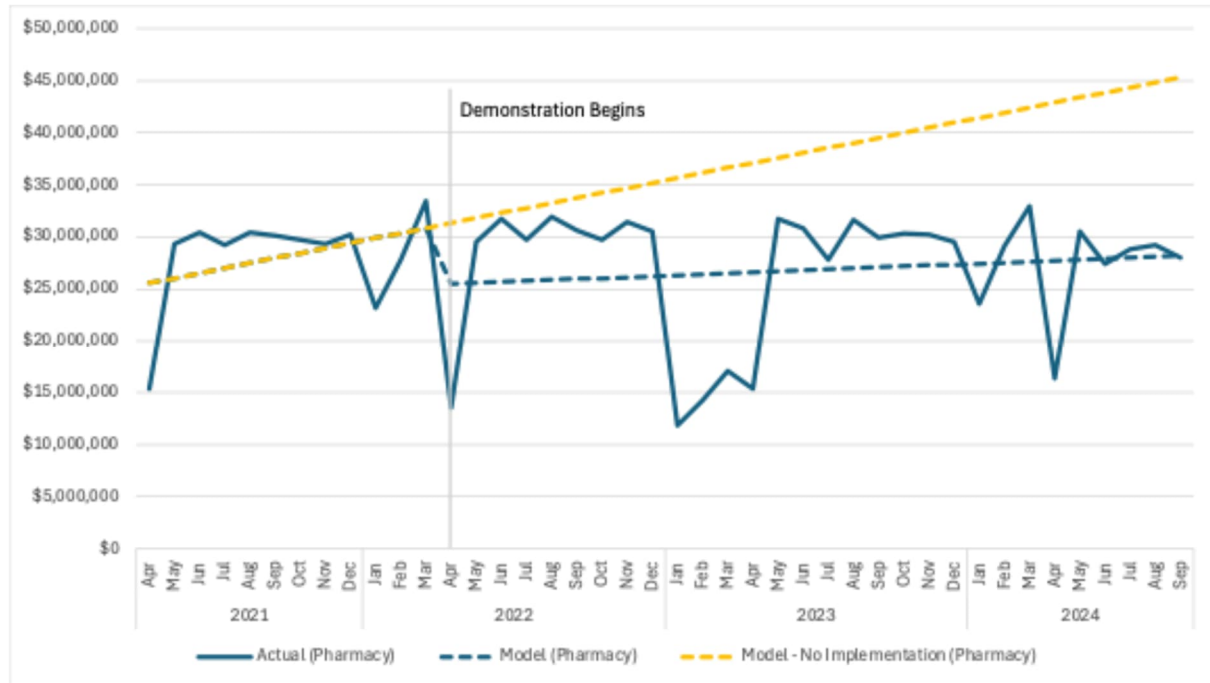


Changes in LTC spending were not statistically significant.

Cost Analysis: LTC Spending Rate Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	0.64813984	-2	0.72319967
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	16.44	-54.97	87.85

Changes in both total pharmacy SUD spending and PMPM SUD spending rates were not significant over the course of the Demonstration.

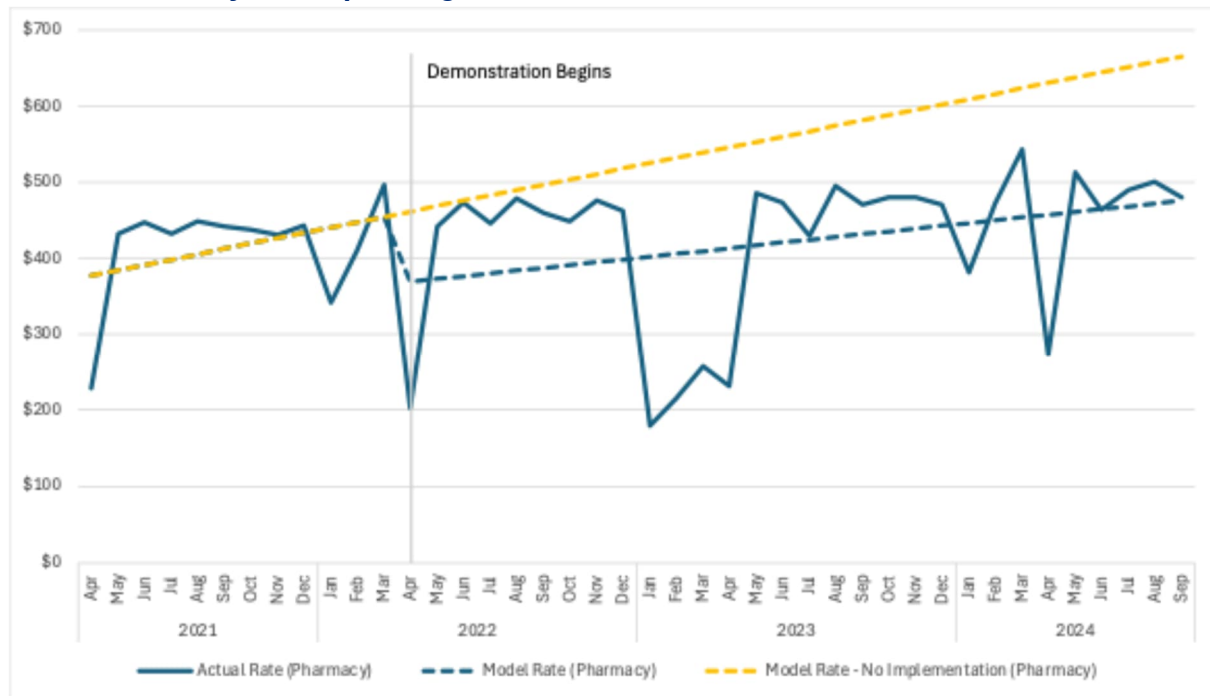
Pharmacy SUD Spending



Cost Analysis: Pharmacy Spending Coefficients

	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	5.08293808	-2	0.07875063
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-11,466,688.47	-23,017,828.77	84,451.83

PMPM Pharmacy SUD Spending



Pharmacy spending did increase, but the change was not statistically significant.

Cost Analysis: Pharmacy Spending Rate Coefficients

	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	4.61834755	-2	0.0993433
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-140.99	-308.50	26.53

Section 7

Conclusions

Conclusions of the interim evaluation analyses are presented below, organized by the primary drivers of change that represent the State's goals for the evaluation.

Connecticut Goal 1

Increase individual access to and use of appropriate Substance Use Disorder Treatment services based on American Society of Addiction Medicine criteria.

As noted above, there are two primary drivers under this goal: Improved access to care via a full continuum of available substance use disorder (SUD) services and improved access to the most beneficial level of care (LOC) via a full continuum of available SUD services.

Primary Driver 1

Hypothesis

Improved access to care via a full continuum of available SUD services.

Hypothesis Summary	Findings
Hypothesis 1: The Demonstration will increase the availability of critical LOCs for Medicaid individuals.	- The State has used reinvestment funds to change rate structures and increase rates; this has increased provider interest, but has not yet translated to better availability. - Some providers are piloting the use of flex-beds to accommodate an expanded continuum of LOCs. - At the start of the Demonstration, the State lost 90 adult residential beds. It has since replaced 28 of those adult residential beds. - Advocates and family members of people in need of treatment did not see any increases in access to care, largely because Medicaid individuals are not aware of what is available or how to access services.
Hypothesis 2: The Demonstration will increase the use of residential, medication assisted treatment (MAT), withdrawal management, early intervention, and ambulatory care available by Medicaid individuals.	- Results for this hypothesis were mixed. - Utilization rates for partial hospitalization program (PHP)/intensive outpatient program (IOP) increased significantly for most groups, but not for children, older adults or dual-eligible subgroups. - Utilization rates for residential and inpatient services increased significantly for nearly all

Hypothesis Summary	Findings
	subgroups. However, service utilization for children/adolescents declined. - Utilization rates for Withdrawal Management services increased significantly for the total population and for all subgroups except for pregnant women and children. - Early intervention, outpatient, and MAT services did not increase because of the Demonstration. However, the Demonstration does appear to have slowed declines in these service areas. - The number of individuals served in Institution for Mental Diseases (IMDs) for SUD and the length of stay for those stays both increased under the Demonstration.
Hypothesis 3: The Demonstration will lead to use of the most recent version of the American Society of Addiction Medicine (ASAM) placement criteria by all providers.	- Results for this hypothesis were mixed. - Stakeholders generally reported that implementation of the ASAM placement criteria has gone well and that training and technical assistance have supported providers during the transition. - The State continues to struggle to expand capacity at the residential levels of care and has lost some outpatient providers. While providers are using placement criteria, it is not translating to greater access to care (see below).
Hypothesis 4: The Demonstration will increase provider capacity for SUD treatment at critical LOCs for individuals in the State.	- Stakeholders report that the onboarding of new providers remains challenging. - Overall, there has been a decrease in the number of SUD providers and an increase in the number of providers providing MAT services.
Hypothesis 5: The Demonstration will improve access and develop capacity for adolescent girls needing SUD residential treatment.	The State has not yet been successful in developing any capacity for residential/inpatient treatment for adolescent girls.
Hypothesis 6: More adolescent SUD treatment services will be provided at the ambulatory ASAM LOCs.	No adolescents reported to be screened positively using Screening, Brief Intervention, and Referral to Treatment (SBIRT) and receiving services. Data under the new SBIRT coding and rates effective July 1, 2025 is not yet available. <i>Screening was conducted by behavioral health providers. There were approximately 1,300 screens conducted in behavioral health clinics on youth that are not included in the coding of the metric. Of those screens, 418 youth screened positively for SUD and were referred to services.</i>

Hypothesis Summary	Findings
	The rate of child/adolescent outpatient SUD services has stayed the same throughout the Demonstration. However, the trend prior to implementation was a declining rate of services, indicating that the Demonstration has likely prevented further service utilization decreases.

Hypothesis 1

The Demonstration will increase the availability of critical LOCs for Medicaid individuals.

The State has completed submission of the two State Plan Amendments to establish coverage and reimbursement for the array of SUD services at each critical ASAM level of care. In addition, implementation activities have been completed to train providers and ensure all have been fully certified under the appropriate LOCs.

However, implementation activities have not necessarily translated into a greater availability of services due to an overall lack of providers at particular LOCs and for specific populations, namely adolescents. There is progress being made, but it is slow, based on stakeholder reports. The State did revise rate structures on July 1, 2025, and this, according to State partners, has led to interest in providing adult services and more levels of care and in providing services to adolescents. Providers are also looking to expand their own continuums of care, to provide multiple LOCs within their own agency or system. The State has begun to allow flex-beds to encourage providers to provide multiple levels of care at a single location, which some providers have begun to implement. Most stakeholders agreed that this, combined with rate increases, is beginning to lead to results in adding capacity and, therefore, access to critical levels of care for adults. These changes, however, are too recent to be reflected in these analyses. The summative evaluation report will include data through the end of the initial Demonstration period, which will allow us to determine the degree to which these changes did expand provider capacity and, consequently, utilization of SUD services across the entire continuum of care.

Hypothesis 2

The Demonstration will increase the use of residential, MAT, withdrawal management, early intervention, and ambulatory care by Medicaid individuals.

The use of higher levels of care, including PHP/IOP, residential and withdrawal management, did increase under the Demonstration, which reflects a significant effort by the State to reach out to these providers to provide support for the transition to ASAM. While all residential beds that had been lost at the start of the Demonstration have not yet been replaced, the State has added additional beds and the increasing utilization trends reflect these efforts.

The Demonstration also focused on providing benefits for individuals to receive SUD care while in an IMD. Commensurately, the number of individuals treated in an IMD for an SUD increased significantly, as did the average length of IMD stays for SUD treatment.

Similar utilization gains, however, have not been seen for lower levels of care. Early intervention services remained very low and declined during the Demonstration. Early in the Demonstration, Connecticut utilized the commercial SBIRT codes for early intervention that only reimbursed for SUD screens in primary care offices if the screen was positive and SUD treatment was provided. Medicaid reimbursement for any screen, positive or negative, did not begin until July 1, 2025. Early intervention was not a focus of the Implementation Plan, but it remains a critical LOC that is difficult to assess because there is not a reimbursement incentive to provide screening only. *Note: SBIRT codes do not include screens conducted by behavioral health providers. There were approximately 900 screens conducted in behavioral health clinics on youth that are not included in the coding of the metric.* As a result, using the metrics outlined in the Evaluation Design early intervention does not appear to be accessible under the Demonstration given these low numbers, but other sources of information report that adolescent screening is occurring in locations other than primary care offices.

Outpatient and MAT services did not increase because of the Demonstration. However, the Demonstration does appear to have slowed declines in these service areas. The decline mirrors a decrease in the number of individuals with an SUD diagnosis. 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 eligibility. Connecticut's Medicaid rolls decreased by 9% from April 2023 to October 2024.¹⁰ In this sense, these findings, while not completely aligned with the State's targets for improvements, can be seen as a positive change for the State and future SUD service delivery.

As mentioned previously, the overall COVID-19 effects, while changing confidence intervals of effect sizes, did not change whether the Demonstration affected the measures. Also, the impacts of COVID-19 were less consequential because they did not impact the confirmation or rejection of the evaluation hypotheses. Ultimately, the effects of the unwinding are not more prominent in the results because most of the results presented here are based on *rates* of treatment, which control for the decline in Medicaid individuals by using the number of individuals with an SUD diagnosis as the denominator in rate calculations.

As the State continues its work in the Demonstration, perhaps adding additional focus on providers at lower levels of care and outreach and engagement of Medicaid individuals earlier in their diagnosis, the State can drive more utilization in these levels of care. Ultimately, increasing prevention, early intervention, and outpatient care can lead to longer-term reductions in more expensive, higher levels of care and could translate into better outcomes for enrollees.

¹⁰ 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 individuals 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. <https://www.kff.org/medicaid/medicaid-enrollment-and-unwinding-tracker/#93469f01-80b8-4f2a-b58e-f00496dfff23f>

Hypothesis 3

The Demonstration will lead to use of the most recent version of the ASAM placement criteria by all providers.

Stakeholders are in agreement that providers are using the most recent version of the ASAM placement criteria and that training and technical assistance (TA) efforts to credential providers in the ASAM have been successful. This effort has also been successful in transitioning existing providers to the ASAM 3rd edition criteria.

As discussed in the midpoint assessment, challenges in appropriately using ASAM placement criteria seem to at least partially 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 with the current State bed capacity. Increased communications with providers and problem solving around managing care transitions when bed capacity is limited will be an important part of ensuring the goals of the Demonstration are met.

Hypothesis 4

The Demonstration will increase provider capacity for SUD treatment at critical LOCs for individuals in the State.

Consistent with trends in utilization at individual LOCs, the number and rate of Medicaid individuals receiving any SUD service has experienced a slight decline, but one that is less drastic than predicted in the absence of the Demonstration. Much of this is driven by a loss of provider capacity throughout the State. It is too early to tell whether recent efforts to increase rates in July 2025 will attract new providers and bolster utilization. Rate increases have not yet resulted in adding new providers to the State's capacity. The number of providers certified at all levels of care have declined since the start of the Demonstration and the State has not yet been successful in securing residential treatment capacity for adolescents.

Losses in the number of certified providers have occurred across all levels of care. New State efforts to better balance reimbursement rates and to encourage providers to offer a continuum of LOCs within their facilities could help to increase provider capacity at the residential/inpatient levels of care. However, rate increases have not been consistent across all LOCs (particularly ambulatory levels), so these efforts likely won't increase capacity at every level.

Other strategies (including changing reimbursement for SBIRT, for example) may be necessary to increase utilization at lower levels of care, including early intervention and outpatient services.

Hypothesis 5

The Demonstration will improve access and develop capacity for adolescent girls needing SUD residential treatment.

The State is continuing its efforts, but has not yet been successful in recruiting any providers for residential/inpatient treatment for adolescent girls. It also has not yet restored capacity for adolescent boys that was lost in January, 2024.

Hypothesis 6

More adolescent SUD treatment services will be provided at the ambulatory ASAM LOCs.

Adolescent utilization of outpatient services stayed stable during the Demonstration years included in this analysis. This was significantly higher, however, than what was predicted had the Demonstration not been implemented. The number of adolescents receiving early intervention services in primary care was reported at zero under the metric, but stakeholders reported that over 1,300 adolescents were screened in behavioral health clinics for SUD and 418 were referred for services.

While the State might consider the value of trying to increase provider capacity at these levels of care, it is understandable that the urgency remains with finding some provider capacity for more urgently needed residential treatment. Even with greater access to ambulatory SUD, there will likely remain at least some need for residential treatment.

Primary Driver 2

Increase rates of identification, initiation, engagement, and retention in treatment.

Hypothesis Summary	Findings
Hypothesis 7: The Demonstration will improve rates of identification, initiation, and engagement in treatment.	- Results for this hypothesis were mixed. - There were some small improvements in initiation of treatment, while the percentage of individuals engaged in treatment decreased.
Hypothesis 8: The Demonstration will improve access and develop capacity for adolescent girls needing SUD residential treatment.	The State has not yet successfully recruited and credentialed any SUD residential providers for adolescent girls.

Hypothesis 7

The Demonstration will improve rates of identification, initiation, and engagement in treatment.

There were small, but statistically significant, improvements in rates of initiation in treatment, though engagement rates fell. Findings from the midpoint assessment indicate that more investment in targeted case management may be important to increasing treatment

engagement. One crucial point identified where clients are lost is during care transitions. Clear communication across partners to ensure that transitions across levels of care will likely increase both engagement and retention.

Hypothesis 8

The Demonstration will improve access and develop capacity for adolescent girls needing SUD residential treatment.

As mentioned throughout this report, the State has not been successful in efforts to improve access and develop capacity for girls needing residential SUD treatment.

Connecticut Goal 2

Improve Quality of Care and population health outcomes for Medicaid individuals with SUD.

Primary Driver

Reduced utilization of Emergency Departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate.

Hypothesis Summary	Findings
Hypothesis 9: The Demonstration will decrease the rate of emergency department (ED) and hospital use among Medicaid individuals with SUD.	- For most Medicaid enrollees, there was no positive effect of the Demonstration on measures of ED or hospital utilization for SUD. - There were some small positive effects on ED utilization for children and on hospital stays for older adults.
Hypothesis 10: The Demonstration will lead to lower hospitalization readmission rates for individuals with SUD.	There was no positive effect of the Demonstration on hospital readmission rates for individuals with an SUD. Rates increased slightly.

Hypothesis 9

The 1115 SUD Demonstration will decrease the rate of ED and hospital use among Medicaid individuals with SUD.

As noted above, for most Medicaid individuals, there was no positive effect of the Demonstration on measures of ED or hospital utilization for SUD. However, there were some small positive effects on ED utilization for children and on hospital stays for older adults.

Hypothesis 10

The 1115 SUD Demonstration will lead to lower hospitalization readmission rates for individuals with SUD.

The Demonstration did not decrease rates of ED or hospital use for Medicaid individuals. This finding is consistent with decreases in the utilization of services designed to divert people from these higher levels of care.

Primary Driver

Increase rates of identification, initiation, engagement, and retention in treatment.

Hypothesis Summary	Findings
Hypothesis 11: Enrollees with SUD will have fewer opioid-related overdose deaths.	There has been a statistically significant decline in overdose deaths, compared to the calendar year before the Demonstration.

Hypothesis 11

Individuals with SUD will have fewer opioid-related overdose deaths.

Although the Demonstration did not lead to lower ED or hospital use for Medicaid individuals with an SUD, the State did see fewer overdose deaths after the start of the Demonstration. This is consistent with decreasing trends in overdose nationally. However, the State's trends in overdose deaths was significantly lower than what was predicted based on the interrupted time series model.

Connecticut Goal 3

Improve care coordination and care transitions for Medicaid individuals with SUD.

Primary Driver

Improved access to care coordination among individuals, including improved discharge planning and transitions.

Hypothesis Summary	Findings
Hypothesis 12: The Demonstration will increase the rate of Medicaid individuals with SUD-related conditions who are also receiving primary/ambulatory care.	- The percentage of Medicaid individuals who also received primary/ambulatory care decreased from baseline. - All rates of follow-up following an ED visit for either a mental health or SUD-related cause also declined from baseline.

Hypothesis Summary	Findings
Hypothesis 13: Medicaid IMD providers will demonstrate consistency in program design and discharge planning policies.	The State has completed training and TA for IMD providers that include program design and discharge planning. Providers, overall, have been positive about training and TA opportunities.

Hypothesis 12

The 1115 SUD Demonstration will increase the rate of Medicaid individuals with SUD-related conditions who are also receiving primary/ambulatory care.

The Demonstration did not increase the rate of Medicaid individuals also receiving primary or ambulatory care. In addition, rates of follow-up after ED visits and hospitalizations for either mental health or SUD concerns declined since the start of the Demonstration.

Primary Driver

Increase rates of identification, initiation, engagement, and retention in treatment.

Hypothesis 13

Medicaid IMD providers will demonstrate consistency in program design and discharge planning policies.

State partners have built close relationships and have good foundations for communications. Providers, while concerned about capacity and rates expressed a willingness to work with the State and appreciated State efforts to work with them on training, TA, and in communication around changes being made to improve the Demonstration. Training and TA activities for IMDs have included consistency in programming and transitions and discharge planning, including documentation and referral requirements. ASO reviews of providers have indicated that providers have significantly improved their adherence to ASAM criteria over the initial Demonstration years.

As discussed previously, the State determined that investments in targeted case management were not feasible within the current Medicaid budget, which may be contributing to less retention in care due to lack of care coordination across levels of care. In the absence of these services, the Demonstration did not increase the rate of Medicaid individuals also receiving primary or ambulatory care. In addition, rates of follow-up after ED visits and hospitalizations for either mental health or SUD concerns declined since the start of the Demonstration.

Connecticut Goal 4

Maintain or reduce Medicaid cost of individuals with SUD.

Primary Driver

Maintain or reduce Medicaid costs for individuals with SUD, where possible.

Hypothesis Summary	Findings
Hypothesis 14: The Demonstration will be budget neutral to the federal government.	The Demonstration is budget neutral under Hypothetical Budget Neutrality Test 1 in each of the first three years of the Demonstration.
Hypothesis 15: Total Medicaid SUD spending during the measurement period will remain constant after adjustment for the new residential services and any other new SUD treatment services, including care coordination, developed under this Demonstration.	- Costs were already beginning to increase before the start of the Demonstration and the effect of implementation was not statistically significant even before adjusting for the cost of the new residential services and other new SUD treatment services, including care coordination, required by ASAM. - Connecticut invested \$152 million into its SUD treatment network to begin covering residential treatment and require ASAM standards, including care coordination, at every level of care. Many providers were provisionally certified through April 2025, which was the beginning of DY 4, and expenditures to continue to come into compliance with ASAM criteria occurred through that timeframe.

Hypothesis 14

The Demonstration will be budget neutral to the federal government.

The Demonstration was budget neutral to the federal government for the first three years of the demonstration.

Hypothesis 15

Total Medicaid SUD spending during the measurement period will remain constant after adjustment for the new residential services and any other new SUD treatment services, including care coordination, developed under this Demonstration.

This hypothesis presumes that costs will first increase as approximately \$152 million new SUD residential treatment services are introduced and ASAM standards, including care coordination, under each level of care are implemented under the Demonstration. The trends here are consistent with increasing costs as residential services have been added and with increasing utilization of residential and inpatient

treatment, as well as sharp increases in IMD stays for SUD. As noted, the effect of implementation was not statistically significant even before adjusting for the cost of the new residential services and other new SUD treatment services, including care coordination, required by ASAM. The summative evaluation will examine whether overall costs remained the same in later Demonstration years.

Section 8

Interpretations, Policy Implications, and Interactions with Other State Initiatives

Initial Demonstration years have focused on transitioning the existing providers to the American Society of Addiction Medicine (ASAM) 3rd edition criteria and to recruiting new providers, particularly at the residential ASAM levels of care. After the Demonstration was implemented, the State had a decrease of 90 substance use disorder (SUD) residential treatment beds, including the only adolescent residential treatment provider. Stakeholders have reported that adding SUD benefits and reimbursements through the Demonstration alone are not sufficient to build back provider loss. The State has made some headway, adding back 28 residential beds, but progress has been slow.

Providers report that adding new levels of care require significant initial capital investments that are not quickly recouped via fee-for-service reimbursement. Two new strategies have been employed by the State: increases in rates for levels of care with a specific capacity gap, and working with providers to pilot the use of internal continuums so that they can adapt treatment intensity to match the individual's needed ASAM level of care and retain individuals in care longer. It is too soon to tell whether this will lead to increases in capacity, utilization, and ultimately, individuals' outcomes. More State funding for the capital projects and investments needed to bring more beds on-line would likely help to increase provider participation, but may not be feasible in the current budget climate.

Advocates and family individuals that participated in focus groups both for this evaluation and for the midpoint assessment at the start of the year said that the largest challenge in the State is that most individuals are unaware of the services available to them or how to access them. Three participants specifically recounted incidents where a person in need was seen in an emergency department for an SUD-related concern, but were never connected to crisis services or referred to care. These stories underscore that creating bed capacity is only part of the solution to increasing SUD service utilization. Increasing rates of identification and engagement in treatment are also vital. Incentivizing more early intervention services, such as Screening, Brief Intervention, and Referral to Treatment represents an opportunity for the State to engage individuals in treatment early, particularly adolescents.

As the State proceeds with its waiver extension, it will do so in an environment where further cuts to Medicaid eligibility are likely. This will represent a new challenge to the State to bring SUD services to individuals of the community who most need it.

Within the context of the Medicaid landscape, the Demonstration was not affected by COVID-19 because implementation did not start until April 2022. The overall COVID-19 effects, while changing confidence intervals of effect sizes, did not change whether the Demonstration affected the measures. Also, the impacts of COVID-19 were less consequential because they did not impact the confirmation or rejection of the evaluation hypotheses.

Decreases in trends of the number of individuals receiving services are likely due at least in part to the decrease in Medicaid individuals during the unwinding of COVID-19 era Medicaid rosters. However, this is largely controlled for by focusing on rates of treatment that include the number of individuals in the denominator. Ultimately, the effects of the unwinding are not more prominent in the results because most of the results presented here are based on *rates* of treatment, which control for the decline in Medicaid individuals by using the number of individuals with an SUD diagnosis as the denominator in rate calculations.

Specifically, 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 eligibility. Connecticut's Medicaid rolls decreased by 9% from April 2023 to October 2024.¹¹ In this sense, these findings, while not completely aligned with the State's targets for improvements, where the declines in utilization were not as great as would have occurred absent the waiver, can be seen as a positive change for the State and future SUD service delivery.

¹¹ 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. <https://www.kff.org/medicaid/medicaid-enrollment-and-unwinding-tracker/#93469f01-80b8-4f2a-b58e-f00496dff23f>

Section 9

Lessons Learned and Recommendations

The most prominent lesson learned conveyed by stakeholders is the amount of time it takes to bring in new providers to increase the capacity to provide services at all critical levels of care (LOCs). This makes retaining current providers as important as recruiting new ones.

Additionally, reimbursements must match the requirements for staff, licensing, and certification in order to incent providers at every level of care, particularly given the capital investment required to open beds at new LOCs.

Because this report is being submitted close after the midpoint assessment, most recommendations remain the same.

Recommendations for the State, carried over from the midpoint assessment, include:

- Continue to work with providers to explore flex-bed options to facilitate increased capacity for level 3.1 and level 3.5 LOCs. Continue to publicize and implement the residential rate adjustments made July 1, 2025.
- Increase focus on providing early intervention and outpatient services, including more widespread screening for substance use disorder (SUD) across all age groups to avoid costs associated with higher LOCs. Continue to publicize and implement the new Screening, Brief Intervention, and Referral to Treatment (SBIRT) coding and payments made July 1, 2025. Consider providing education in primary care settings for the new SBIRT coding and reimbursement.
- 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 enhancing regular meetings with State agencies and providers to move beyond policy and procedure updates and instead focus on problem-solving discussions for metrics that are not meeting Demonstration targets.
- Enhance bi-directional, problem-focused communications with providers and Administrative Service Organizations around managing care transitions across LOCs when bed capacity is limited. The State should ensure that American Society of Addiction Medicine LOCs focus on individualized treatment planning and not cost-control mechanisms.
- Communicate more information to providers when provider on-site reviews find areas of concern around quality of care (e.g., insufficient daily treatment dosage received by individuals) and use those opportunities to improve individualized care.
- Consider the following options to improve retention and continuity in care:
 - A targeted case management 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 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.

Appendix A

CMS-Approved Evaluation Design

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850



State Demonstrations Group

May 22, 2023

Ms. Deidre Gifford
Commissioner, Office of the Commissioner
Connecticut Department of Social Services
55 Farmington Avenue Hartford, CT 06105

Dear Ms. Gifford,

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the Connecticut Substance Use Disorder (SUD) Evaluation Design, which is required by the Special Terms and Conditions (STCs), specifically STC #36, of Connecticut's section 1115 demonstration, "Connecticut Substance Use Disorder Demonstration" (Project No: 11-W-00372/1 and 21-W-00069/1). CMS has determined that the Evaluation Design, which was submitted on February 11, 2023 and revised on May 10, 2023 meets the requirements set forth in the STCs and our evaluation design guidance, and therefore approves the state's SUD Evaluation Design.

CMS has added the approved SUD Evaluation Design to the demonstration's STCs as Attachment E. A copy of the STCs, which includes the new attachment, is enclosed with this letter. In accordance with 42 CFR 431.424, the approved Evaluation Design may now be posted to the state's Medicaid website within 30 days. CMS will also post the approved Evaluation Design as a standalone document, separate from the STCs, on Medicaid.gov.

Please note that an Interim Evaluation Report, consistent with the approved Evaluation Design, is due to CMS one year prior to the expiration of the demonstration, or at the time of the extension application, if the state chooses to extend the demonstration. Likewise, a Summative Evaluation Report, consistent with this approved design, is due to CMS within 18 months of the end of the demonstration period. In accordance with 42 CFR 431.428 and the STCs, we look forward to receiving updates on evaluation activities in the demonstration monitoring reports.

We appreciate our continued partnership on the Connecticut SUD section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

**Danielle
Daly -S**  Digitally signed by
Danielle Daly -S
Date: 2023.05.22
12:33:11 -04'00'

Danielle Daly
Director
Division of Demonstration
Monitoring and Evaluation

cc: Marie DiMartino, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Substance Use Disorder 1115 Waiver

Evaluation Design

State of Connecticut

May 10, 2023

Contents

1. General Background Information	1
• History and Overview	1
• Recent Context for Connecticut's Medicaid Program	1
• Substance Use Disorder Treatment in Connecticut	3
• Demonstration Approval	4
• Description of the Demonstration	4
• Demonstration Evaluation	9
2. Evaluation Questions and Hypotheses	10
• Targets for Improvement	11
• Driver Diagrams, Research Questions, and Hypotheses	12
3. Methodology	15
• Evaluation Design	15
• Evaluation Period	17
• Evaluation Measures and Data Sources	17
• Analytic Methods	37
4. Methodological Limitations	40
5. Attachments	43
Appendix A: Conflict of Interest Statement	44
Appendix B: Evaluation Budget	46
Appendix C: Potential Timeline and Major Deliverables	51

Section 1

General Background Information

History and Overview

Modernizing the State of Connecticut's (Connecticut's or State's) Medicaid system of delivering Substance Use Disorder (SUD) treatment services has been an ongoing and sequential process beginning with the contracting for a Behavioral Health (BH) administrative services organization (ASO) in 2006 to better manage the continuum of BH services. In keeping with the goal of modernization, 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), has implemented a comprehensive SUD benefit package of services provided by a statewide network of SUD treatment service providers that will be financed by Medicaid for Medicaid beneficiaries. Except as otherwise specified, references to Medicaid throughout this Evaluation Design also include the Children's Health Insurance Program (CHIP).

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

From calendar year 2012 through 2018, the rate of unintentional drug-related overdose deaths in Connecticut grew from 12.2 per 100,000 to 29.9 per 100,000.¹ Connecticut's overdose deaths continue to climb with no sign of relenting. In calendar years 2019 and 2020, fatal drug overdose deaths in Connecticut rose 16.7% and 14.3% respectively from the previous year. The majority (82%) of overdose deaths in 2019 were related to fentanyl or fentanyl analogs.²

Recent Context for Connecticut's Medicaid Program

In 2006, DCF, which oversees BH for children in the State and DSS, in conjunction with a legislatively mandated oversight council, formed the Connecticut Behavioral Health Partnership (CT BHP), authorized pursuant to State statute (section 17a-22h of the Connecticut General Statutes), with ValueOptions³ serving as the ASO.

In 2010, DMHAS, which oversees BH for adults in the State, joined the CT BHP (and the authorizing statute was amended accordingly) and, collectively, a request for proposal for an ASO vendor for the expanded CT BHP was issued. ValueOptions bid on, and was awarded, the contract to be the ASO for the expanded CT BHP. The new contract went live on April 1, 2011,

¹ Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999–2018 on CDC WONDER Online Database, released in 2020. Data are from the Multiple Cause of Death Files, 1999–2018, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Available at: <http://wonder.cdc.gov/ucd-icd10.html> on May 13, 2020.

² Connecticut Office of the Chief Medical Examiner, per CDC-SUDORS grant guidelines (April 19, 2021) as published in the CT Department of Public Health Drug Overdose Monthly Report, March 2021.

³ As a result of the 2014 merger between ValueOptions, Inc. and Beacon Health Strategies, LLC, ValueOptions, Inc. officially changed its name to Beacon Health Options on December 9, 2015.

when more than 200,000 additional Medicaid members, primarily adults, but also a small number of youth, were added. That change brought the total membership included under the CT BHP to more than 600,000 members at that time.

While the goals of the original CT BHP described above remained in place, ValueOptions as the ASO was described in the new contract as being “the primary vehicle for organizing and integrating clinical management processes across the payer streams, supporting access to community-based services, assuring the delivery of quality services and preventing unnecessary institutional care.” Additionally, ValueOptions was expected to enhance communication and collaboration within the BH delivery system, assess network adequacy on an ongoing basis, improve the overall delivery system and provide integrated services supporting health and recovery by working with the Departments (DSS, DCF, and DMHAS) to recruit and retain both traditional and non-traditional providers.

Effective January 1, 2012, DSS transitioned from three managed care organizations (MCOs) managing the physical health care of a large portion of the State’s Medicaid population to a managed fee-for-service (FFS) structure with a single ASO for physical health, similar to the model in place for BH with ValueOptions. ValueOptions partnered with the MCO that ultimately won the bid for this contract, Community Health Network of Connecticut (CHNCT). While this contract did not increase membership, it did result in increased responsibility for ValueOptions to coordinate care provided to Medicaid members. The new contract, which went live in 2012, embedded ValueOptions clinical care managers in the CHNCT office and leveraged McKesson technology to identify the most at-risk members to ultimately impact health outcomes.

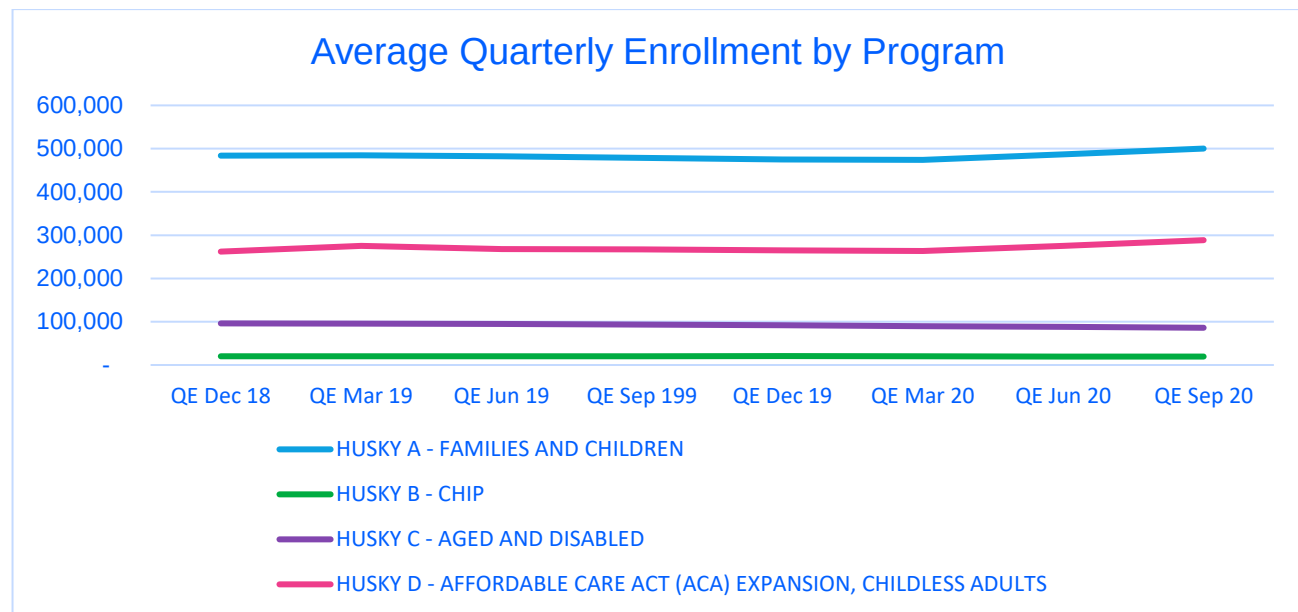
As of September 2020, Connecticut Medicaid and CHIP had approximately 895,000 enrollees, including almost 20,000 CHIP enrollees (HUSKY B) and approximately 289,000 Medicaid adult expansion enrollees (HUSKY D) who receive the Alternative Benefit Plan (ABP) covered services as required under federal law.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

The HUSKY D benefits under the ABP were aligned with the underlying Medicaid State Plan benefits. Although Connecticut Medicaid did not reimburse for residential SUD services, there was a State-funded benefit for HUSKY D Medicaid beneficiaries using a former edition of the American Society of Addiction Medicine (ASAM) Criteria for utilization management (UM).

Today, the CT BHP is composed of DSS, DMHAS, and DCF. CT BHP contracts with Beacon Health Options, the BH ASO, to authorize and coordinate Medicaid BH services (mental health and SUD services) for HUSKY Health members in Connecticut. Covered benefits and services administered by the CT BHP are available to members who are enrolled in HUSKY A, HUSKY B, HUSKY C, and HUSKY D. (Separate from its HUSKY Health/Medicaid responsibilities, the BH ASO also provides administrative support to a small set of services for the non-Medicaid DCF limited benefit group.) See below for a chart reflecting the relative size of each HUSKY population.

Under the Demonstration, a full continuum of SUD care for HUSKY A, HUSKY B, HUSKY C, and HUSKY D will be financed by Medicaid subject under a new Medicaid Rehabilitative State Plan. In addition, the Judicial Branch Court Support Services Division (JB-CSSD) and the Department of Corrections (DOC) have joined with the 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.

Relative Size of Each Medicaid Population⁴



Substance Use Disorder Treatment in Connecticut

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

- Screening, Brief Intervention and Referral to Treatment (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

⁴ Source: DSS January 8, 2021 presentation to MAPOC, Financial Trends in the Connecticut HUSKY Health Program Transparency, Sustainability and COVID Impacts. Available at:

https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&%20Presentations/20210108/HUSKY%20Financial%20Trends%20January%202021%20.pdf

- Targeted Case Management (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 Levels of Care (LOCs).

There are no residential services for adolescent girls in Connecticut. All residential services must be provided out of State, which reduces the ability of the facility to provide family therapy. The State would like to recruit providers within the State's border to provide these services to improve care for adolescent girls. In order to meet demonstration requirements accessibility to ASAM residential services for all Medicaid eligible populations, the Demonstration contains a specific focus on treatment for adolescent girls.

Demonstration Approval

On April 14, 2022, Connecticut received approval for its application for a section 1115(a) demonstration titled "Connecticut Substance Use Disorder Demonstration" (Project Number 11-W-00372/1 and 21-W-00069/1) effective April 14, 2022 through March 31, 2027.

Description of the Demonstration

The 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.

This Demonstration seeks to improve outcomes for Medicaid members diagnosed with SUD by providing critical access to SUD treatment services, including inpatient and residential SUD treatment in IMDs, as part of a full continuum of treatment services that follow ASAM LOCs. Under a new SUD State Plan Amendment (SPA), which will be associated with this Demonstration, Connecticut will implement a comprehensive, integrated SUD benefit that includes residential treatment settings. However, existing IMD limitations in FFS create barriers to ensuring members are able to access SUD treatment at a LOC appropriate to their needs using the ASAM criteria. Connecticut seeks Demonstration authority to remove Federal Medicaid restrictions on IMDs as SUD treatment settings in FFS. The new Medicaid SUD treatment continuum will enhance critical access to the full ASAM SUD treatment continuum. Mercer Government Human Services Consulting (Mercer) anticipate that this demonstration will accomplish the following goals, which make up our demonstration hypothesis. This waiver Demonstration will:

1. Increase rates of identification, initiation, and engagement in treatment for Opioid Use Disorder (OUD) and other SUDs.
2. Increase adherence to and retention in treatment for OUD and other SUDs.
3. Reduce overdose deaths, particularly those due to opioids.

4. Reduce utilization of emergency departments (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.
5. Lead to fewer readmissions to the same or higher LOC where readmissions is preventable or medically inappropriate for OUD and other SUDs.
6. 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 Milestones:

1. Access to critical LOCs for OUD and other SUDs
2. Widespread use of evidence-based, SUD-specific patient placement criteria
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications
4. Sufficient provider capacity at each LOC, including MAT
5. Implementation of comprehensive treatment and prevention strategies to address opioid misuse and Connecticut Substance Use Disorder Section 1115(a) Medicaid Demonstration OUD
6. Improved care coordination and transitions between LOCs

Milestone 1: Access to Critical LOCs for SUDs

Connecticut's pre-Demonstration SUD Medicaid treatment system included coverage of the following:

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

Under the Demonstration, the State will submit a SPA to provide a more complete continuum of care using ASAM criteria and standards including intensive LOCs in residential settings and withdrawal management.

Milestone 2: Use of ASAM Placement Criteria

Connecticut contracts with two entities for review of SUD admissions and placements using prior authorization and UM standards in the FFS Medicaid, block grant, and State-funded SUD

delivery systems. The State requires both the DSS-contracted Medicaid BH ASO for UM (currently Beacon Health Options) and DMHAS' contractor for quality management (QM) (currently Advanced Behavioral Health, Inc.) that is funded with State general funds and federal Substance Abuse and Mental Health Services Administration (SAMHSA) block grant dollars to utilize ASAM principles to ensure provider quality. Pre-Demonstration, the BH ASO utilized the ASAM placement criteria third edition and the DMHAS UM contractor utilized the ASAM placement criteria second edition. Prior to the Demonstration, Connecticut had not trained nor required treatment providers to create individualized treatment plans for individuals using multi-dimensional assessments based on the six dimensions of care as outlined in ASAM.

Under the Demonstration, SUD treatment services provided in the Medicaid FFS delivery system will comply with the current ASAM criteria for all prior authorization and utilization review decisions resulting in continuity across the Medicaid delivery systems. Connecticut will train all providers to utilize multi-dimensional assessments based on the six dimensions of care as outlined in ASAM to create individualized treatment plans. DSS, or its designee, will ensure appropriate UM is in place for SUD services for all LOCs, including prior authorization for SUD residential treatment services for individuals enrolled in the FFS delivery system. DSS will ensure Medicaid members have access to interventions at the SUD LOC appropriate for each person's diagnosis and individual circumstances. DSS will update any provider agreements necessary to emphasize the required use of the most current edition of ASAM placement criteria for providers of SUD treatment services. The State also intends to implement provider training on this requirement for ASAM placement criteria and its application to all SUD treatment services.

Milestone 3: Use of ASAM Program Standards for Residential Provider Qualifications

Connecticut Medicaid did not previously cover adult SUD residential services. Under the Demonstration, Connecticut will submit a SPA to cover residential treatment delivered by providers whose qualifications are consistent with the most current version of ASAM. Currently, requirements for State-funded and federal SAMHSA block grant-funded residential SUD treatment, residential withdrawal management, and inpatient SUD treatment services require general compliance with ASAM second edition standards.

Under the Demonstration and SPA, Medicaid policy manuals will be modified to reflect the current ASAM criteria for residential programs, including requirements for specific services, hours of clinical care, and credentials of staff for residential treatment. The amended policies will include a requirement that residential treatment providers offer MAT either onsite or by facilitating access offsite with a MAT provider. Connecticut will also implement a process for initial certification and ongoing monitoring of residential treatment providers to ensure compliance with the ASAM requirements under the Demonstration.

Milestone 4: Provider Capacity of SUD Treatment including MAT

Connecticut currently contracts for 948 adult SUD residential treatment beds across 19 providers and 12 adolescent beds in one provider, using non-Medicaid funds. All but three of these certified SUD residential, withdrawal management, and inpatient SUD treatment service providers have 17 or more beds and meet the definition of an IMD.

The State will develop an assessment of the availability of the ambulatory providers enrolled in Medicaid and whether they are accepting new patients for each of the SUD ambulatory ASAM LOCs. This assessment will indicate whether facilities are currently accepting Medicaid members.

DSS will work with its partner agencies in the State to ensure the SUD provider network is adequate and distributed geographically to meet the demands for these services. If services are unavailable within a specific geographic region, DSS will recruit qualified providers within the region or seek expansion from existing providers, including those that may be outside the defined geographical boundaries in need.

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

To address the opioid and prescription medication crisis, the Connecticut Department of Public Health (DPH) has implemented prescribing guidelines to prevent opioid over-use through updates to Connecticut policy and law affecting the prescribing of controlled substances and opioid medications.⁵ The relevant State agencies have also collaborated with legislators and various professional groups to enhance the Connecticut Prescription Monitoring and Reporting System (CPMRS), sometimes known as the Prescription Drug Monitoring Program (PDMP).

Effective October 1, 2019, Connecticut amended the Medicaid State Plan to reflect new Drug Utilization Review provisions required in Federal law (Section 1004 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act [SUPPORT Act; P.L. 115-271]). These provisions are designed to reduce opioid-related overprescribing and misuse. The required provisions include: 136 separate opioid prescription claim reviews at the point of sale as well as retrospective reviews, monitoring, and management of antipsychotic medication in children, and identification of processes to detect fraud and abuse.

Connecticut's Expanded Coverage of, and Access to, Naloxone for Overdose Reversal

Connecticut has taken steps over the past decade to make naloxone more widely available. Legislation was first introduced in 2011 in the Connecticut General Assembly and subsequent legislative sessions have included new pieces of legislation that have made naloxone more accessible over the years. A “Good Samaritan” law passed in 2011 that protects people who call 911 seeking emergency medical services for an overdose from arrest for possession of drugs/paraphernalia. State legislation enacted in 2012, which allowed prescribers (e.g., physicians, surgeons, physicians’ assistants, advanced practice registered nurses, dentists and podiatrists) to prescribe, dispense or administer naloxone to any person to prevent or treat a drug overdose, protects the prescriber from civil liability and criminal prosecution. The protection from civil liability and criminal prosecution was extended to the person administering the naloxone in response to an overdose in 2014. Legislation enacted in 2015 allows

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

pharmacists, who have been trained and certified, to prescribe and dispense naloxone directly to customers requesting it. Most recently, Public Act (PA) 18-166 allows prescribers to develop agreements with organizations wishing to train and distribute naloxone. This legislation established new reporting requirements, established a framework for expanding distribution and availability of naloxone, enacted limitations on prescribing controlled substances, and commissioned a feasibility study for opioid intervention courts. All these changes have made naloxone more readily available.

In addition, as outlined in the State's Implementation Plan, Connecticut has established other initiatives addressing OUD, including expanding availability of naloxone using federal grant funds, such as the federal State Opioid Response grant. A total of 12,000 naloxone kits were made available for distribution in State Fiscal Year (SFY) 2019 through DMHAS, DOC, DPH, the Connecticut Hospital Association and the Regional Behavioral Health Action Organizations.

Increasing Utilization and Improving Functionality of PDMPs

Connecticut first mandated prescriber use of the CPMRS, the State's PDMP, in 2015, with additional provisions added in 2016. CPMRS is a tool to track the dispensing of controlled prescription drugs to patients. CPMRS is designed to monitor this information for suspected misuse or diversion (i.e., channeling drugs into illegal use), and can give a prescriber or pharmacist critical information regarding a patient's controlled substance prescription history. This information has helped prescribers and pharmacists identify high-risk patients who would benefit from early interventions.

Since implementation, the use of CPMRS has grown. In 2018, CPMRS reported 1.9 million annual requests from law enforcement, pharmacists, and prescribers. This is nearly double the annual law enforcement, pharmacist, and prescriber requests from four years earlier when there were approximately one million requests.

Connecticut plans to continue to leverage opportunities described in State Medicaid Director Letter (SMDL) 16-003 to help professionals and hospitals eligible for the Medicaid Promoting Interoperability Program, formerly known as the Medicaid Electronic Health Record (EHR) Incentive Program, connect to other Medicaid providers through the integration of CPMRS into EHRs and pharmacy management systems.

Milestone 6: Improved Care Coordination and Transitions between LOCs

Connecticut has multiple interventions for coordinating the care of individuals with SUD and transitioning between LOCs including, but not limited to, facility credentialing, discharge, referral and transition requirements, and care management initiatives at DSS, DCF, and DMHAS.

Under the Demonstration, Connecticut will examine all of the service definitions and existing care management models and strengthen the transition management component for SUD populations between LOCs. DSS, DCF, and DMHAS will create a clear delineation of responsibility for improved coordination and transitions between LOCs to ensure individuals receive appropriate follow-up care following residential treatment.

In addition, to ensure improved care coordination and transitions between LOCs under the Demonstration, Connecticut will also monitor access and health care outcome measures by demographic information, including race and ethnicity. In addition, Connecticut intends to

implement coverage of enhanced individualized care coordination for individuals with SUD that is designed to identify, prevent, and address health inequities and challenges related to social determinants of health.

Population Impacted

This Demonstration will not change the current delivery system structure. All Medicaid services will continue to be delivered through a FFS delivery system. However, as the State will make various improvements to the SUD service system statewide, including aligning with ASAM third 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 will streamline, clarify, and improve the content of each LOC and improve transitions in the care management system.

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

Demonstration Evaluation

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

Connecticut's independent evaluation will measure and monitor the outcomes of the SUD Demonstration. The evaluation will focus on the key goals and milestones of the Demonstration. The researchers will assess the impact of providing the full continuum of SUD treatment services, particularly residential treatment, on hospital ED utilization, inpatient hospital utilization, and readmission rates. Both a midpoint assessment and an interim evaluation at the end of the five-year waiver period will be completed. The evaluation will be designed to demonstrate achievement of the Demonstration's goals, objectives, and metrics. As required by the Centers for Medicare & Medicaid Services (CMS), the Evaluation Design will include the following elements:

- General background information
- Evaluation questions and hypotheses
- Methodology
- Methodological limitations
- Attachments

Section 2

Evaluation Questions and Hypotheses

Evaluation questions and hypotheses to be addressed were derived from and organized based on the Driver Diagrams below. The overall Connecticut Goals of the project are to: 1) Increase enrollee access to and use of appropriate SUD treatment services based on ASAM criteria, 2) Improve quality of care and population health outcomes for Medicaid enrollees with SUD, 3) Improve care coordination and care transitions for Medicaid enrollees with SUD, and 4) Maintain or reduce Medicaid cost of individuals with SUD.

To accomplish these Connecticut Goals, the Demonstration includes several key activities, organized by **primary drivers** of change as they occur in the driver diagrams below:

- Improved access to the most beneficial LOC via a full continuum of available SUD services
- Improved rates of initiation, engagement, and retention in treatment
- Reduced utilization of EDs and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate
- Reduce readmissions to the same or higher LOC where the readmission is preventable or medically inappropriate
- Improved access to care coordination among beneficiaries, including improved discharge planning and transitions
- Maintained or reduced costs, where possible

The specific evaluation questions to be addressed were selected based on the following criteria:

1. Potential for improvement, consistent with the key milestones of the Demonstration listed above.
2. Potential for measurement, including (where possible and relevant) baseline measures that can help to isolate the effects of Demonstration initiatives and activities over time.
3. Potential to coordinate with ongoing performance evaluation and monitoring efforts.

Questions were selected to address the Demonstration's major program goals, to be accomplished by Demonstration activities associated with each of the primary drivers. Specific hypotheses regarding the Demonstration's impact are posed for each of these evaluation questions. These are linked to the primary drivers in the diagrams and tables beginning in Section 2 "Driver Diagrams, Research Questions, and Hypotheses," directly following the next section "Targets for Improvement".

Targets for Improvement

The table below outlines the targets for improvement of the SUD waiver, organized by Primary Drivers of change.

Primary Drivers	Targets
Improved access to the most beneficial LOC via a full continuum of available SUD services	- Increased use of evidence-based treatment criteria. - Ensure sufficient provider capacity.
Increase rates of identification, initiation, engagement, and retention in treatment	- Increased access to critical LOCs for OUD and other SUDs. - Improved access for youth through early intervention and SUD treatment in ambulatory ASAM LOC.
Reduced utilization of EDs and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate	- Increased use of Evidence-based SUD Specific Patient Placement Criteria. - Increased provider capacity at each LOC, including MAT for SUD/OUD.
Reduced readmissions to the same or higher LOC where the readmission is preventable or medically inappropriate	- Increased use of Evidence-based SUD Specific Patient Placement Criteria. - Increased use of comprehensive treatment and prevention strategies to address opioid misuse and OUD.
Improved access to care coordination among beneficiaries, including improved discharge planning and transitions	- Improved care coordination and transitions between LOCs for physical care. - Improved discharge planning and continuity of care between providers.
Maintain or reduce Medicaid costs for individuals with SUD, where possible	- The Demonstration will remain budget neutral to the Federal government. - Residential services and any other new SUD treatment services including care coordination developed under this Demonstration.

Driver Diagrams, Research Questions, and Hypotheses

The four Connecticut Goals represent the ultimate intentions of the waiver. The primary drivers are strategic improvements necessary to achieve the Connecticut Goals. The secondary drivers describe the interventions (milestones) targeted for improvement in order to achieve the strategic improvements.

These primary and secondary drivers of change are based on the March 2017 CMS letter to State Medical Directors, which outlined the interest of CMS to work with the states “to provide a full continuum of care for people struggling with addiction,” and in hearing state-proposed “solutions that focus on improving quality, accessibility, and outcomes in the most cost-effective manner.” The letter offered states the flexibility to design 1115 Demonstrations aimed at making significant improvements over the course of a five-year period on the following six goals and six milestones specific to addiction to opioids or other substances.⁶

Goals:

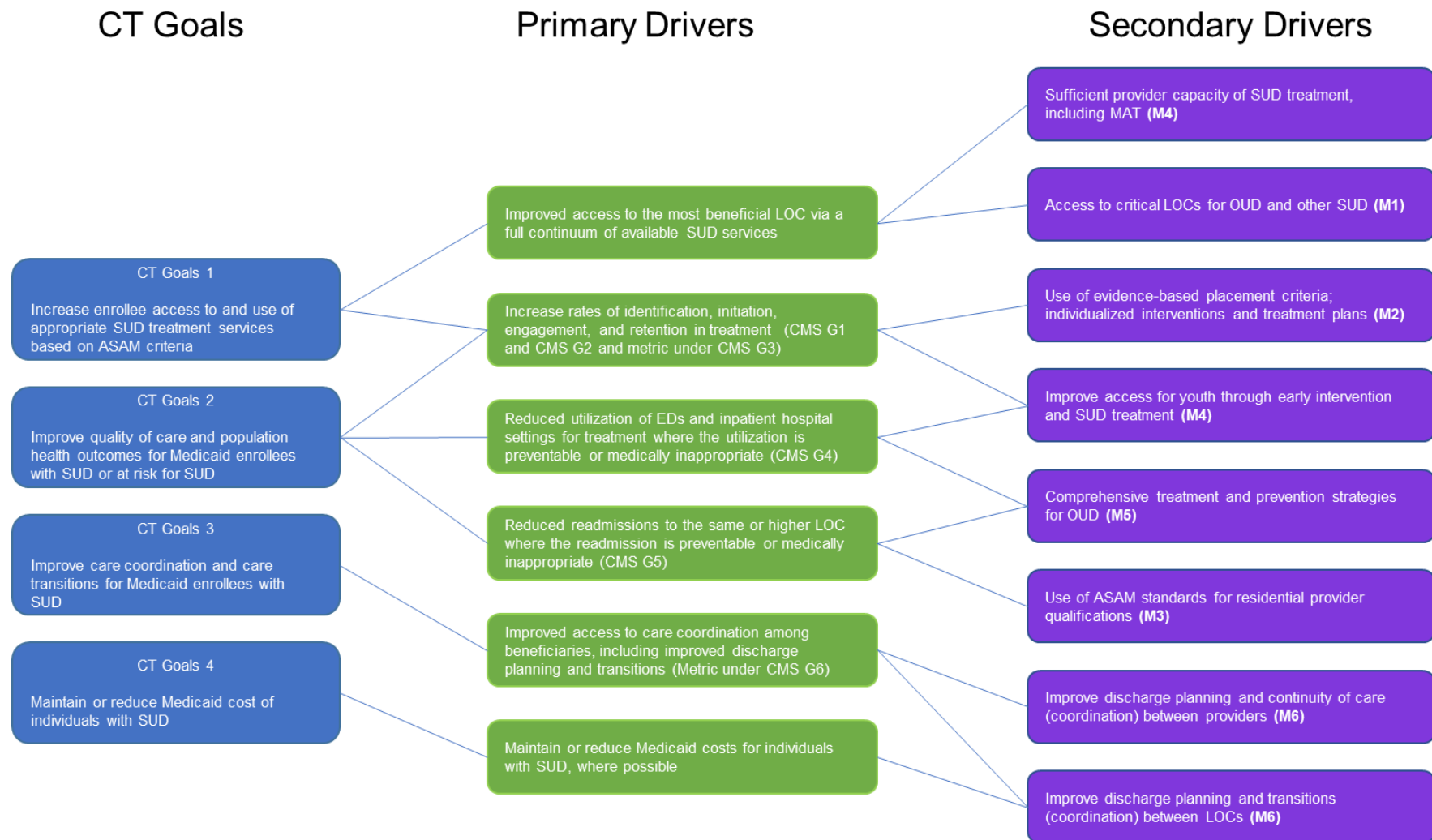
1. Increased rates of identification, initiation, and engagement in treatment. (Primary Driver 2)
2. Increased adherence to and retention in treatment. (Primary Driver 2)
3. Reductions in overdose deaths, particularly those due to opioids. (Metric under Primary Driver 2)
4. Reduced utilization of EDs and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services. (Primary Driver 3)
5. Fewer readmissions to the same or higher LOC where the readmission is preventable or medically inappropriate. (Primary Driver 4)
6. Improved access to care for physical health conditions among beneficiaries. (Metric under Primary Driver 5)

Milestones:

1. Access to critical LOCs for OUD and other SUDs.
2. Widespread use of evidence-based, SUD-specific patient placement criteria.
3. Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications.
4. Sufficient provider capacity at each LOC.
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD.
6. Improved care coordination and transitions between LOCs.

⁶ State Medicaid Director Letter #17-0003 is available at: <https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd17003.pdf>.

High Level Driver Diagram



Measuring Effects on the Four Connecticut Goals

For the outcome evaluation, select performance measures will be used to demonstrate observed changes in outcomes, using an interrupted time-series (ITS) design where sufficient pre-demonstration data is available, or with pre-post comparisons or comparisons to national benchmarks where sufficient pre-demonstration data is not available. Additional performance measures will be collected to monitor progress on meeting the milestones and project goals. These performance measures are grouped and described under the related primary drivers.

The research design table in Section 3, outlines the research questions and hypotheses of the evaluation, organized by each primary driver.

Section 3

Methodology

Evaluation Design

The evaluation of the Connecticut SUD 1115 Waiver Demonstration will utilize a mixed-methods Evaluation Design with three main goals:

1. Describe the progress made on specific Demonstration-supported activities (process/implementation evaluation).
2. Demonstrate change/accomplishments in each of the Demonstration milestones (short-term outcomes).
3. Demonstrate progress in meeting the overall project goals/Connecticut Goals.

A combination of qualitative and quantitative approaches will be used throughout the evaluation. Qualitative methods will include key informant interviews with DSS, DCF, DMHAS, JB-CSSD, DOC and provider staff, ASOs, and other identified stakeholders regarding Demonstration activities, as well as document reviews of contracts, policy guides, and manuals. Quantitative methods will include descriptive statistics and time series analyses showing change over time in both counts and rates for specific metrics and ITS analysis to assess the degree to which the timing of waiver interventions affect changes across specific outcome measures.

Qualitative analysis will include document review and interviews with key informants. It will identify and describe the SUD service delivery system and changes occurring during the Demonstration for Medicaid enrollees. Each of the milestones will be discussed and documented. This will allow identification of key elements Connecticut intends to modify through the Demonstration and measure the effects of those changes. Using a combination of case study methods, including document review, telephone interviews, and face-to-face meetings, a descriptive analysis of the key Connecticut Demonstration features will be conducted.

The evaluation will analyze how the State is carrying out its implementation plan and track any changes it makes to its initial design as implementation proceeds. Both planned changes that are part of the Demonstration design (e.g., expansion of ASAM) and operational and policy modifications the State makes based on changing circumstances and the creation of a new SPA will be identified. Finally, it is possible that, in some instances, changes in the policy environment in the State will trigger alterations to the original Demonstration implementation plan.

During ongoing communication with the State, detailed information on how Connecticut has implemented each milestone, including how it has structured the submission of a SPA supporting ASAM expansion, identified providers at each ASAM level, implemented PDMP and other Health Information Technology (HIT) changes, and structured care coordination between LOCs for beneficiaries enrolled in the Demonstration, will be collected. The evaluation will analyze the scope of each of these milestones as implemented, the extent to which they conduct these functions

directly or through contract, and internal structures established to promote implementation of the milestones.

Key informant interviews and document reviews will occur at four critical junctures: initially, prior to the mid-point assessment, prior to the interim evaluation report being written, and prior to the final summative evaluation report being finalized.

The key informant interviews will be conducted with staff members in the following departments who are directly responsible for SUD 1115 implementation and operations: DSS, DMHAS, DCF, JB-CSSD, DOC, ASOs, and service providers.

To maximize efficiency in the evaluation, most outcome measures align with performance measures being reported to CMS for each of the six milestones. As the independent evaluator/contractor, Mercer will calculate the quantitative performance measures, according to metrics specifications, and based on data provided by DSS, along with other State agencies, as needed. Mercer is currently receiving monthly transfers of Connecticut's Medicaid Management Information System (MMIS) data, through a Health Insurance Portability and Accountability Act (HIPAA)-compliant secure portal. Mercer is also arranging to receive pre-demonstration detailed claims data on inpatient, residential, and ambulatory SUD services delivered prior to the Demonstration start date. Mercer will calculate all performance measures using the period of time specified in the CMS technical manual (e.g., monthly, quarterly, or annually).

The Demonstration is open to all adult and adolescent (Medicaid and CHIP) non-expansion and expansion members, so a concurrent comparison group of Connecticut Medicaid members is not available. Outcomes will be assessed, where possible, using an ITS quasi-experimental design. The ITS analysis projects metrics derived from a pre-demonstration time period into the post-demonstration implementation time period as a comparison for actual post-demonstration implementation metrics. In cases where there are not enough data points for reliable projects (e.g., annual measures) we will use a basic time series analysis, or pre-post analyses, to describe changes over time.

Target and Comparison Populations

Because there is not an available comparison population, the "comparison population groups" in this design will be a projection of each measure, based on historical data, of what the group would look like in the absence of the Demonstration.

The Target population includes non-expansion and expansion adult and adolescent Medicaid beneficiaries with a SUD diagnosis. Based on Demonstration goals and activities, we do not anticipate that the Demonstration will have *intentional* differential impacts on specific subgroups, except for adolescents, and adolescent girls, as noted in the evaluation table below. However, to account for known long-term disparities in access to care, engagement, and outcomes, we will use some demographic categories as covariates in our analyses. Additionally, some covariates based on OUD diagnosis will be used in examining changes in specific SUD utilization metrics. Other specified subpopulations (e.g., dual eligible, pregnant women, and the criminal justice population) will likely have insufficient data to provide reliable analysis. All members

who are eligible for and/or receive services will be included in all descriptive time series and ITS analysis, so no sampling strategy is needed.

Evaluation Period

The evaluation period is April 1, 2022 through March 31, 2027. The draft SUD Mid-point assessment is due 60 days after March 31, 2025. The Draft Interim Evaluation is due March 31, 2026 or with the extension application. Draft interim results derived from a portion of this evaluation period, April 1, 2022 through June 30, 2023 (with three months run out of claims data) will be reported in the Draft Interim Evaluation Report due to CMS on June 30, 2024. The Draft Summative Evaluation Report analysis will allow for a three-month run out of claims data. Results across this time period will be included in the Draft Summative Evaluation Report due to CMS by June 30, 2027.

Evaluation Measures and Data Sources

The Evaluation Design and evaluation measures are based on sources that provide valid and reliable data that will be readily available throughout the demonstration and final evaluation. To determine if data to be used for the evaluation are complete and accurate, the independent evaluator will review the quality and completeness of data sources (including but not limited to claims for pharmacy, professional, and facility services as well as eligibility data). Example analyses the independent evaluator will use to determine reliability and accuracy of claims data include, but are not limited to: frequency reports, valid values, missing values, date and numerical distributions, and duplicates (part of adjustment logic).

As often as possible, measures in the evaluation have been selected from nationally recognized measure stewards for which there are strict data collection processes and audited results.

The following tables summarize: the primary drivers and hypotheses, process (implementation) and outcome measures for the evaluation, measure steward (if applicable), numerator and denominator definitions where appropriate, types of data (quantitative or qualitative), and data sources.

Mercer will calculate all performance measures for the Demonstration period using claims data from DSS, except for overdose deaths, which is calculated using vital statistics data maintained by DPH.

CONNECTICUT GOAL 1: Increase enrollee access to and use of appropriate SUD treatment services based on ASAM criteria.

Research question	Measure	Measure Steward	Time Period	Numerator	Denominator ^a	Data Sources	Analytic Method
Primary Driver: Improved access to care via a full continuum of available SUD services.							
Hypothesis 1: The Demonstration will increase the availability of critical LOCs for Medicaid enrollees.							
Research Question 1.1: 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.	N/A	Cumulative for interim reporting period, and for summative reporting period.	None	None	Key Informant Interviews (DSS, DMHAS, DCF/ JB-CSSD/DOC staff, Medicaid, and DMHAS/DCF ASO representatives; Document Review (ASO policies and procedures, provider addendums, provider review tools)	Thematic analysis of interviews and final SPA.
	Stakeholder reports of successful implementation and adequate access to each ASAM critical LOC.	N/A	Cumulative for interim reporting period, and for summative reporting period.	None	None	Key Informant Interviews (DSS, DMHAS/DCF/ JB-CSSD, DOC staff, Medicaid, and DMHAS/DCF ASO representatives;	Thematic analysis of interviews and final SPA. We area also exploring beneficiary focus groups,

Research question	Measure	Measure Steward	Time Period	Numerator	Denominator ^a	Data Sources	Analytic Method
						Document Review (ASO policies and procedures, provider addendums, review tools, SPA)	leveraged through existing participatory and advocacy organizations.
Primary Driver: Improved access to care via a full continuum of available SUD services. Hypothesis 2: The Demonstration will increase the use of residential, MAT, withdrawal management, early intervention, and ambulatory care available by Medicaid enrollees.							
Research Question 2.1 Since the development of the 1115 SUD waiver, are more individuals receiving services at critical LOCs when compared to the numbers prior to the waiver?	Number/percent of beneficiaries who receive prevention or early intervention services (CMS #7).	CMS	Monthly	Number of unique members in the denominator with a service claim for early intervention services (e.g., procedure codes associated with SBIRT).	Members with a SUD diagnosis (CMS #3) for percentage	Claims	ITS; controlling for demographic subgroups
	Number/percent of beneficiaries who use outpatient	CMS	Monthly	Number of unique members in the	Members with a SUD diagnosis (CMS #3) for percentage	Claims	ITS; controlling for demographic subgroups

Research question	Measure	Measure Steward	Time Period	Numerator	Denominator ^a	Data Sources	Analytic Method
	services (CMS #8).			denominator with a claim for outpatient services for SUD (e.g., outpatient recovery or motivational enhancement therapies, step-down care, and monitoring for stable patients).			
	Number/percent of beneficiaries who use intensive outpatient and partial hospitalization services (CMS #9).	CMS	Monthly	Number of unique members in the denominator with a claim for intensive outpatient and/or partial hospitalization services for SUD (e.g., specialized outpatient SUD	Members with a SUD diagnosis (CMS #3) for percentage	Claims	ITS; controlling for demographic subgroups

Research question	Measure	Measure Steward	Time Period	Numerator	Denominator ^a	Data Sources	Analytic Method
				therapy and other clinical services).			
	Number/percent of beneficiaries who use residential and/or inpatient services for SUD (CMS #10).	CMS	Monthly	Number of unique members in the denominator with a service for residential and/or inpatient services for SUD.	Members with a SUD diagnosis (CMS #3) for percentage	Claims	ITS; controlling for demographic subgroups
	Number of beneficiaries who have a claim for MAT for SUD during the measurement period (CMS #12).	CMS	Monthly	Number of unique members in the denominator with a service for MAT services.	Members with a SUD diagnosis (CMS #3) for percentage	Claims	ITS; controlling for demographic subgroups
	Number/percent of beneficiaries who use withdrawal management	CMS	Monthly	Number of unique members in the denominator	Members with a SUD diagnosis (CMS #3) for percentage	Claims Include DMHAS data in numerator for baseline years	ITS; controlling for demographic subgroups

Research question	Measure	Measure Steward	Time Period	Numerator	Denominator ^a	Data Sources	Analytic Method
	services (CMS #11).			with a service or pharmacy claim for withdrawal management services.			
	Number and length of IMD stays for SUD (CMS #36).	CMS	Yearly	Total number of days in an IMD for inpatient/residential discharges for SUD.	Total number of discharges from an IMD for beneficiaries with an inpatient or residential treatment stay for SUD.	Claims Include DMHAS data in numerator for baseline years	Descriptive Time Series; pre-post one-way ANCOVA statistic comparing baseline average to post-demonstration average, controlling for demographic subgroups

Primary Driver: Improved access to the most beneficial LOC via a full continuum of available SUD services

Hypothesis 3: The Demonstration will lead to use of the most recent version of the ASAM placement criteria by all providers.

Research Question 3.1: Has the use of evidence-based SUD-specific patient placement criteria (ASAM criteria) been	Number/percent of providers certified at each LOC.	Evaluator, with input from the agency collecting the data	Yearly	Number of providers in the denominator licensed at each LOC.	Total number of SUD providers (CMS #13) for percentage	DMHAS and DCF certification records	Descriptive time series; pre-post chi square test of significance comparing baseline proportion to post-demonstration period proportion (for each LOC)

Research question	Measure	Measure Steward	Time Period	Numerator	Denominator ^a	Data Sources	Analytic Method
implemented across all LOCs for all patient populations? (Process Question)	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 1 LOCs.	N/A	Cumulative for interim reporting period, and for summative reporting period.	None	None	Key Informant interviews from Medicaid ASO and DMHAS/DCF ASO staff; aggregate reports from onsite provider monitoring records	Thematic analysis of interviews and documents Medicaid ASO reports on the number of ASAM LOC requested by the provider and either denied or changed by the Medicaid ASO for providers at all LOCs DMHAS/DCF ASO Numeric reports on provider compliance with use of ASAM Placement criteria
	Description of training and technical assistance activities to align providers with new ASAM standards.	N/A	Cumulative for interim reporting period, and for summative reporting period.	None	None	Key Informant interviews and document review from ASOs and State agency partners	Thematic analysis of interviews and documents Numeric reports on the number of provider staff trained in ASAM

Research question	Measure	Measure Steward	Time Period	Numerator	Denominator ^a	Data Sources	Analytic Method
Primary Driver: Improved access to care via a full continuum of available SUD services.							
Hypothesis 4: The Demonstration will increase provider capacity for SUD treatment at critical LOCs for individuals in the State.							
Research Question 4.1: Has the availability of providers in Medicaid accepting new patients, including MAT providers, improved under the Demonstration?	Number/percent of Medicaid-accepting providers licensed at each LOC.	Evaluator, with input from the agency collecting the data	Yearly	Number of Medicaid providers in the denominator licensed at each LOC.	Total number of SUD providers (CMS #13) for percentage	Medicaid ASO and DMHAS provider capacity tracking records	Descriptive time series; pre-post chi square test of significance comparing baseline proportion to post-demonstration period proportion (for each LOC)
	Number/percent of beneficiaries receiving any SUD treatment service (CMS #6).	CMS	Monthly	Number of unique members in the denominator receiving at least one SUD treatment service or pharmacy claim during the measurement period.	Number of unique members enrolled in the measurement period (for percentage) Subpopulations: OUD, Age, Dual, Pregnant, and Criminal Justice	Claims	ITS; controlling for demographic subgroups Compare “Received Any Substance Use Treatment in the Past Year” as benchmark if DMHAS data is not available/useable for ITS
	The number of providers who were enrolled in	CMS	Yearly	Number of providers.	None	Key Informant interviews and document review	Time series

Research question	Measure	Measure Steward	Time Period	Numerator	Denominator ^a	Data Sources	Analytic Method
	Medicaid and qualified to deliver SUD services during the measurement period (CMS #13).					from ASOs and State agency partners	
	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 (CMS #14).	CMS	Yearly	Number of providers.	None	Key Informant interviews and document review from ASOs and State agency partners	Time series

Primary Driver: Improved access to care via a full continuum of available SUD services.

Hypothesis 5: The Demonstration will improve access and develop capacity for adolescent girls needing SUD residential treatment.

Research question	Measure	Measure Steward	Time Period	Numerator	Denominator ^a	Data Sources	Analytic Method
Research Question 5.1: Has access to SUD residential treatment improved for adolescent girls?	Number/percent of adolescent girls enrolled in Medicaid who use residential and/or inpatient services for SUD (CMS #10 — specific subgroup).	CMS	Monthly	Number of unique members in the denominator with a service for residential and/or inpatient services for SUD.	Adolescent (12–17) girls with a SUD diagnosis (CMS #3) for percentage.	Claims Qualitative Interview Have any residential providers been certified to serve adolescent girls	ITS
Primary Driver: Improved access to care via a full continuum of available SUD services.							
Hypothesis 6: More adolescent SUD treatment services will be provided at the ambulatory ASAM LOCs.							
Research Question 6.1 Will more adolescents be treated for SUD using early identification and ambulatory ASAM LOCs including early access to treatment?	Number/percent of adolescent beneficiaries who receive prevention or early intervention services (CMS #7).	CMS	Monthly	Number of unique members in the denominator with a service claim for early intervention services (e.g., procedure codes associated with SBIRT).	Adolescent (ages 12–17) members with a SUD diagnosis (CMS #3) for percentage	Claims	ITS
	Number/percent of adolescent	CMS	Monthly	Number of unique	Adolescent (ages 12–17)	Claims	ITS

Research question	Measure	Measure Steward	Time Period	Numerator	Denominator ^a	Data Sources	Analytic Method
	beneficiaries who use outpatient services (CMS #8).			members in the denominator with a claim for outpatient services for SUD (e.g., outpatient recovery or motivational enhancement therapies, step-down care, and monitoring for stable patients).	members with a SUD diagnosis (CMS #3) for percentage		
Primary Driver: Increase rates of identification, initiation, engagement, and retention in treatment. Hypothesis 7: The Demonstration will improve rates of identification, initiation, and engagement in treatment.							
Research Question 7.1: Has the widespread use of ASAM patient placement criteria resulted in increased rates of	Initiation of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET-AD) (CMS #15).	National Committee for Quality Assurance (NCQA) National Quality Forum	Yearly	Number of unique members in the denominator who initiate treatment through an inpatient AOD admission,	Number of unique members with a new episode of AOD abuse or dependence	Claims	Descriptive time series; pre-post chi square test of significance comparing baseline proportion to post-demonstration period proportion

Research question	Measure	Measure Steward	Time Period	Numerator	Denominator ^a	Data Sources	Analytic Method
identification, initiation, and engagement in treatment for members with SUD diagnoses?		(NQF) #0004		outpatient visit, intensive outpatient visit or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis.			Compare to CMS Medicaid Adult Core Set national median as benchmark if pre-demonstration data is not available/ useable
	Engagement of AOD Abuse or Dependence Treatment (IET-AD) (CMS #15).	NCQA NQF #0004	Yearly	Number of unique members in the denominator who were engaged in ongoing AOD treatment within 34 days of the initiation visit.	Number of unique members with a new episode of AOD abuse or dependence and initiated treatment	Claims	Descriptive time series; pre-post chi square test of significance comparing baseline proportion to post-demonstration period proportion Compare to CMS Medicaid Adult Core Set national median as benchmark if pre-demonstration data is not available/ useable

Research question	Measure	Measure Steward	Time Period	Numerator	Denominator ^a	Data Sources	Analytic Method
Primary Driver: Improved access to the most beneficial LOC via a full continuum of available SUD services. Hypothesis 8: The Demonstration will improve access and develop capacity for adolescent girls needing SUD residential treatment.							
Research Question 8.1: Did more adolescent girls receive residential SUD treatment as a result of the Demonstration?	Number/percent of adolescent female beneficiaries who use residential and/or inpatient services for SUD (CMS #10).	CMS	Monthly	Number of unique members in the denominator with a service for residential and/or inpatient services for SUD.	Adolescent female members with a SUD diagnosis (CMS #3) for percentage	Claims Qualitative Interview Have any residential providers been certified to serve adolescent girls	ITS; controlling for demographic subgroups

CONNECTICUT GOAL 2: Improve quality of care and population health outcomes for Medicaid enrollees with SUD.

Research question	Measure	Measure Steward	Time Period	Numerator	Denominator ^a	Data Sources	Analytic Method
Primary Driver: Reduced utilization of EDs and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate Hypothesis 9: The 1115 SUD Demonstration will decrease the rate of ED and hospital use among Medicaid enrollees with SUD.							
Research Question 9.1: What is the impact of the Demonstration on ED	ED Utilization for SUD per 1,000 Medicaid Beneficiaries (CMS #23).	CMS	Monthly	Number of ED visits for SUD.	All Medicaid members	Claims	ITS; controlling for demographic subgroups

Research question	Measure	Measure Steward	Time Period	Numerator	Denominator ^a	Data Sources	Analytic Method
utilization by Medicaid enrollees with SUD?							
Research Question 9.2: Did inpatient stays decrease after implementation of UM?	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries (CMS #24).	CMS	Monthly	Number of inpatient stays for SUD.	All Medicaid members	Claims Include DMHAS data in numerator for baseline years	ITS; controlling for demographic subgroups
Primary Driver: Reduced utilization of EDs and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate Hypothesis 10: The 1115 SUD Demonstration will lead to lower hospitalization readmission rates for enrollees with SUD.							
Research question 10.1: Did readmissions to the same or higher LOC, where readmission is preventable or medically inappropriate for OUD and other SUD, decrease?	Readmissions Among Beneficiaries with SUD (CMS #25).	CMS	Yearly	Acute hospital admissions from the denominator with at least one acute readmission for any diagnosis within 30 days of discharge.	Acute hospital admissions for members with SUD diagnosis	Claims	Descriptive time series; pre-post chi square test of significance comparing baseline proportion to post-demonstration period proportion

Research question	Measure	Measure Steward	Time Period	Numerator	Denominator ^a	Data Sources	Analytic Method
Primary Driver: Increase rates of identification, initiation, engagement, and retention in treatment . Hypothesis 11: Enrollees with SUD will have fewer opioid-related overdose deaths.							
Research question 11.1: Did comprehensive treatment and prevention strategies correspond to a reduction in overdose deaths and activities that support overdose death reduction?	Overdose Deaths (rate) (CMS#27).	Evaluator, with input from the agency collecting the data	Yearly	Number of Medicaid members with overdose as cause of death.	All Medicaid members	State data on cause of death	Descriptive time series (data ID's Medicaid members? Possible ITS); pre-post chi square test of significance comparing baseline proportion to post-demonstration period proportion Also compare to National Center for Health Statistics national drug overdose death rate as benchmark

CONNECTICUT GOAL 3: Improve care coordination and care transitions for Medicaid enrollees with SUD.

Research question	Measure	Measure Steward	Time Period	Numerator	Denominator ^a	Data Sources	Analytic Method
Primary Driver: Improved access to care coordination among beneficiaries, including improved discharge planning and transitions							
Hypothesis 12: The 1115 SUD Demonstration will increase the rate of Medicaid enrollees with SUD-related conditions who are also receiving primary/ambulatory care.							
Research Question 12.1: What is the impact of the Demonstration on the integration of physical and BH care among Medicaid enrollees with SUD and co-morbid conditions?	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD (AAP) (Adjusted Healthcare Effectiveness Data and Information Set [HEDIS] measure) (CMS #32).	NCQA	Yearly	Number of unique members with SUD with an ambulatory or preventative care visit.	Number of unique members with a SUD diagnosis (CMS #4)	Claims	Descriptive time series; pre-post chi square test of significance comparing baseline proportion to post-demonstration period proportion
Research Question 12.2 Has the Demonstration impacted access to care for individuals	Follow-Up After ED Visit for AOD Abuse or Dependence (FUA-AD) (CMS #17-1).	NCQA	Yearly	Number of ED visits for members in the denominator who had a follow-up visit	Number of ED visits for members with a principal diagnosis of AOD abuse or dependence.	Claims	Descriptive time series; pre-post one-way ANCOVA comparing baseline average to post-demonstration average, controlling

Research question	Measure	Measure Steward	Time Period	Numerator	Denominator ^a	Data Sources	Analytic Method
with SUD by linking beneficiaries with community-based services and supports following ED visits and reducing readmission rates for hospital stays?				for AOD abuse or dependence within: 30 days 7 days			for demographic subgroups Also compare to CMS Medicaid Adult Core Set national median as benchmark
	Follow-Up After ED Visit for Mental Illness (FUM-AD) (CMS #17-2). Follow-Up After Hospital Admission for Mental Illness	NCQA	Yearly	Number of ED visits for members with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness within: 30 days 7 days	Number of ED visits for members with a principal diagnosis of mental illness or intentional self-harm	Claims	Descriptive time series; pre-post one-way ANCOVA comparing baseline average to post-demonstration average, controlling for demographic subgroups Also compare to CMS Medicaid Adult Core Set national median as benchmark

Primary Driver: Increase rates of identification, initiation, engagement, and retention in treatment .							
Hypothesis 13: Medicaid IMD providers will demonstrate consistency in program design and discharge planning policies.							
Research question 13.1: 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.	N/A	Cumulative for interim reporting period, and for summative reporting period.	None	None	Key Informant interviews and document review with SUD providers	Thematic analysis of interviews and documents

CONNECTICUT GOAL 4: Maintain or reduce Medicaid cost of individuals with SUD.

Research question	Measure	Measure Steward	Time Period	Numerator	Denominator ^a	Data Sources	Analytic Method
Primary Driver: Maintain or reduce Medicaid costs for individuals with SUD, where possible							
Hypothesis 14: The Demonstration will be budget neutral to the Federal government.							
Hypothesis 15: Total Medicaid SUD spending during the measurement period will remain constant after adjustment for the new residential services and any other new SUD treatment services including care coordination developed under this Demonstration.							
Research Question 14.1: Will Medicaid maintain or decrease	SUD Spending (CMS #28).	CMS	Yearly	The sum of all Medicaid spending on SUD treatment services.	None	Claims Use provider paid amounts	Descriptive time series

Research question	Measure	Measure Steward	Time Period	Numerator	Denominator ^a	Data Sources	Analytic Method
overall costs after accounting for the newly added residential and withdrawal management services?	SUD Spending within IMDs (CMS #29).	CMS	Yearly	The sum of all Medicaid spending on inpatient/residential treatment for SUD provided within IMDs.	None	Claims Use provider paid amounts	Descriptive time series
	Per Capita SUD Spending (CMS #30).	CMS	Yearly	The sum of all Medicaid spending on SUD treatment services (CMS #28).	Members with a SUD diagnosis (CMS #4)	Claims Use provider paid amounts	Descriptive time series; pre-post one-way ANCOVA statistic comparing baseline average to post-demonstration average, controlling for demographic subgroups
	Per Capital SUD Spending within IMDs (CMS #31).	CMS	Yearly	The sum of all Medicaid spending on inpatient/residential treatment for SUD provided within IMDs (CMS #29).	Number of members with a claim for inpatient/residential treatment for SUD in an IMD	Claims Use provider paid amounts	Descriptive time series; pre-post one-way ANCOVA statistic comparing baseline average to post-demonstration average, controlling for demographic subgroups

Research question	Measure	Measure Steward	Time Period	Numerator	Denominator ^a	Data Sources	Analytic Method
	Total Cost PMPM	CMS SUD Evaluation Design Guidance, Appendix C	Quarterly	The sum of all Medicaid spending (Inpatient, Outpatient, Pharmacy, Long Term Care, Capitation payments, Administrative Costs, Federal Costs) for members with a SUD diagnosis	Member months per quarter for members with a SUD diagnosis	Claims Use provider paid amounts CMS 64 for Federal Costs Data source for administrative costs:	ITS; controlling for demographic subgroups

Analytic Methods

Multiple analytic techniques will be used, 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). Descriptive, content analysis will be used to present data related to process evaluation measures gathered from document reviews, key informant interviews, etc., as discussed previously. Qualitative analysis software (R Qualitative, ATLAS, or similar) will be used to organize documentation, including key informant interview transcripts. Analysis will identify common themes across interviews and documents. In some cases, checklists may be used to analyze documentation (e.g., licensure) for compliance with standards. These data will be summarized in order to describe the activities undertaken for each project milestone, including highlighting specific successes and challenges.

Descriptive statistics including frequency distributions and time series (presentation of rates over time) will be used for quantitative process measures in order to describe the output of specific waiver activities. These analysis techniques will also be used for some short-term outcome measures in cases where the role of the measure is to describe changes in the population, but not to show specific effects of the waiver Demonstration. Where pre-demonstration and post-demonstration rates are comparable, pre-post distributional test will be made to quantify statistical differences in process measures before and after the demonstration.

An ITS will be used to describe the effects of waiver implementation in metrics that are measured on a monthly or quarterly basis. Specific outcome measure(s) will be collected for multiple time periods both before and after start of intervention.

Segmented regression analysis will be used to measure statistically the changes in level and slope in the post-intervention period (after the waiver) compared to the pre-intervention period (before the waiver). The ITS design will be dependent on being able to use similar historical data on specific outcome measures collected from DSS based on SUD services provided prior to the Demonstration. The ITS design uses historical data to forecast the “counterfactual” of the evaluation, that is to say, what would happen if the Demonstration did not occur. We propose using basic time series linear modeling to forecast these “counterfactual” rates for three years following the Demonstration implementation.⁷ The more historical data available, the better these predictions will be. ITS models are commonly used in situations where a contemporary comparison group is not available.⁸ The State has considered options for a contemporary comparison group. Since the Demonstration will target all adult and adolescent non-expansion and expansion Medicaid members in need of SUD services, the only viable groups for comparison within the State would be those covered with private insurance, which would include a very different demographic population.

For this Demonstration, establishing the counterfactual is somewhat nuanced. The driver diagram and evaluation hypotheses assume that Demonstration activities will have overall positive impacts on outcome measures. The figure below illustrates an

⁷ E Kontopantelis (2015). Regression based quasi-experimental approach when randomisation is not an option: interrupted time series analysis. British Medical Journal (BMJ). Available at: <https://www.bmj.com/content/350/bmj.h2750>.

⁸ Ibid.

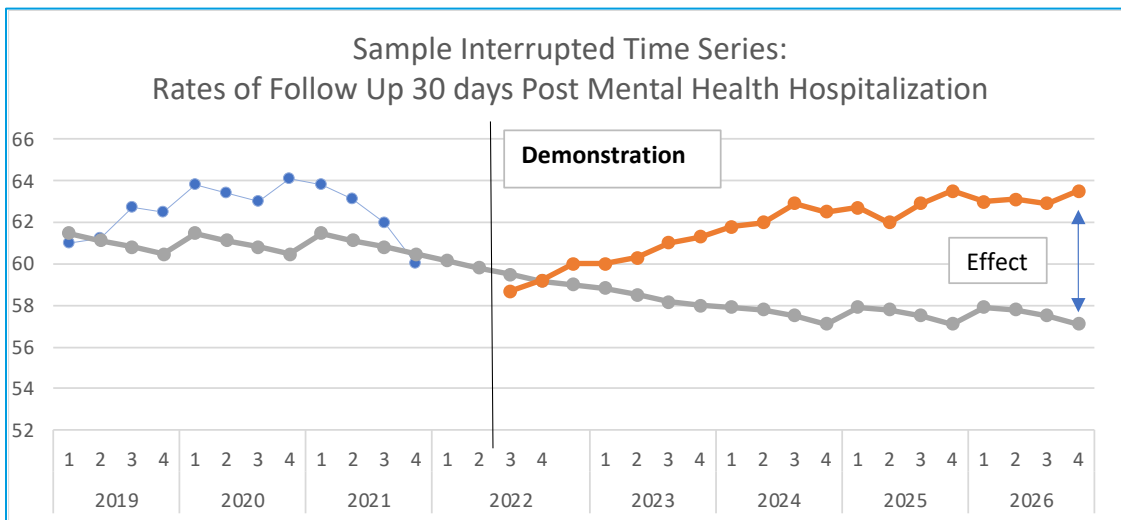
ITS design that uses basic regression forecasting to establish the counterfactual — this is represented by the grey line in the graphic. The counterfactual is based on historical data (the blue line). It uses time series averaging (trend smoothing) and linear regression to create a predicted trend line (shown below as the grey line). The orange line in the graph is the (sample) actual observed data. Segmented regression analysis will be used to measure statistically the changes in level and slope in the post-intervention period compared to the predicted trend (see “effect” in the graph below).

$$Y_t = \beta_0 + \beta_1 T + \beta_2 X_t + \beta_3 TX_t$$

Where β_0 represents the baseline observation, β_1 is the change in the measure associated with a time unit (quarter or year) increase (representing the underlying pre-intervention trend), β_2 is the level change following the intervention and β_3 is the slope change following the intervention (using the interaction between time and intervention: TX_t).⁹

This can be represented graphically as follows.

Figure 1: (SAMPLE data only) Rates of Follow-Up Post Mental Health Hospitalization



Pre-demonstration data from January 1, 2018 to March 30, 2022 will be calculated using the monthly, quarterly, or annual period of time as specified in the CMS technical specifications for each metric. Trends in these data for each measure will be used to predict the counterfactual (what would have happened without the Demonstration). Outcomes measures will be calculated beginning April 1, 2022 through the end of the waiver Demonstration project (March 31, 2027). A discussion of including confounding variables (e.g., COVID-19, other SUD efforts) is included in the next section.

⁹ Bernal JL, Cummins S, Gasparrini A. "Interrupted time series regression for the evaluation of public health interventions: a tutorial" (2017 Feb.). International Journal of Epidemiology 46(1): 348-355.

Quantitative outcome measures with yearly measurement periods that are expressed as averages or proportions will be analyzed with pre-post tests. While two or three pre-demonstration measurement periods for yearly metrics may not be enough information to establish a trend for the ITS analysis, pre-post analyses may reveal differences in outcomes before and after the Demonstration. One-way analysis of covariance, or t-tests will be used to compare pre-demonstration averages with post-demonstration averages, and chi-square tests will be used to compare proportions.

Qualitative analysis will utilize data collected from three main sources: 1) key informant interviews with State staff working on implementation efforts, ASO representatives, and providers, 2) key process documentation (e.g., policy and procedure manuals, guidance documents), and 3) provider addendums. Informant sampling will be largely based on convenience/snowball sampling where key stakeholders provide initial lists of potential interviewees, based on their perspective on Demonstration implementation activities. Meeting minutes listing attendees will also be reviewed to identify potential interviewees. ASO staff and provider staff will also be included. Because this likely will be a large number of people, the independent evaluator will work with the State to determine whether to conduct focus groups with these populations, or to engage in a strategic stratified sampling process. The latter will ensure representation across the industry, and from providers stratified by geography/location, size, and services provided. Document reviews will include meeting minutes, policy and procedure documents, provider contracts, and others identified during the qualitative analysis process. Themes will be identified by multiple coders who review documents, identify initial themes, then collaborate in the creation of a central list of primary and secondary themes.

Key informant interviews and document reviews will occur at four critical junctures: initially, prior to the mid-point assessment, prior to the interim evaluation report being written, and prior to the final summative evaluation report being finalized. Specifically, the initial qualitative analysis will occur October 2024–December 2024. The second qualitative analysis will occur October 2025–December 2025. The third qualitative analysis will occur March 2026–May 2026. The final qualitative analysis will occur April 2027–June 2027 if the waiver is not renewed.

Section 4

Methodological Limitations

There are two primary limitations to the evaluation methodology presented here. The first involves issues of data quality and data sources that either: 1) are not sufficient to conduct the analysis proposed here (e.g., not enough historical data for needed prior time periods), or 2) contain errors. An additional limitation is related to the design itself because this evaluation plan relies heavily on descriptive, time series analysis, and qualitative data, this evaluation will describe what happened after the Demonstration was implemented, but it will be difficult to isolate why changes occurred. In other words, it will be difficult to directly attribute changes after waiver implementation to the activities undertaken as part of the waiver. Each of these limitations is discussed in greater detail within this section.

Some of the metrics being computed by Mercer will be calculated for the historic period using non-Medicaid data for residential services. Both Mercer and the Department are working closely to request and test extracts of pre-demonstration data. While it is unclear at this time the degree to which it will be possible to generate historical data needed to forecast the slope of the “counterfactual” trend line (what would have happened without the Demonstration), Mercer has access to this historical data and utilized it in the past. This historical data is an important component of the ITS design, but also supports the descriptive time series analysis. In particular, there will be a limitation in estimating the slope of what the trend line would be without the Demonstration if the data is not sufficient to model what would have happened without implementation.

While the ITS design is the strongest available research method, in the absence of a randomized trial or matched control group, there are some threats to the validity of results in the design.¹⁰ The primary threat is that of history, or other changes over time happening during the waiver period. This ITS design is only valid to the extent that the Demonstration program was the only thing that changed during the evaluation period. Other changes to policies or programs could affect the outcomes being measured under the Demonstration. Mercer will attempt to control this threat by considering other policy and program changes happening concurrent to the waiver period interventions. At a minimum, we will use qualitative methods, in the form of key informant interviews, to identify other initiatives or events may have occurred during the Demonstration that might influence Demonstration effects. Mercer will conduct a qualitative assessment of these likely impacts and will use time series analysis to show how trends may have changed at these critical time periods. In order to isolate the effects of these efforts, Mercer will also conduct additional iterations of the ITS. Using identified critical time points as additional variables, we will test whether other major efforts had a statistically significant impact in the post-demonstration waiver trend. The analysis will note the

¹⁰ Penfold RB, Zhang F. “Use of interrupted time series analysis in evaluating health care quality improvements.” *Academic Pediatrics*, 2013 Nov-Dec, 13(6Suppl): S38-44.

dates of other changes and analyze the degree to which the slope of the trend line changes after implementation of other interventions are made.

The impact of COVID-19 most likely affected the pre-demonstration period, and Mercer anticipates a statically significant impact on most metrics. Therefore, in the initial forecasting within the ITS model, the independent evaluator will include a COVID-19 covariant for the start of the pandemic in the forecast model. Essentially, the ITS for this evaluation will create two counterfactual scenarios using historical data. Mercer will create a “without” COVID-19 forecast using historical data only prior to March of 2020 as one potential counterfactual to compare against actual trends. If we can establish sufficient data points between March 2020 and the waiver start date of April 2022, we can estimate the COVID-19 impact on the forecast. Mercer will also create a forecast with data through the pre-demonstration period (up to January 2021) that includes data during the times COVID-19 was prevalent in the State. As long as COVID-19 remains prevalent during the Demonstration period, we anticipate that using the “with COVID-19” model as the counterfactual will be more accurate. Additional covariate time periods can be added to the model if there are significant shifts in either COVID-19 prevalence numbers or policy shifts (e.g., new stay at home orders) in the State. Mercer will also qualitatively explore how COVID-19 impacted the implementation of the waiver, based on data from key informant interviews.

A related threat to the validity of this evaluation is external (history such as the pandemic). Because we have not identified a comparison group (a group of Medicaid members who would be eligible for the waiver interventions but who will not receive them and/or for whom data will not be collected), it will be difficult to attribute causality. It will be less certain whether the changes observed in outcomes are due entirely to the waiver interventions, rather than some external, outside cause (including other program and policy changes described earlier). However, the ITS design controls for this threat to some degree, by linking what would have likely happened (e.g., forecasting the trajectory of counts and rates over time) without any program changes and comparing this forecast to actual changes over time. To strengthen this design as much as possible, as many data points will be collected as possible across multiple years preceding waiver changes. This will allow for adjustment of seasonal or other, cyclical variations in the data. Additionally, the design will examine multiple change points and identifying key areas of major program and policy adjustments, so that with each major milestone accomplishment, corresponding changes to metrics can be observed

The ITS analysis will also include a sensitivity analysis to determine the degree to which specific ITS assumptions impact the analysis. Specifically, the degree to which the assumption that trends in time are linear versus non-linear will be addressed. Additionally, this model assumes that changes will occur directly after the intervention. However, it is possible that for some outcomes, there will be a lag between the start of the waiver and observed outcomes.

Mercer will also attempt to limit this threat to validity by triangulating our data. Claims data trends across multiple time periods will be compared to trends happening at other points in time (other large policy or program shifts that might influence the slope of the trend in addition to the demonstration). Also, key informant interviews will be used to inform the quantitative findings and explain the degree to which individuals are seeing

demonstration impacts. Mercer will also attempt to seek out national and other State data for benchmarking, that will allow us to determine whether Connecticut is performing in a similar fashion to other demonstration states, non-demonstration states, or national benchmarks overall.

According to the literature on ITS analysis, estimating the level and slope parameters requires a minimum of eight observations before and after implementation in order to have sufficient power to estimate the regression coefficients.¹¹ Evaluators will need to work closely with the DSS, DMHAS, and their respective data teams to gather as many data points as possible and discuss limitations within the evaluation findings if enough points cannot be collected.

It should also be noted that ITS cannot be used to make inferences about any one individual's outcomes as a result of the waiver. Conclusions can be drawn about changes to population rates, in aggregate, but not speak to the likelihood of any individual Medicaid member having positive outcomes as a result of the waiver.

Qualitative data, while useful in confirming quantitative data and providing rich detail, can be compromised by individual biases or perceptions. Key informant interviews, for example, represent a needed perspective around context for Demonstration activities and outcomes. However, individuals may be limited in their insight or understanding of specific programmatic components, meaning that the data reflects perceptions, rather than objective program realities. The evaluation will work to address these limitations by collecting data from a variety of different perspectives to help validate individuals' reports. In addition, standardized data collection protocols will be used in interviews and interviewers will be trained to avoid "leading" the interviewee or inappropriately biasing the interview. It will also utilize multiple "coders" to analyze data and will create a structured analysis framework, based on research questions that analysts will use to organize the data and to check interpretations across analysts. Finally, results will be reviewed with stakeholders to confirm findings.

¹¹ Ibid.
Mercer

Section 5

Attachments

As part of the STCs, as set forth by CMS, the Demonstration project is required to arrange with an independent party to conduct an evaluation of the SUD Demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. Mercer, through a request for proposal (RFP) process, contracts to provide technical assistance to DSS, including this independent evaluation work.

Mercer was selected as the waiver evaluator. Mercer will develop the Evaluation Design, calculate the results of the study, evaluate the results for conclusions, and write the Interim and Summative Evaluation Reports.

Mercer has over 25 years of experience assisting state governments with the design, implementation, and evaluation of publicly sponsored health care programs. Mercer currently has over 25 states under contract and has worked with over 35 different states in total. They have assisted states like Arizona, Connecticut, Missouri, and New Jersey in performing independent evaluations of their Medicaid programs; many of which include 1115 Demonstration waiver evaluation experience. Given their extensive experience, the Mercer team is well equipped to work effectively as the external evaluator for the Demonstration project. The table below includes contact information for the lead coordinators from Mercer for the evaluation:

Name	Position	Email Address
Charles Lassiter	Engagement Leader	charles.lassiter@mercer.com
Shawn Thiele Sacks, LCSW	Program Manager	shawn.thiele.sac@mercer.com
Vinaya Krishnaswamy	Project Manager	vinaya.krishnaswamy@mercer.com
Brenda Jenney, PhD	Statistician	brenda.jenney@mercer.com
Tonya Aultman-Bettridge, PhD	Evaluator	taultman-bettridge@triwestgroup.net
Laurie Klanchar, RN, MSN	Clinician	laurie.klanchar@mercer.com
Brenda Jackson, MPP	Specialty Consulting Sector	brenda.jackson@mercer.com

Appendix A

Conflict of Interest Statement

Connecticut (DSS) has taken steps to ensure that Mercer 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's Government specialty practice 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's Government group is the designated primary operating group 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's Government group. 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's Government group 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 regards 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

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.

Appendix B

Evaluation Budget

	DY 1	DY2	DY3	DY4	DY5	Final Evaluation	Total Evaluation Cost
	2021	2022	2023	2024	2025	6/30/2027	
State of Connecticut							
DSS	\$100,000*	\$50,000**	\$50,000	\$50,000	\$50,000	\$50,000	\$350,000

*Estimates based on 1) Demonstration Year 1 (DY1) data infrastructure and data sharing protocol build between Departments and vendor; and 2) staff review of DY1 deliverables.

**Estimates for DY2–DY5 based on State of Connecticut review of annual, ongoing deliverables.

Evaluation Budget — Independent Evaluator/Contractor — Mercer Hours					
	Senior Consultant	Junior Consultant	Consultant	Project Management	Total Hours
Evaluation Activities					
Develop and draft Evaluation Design	288	72	--	30	390
Revise drafted Evaluation Design	28	7	--	--	35
Draft Interim Evaluation report	72	18	--	26	116
Finalize Interim Evaluation report	40	10	--	--	50
Draft Summative Evaluation report	92	23	--	26	141
Finalize Summative Evaluation report	40	10	--	--	50

Evaluation Budget — Independent Evaluator/Contractor — Mercer Hours					
	Senior Consultant	Junior Consultant	Consultant	Project Management	Total Hours
Data Activities					
Load, validate, and scrub raw data — Evaluation measures for Annual reports.	--	250	250	10	510
Load, validate, and scrub raw data — Evaluation measures for Interim and Final Evaluation report	148	148	35	--	331
File mapping to standardize file format — Evaluation measures for Annual reports.	100	195	100	10	405
File mapping to standardize file format — Evaluation measures for Interim and Final Evaluation report	--	128	128	10	266
Initial programming/validation of code for measure development — Evaluation measures (37)	88	10	88	--	186
Run and validate programming/coding for each measure, generate the measures — Evaluation measures for annual reports. (10 measures; 40 hours/year; 10 PM)	--	100	100	10	210
Statistical measures for the evaluation: Interim and Final report (300 hours/report)	100	250	250	10	610
Final Total:					3,300

Evaluation Budget — Independent Evaluator/Contractor — Mercer Costs									
	FY1 – DY1	FY2 – DY1, 2	FY3 – DY2, 3	FY4 – DY3, 4	FY5 – DY4, 5	FY6 – DY5	FY7 – DY6	FY8	Total Cost
Evaluation Activities									
Develop and draft Evaluation Design	\$115,140	--	--	--	--	--	--	--	\$ 115,140
Revise drafted Evaluation Design	--	\$10,465	--	--	--	--	--	--	\$ 10,465
Draft Interim Evaluation report	--	--	--	--	\$33,410	--	--	--	\$ 33,410
Finalize Interim Evaluation report	--	--	--	--	--	\$14,950	--	--	\$ 14,950
Draft Summative Evaluation report	--	--	--	--	--	--	\$40,885	--	\$ 40,885
Finalize Summative Evaluation report	--	--	--	--	--	--	--	\$14,950	\$ 14,950
Data Activities									
Load, validate, and scrub raw data — Evaluation measures for Annual reports.	--	\$27,750	\$27,750	\$27,750	\$27,750	\$27,750	--	--	\$ 138,750
Load, validate, and scrub raw data — Evaluation measures for Interim and Final Evaluation report (190 hours initial	--	\$52,975	--	\$30,263	--	--	\$30,263	--	\$ 113,501

Evaluation Budget — Independent Evaluator/Contractor — Mercer Costs									
	FY1 – DY1	FY2 – DY1, 2	FY3 – DY2, 3	FY4 – DY3, 4	FY5 – DY4, 5	FY6 – DY5	FY7 – DY6	FY8	Total Cost
File mapping to standardize file format — Evaluation measures for Annual reports.	--	\$44,163	\$17,650	\$17,650	\$17,650	\$17,650	--	--	\$ 114,763
File mapping to standardize file format — Evaluation measures for Interim and Final Evaluation report	--	--	--	\$34,694	--	\$34,694	--	--	\$ 69,388
Initial programming/validation of code for measure development — Evaluation measures (37)	--	\$172,744	--	--	--	--	--	--	\$ 172,744
Run and validate programming/coding for each measure, generate the measures — Evaluation measures for Annual reports.	--	\$12,600	\$12,600	\$12,600	\$12,600	\$12,600	--	--	\$ 63,000

Evaluation Budget — Independent Evaluator/Contractor — Mercer Costs									
	FY1 – DY1	FY2 – DY1, 2	FY3 – DY2, 3	FY4 – DY3, 4	FY5 – DY4, 5	FY6 – DY5	FY7 – DY6	FY8	Total Cost
Statistical measures for the evaluation: Interim and Final report	--	--	--	\$78,250	--	\$78,250	--	--	\$ 156,500
Final Total:									\$ 1,058,446

Appendix C

Potential Timeline and Major Deliverables

The table below highlights key evaluation milestones and activities for the waiver and the dates for completion.

Deliverable	STC Reference	Date
Submit evaluation design plan to CMS	36	October 11, 2022
Final evaluation design due 60 days after comments received from CMS	36	60 days after comments received from CMS
Mid-point assessment due	29	No later than 60 days after March 31, 2025
Draft Interim Report due	40	March 31, 2026
Final Interim Report due 60 days after CMS comments received	40(d)	60 days after comments received from CMS
Draft Summative Evaluation Report due 18 months following demonstration	41	Within 18 months after March 31, 2027 if the waiver is not renewed
Final Summative Evaluation Report due 60 days after CMS comments received	41(a)	60 days after comments received from CMS



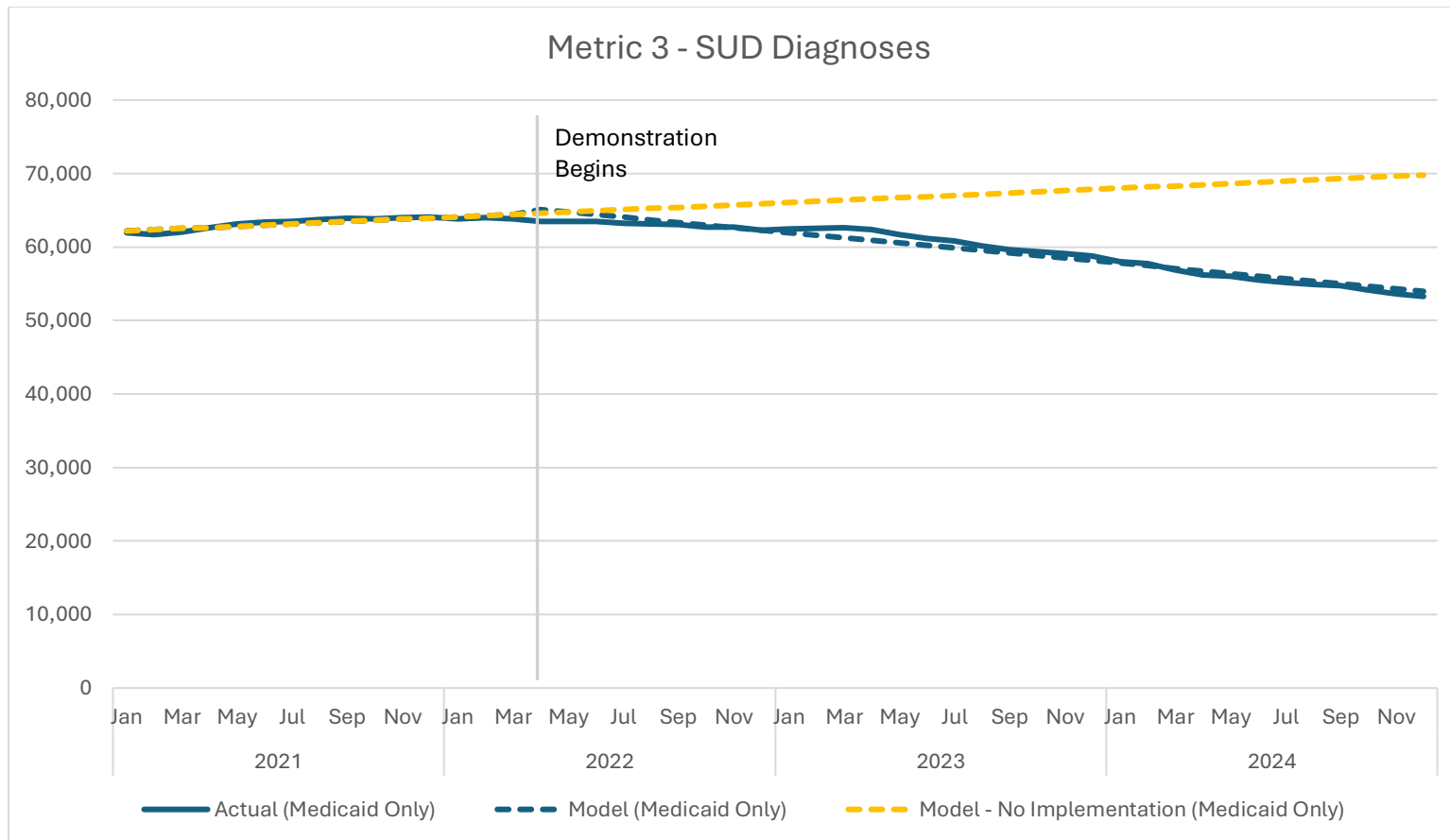
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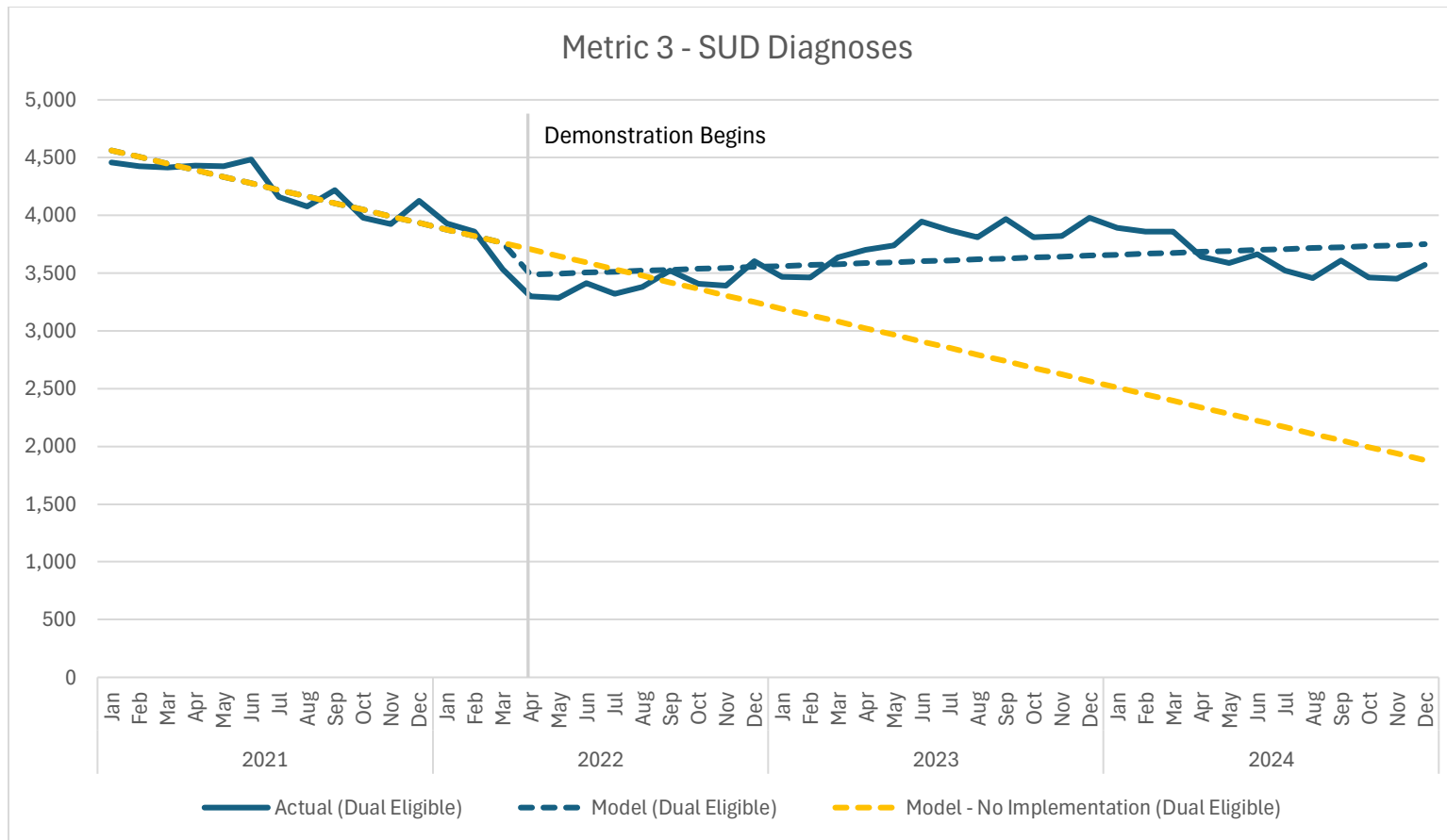
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Appendix B

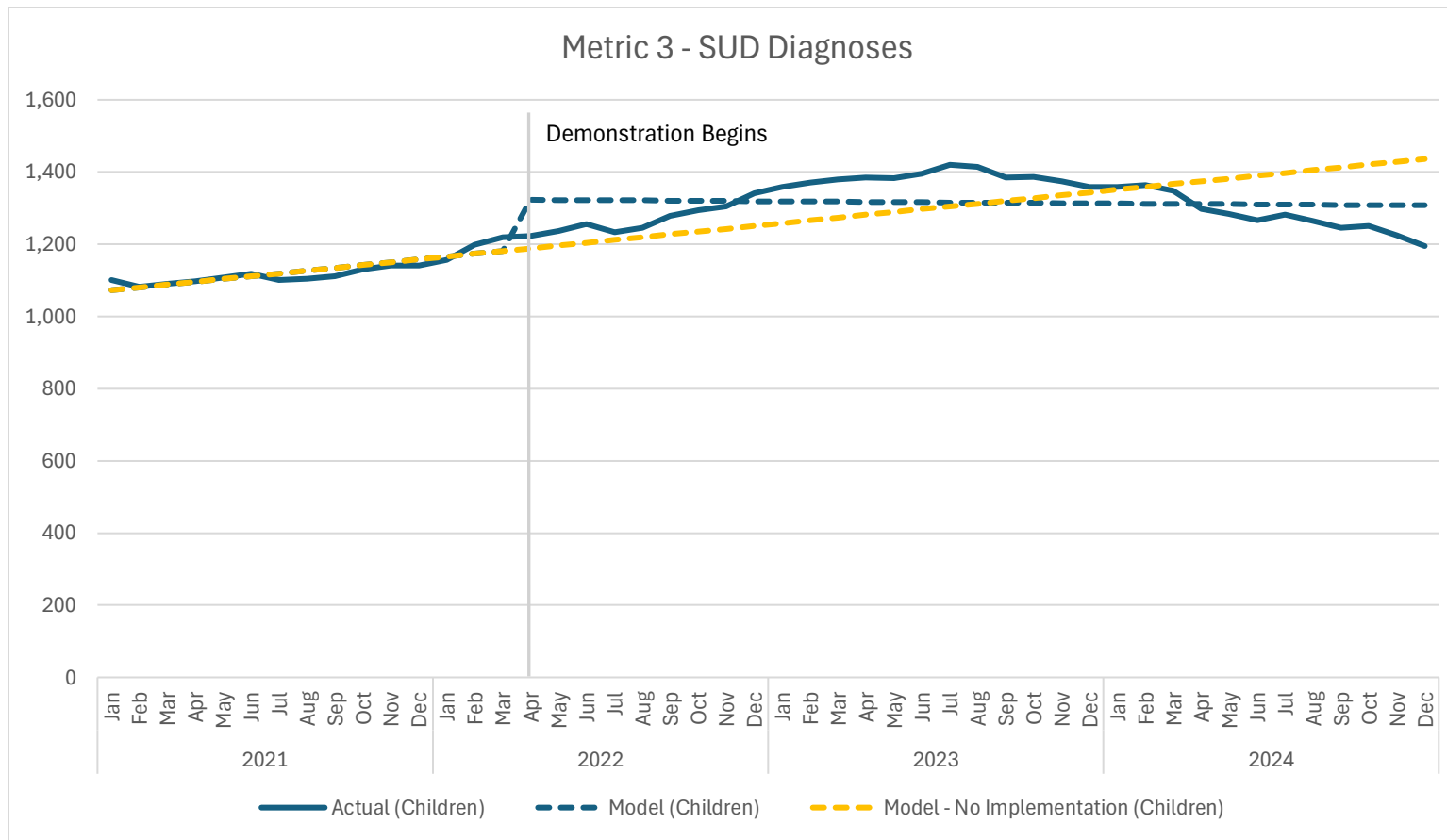
All ITS Charts and Tables



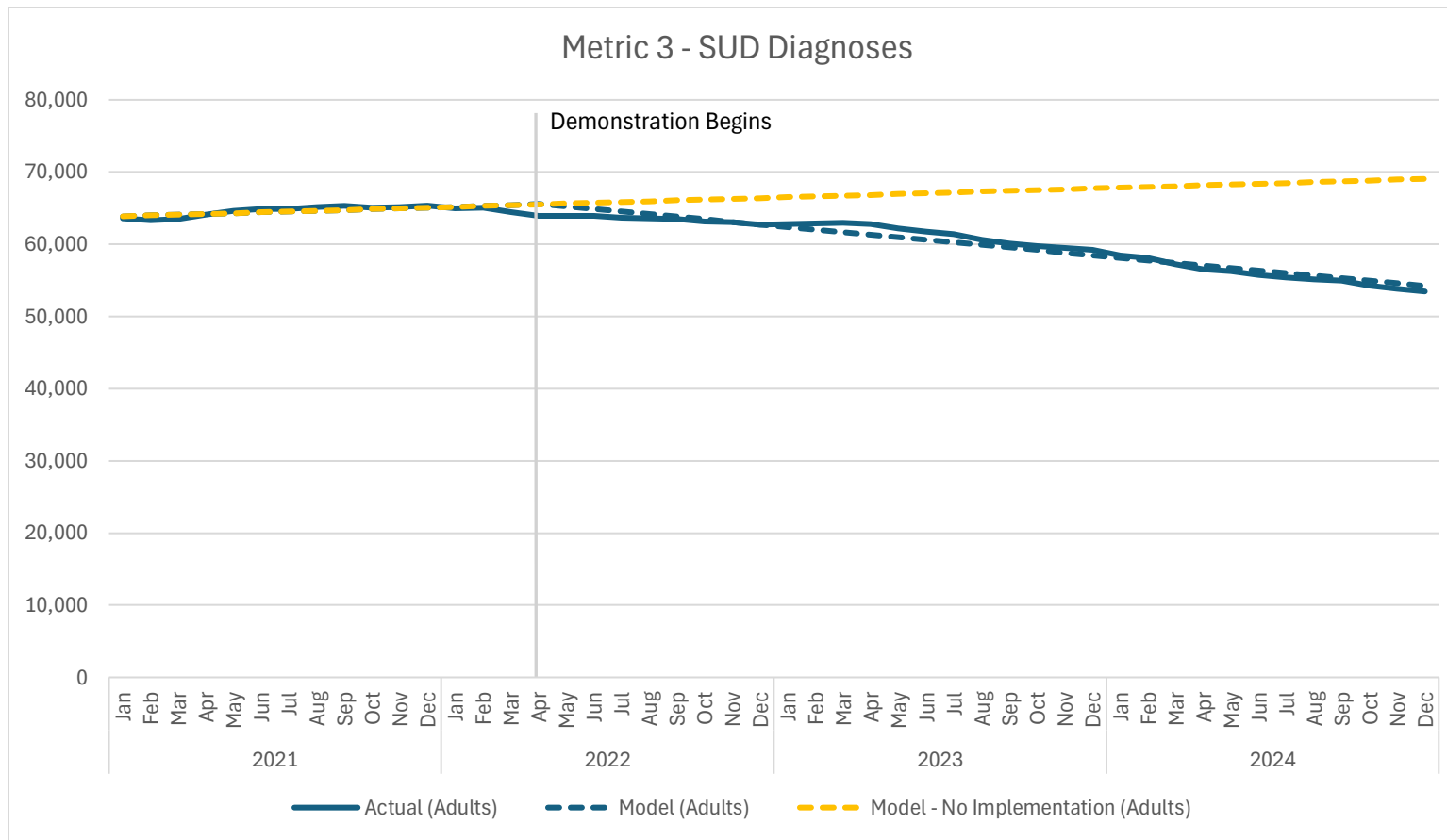
Metric 3 – Medicaid Only Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	103.96798	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-7,663.29	-9,185.44	-6,141.15



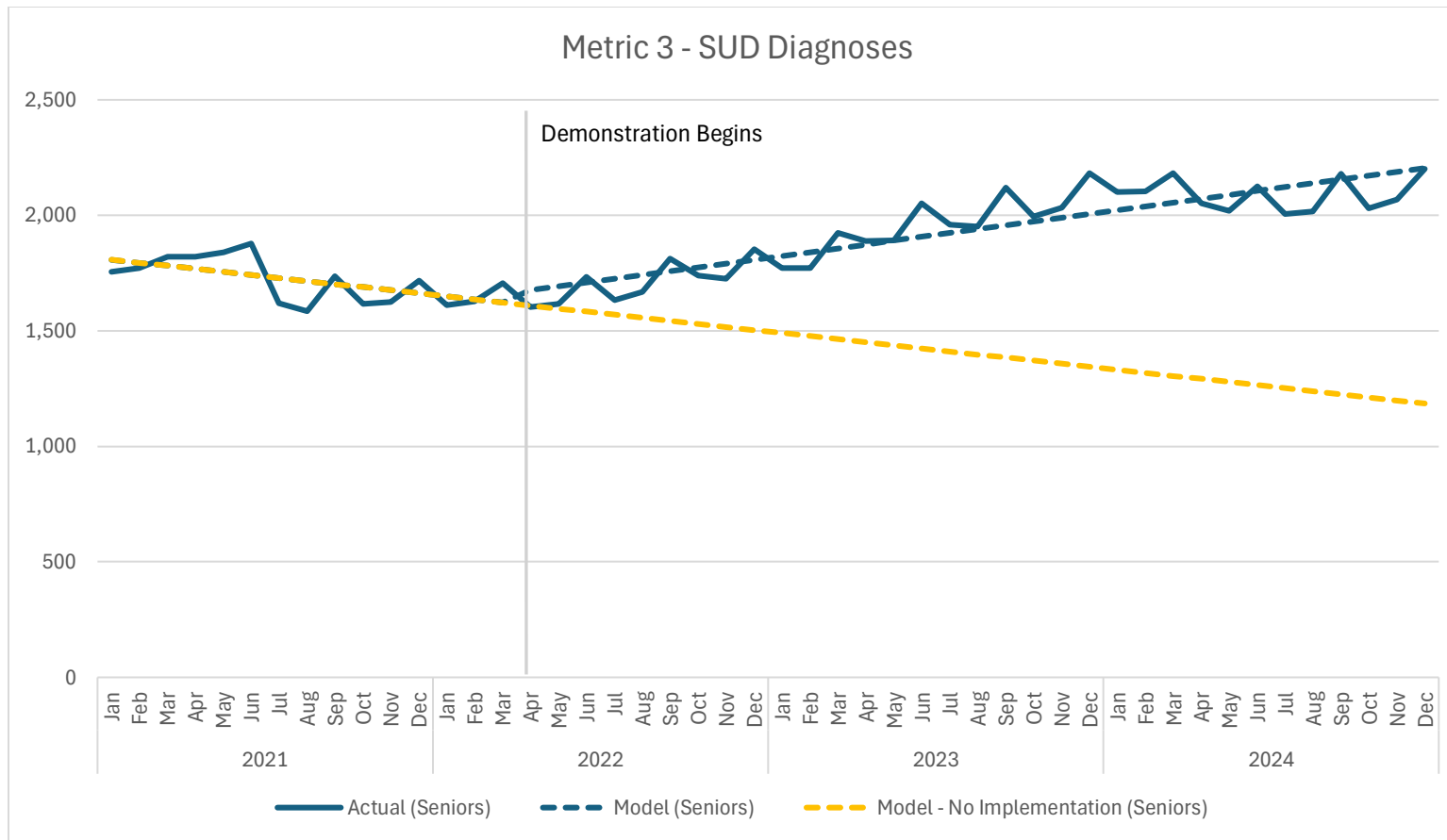
Metric 3 – Dual Eligible Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	50.208491	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	824.77	575.79	1,073.75



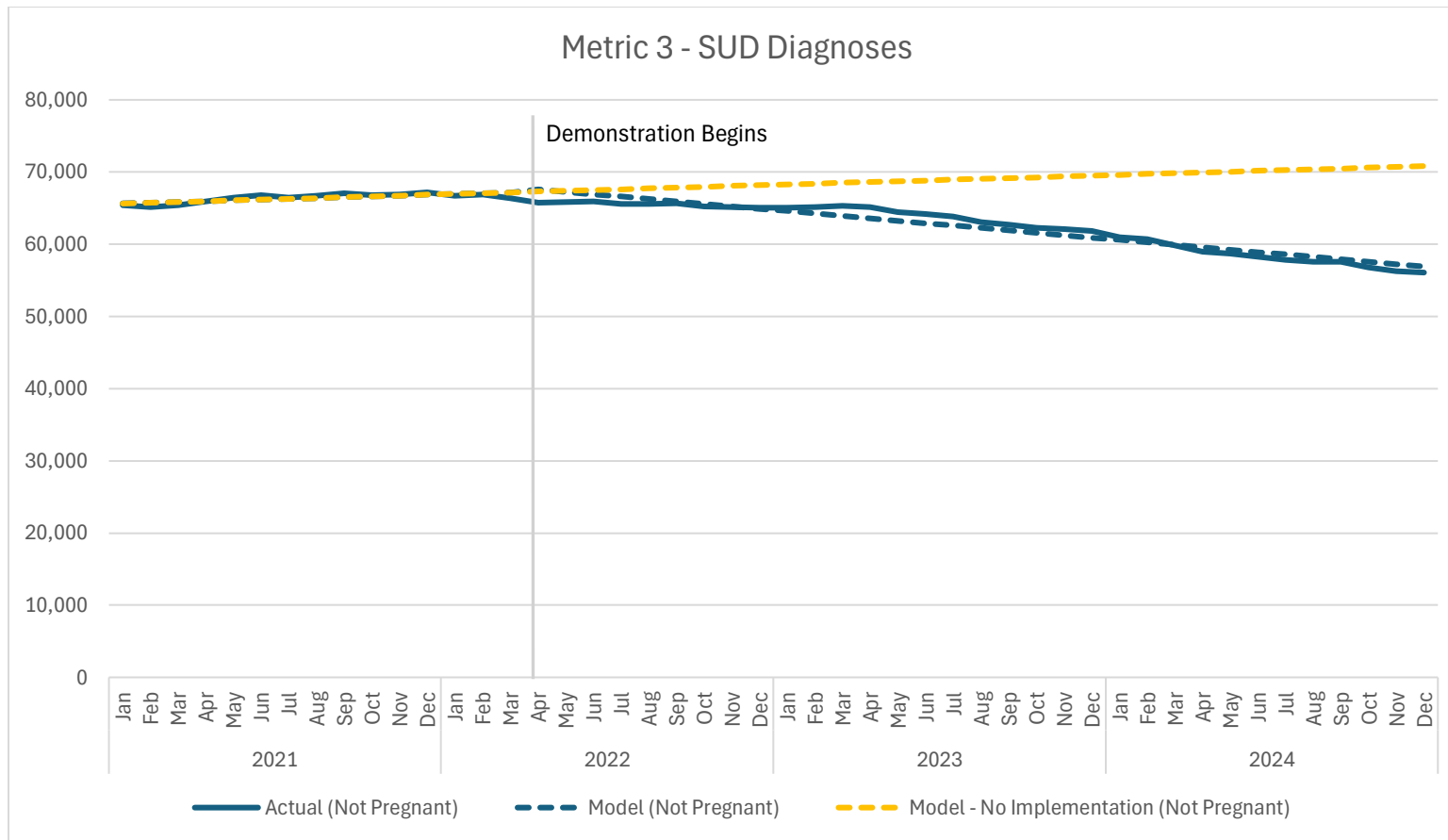
Metric 3 – Children Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	11.441571	-2	0.003
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	2.89	-98.40	104.18



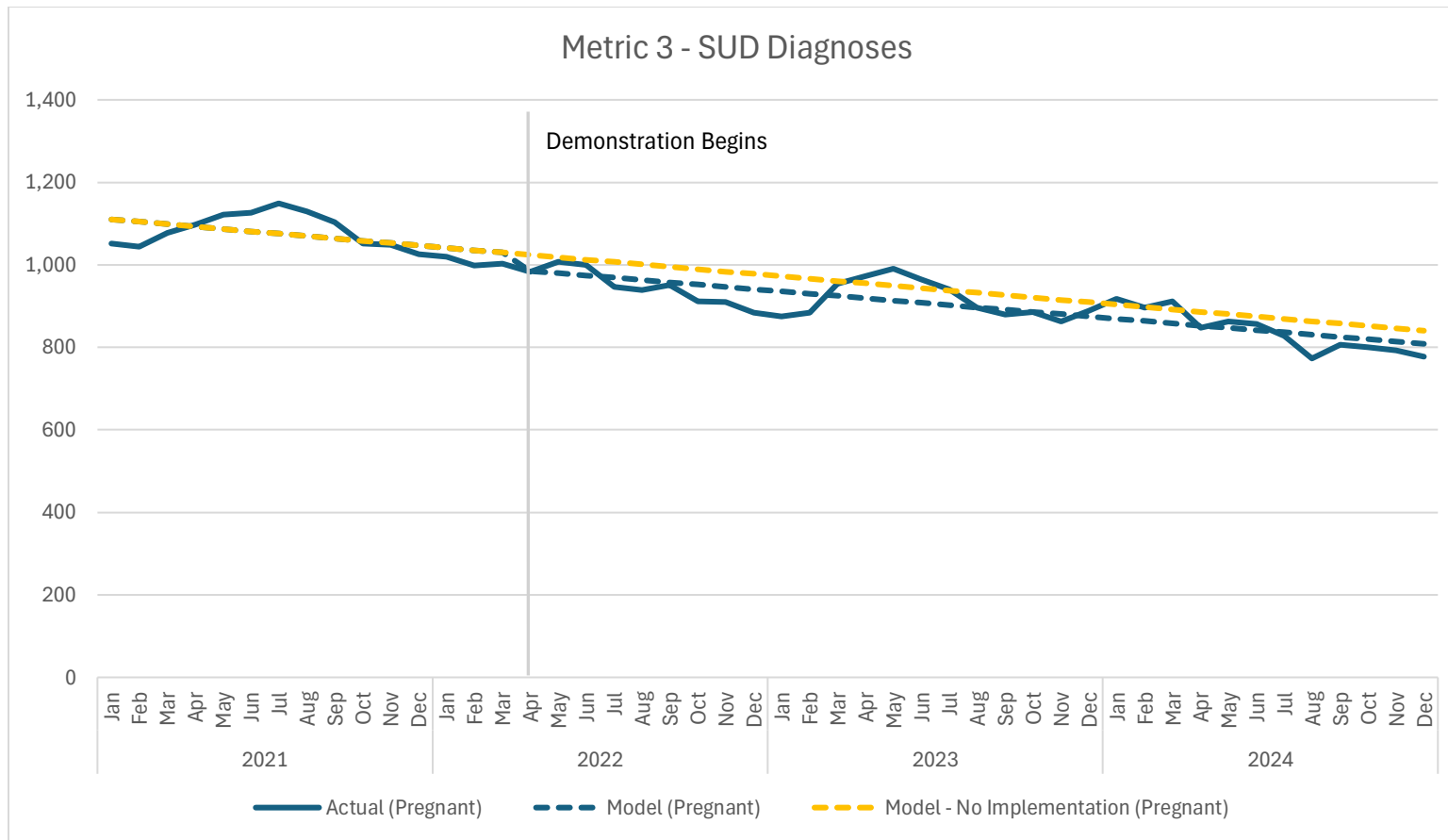
Metric 3 – Adults Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	64.322664	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-7,383.69	-9,229.22	-5,538.15



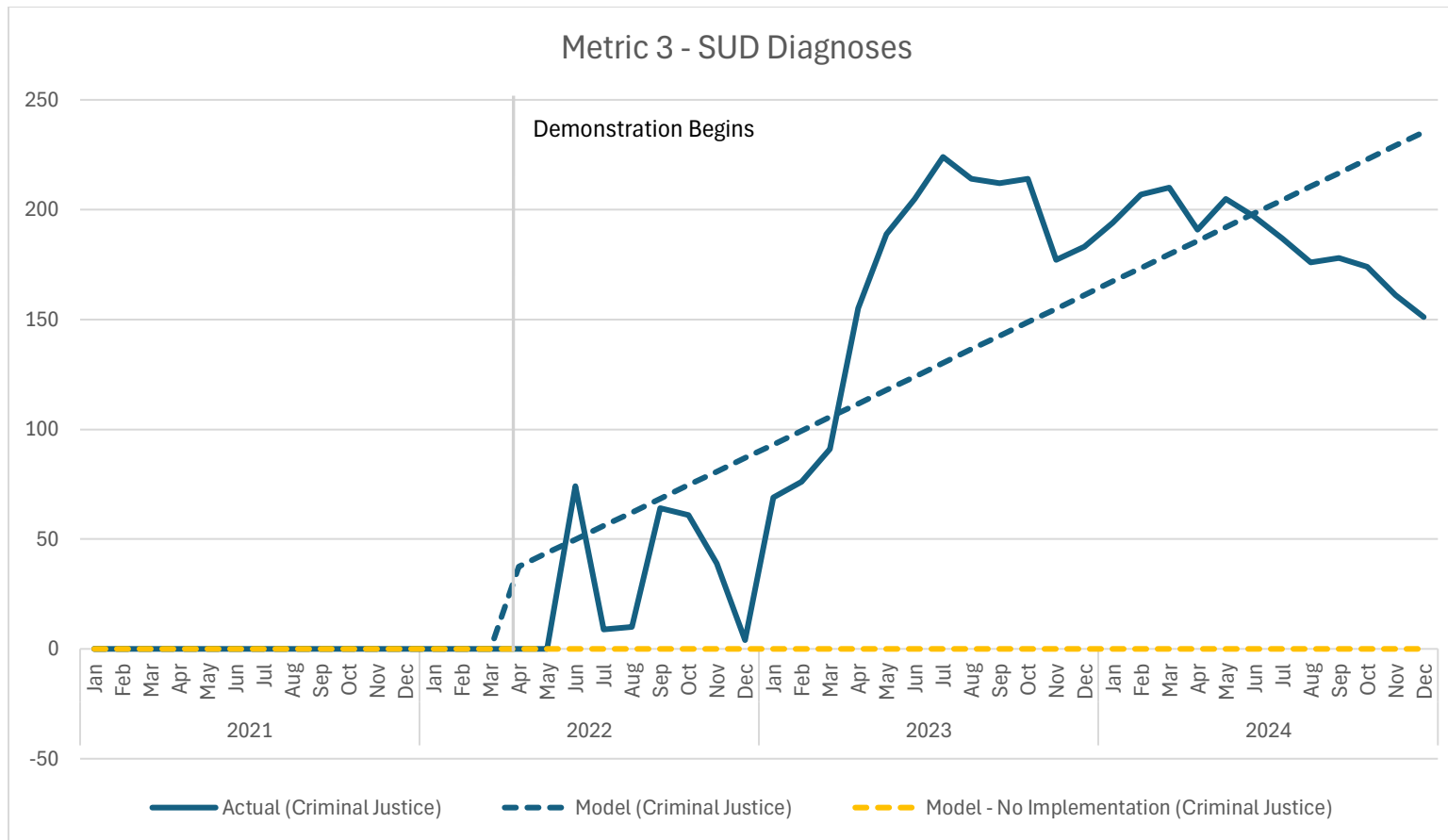
Metric 3 – Seniors Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	94.714754	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	542.27	400.38	684.16



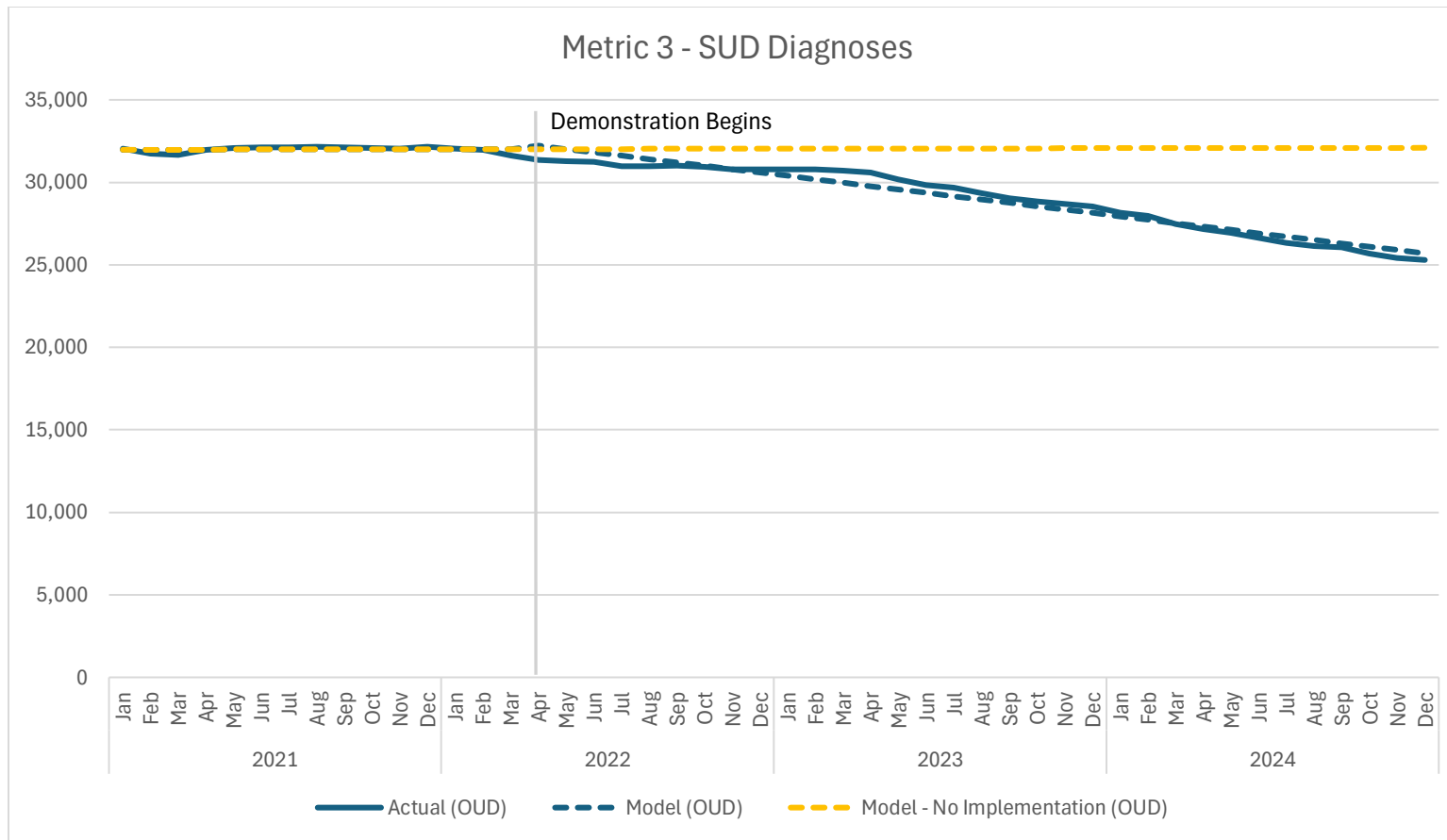
Metric 3 – Not Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	72.890385	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-6,803.26	-8,392.00	-5,214.52



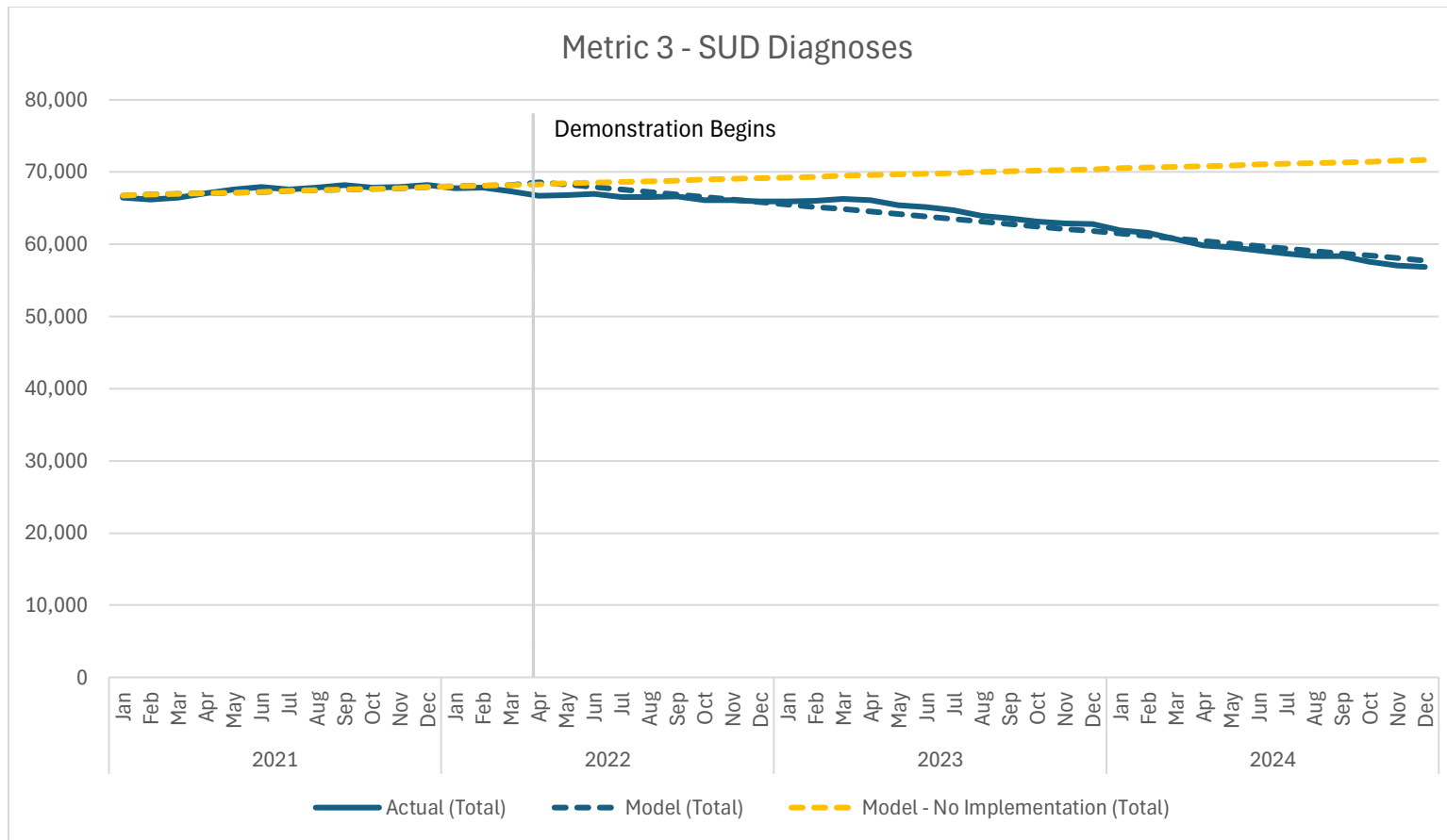
Metric 3 – Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	3.3755595	-2	0.185
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-35.26	-198.28	127.75



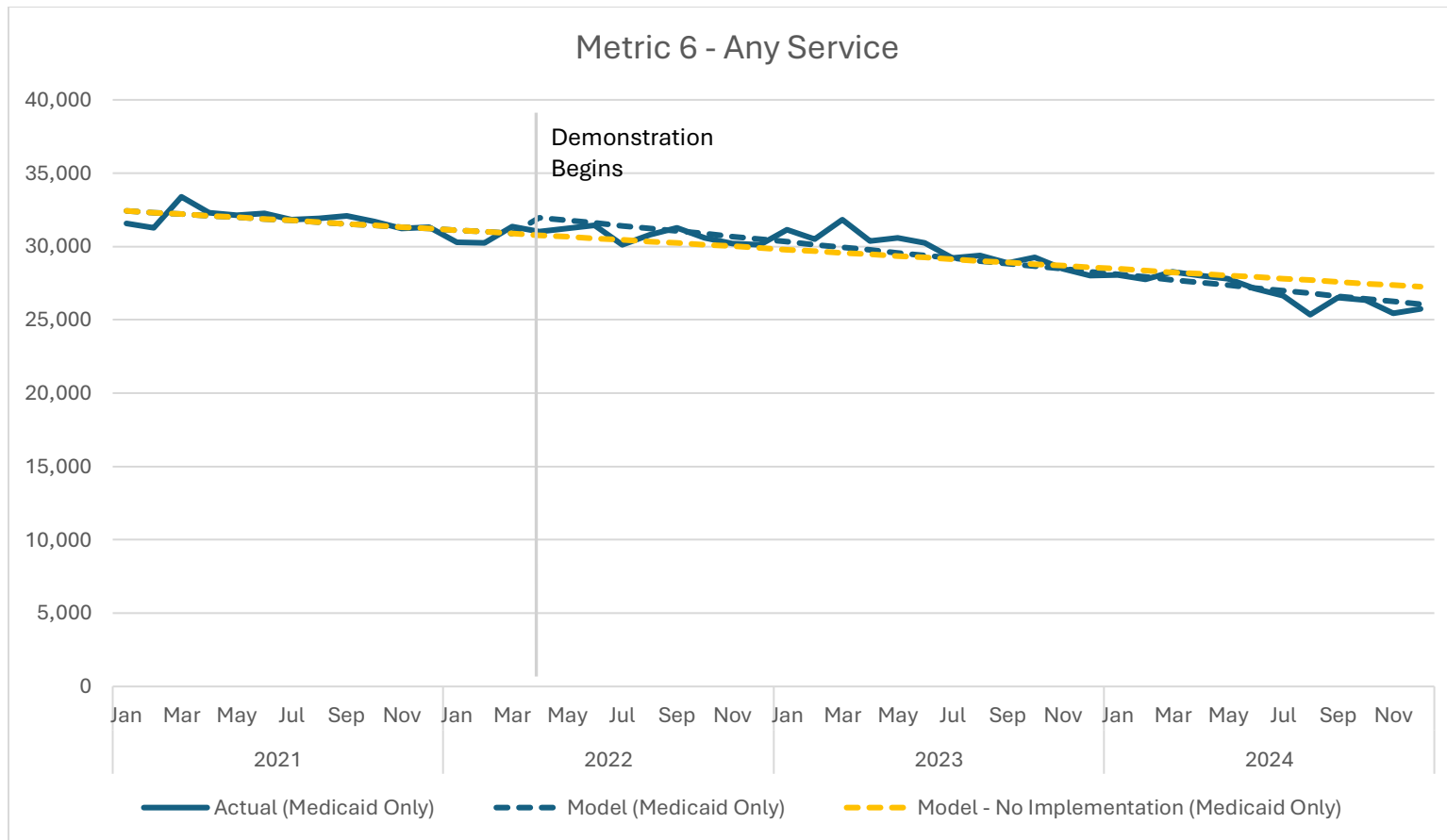
Metric 3 – Criminal Justice Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	61.910419	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	136.39	100.15	172.64



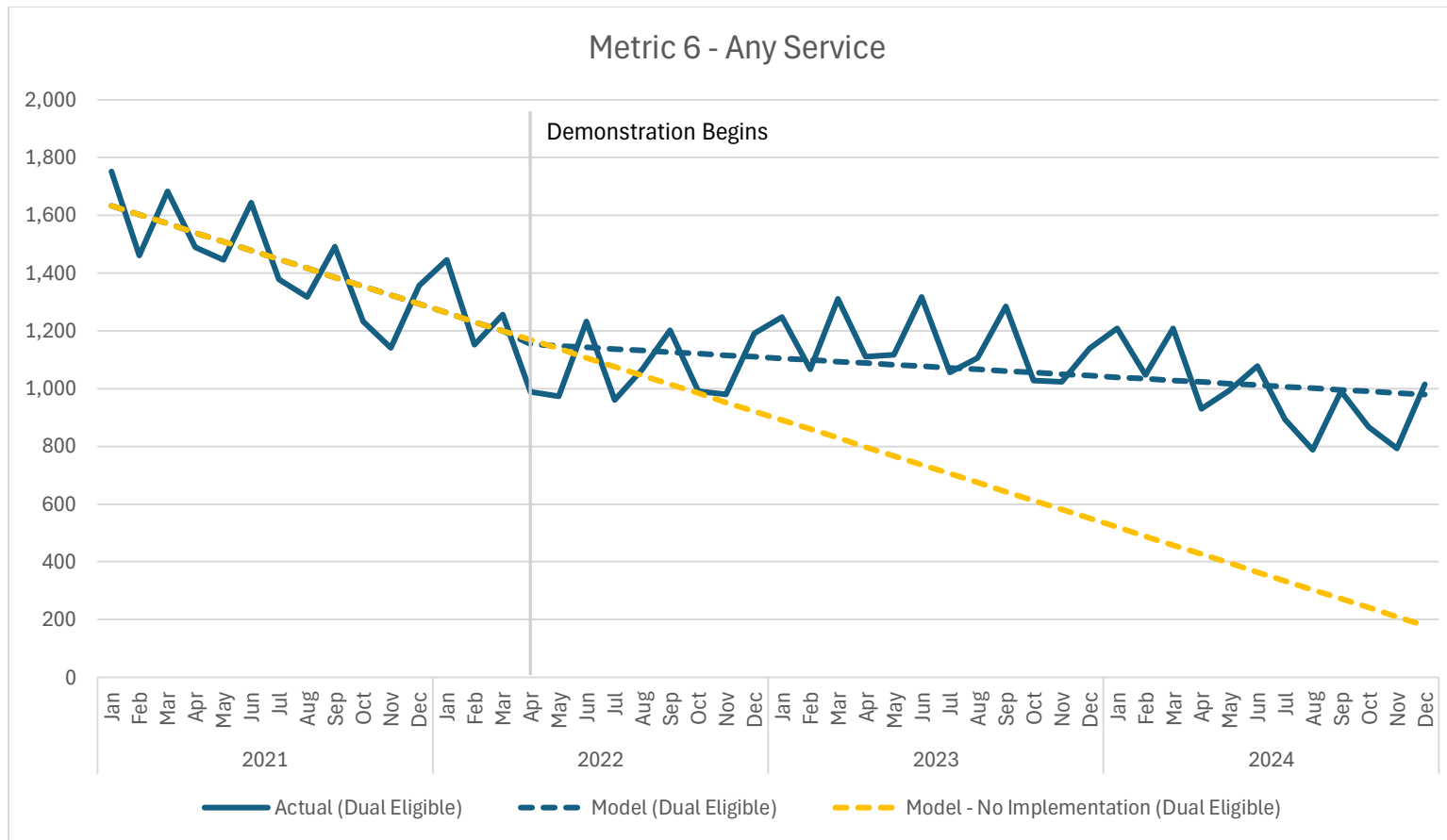
Metric 3 – OUD Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	106.24123	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-3,098.22	-3,698.05	-2,498.39



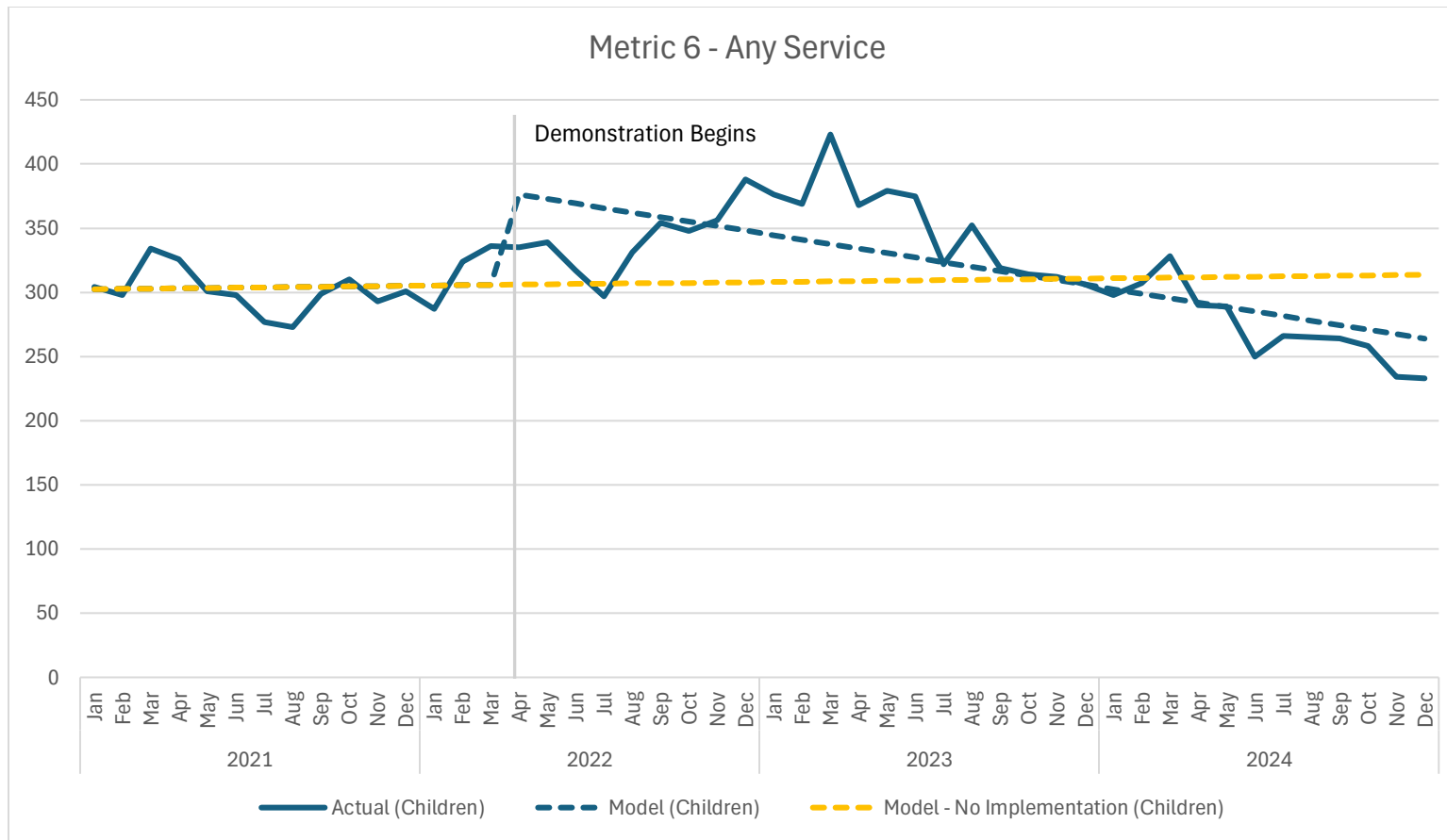
Metric 3 – Total Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	62.36452	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-6,838.52	-8,569.51	-5,107.54



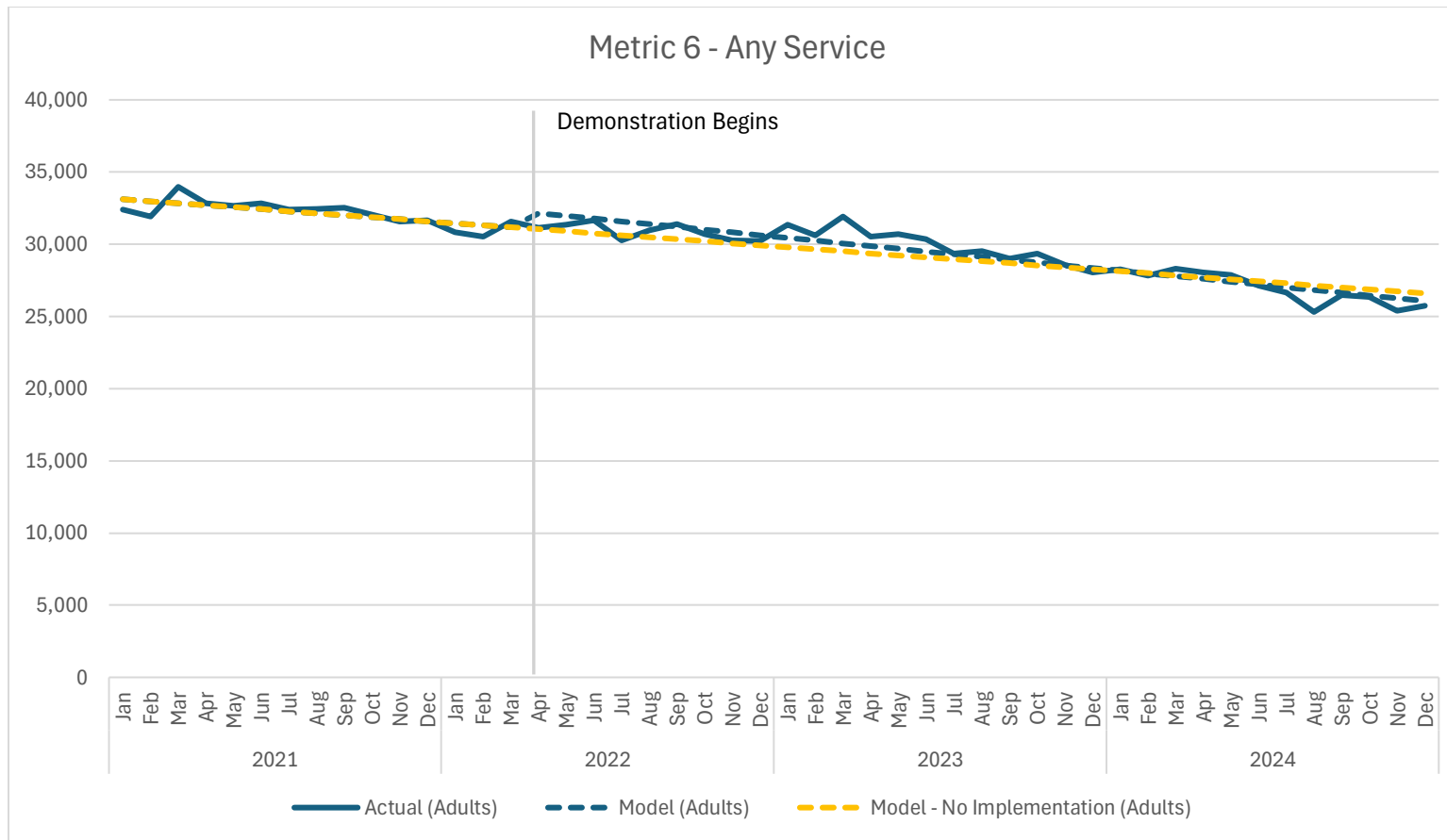
Metric 6 – Medicaid Only Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	10.420781	-2	0.005
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	1.96	-1,481.16	1,485.08



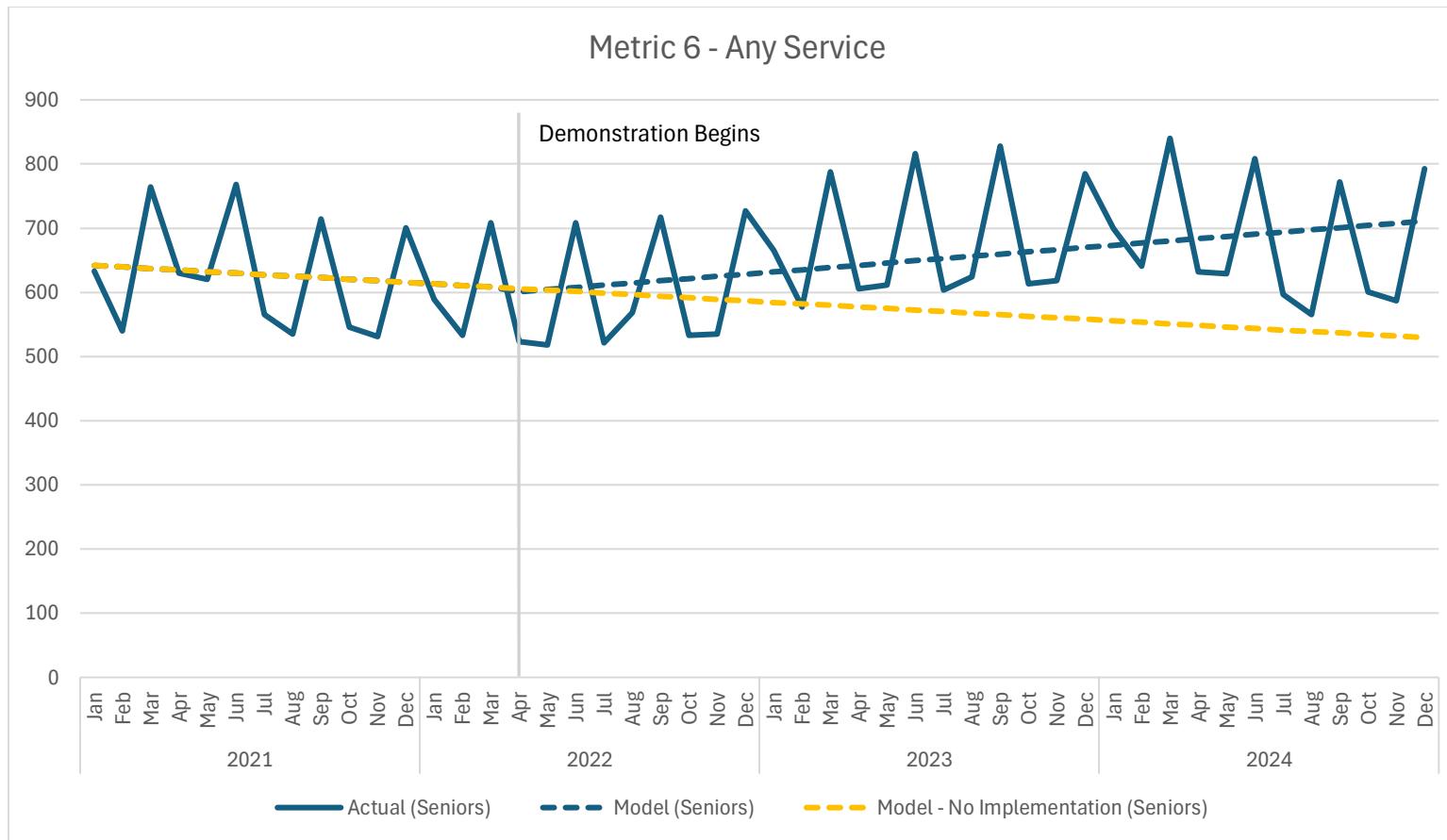
Metric 6 – Dual Eligible Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	55.082601	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	392.38	222.79	561.97



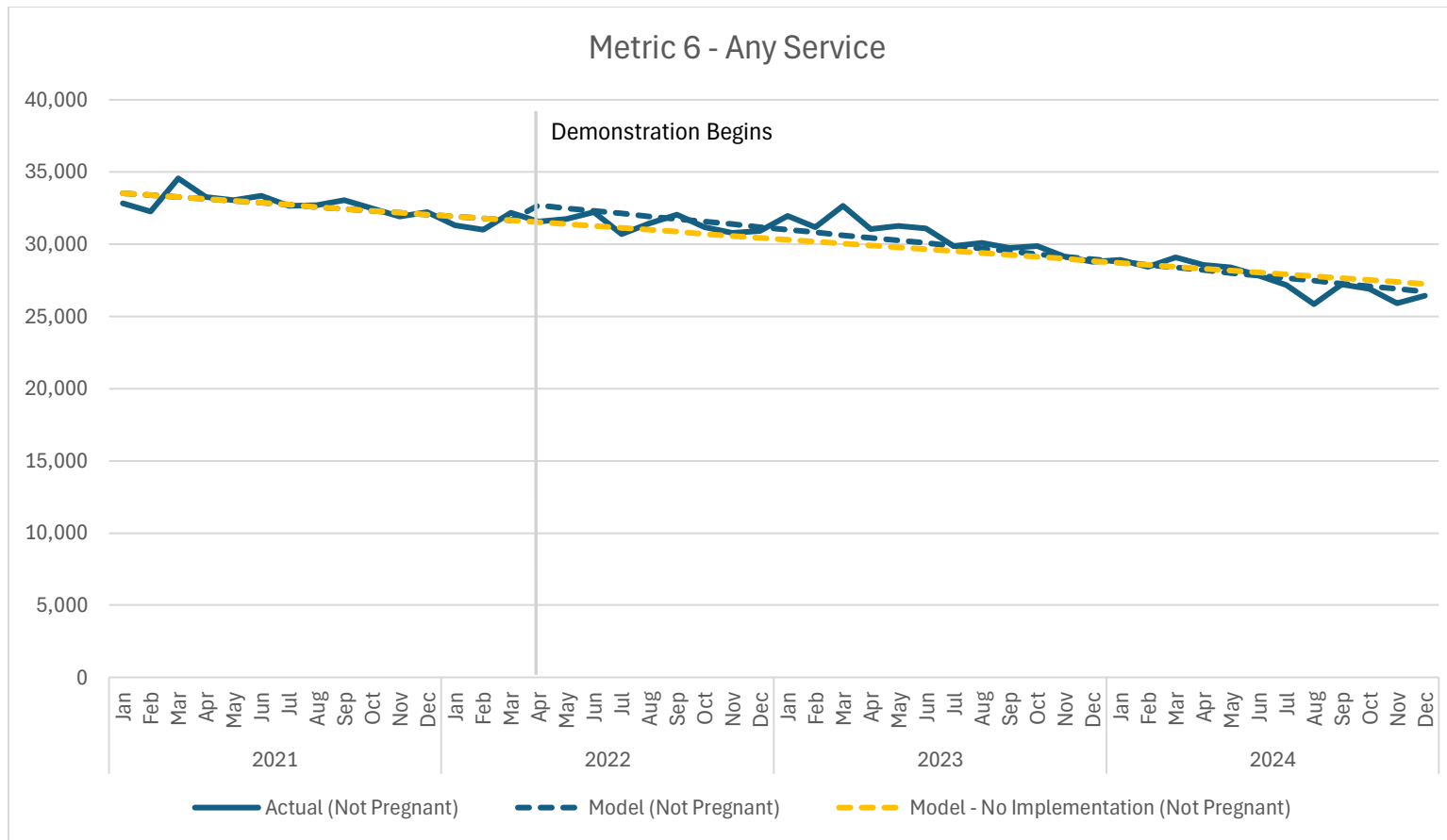
Metric 6 – Children Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	12.095785	-2	0.002
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	10.25	-55.56	76.06



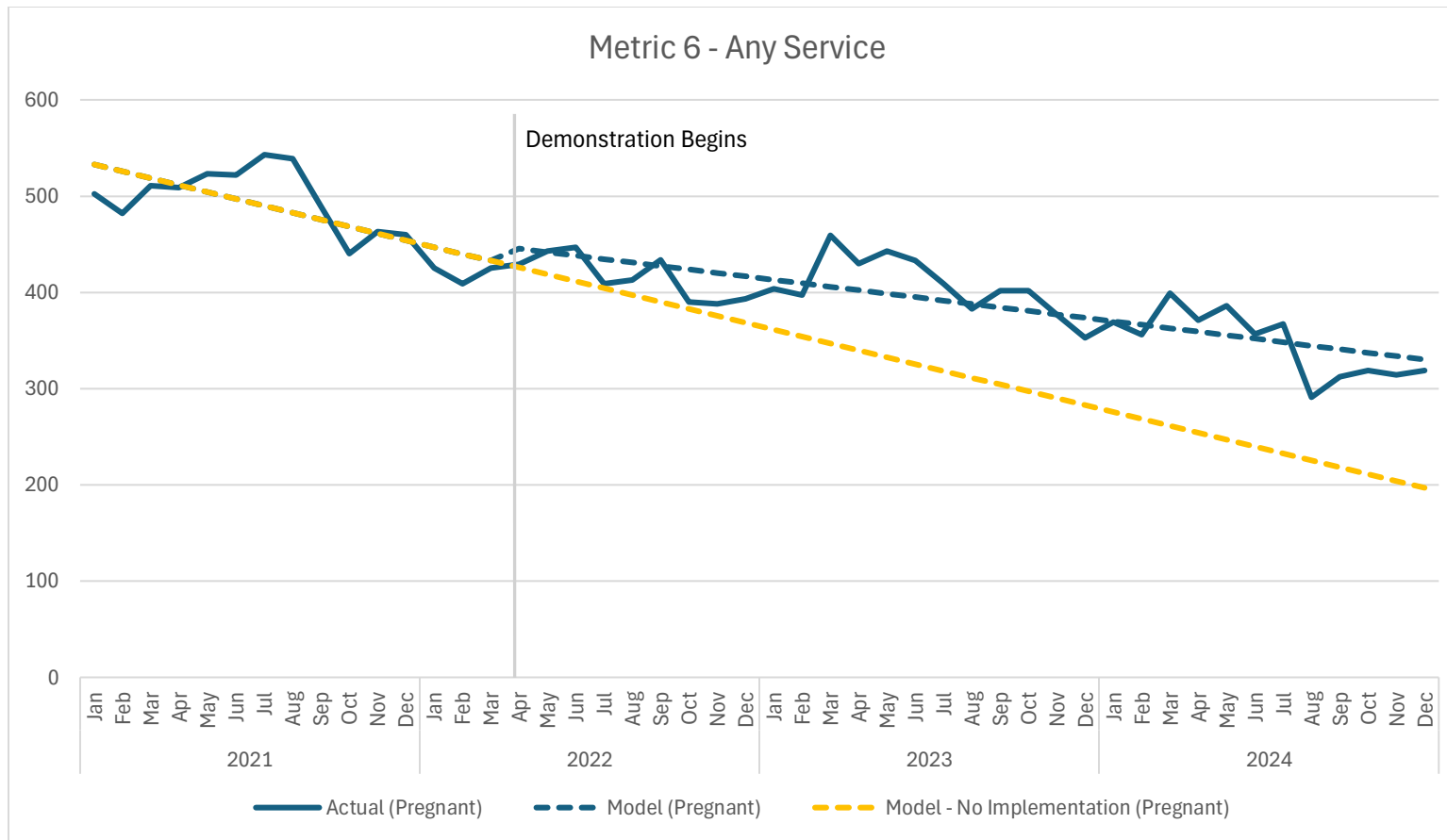
Metric 6 – Adults Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	7.5663829	-2	0.023
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	295.74	-1,094.05	1,685.53



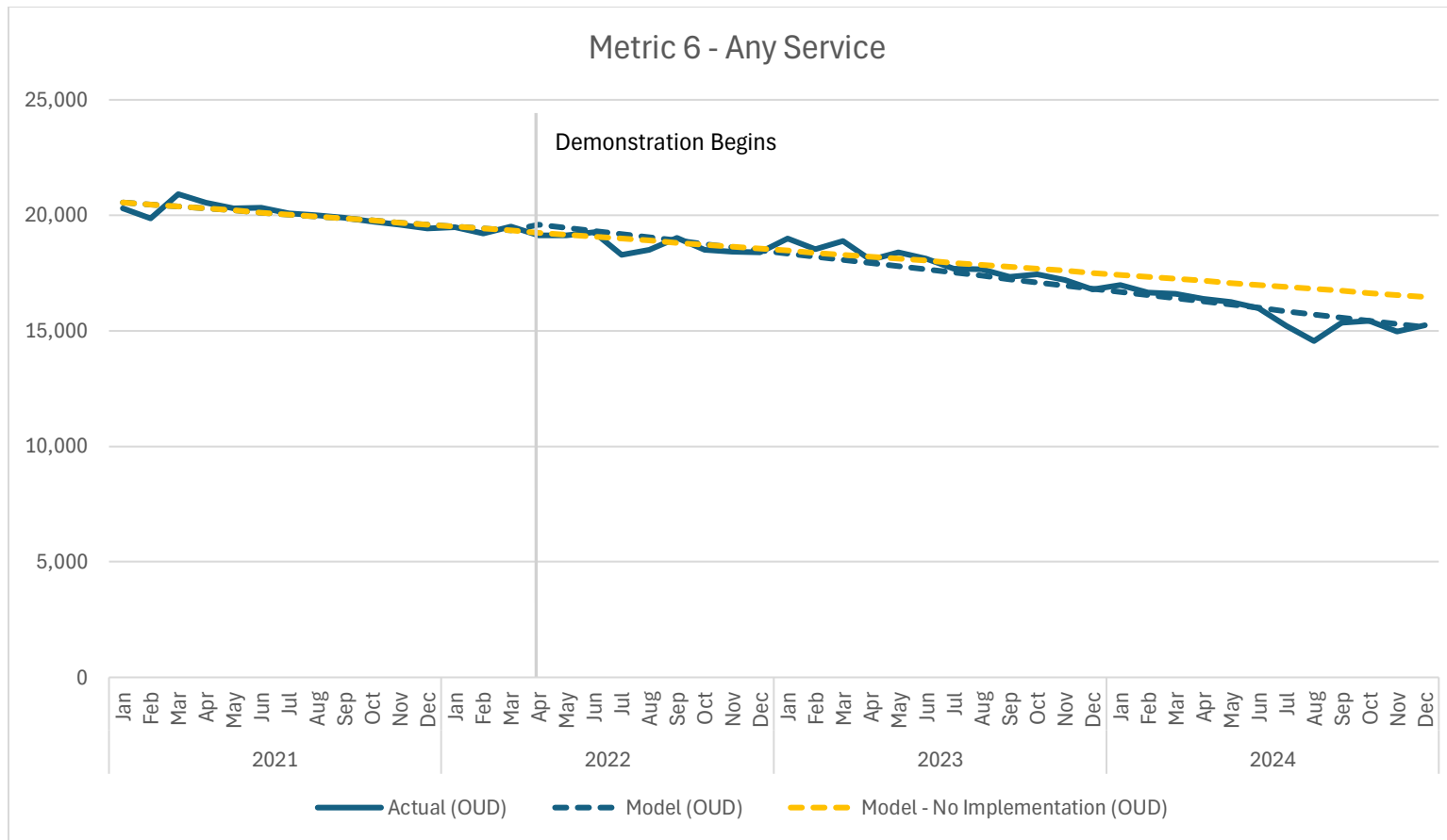
Metric 6 – Seniors Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	8.3570192	-2	0.015
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	88.36	-11.13	187.84



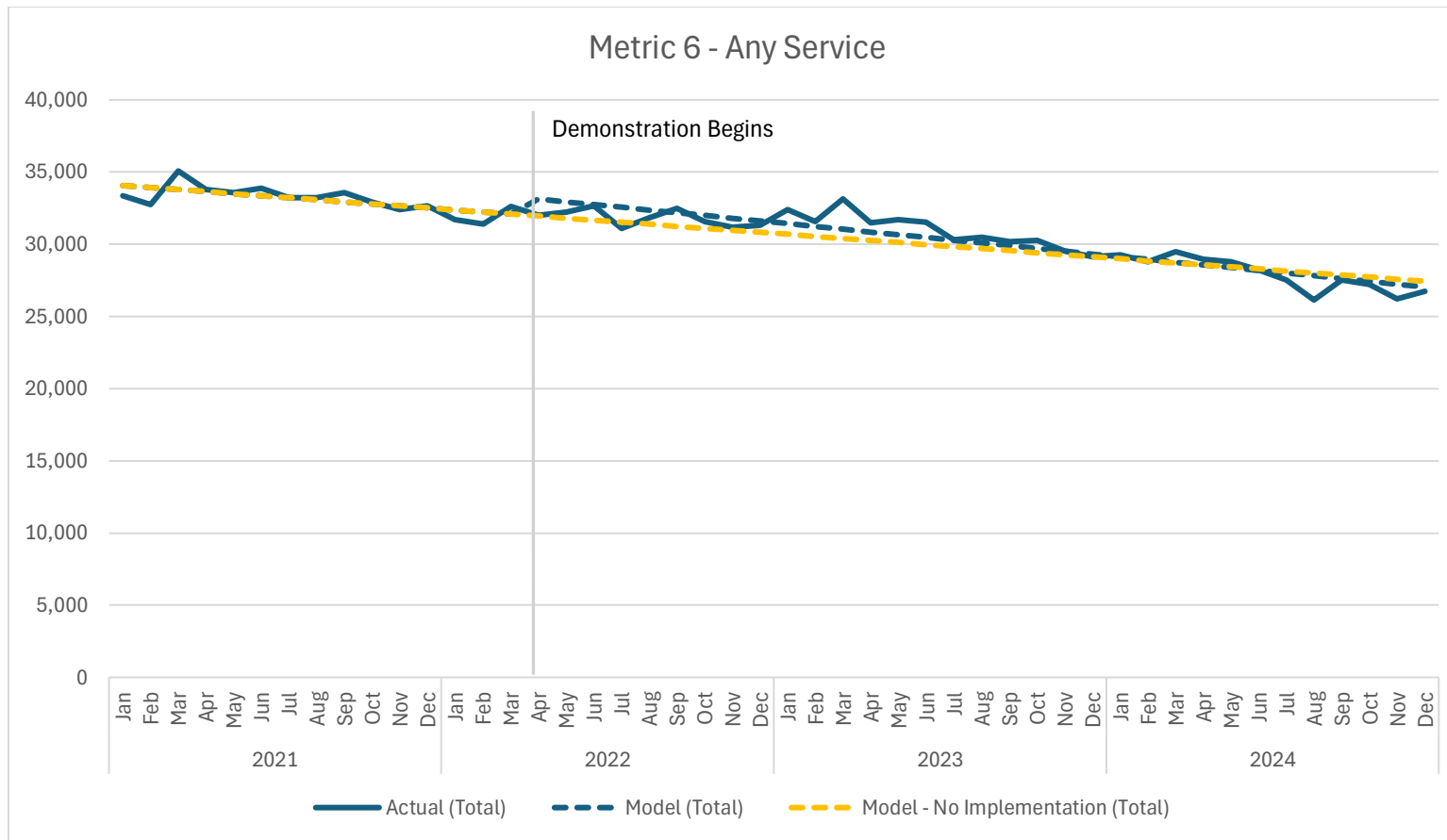
Metric 6 – Not Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	6.6549925	-2	0.036
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	317.81	-1,008.74	1,644.37



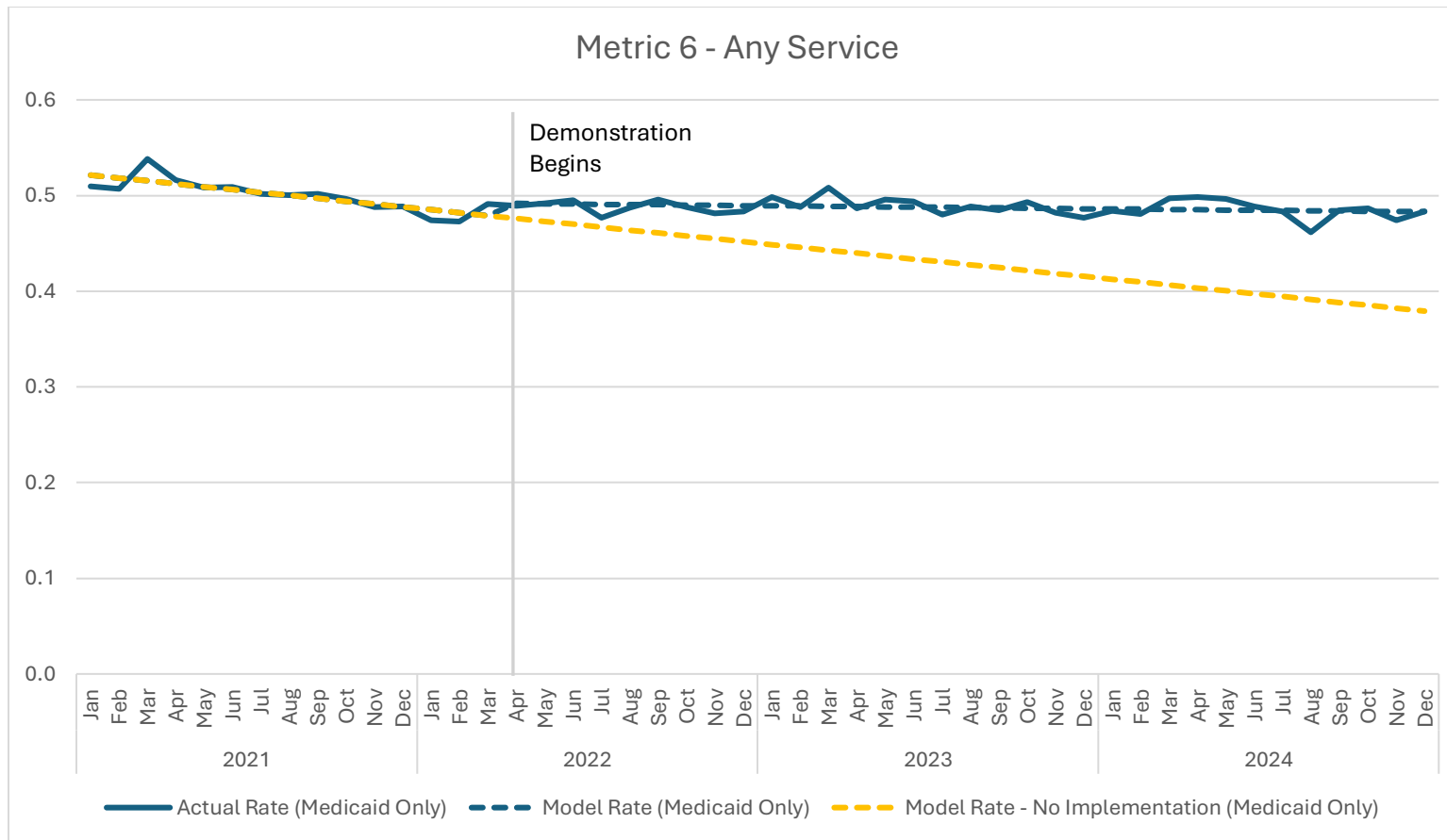
Metric 6 – Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	2.3886257	-2	0.303
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	76.53	-21.38	174.45



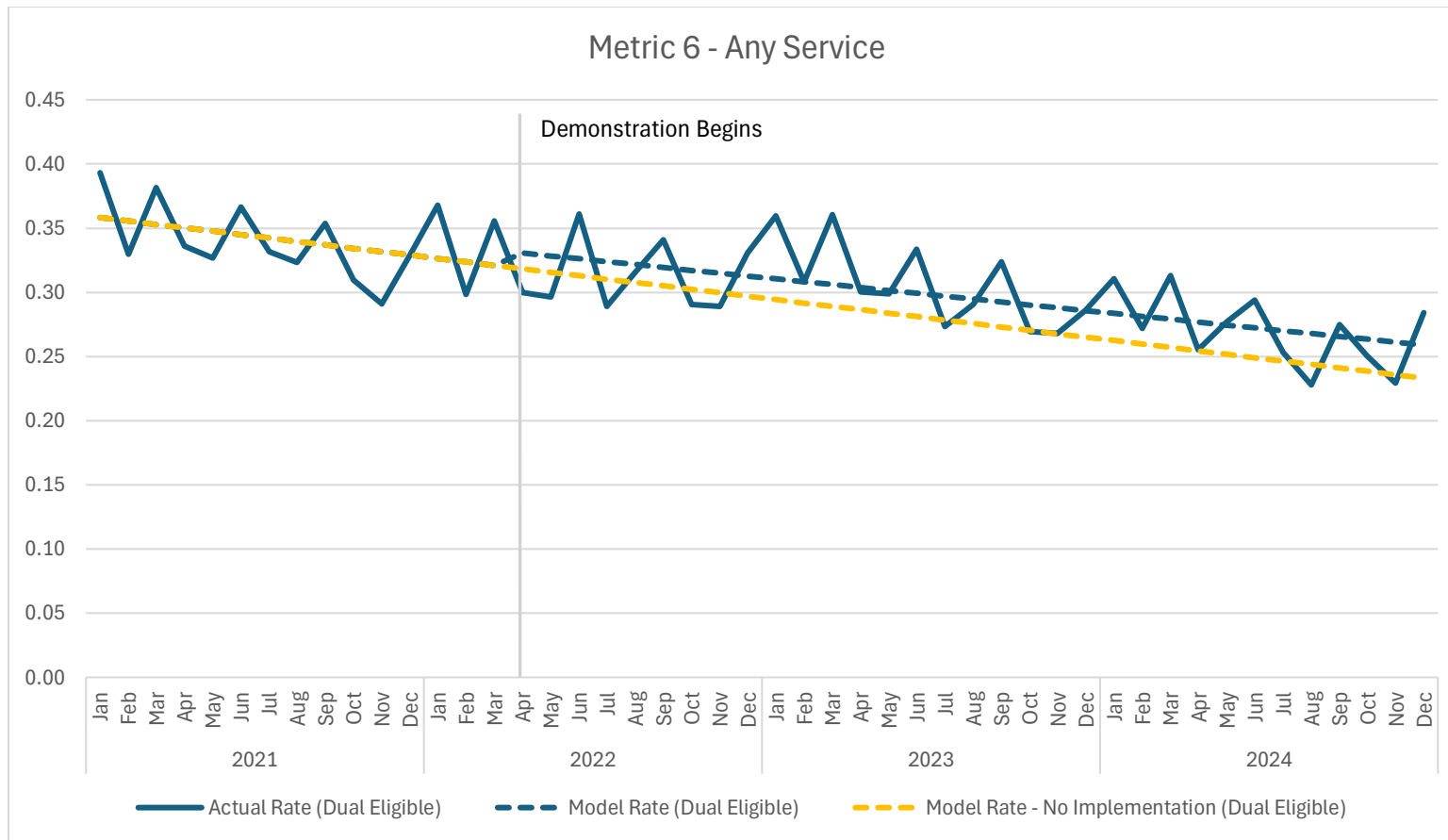
Metric 6 – OUD Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	7.8154439	-2	0.020
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-481.13	-1,063.69	101.43



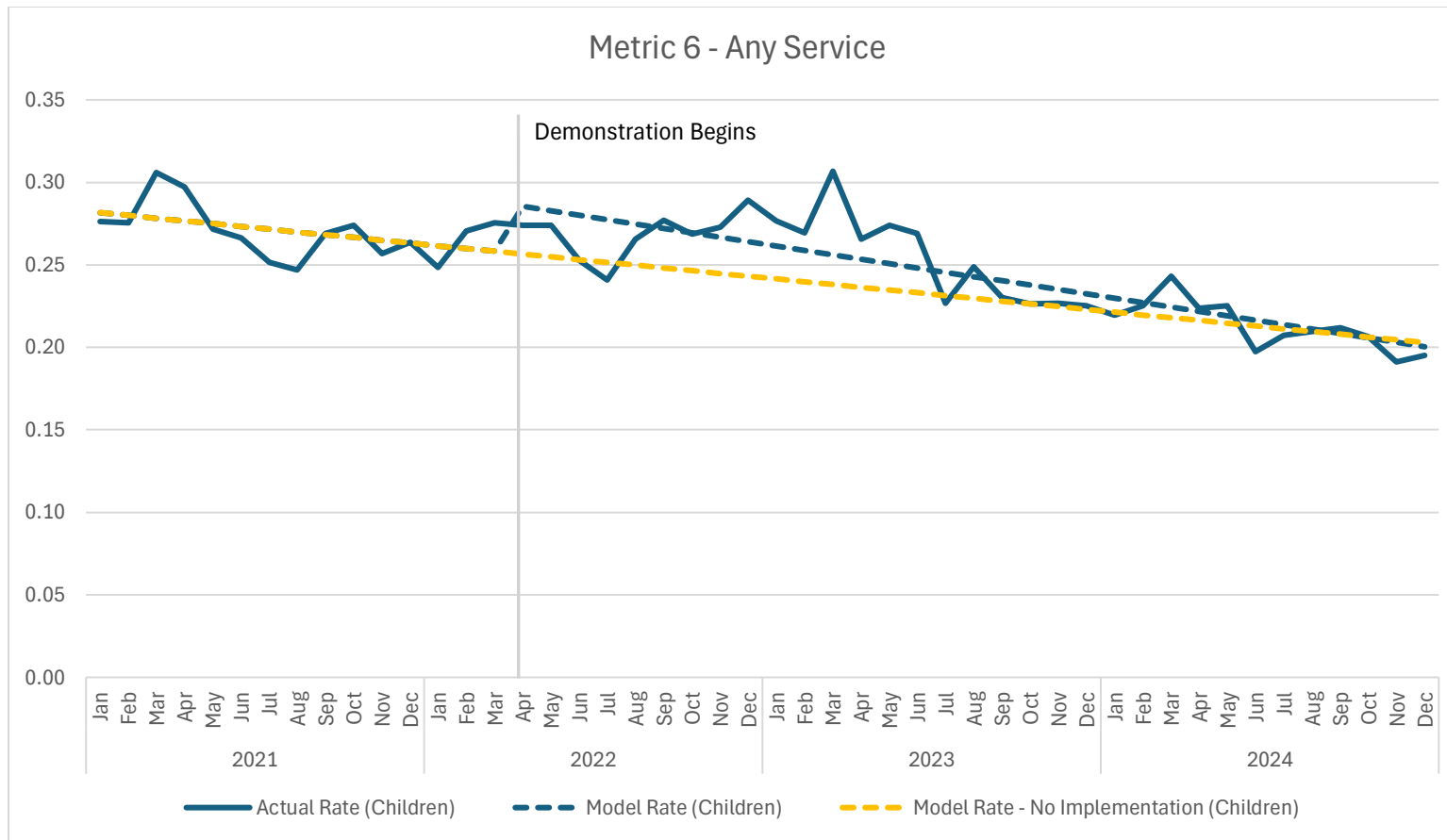
Metric 6 – Total Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	6.5466437	-2	0.038
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	394.35	-1,014.25	1,802.94



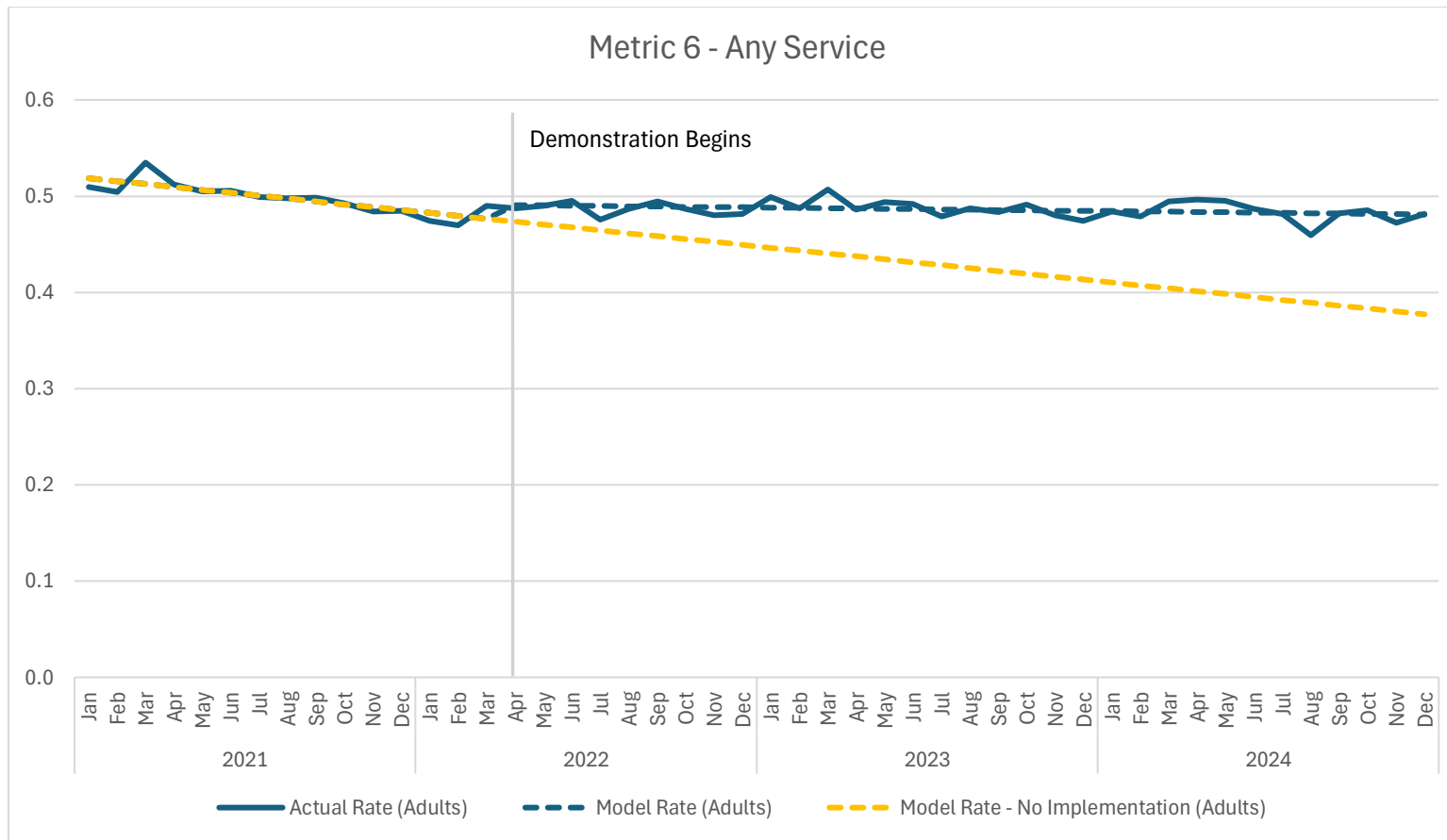
Metric 6 Rate – Medicaid Only Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	54.55772	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.060	0.043	0.076



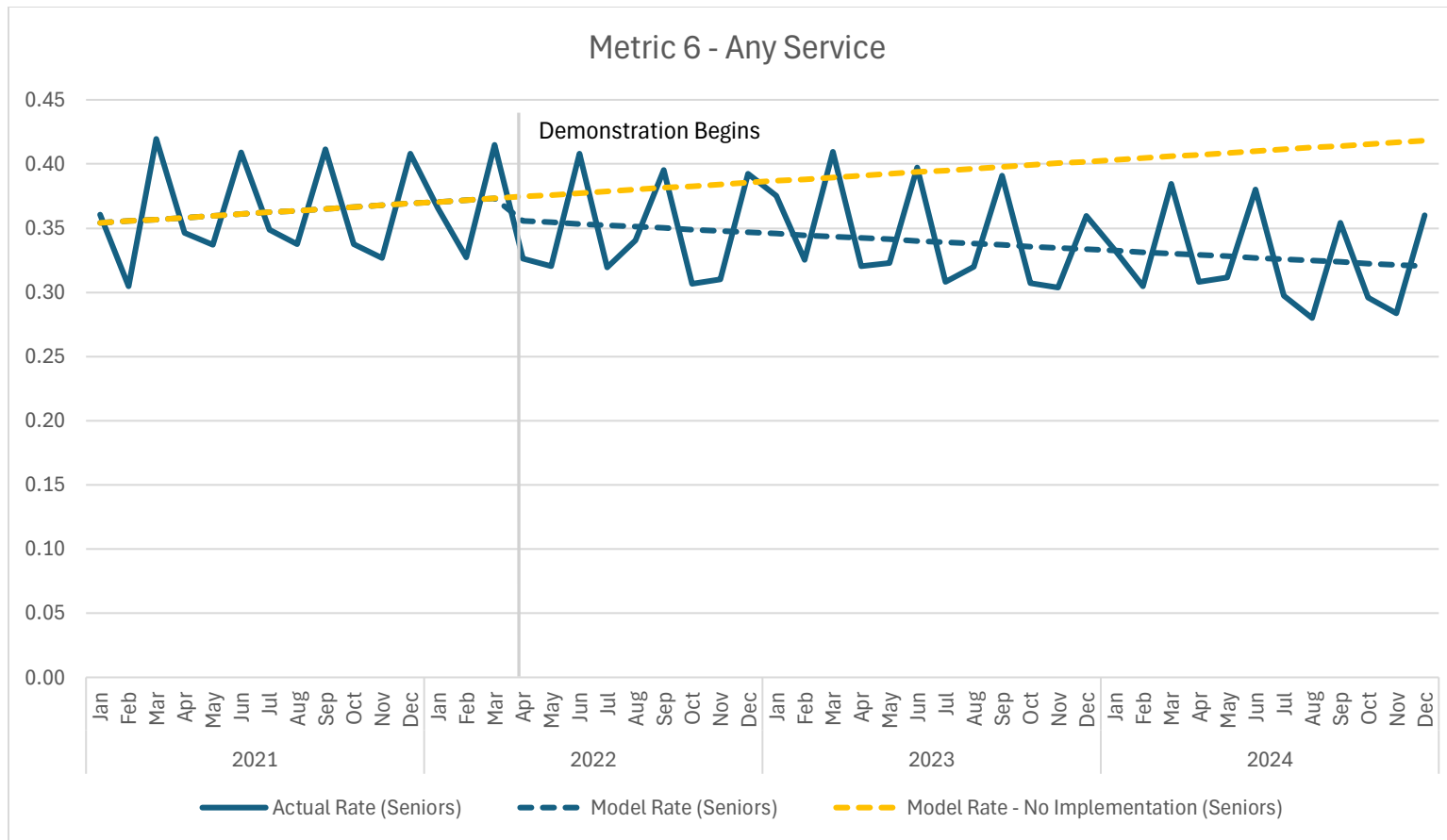
Metric 6 Rate – Dual Eligible Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	0.6155843	-2	0.735
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.019	-0.032	0.070



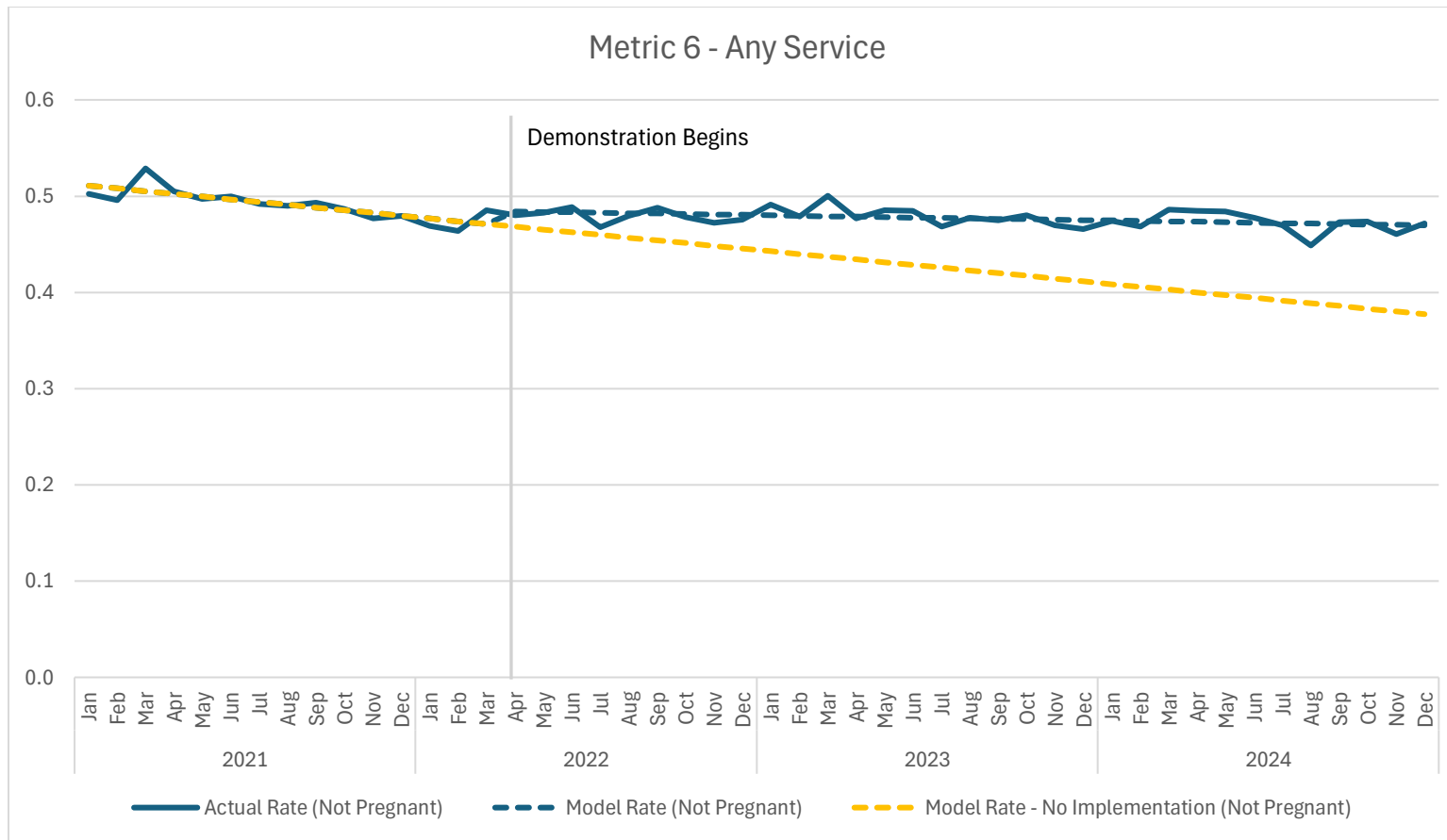
Metric 6 Rate – Children Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	7.531685	-2	0.023
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.013	-0.024	0.050



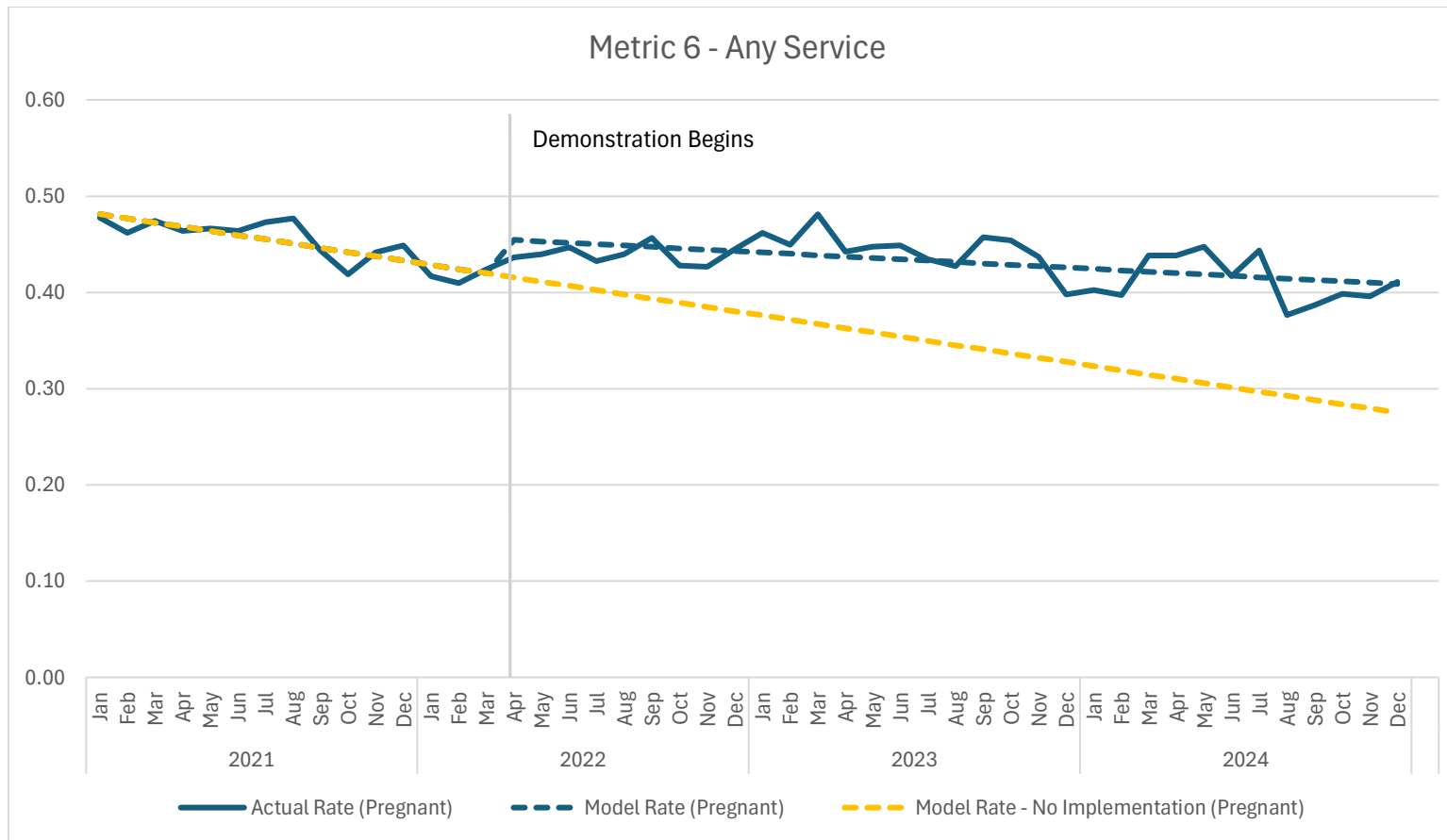
Metric 6 Rate – Adults Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	67.874347	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.061	0.046	0.076



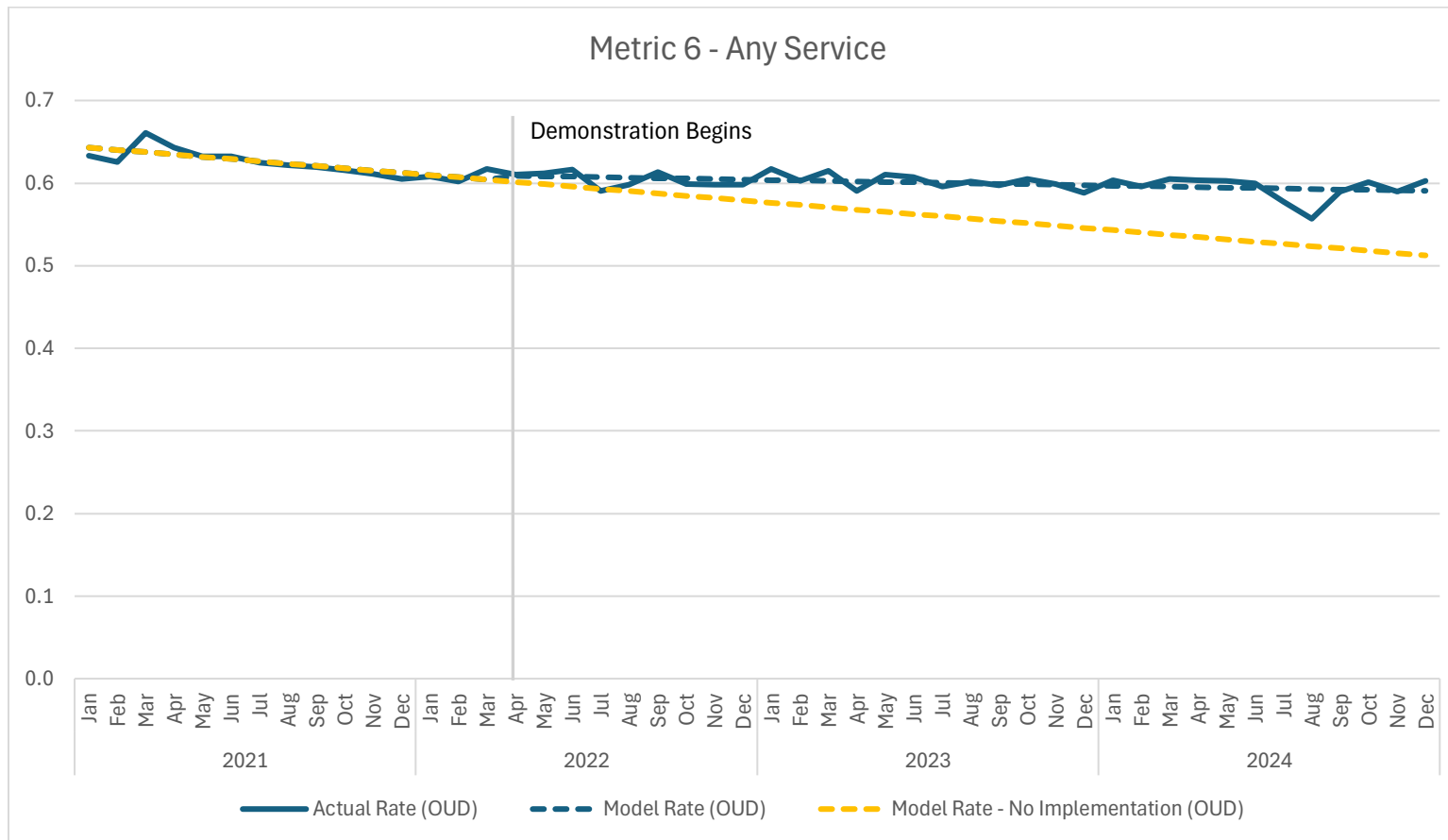
Metric 6 Rate – Seniors Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	12.907993	-2	0.002
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-0.058	-0.092	-0.025



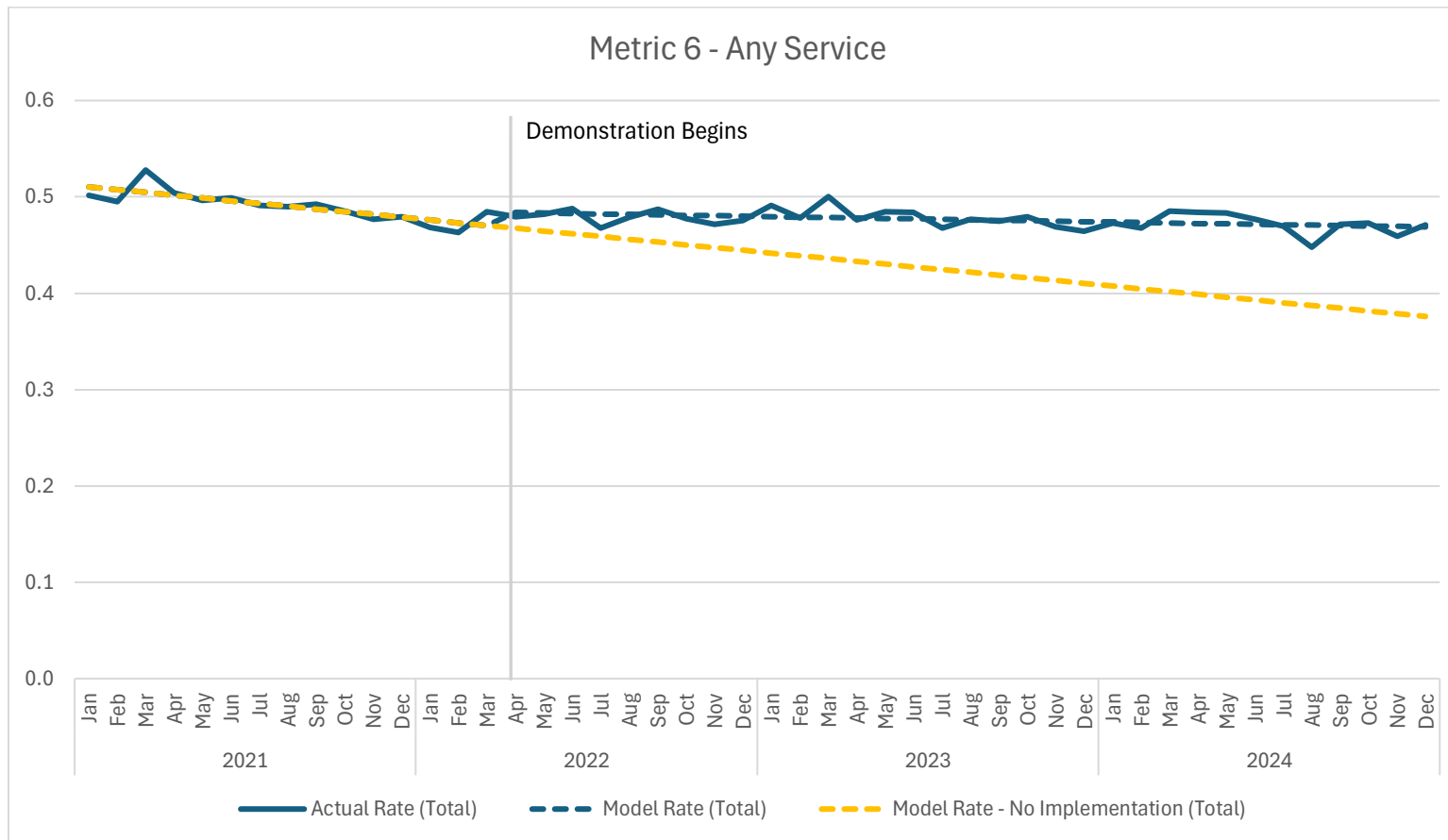
Metric 6 Rate – Not Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	52.343528	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.054	0.039	0.069



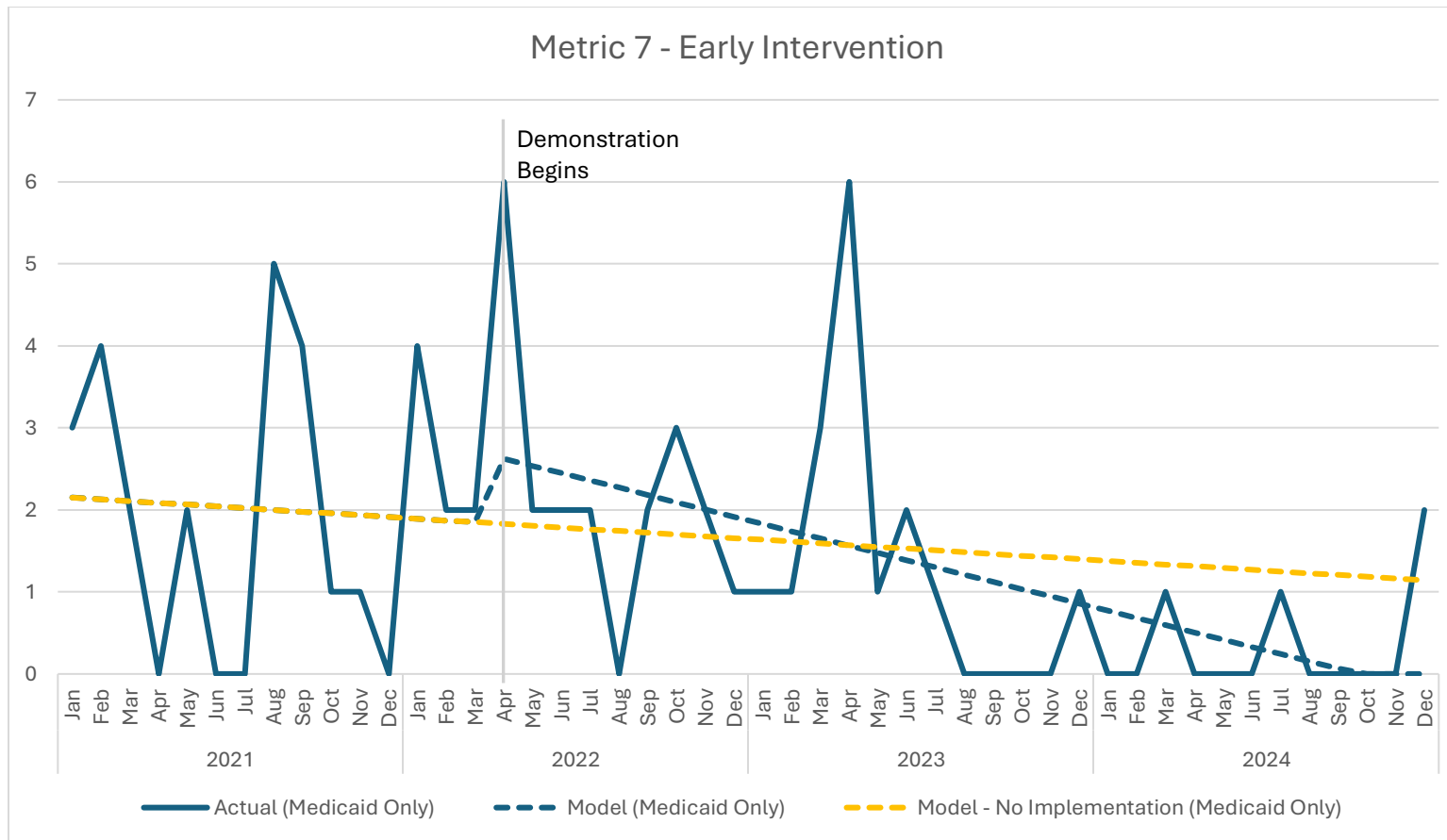
Metric 6 Rate – Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	54.711626	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.086	0.062	0.111



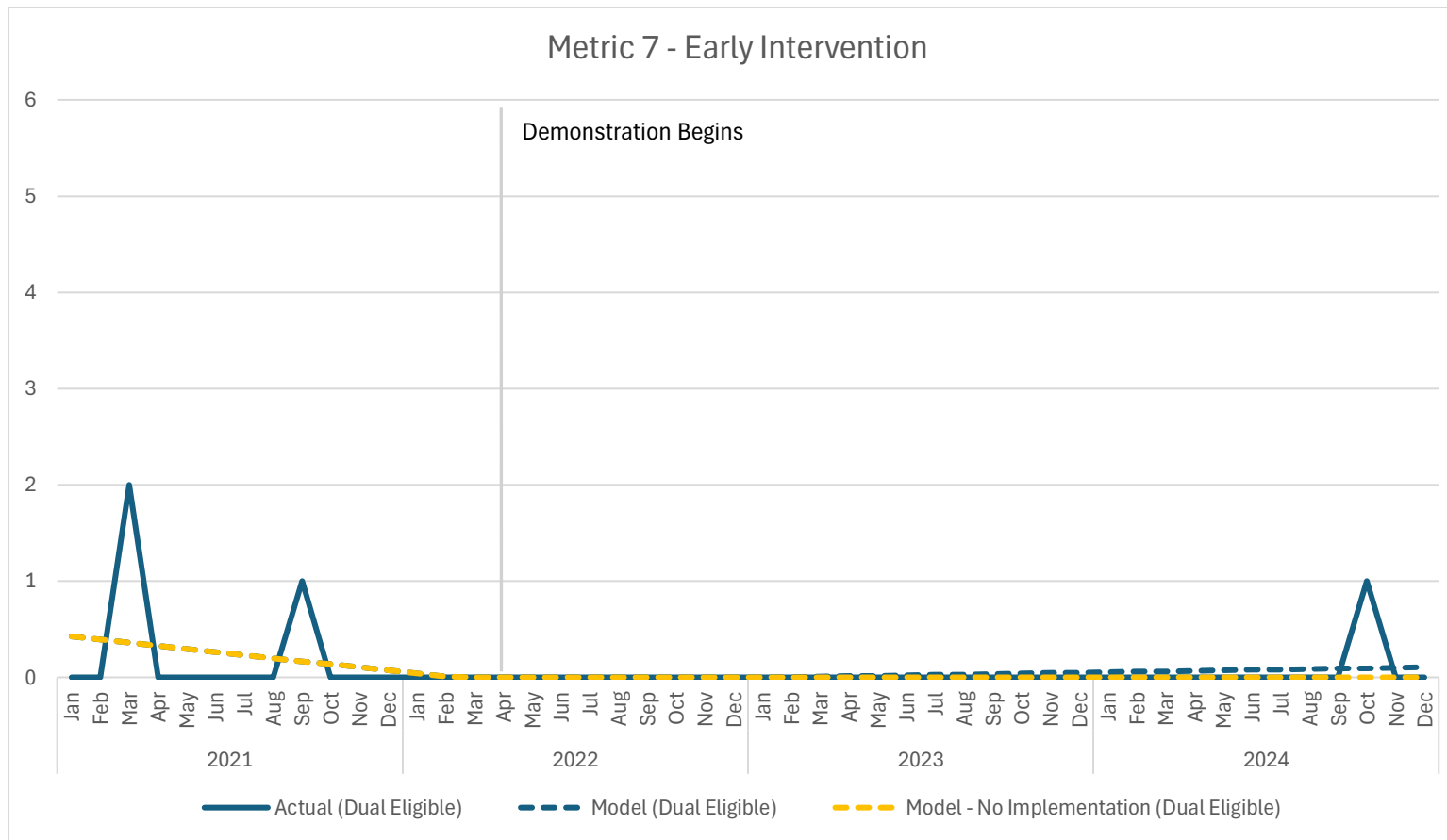
Metric 6 Rate – OUD Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	33.140143	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.043	0.024	0.062



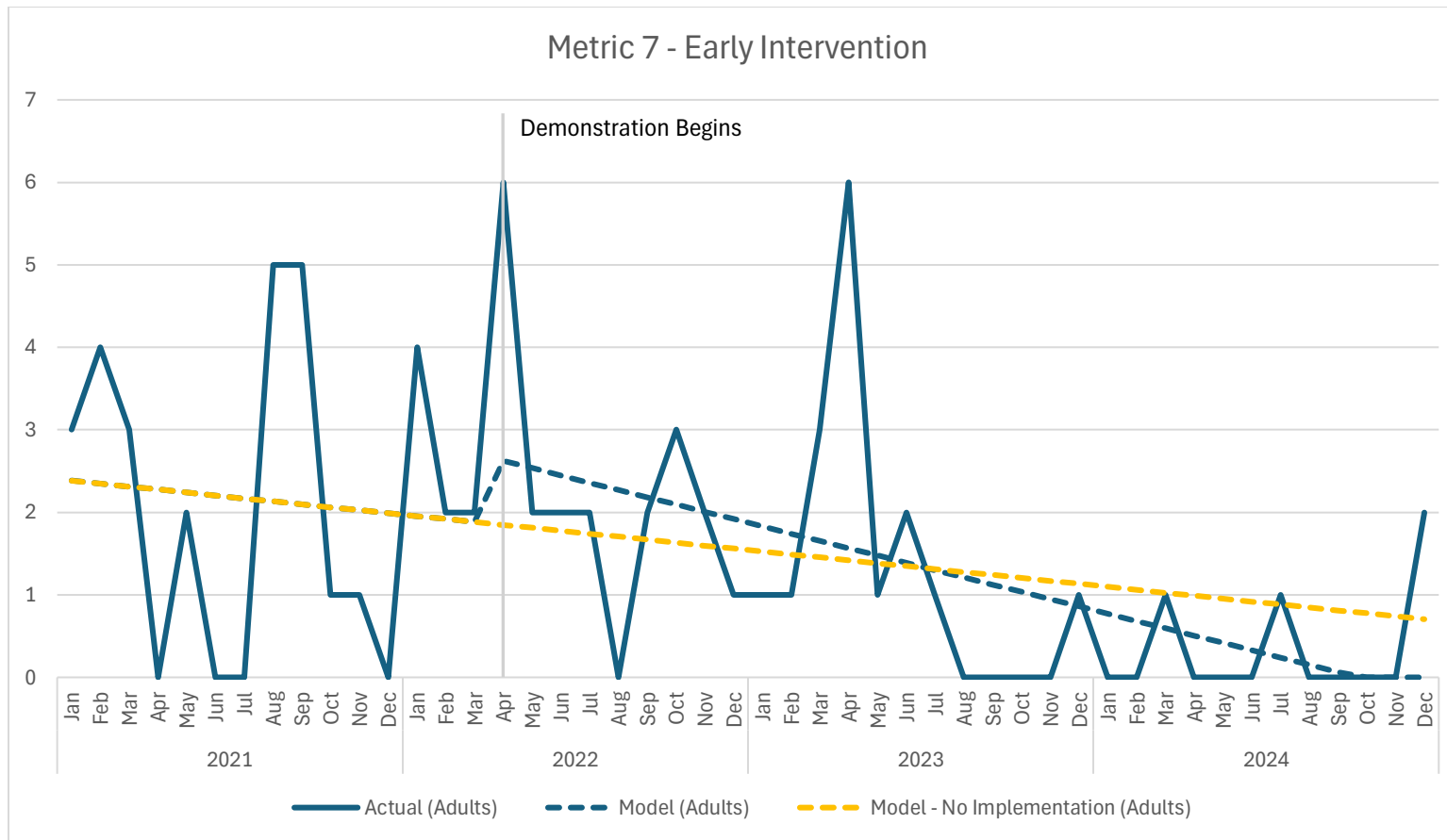
Metric 6 Rate – Total Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	53.372077	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.055	0.039	0.070



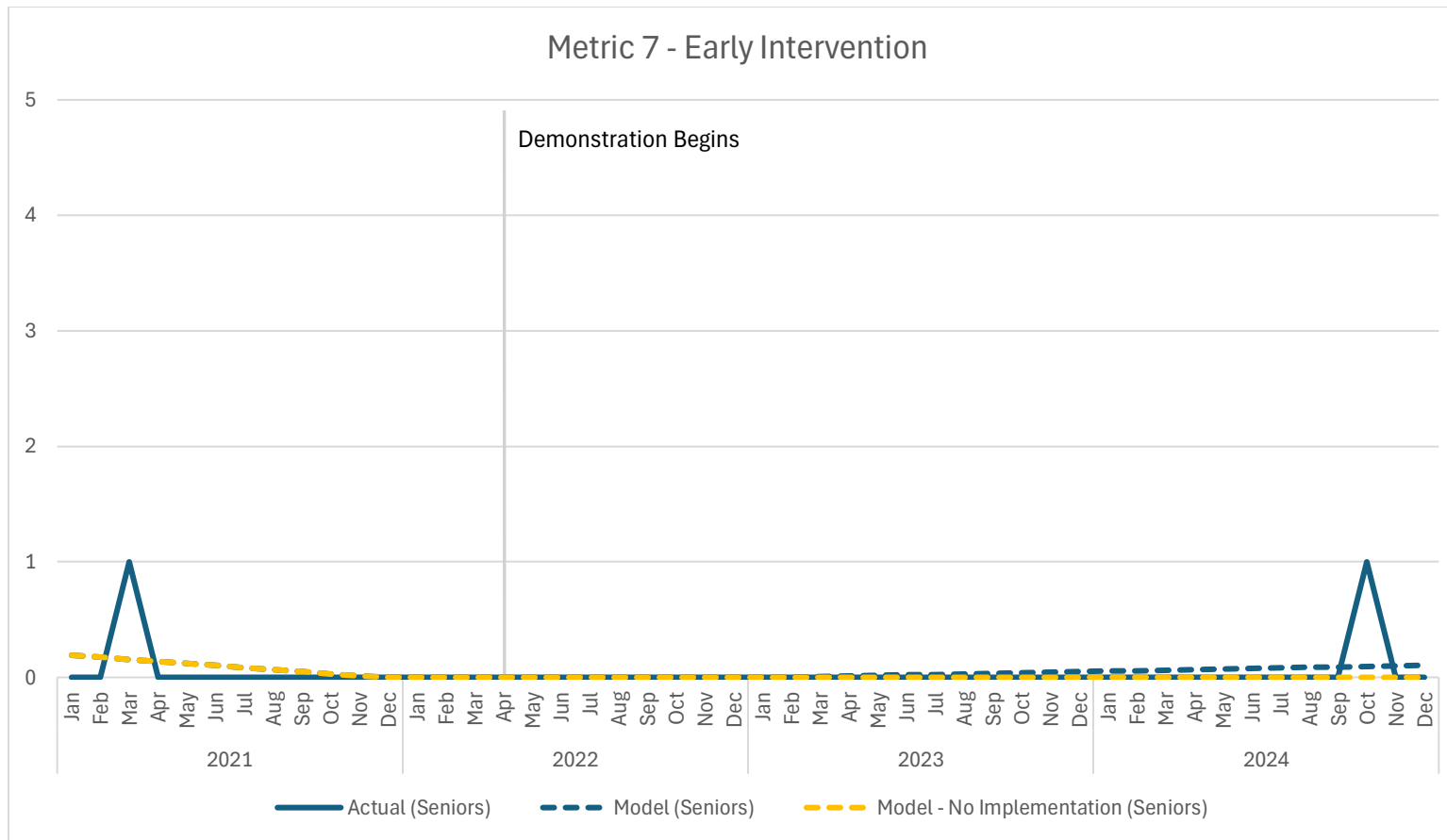
Metric 7 – Medicaid Only Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	8.9040278	-2	0.012
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-0.27	-2.33	1.79



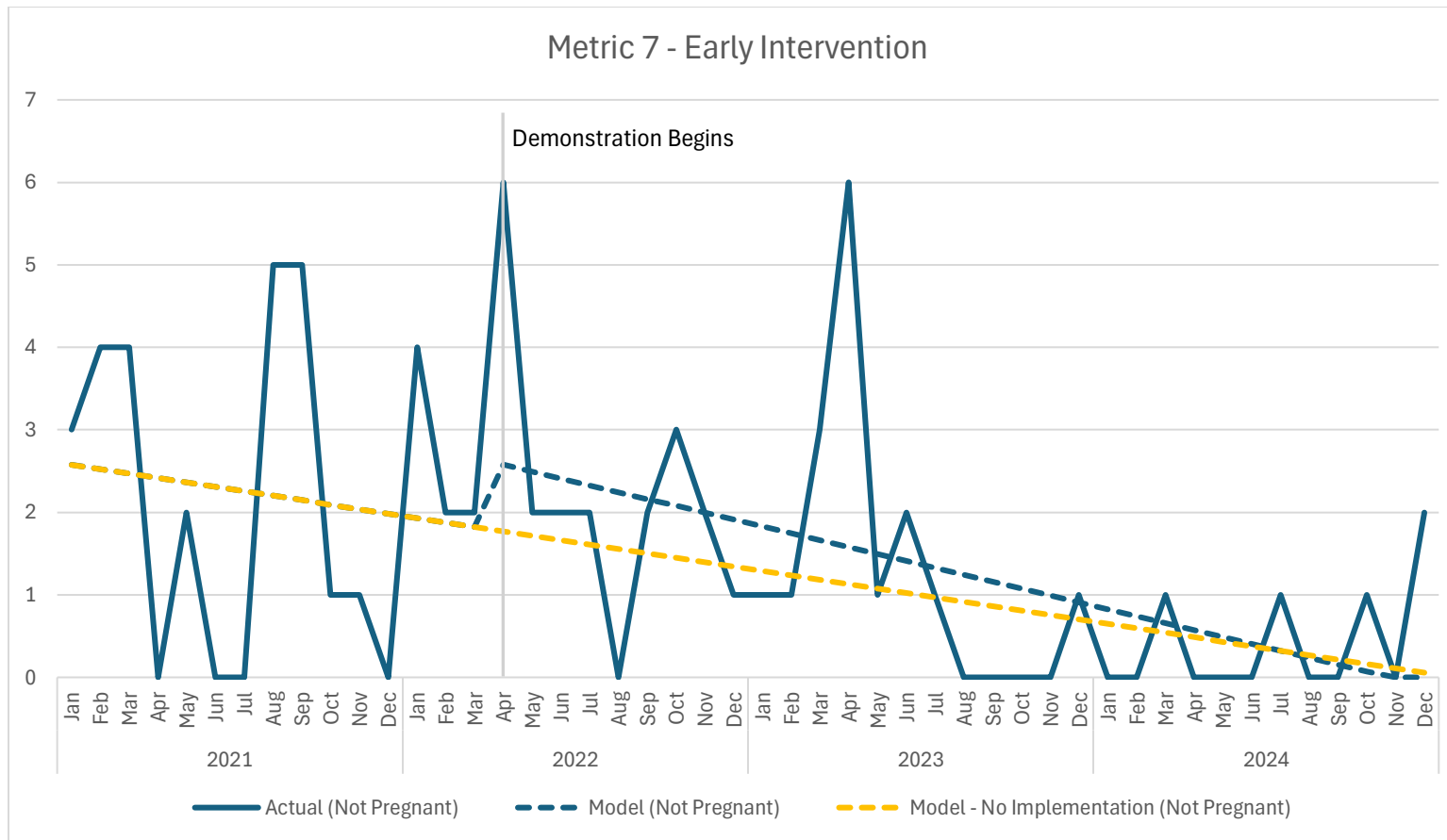
Metric 7 – Dual Eligible Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	17.36689	-2	0.000
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.60	0.14	1.07



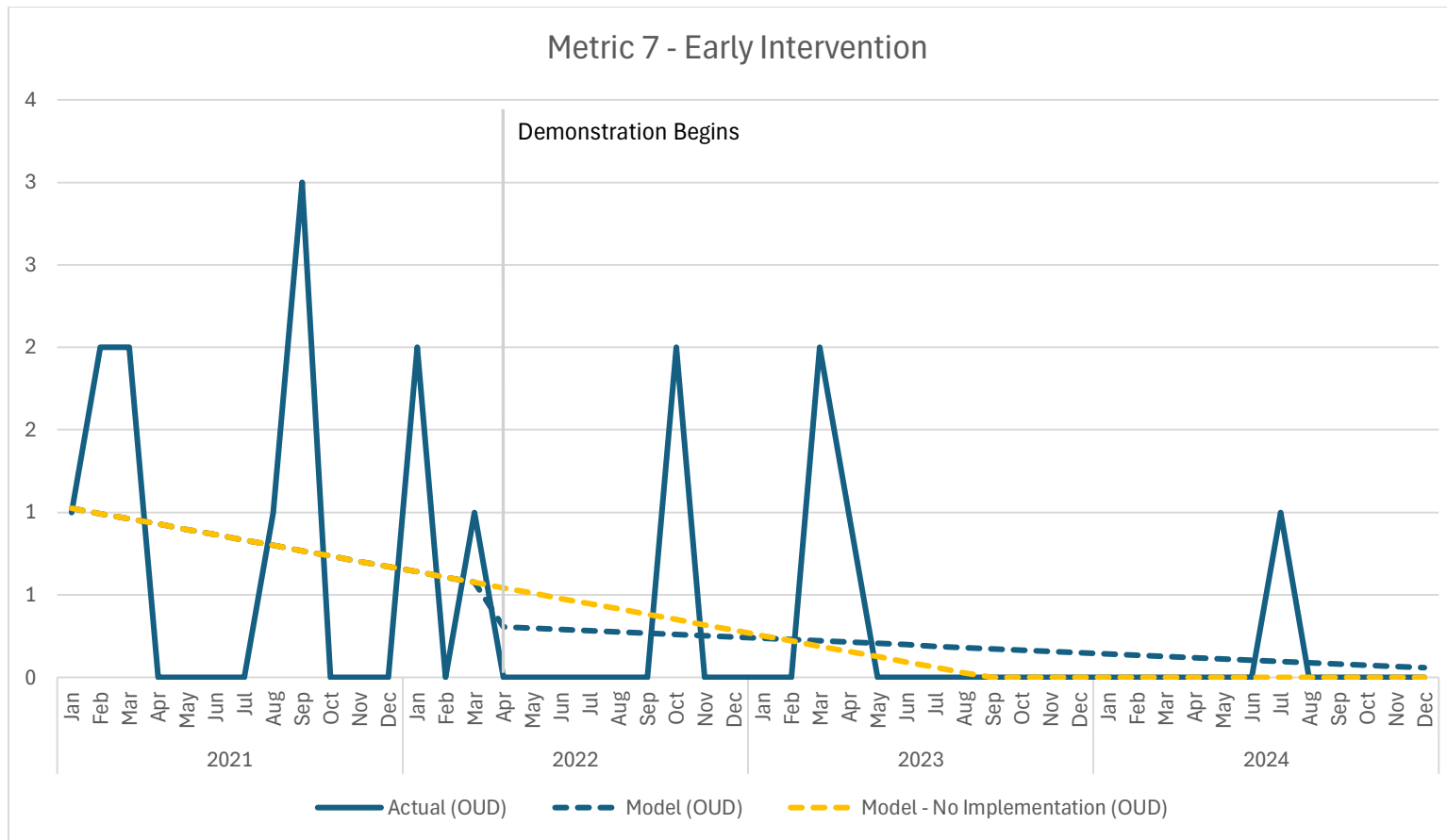
Metric 7 – Adults Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	7.363456	-2	0.025
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-0.06	-2.03	1.90



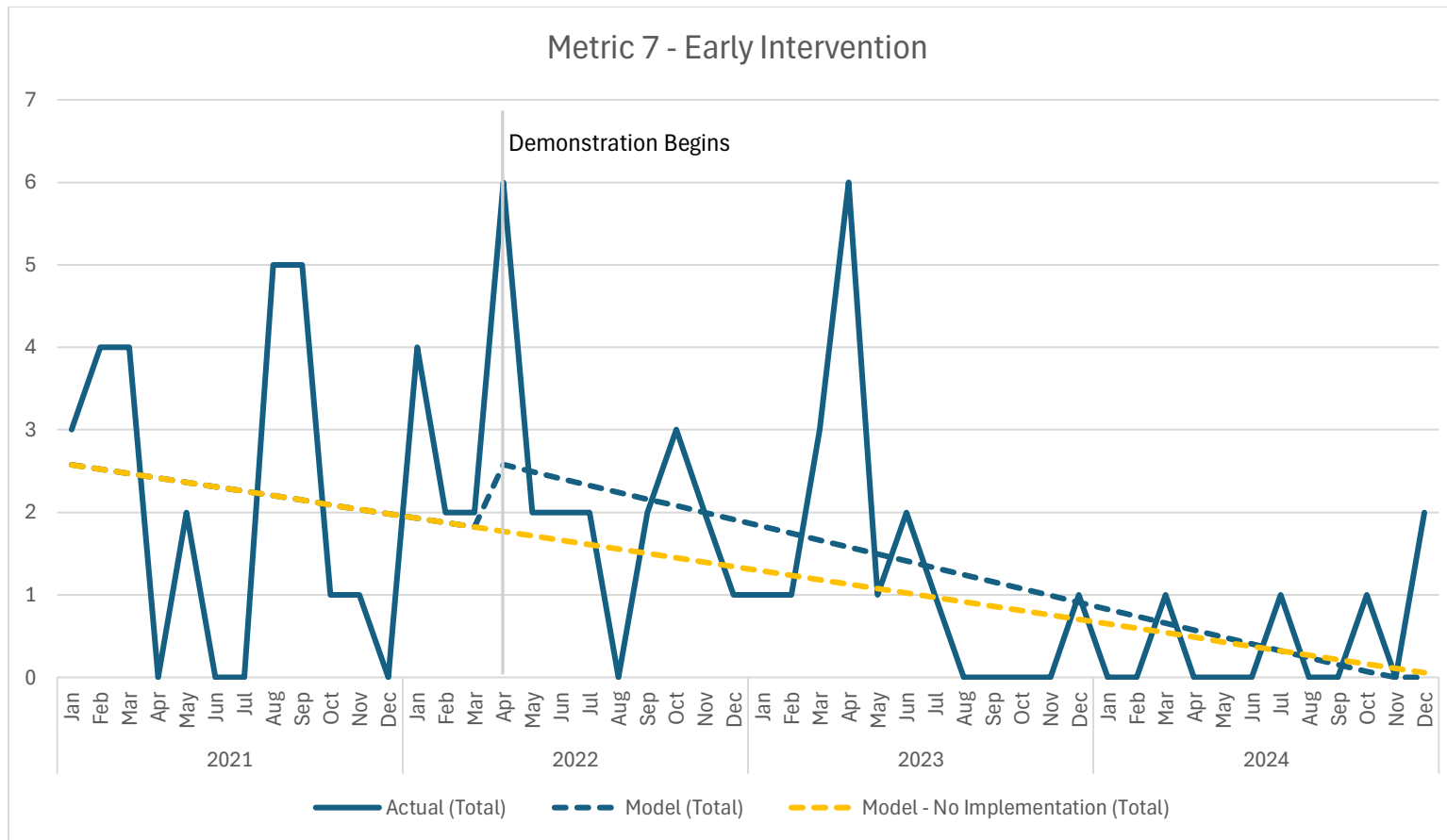
Metric 7 – Seniors Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	9.4845172	-2	0.009
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.39	0.09	0.69



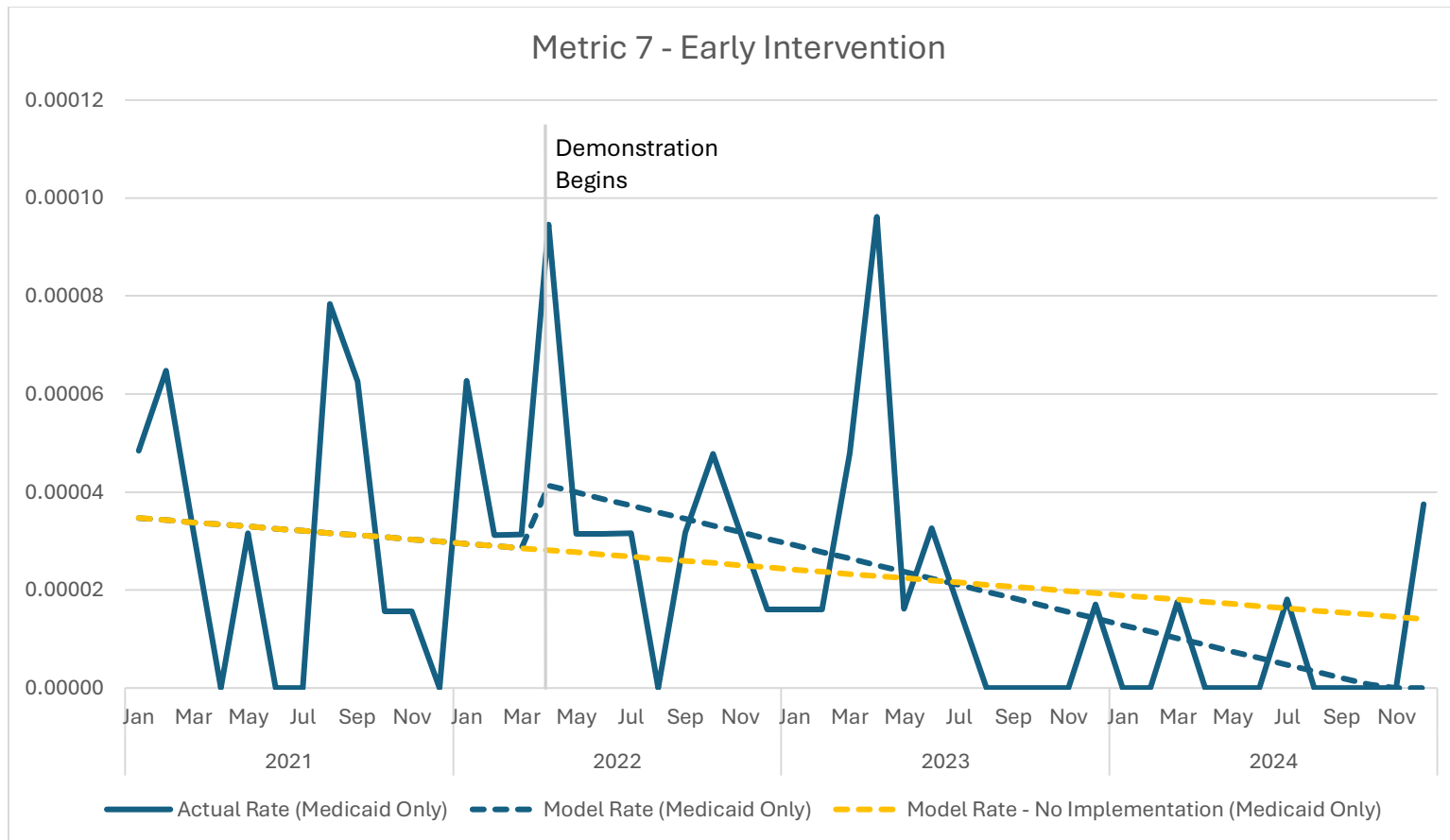
Metric 7 – Not Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	5.8290503	-2	0.054
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.33	-1.73	2.39



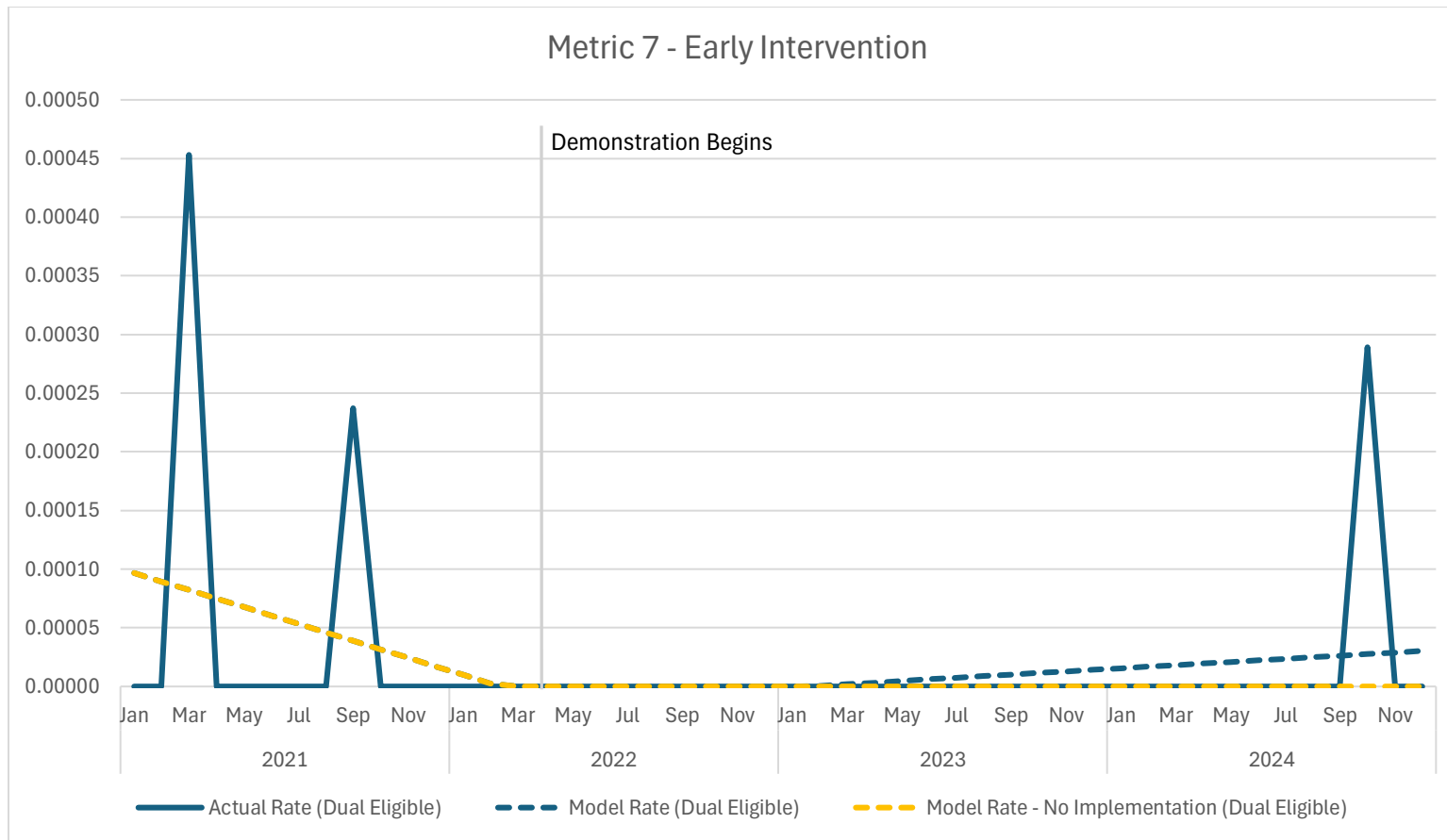
Metric 7 – OUD Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	3.3028018	-2	0.192
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.15	-1.08	1.39



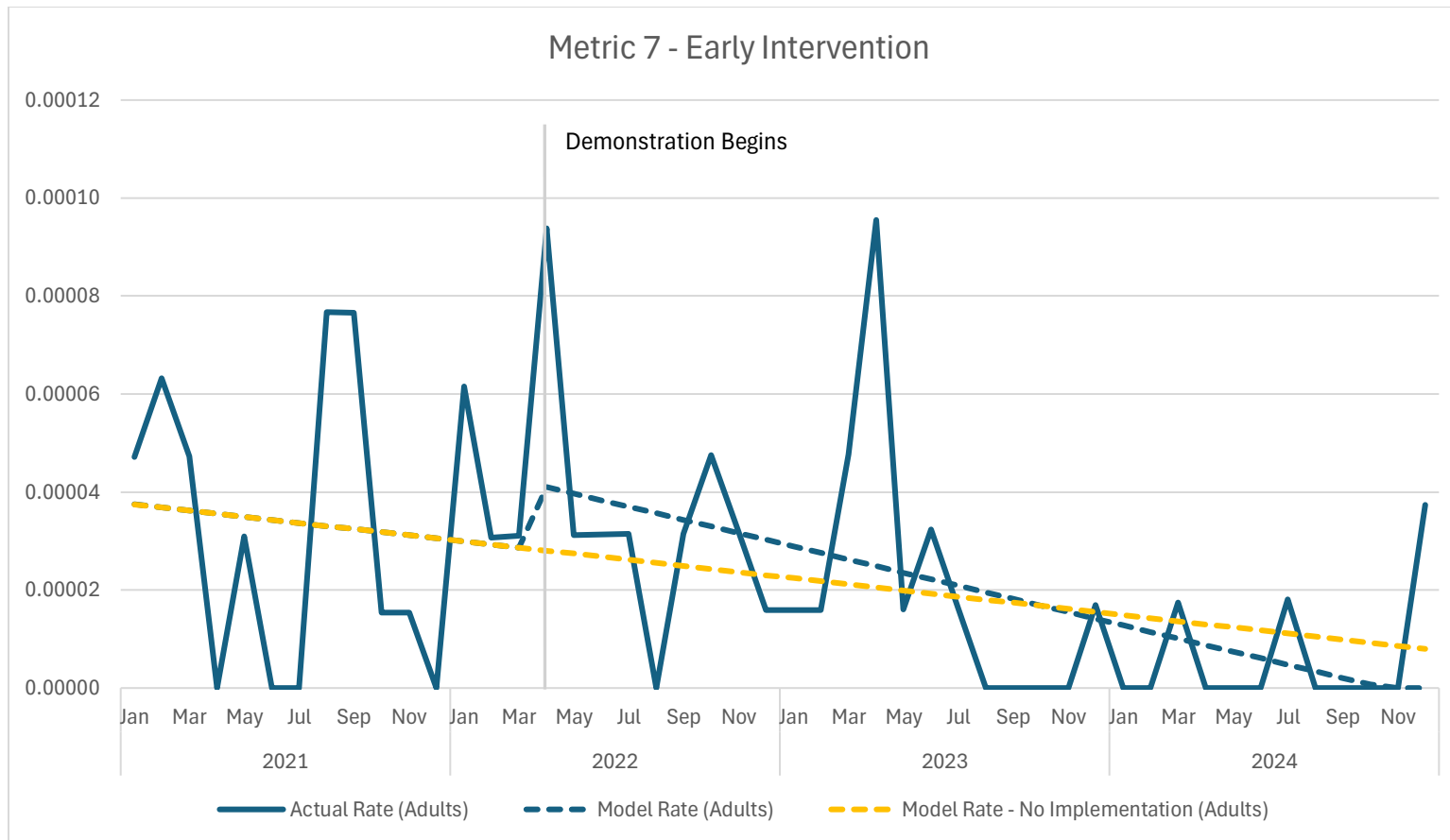
Metric 7 – Total Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	5.8290503	-2	0.054
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.33	-1.73	2.39



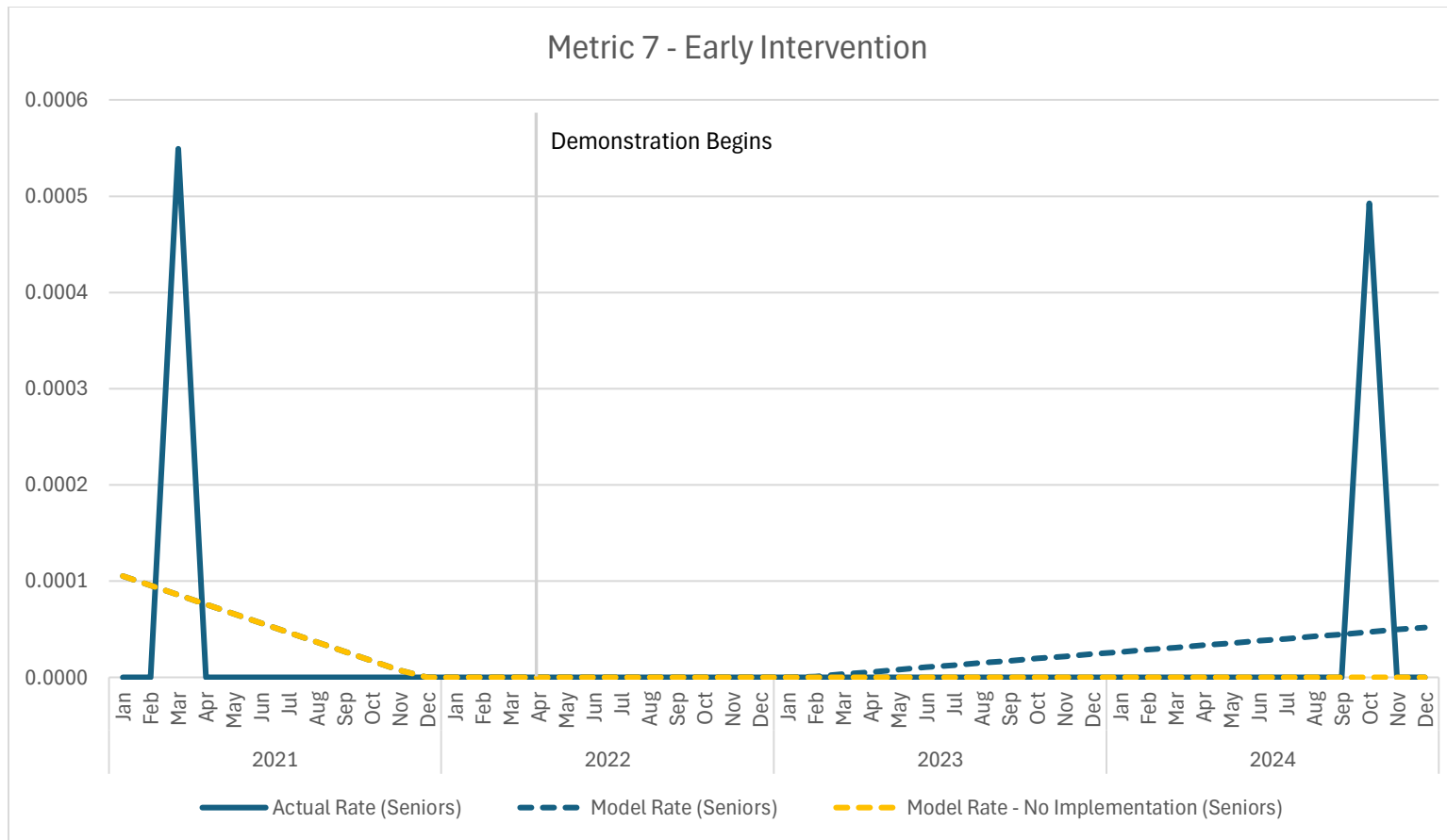
Metric 7 Rate – Medicaid Only Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	8.3474131	-2	0.015
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	<0.00001	-0.00004	0.00003



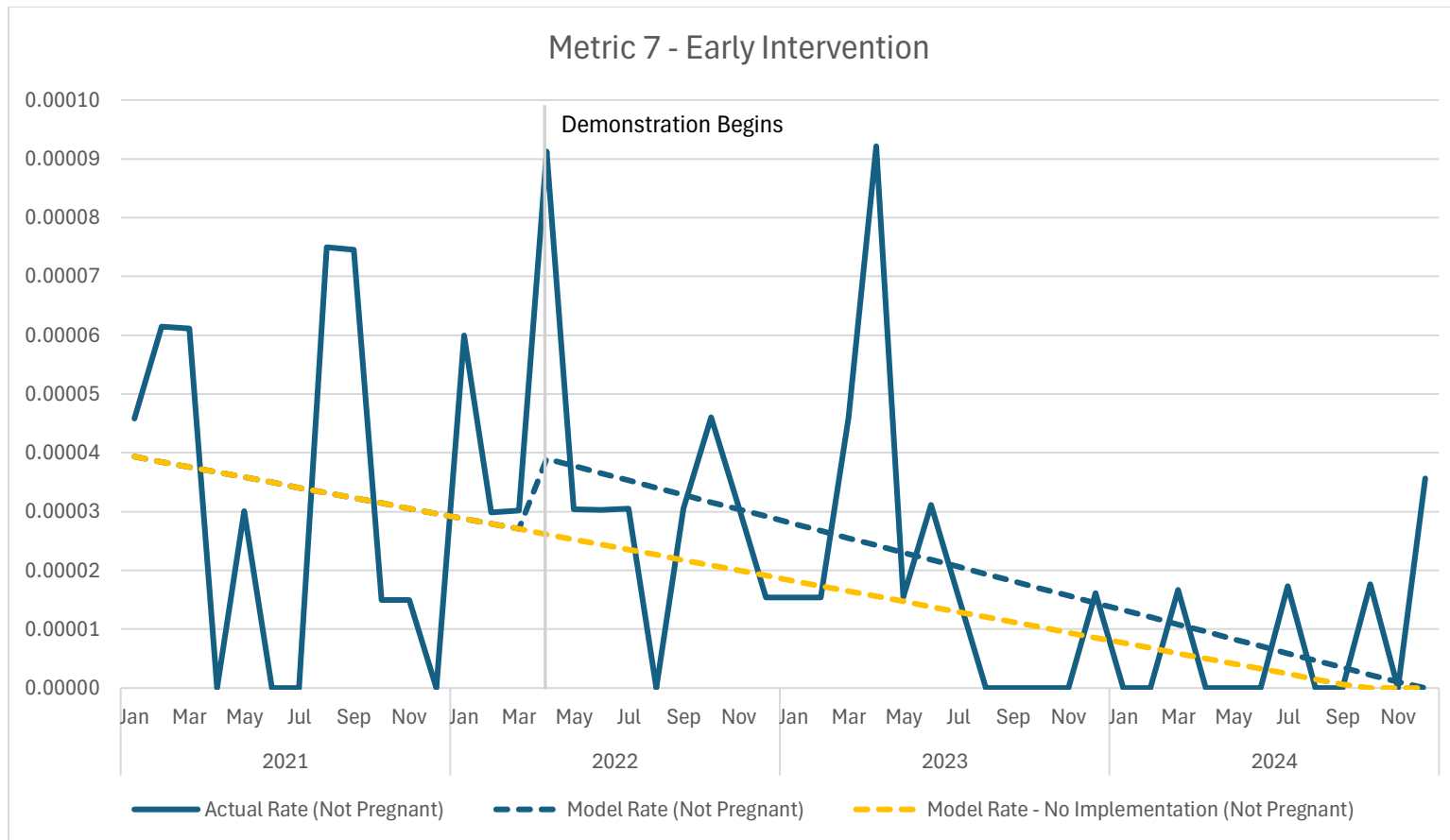
Metric 7 Rate – Dual Eligible Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	15.953235	-2	0.000
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.0001	0.00003	0.00024



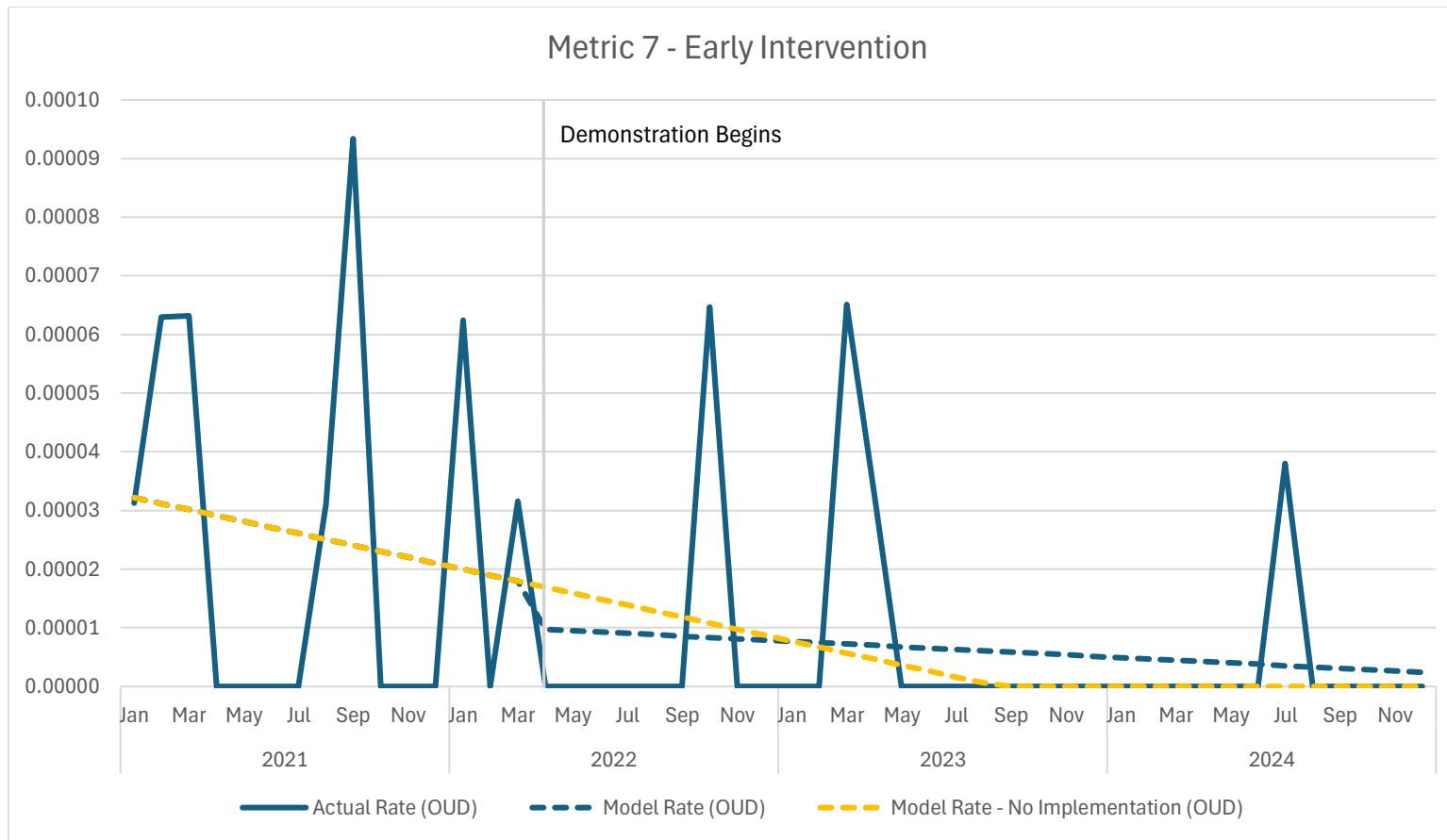
Metric 7 Rate – Adults Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	7.2800828	-2	0.026
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	<0.00001	-0.00003	0.00003



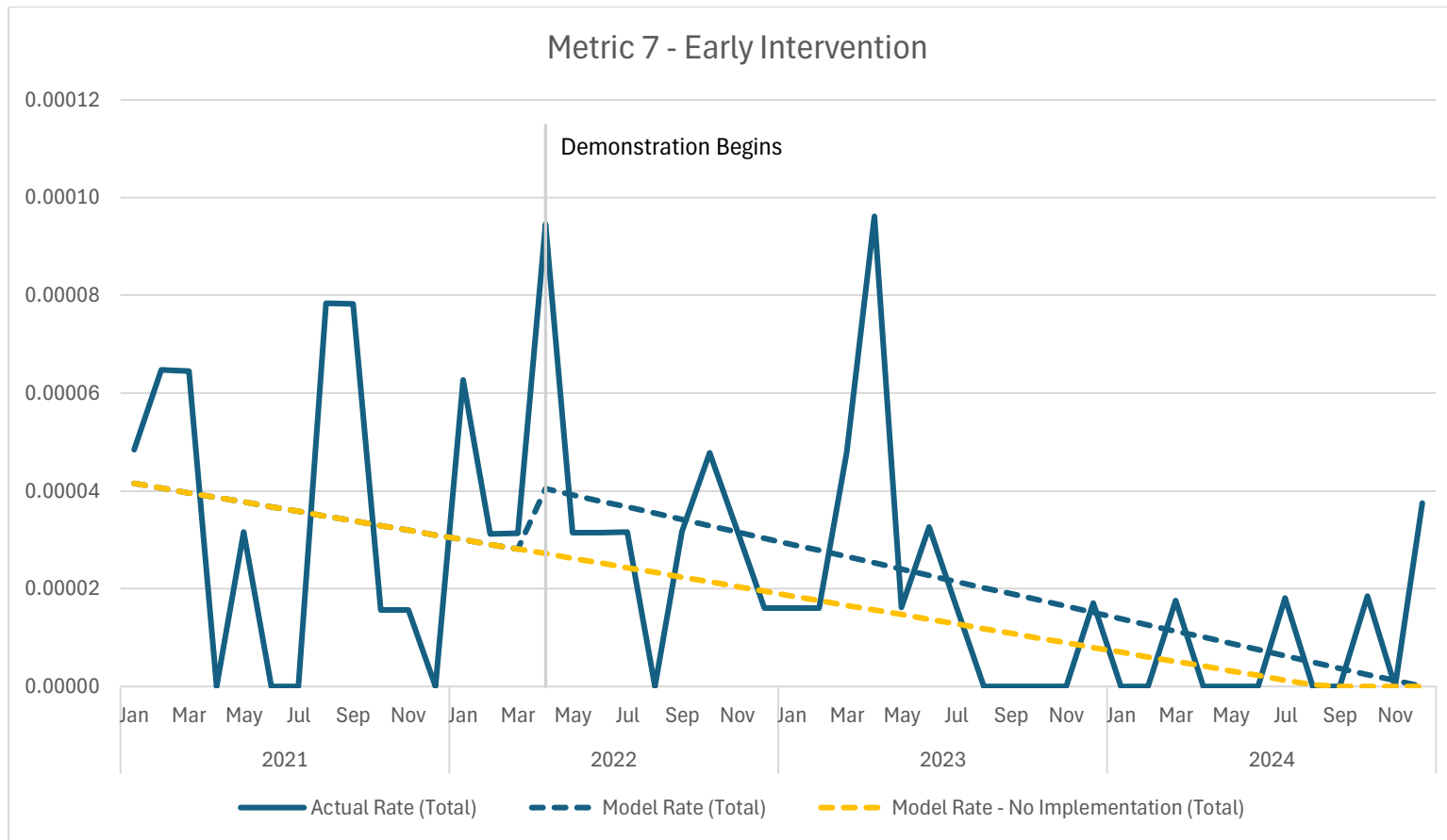
Metric 7 Rate – Seniors Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	9.6912072	-2	0.008
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.0002	0.00005	0.00038



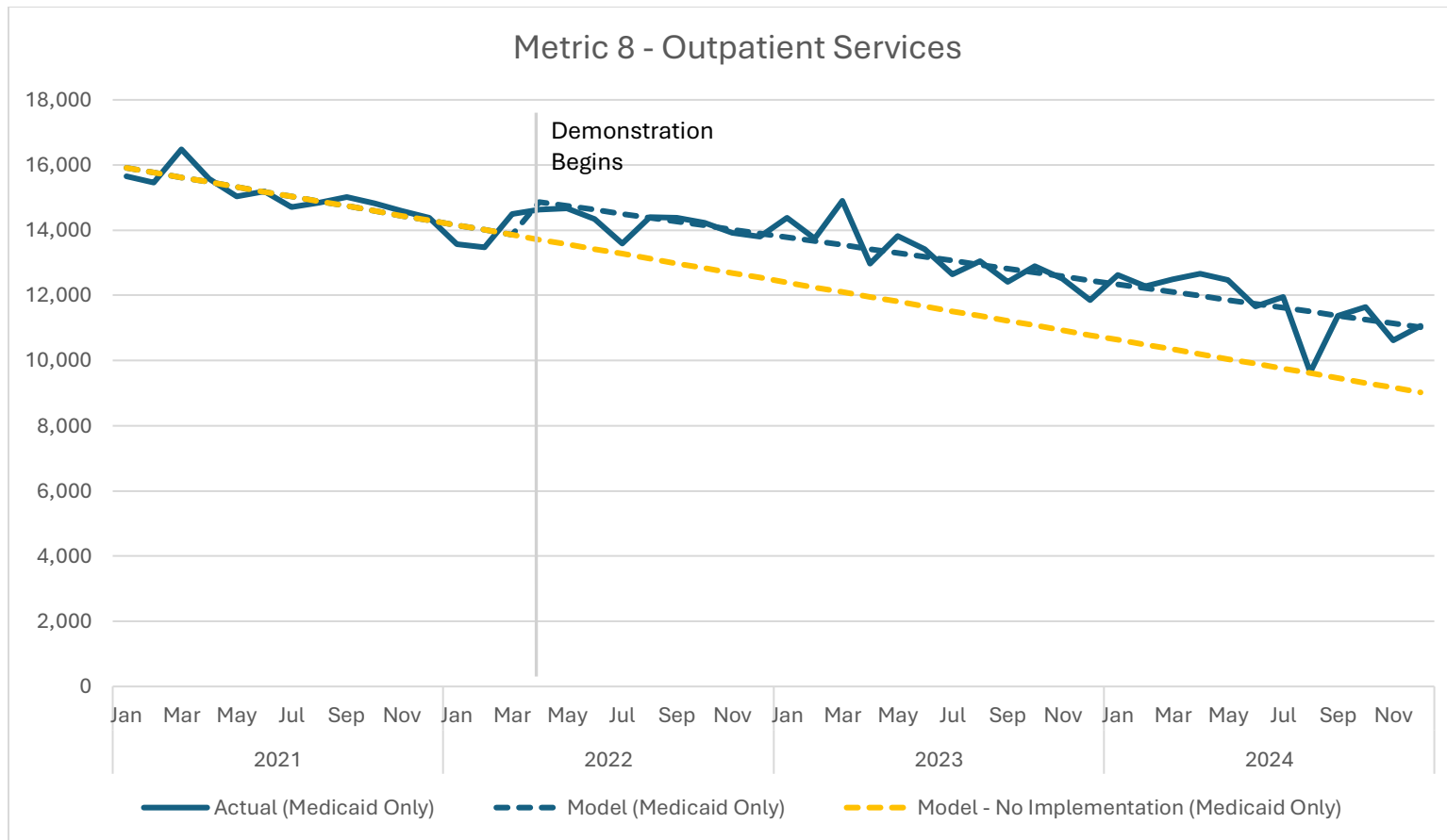
Metric 7 Rate – Not Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	5.6556271	-2	0.059
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	<0.00001	-0.00002	0.00004



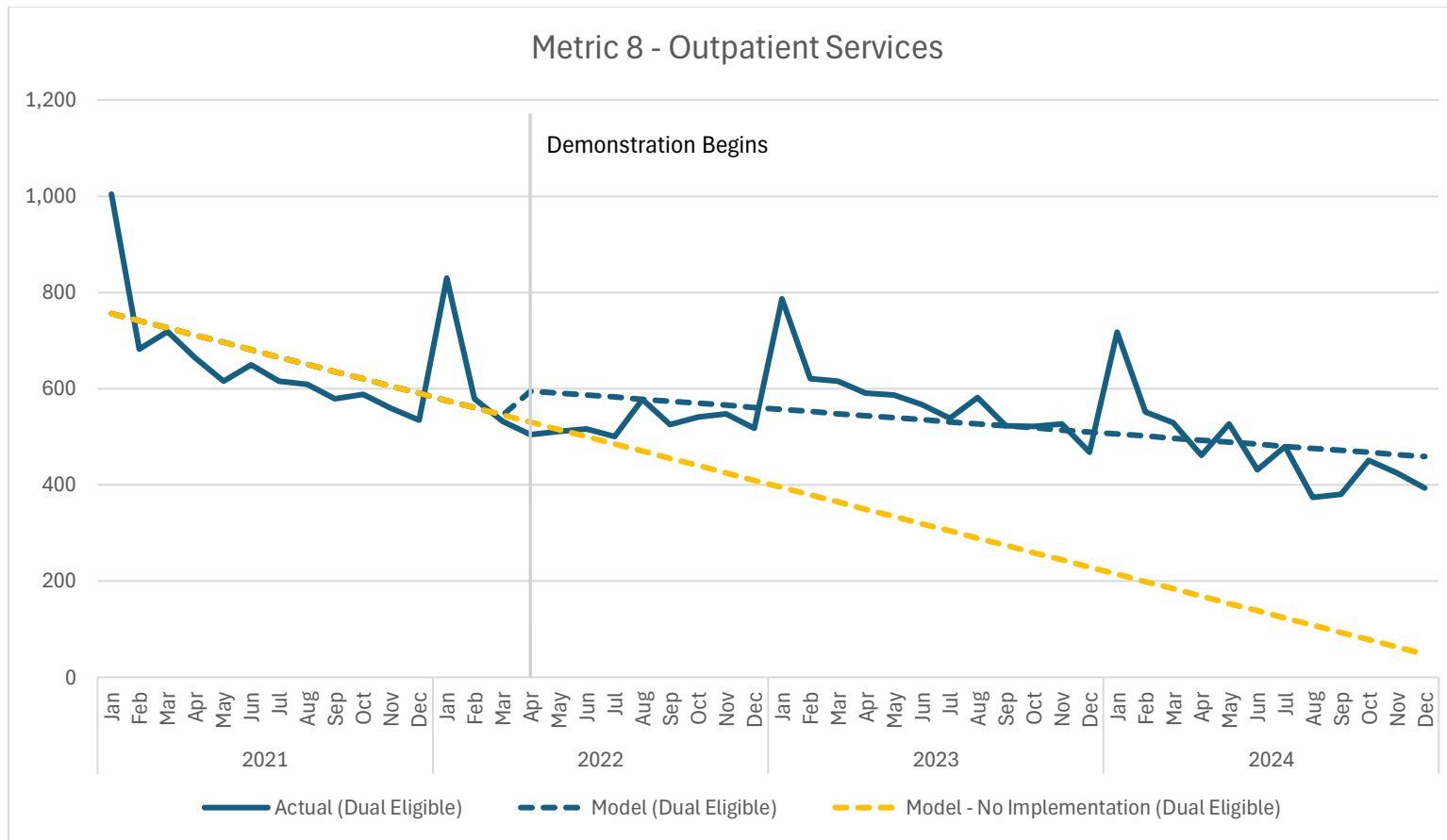
Metric 7 Rate – OUD Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	3.1529791	-2	0.207
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	<0.00001	-0.00003	0.00004



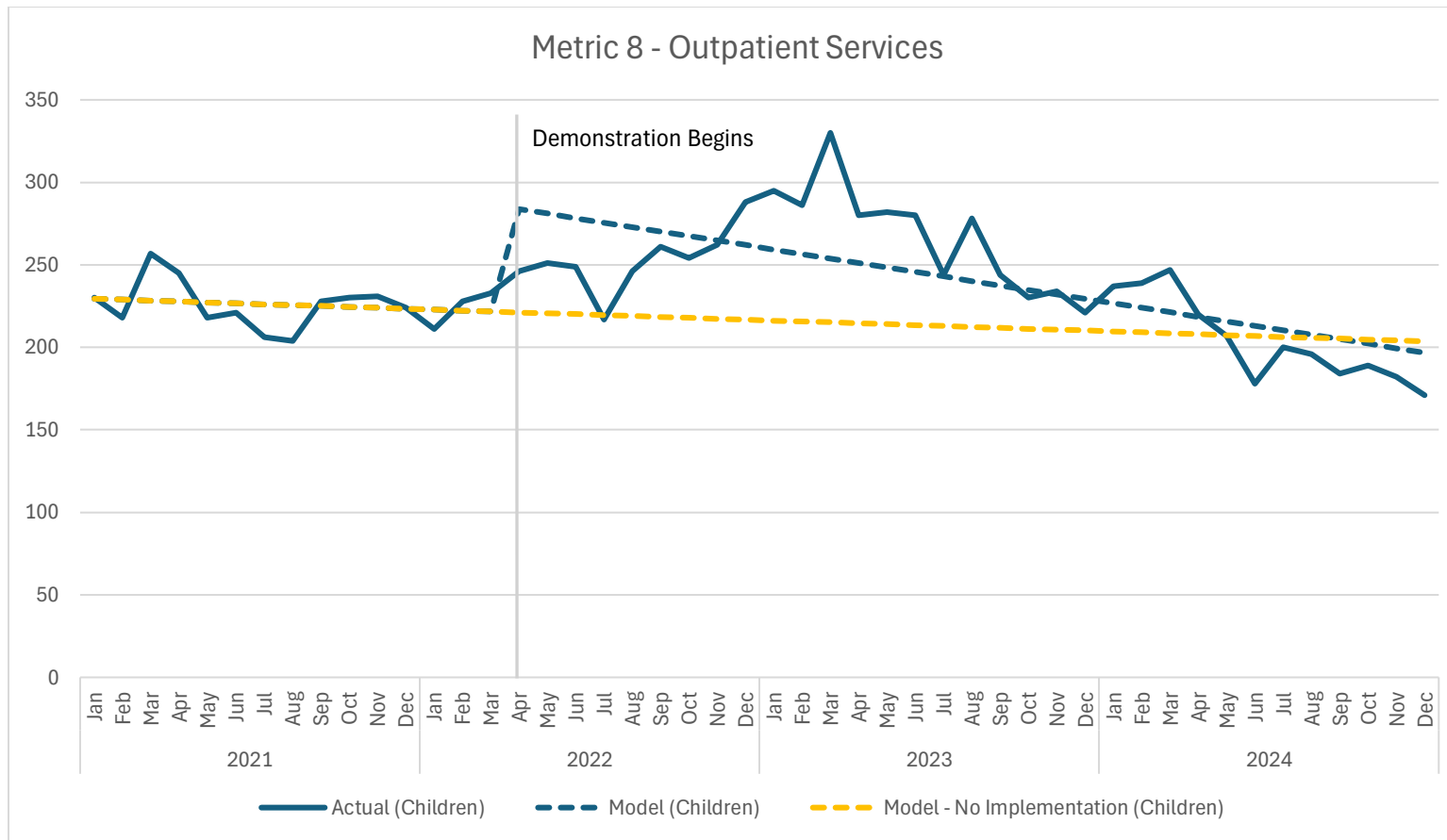
Metric 7 Rate – Total Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	5.4935447	-2	0.064
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	<0.00001	-0.00003	0.00004



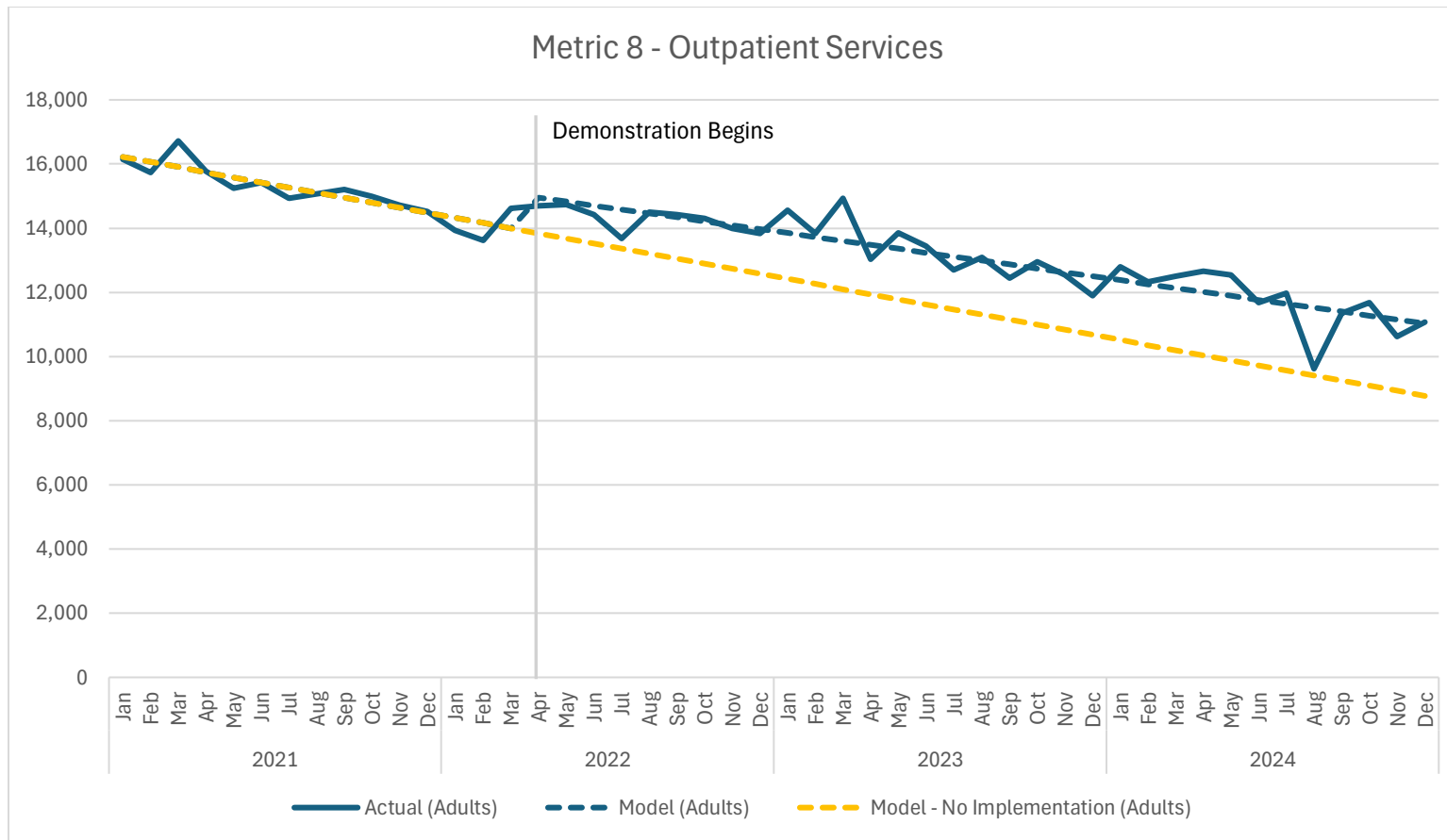
Metric 8 – Medicaid Only Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	42.820198	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	1,574.81	1,043.32	2,106.29



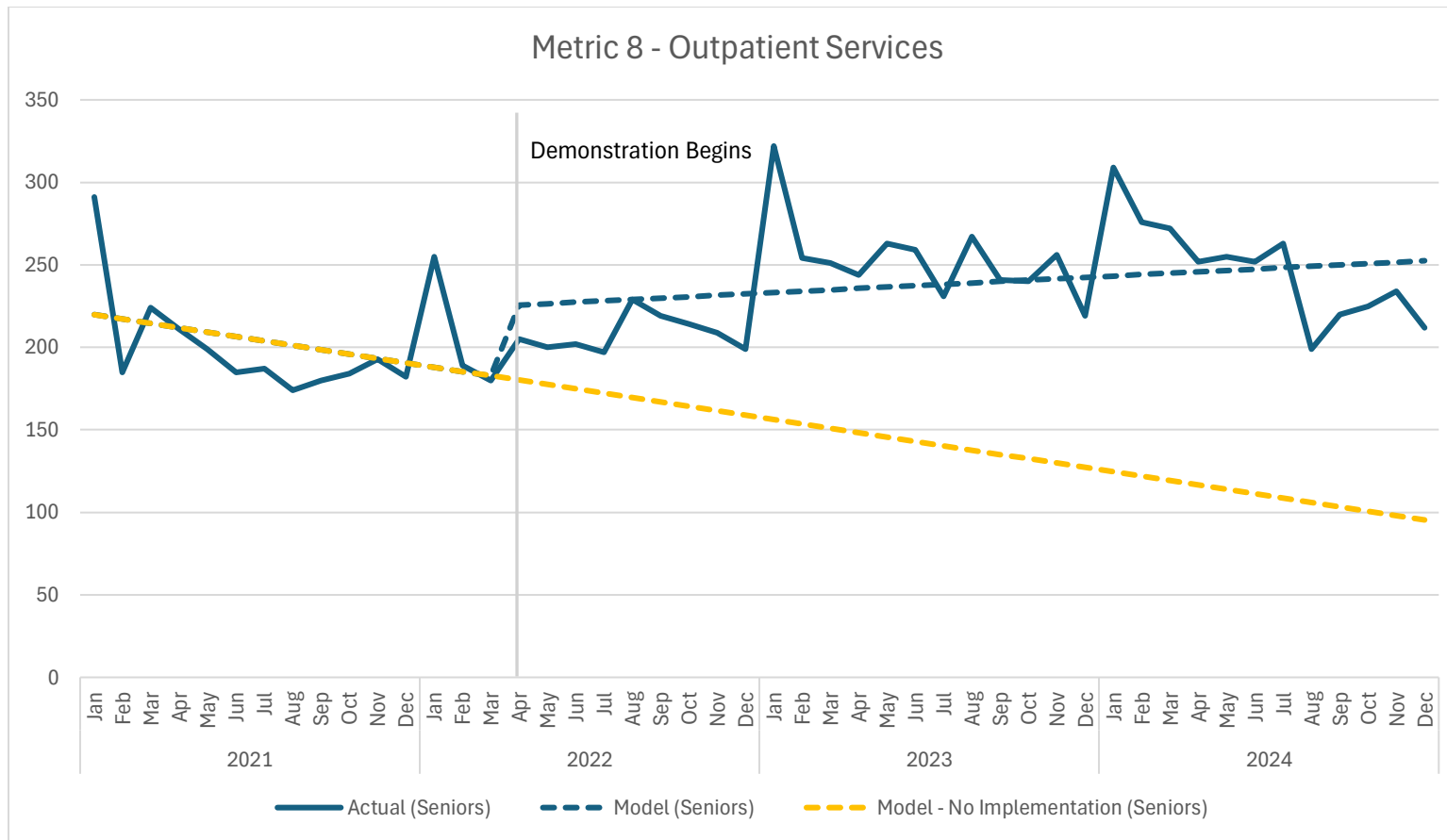
Metric 8 – Dual Eligible Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	3.8211861	-2	0.148
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	237.65	-43.26	518.56



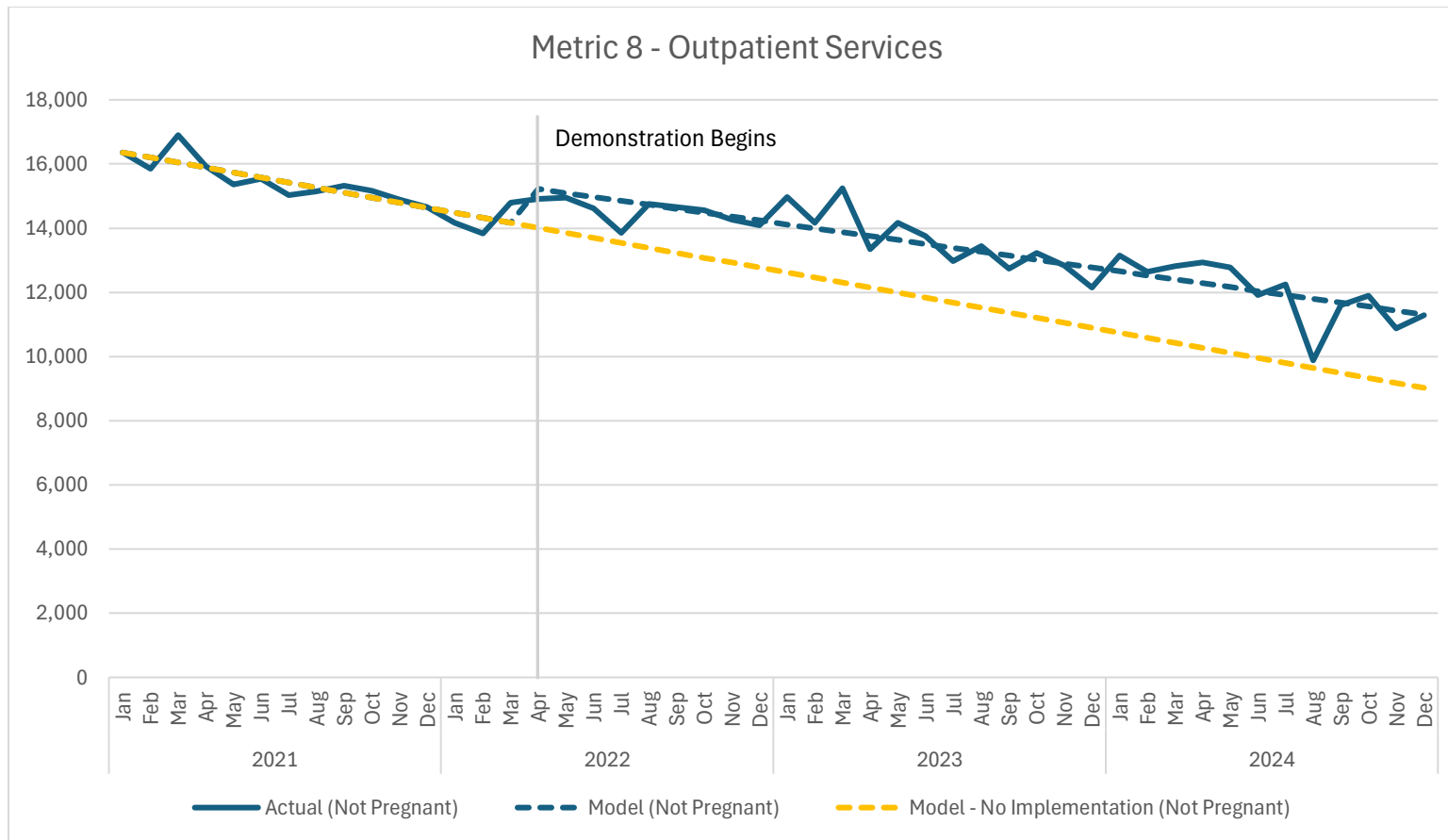
Metric 8 – Children Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	7.2810148	-2	0.026
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	27.84	-7.39	63.08



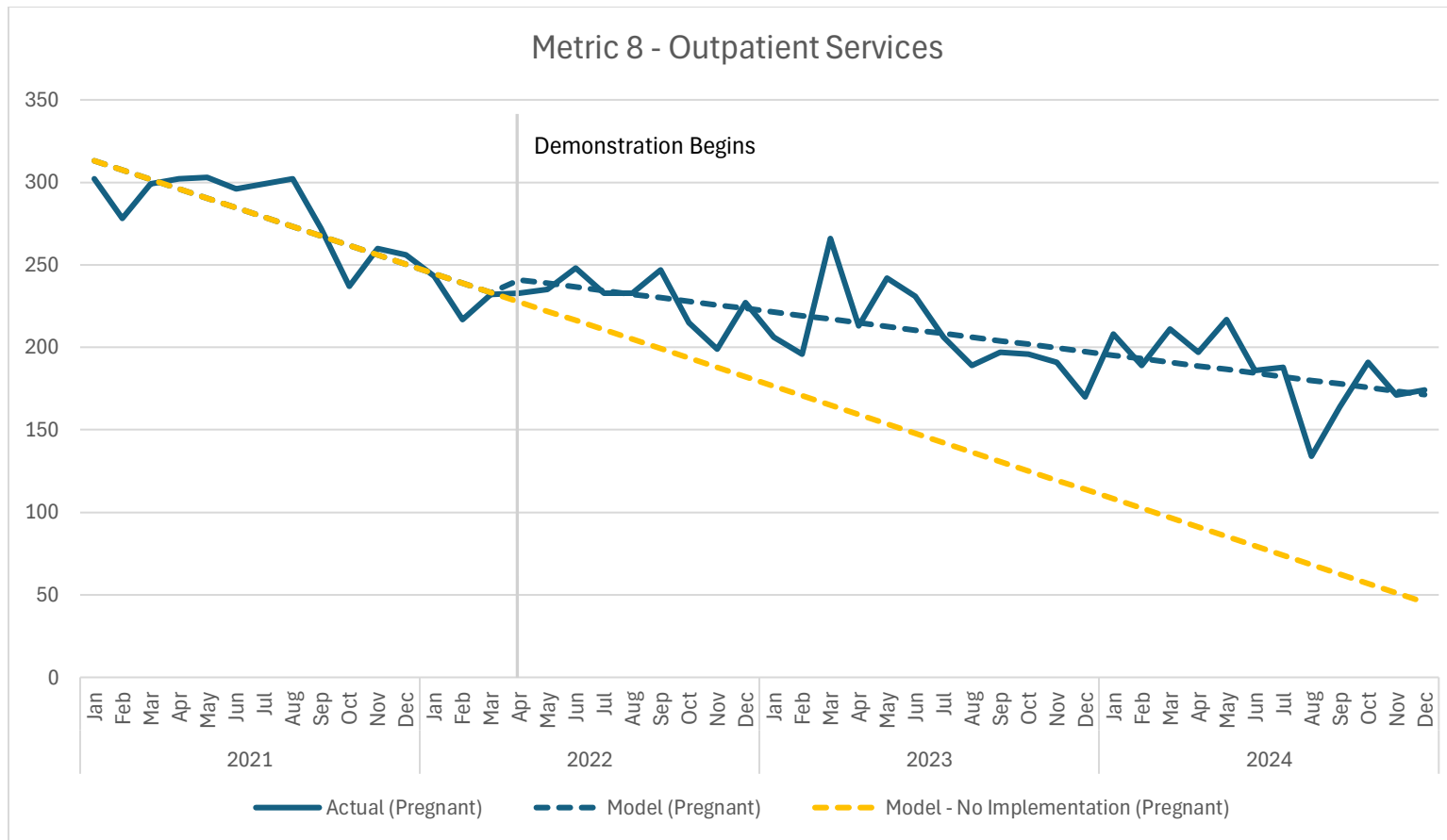
Metric 8 – Adults Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	52.750182	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	1,683.27	1,223.05	2,143.50



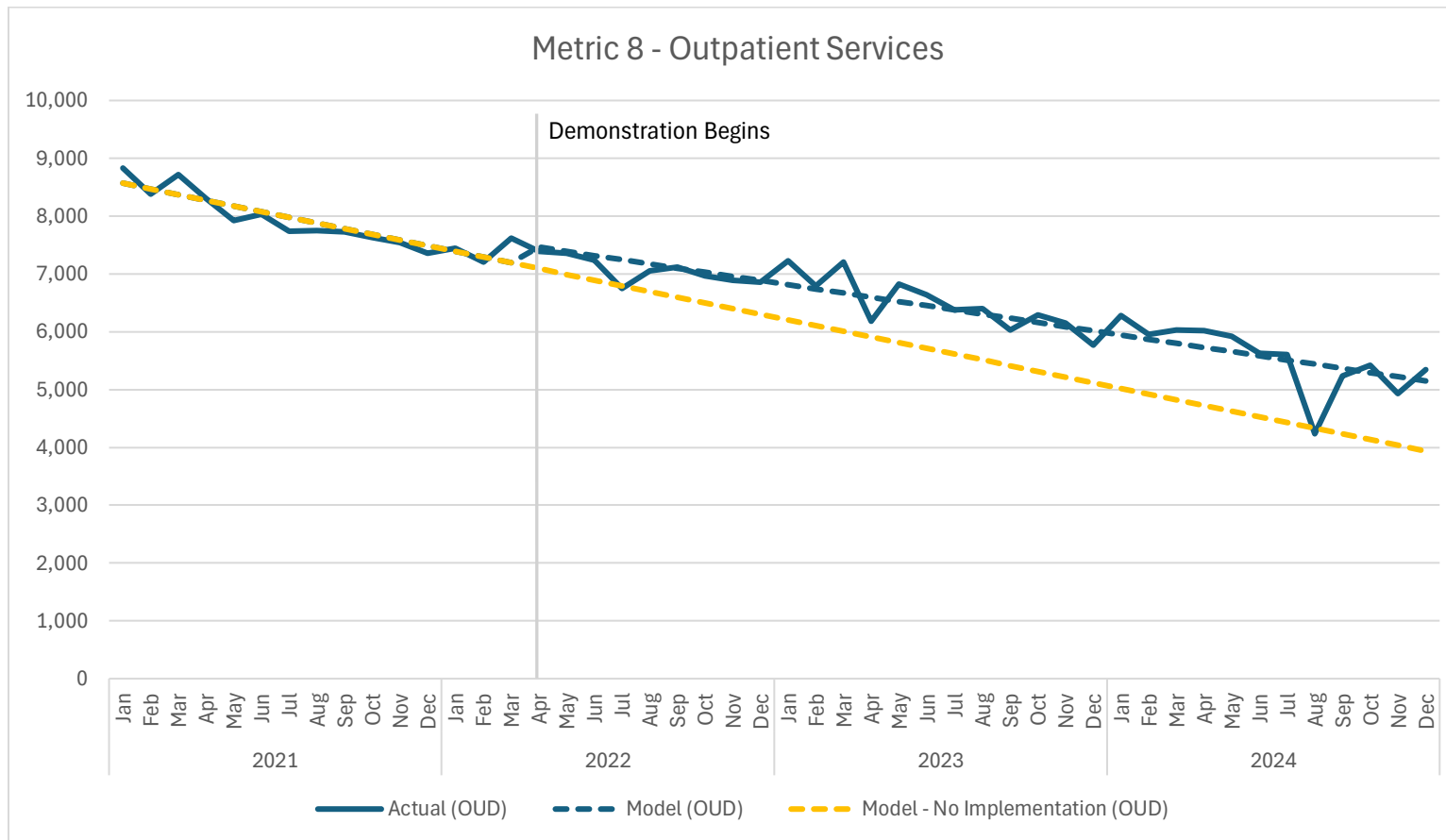
Metric 8 – Seniors Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	5.7821534	-2	0.056
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	101.34	18.67	184.00



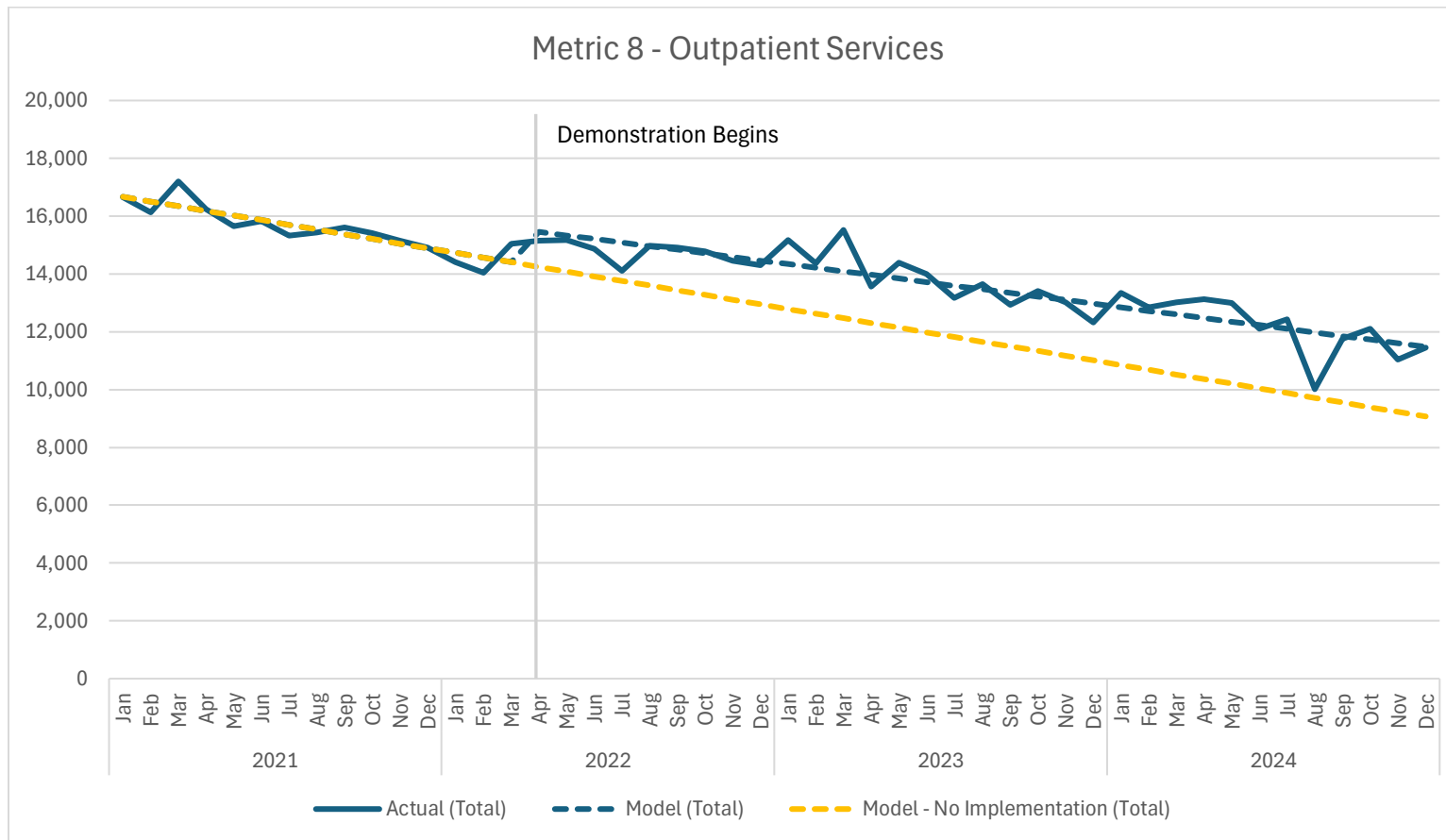
Metric 8 – Not Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	45.766761	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	1,742.88	1,236.93	2,248.82



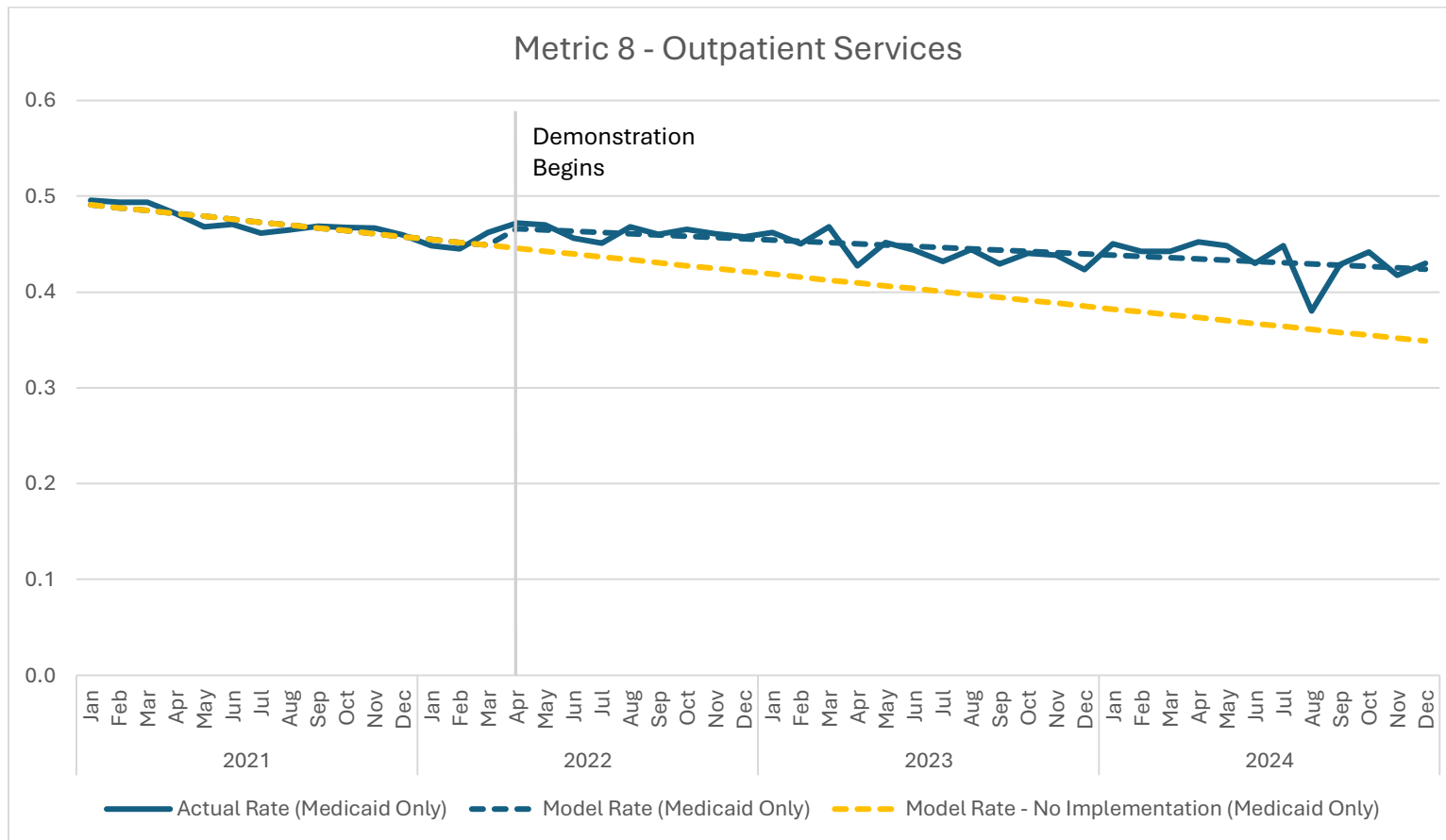
Metric 8 – Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	15.835123	-2	0.000
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	69.58	24.62	114.54



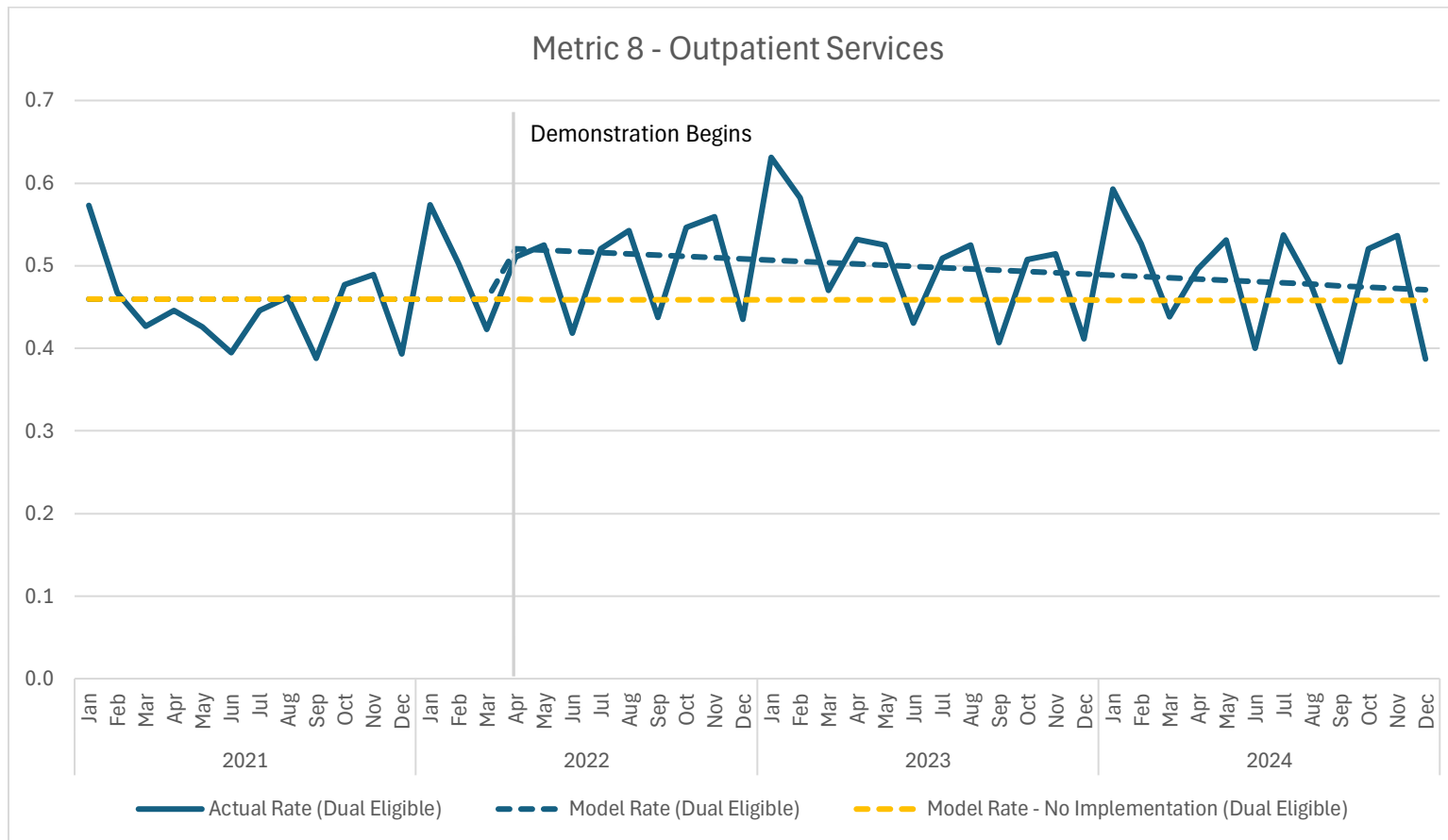
Metric 8 – OUD Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	6.0957257	-2	0.047
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	792.90	163.31	1,422.50



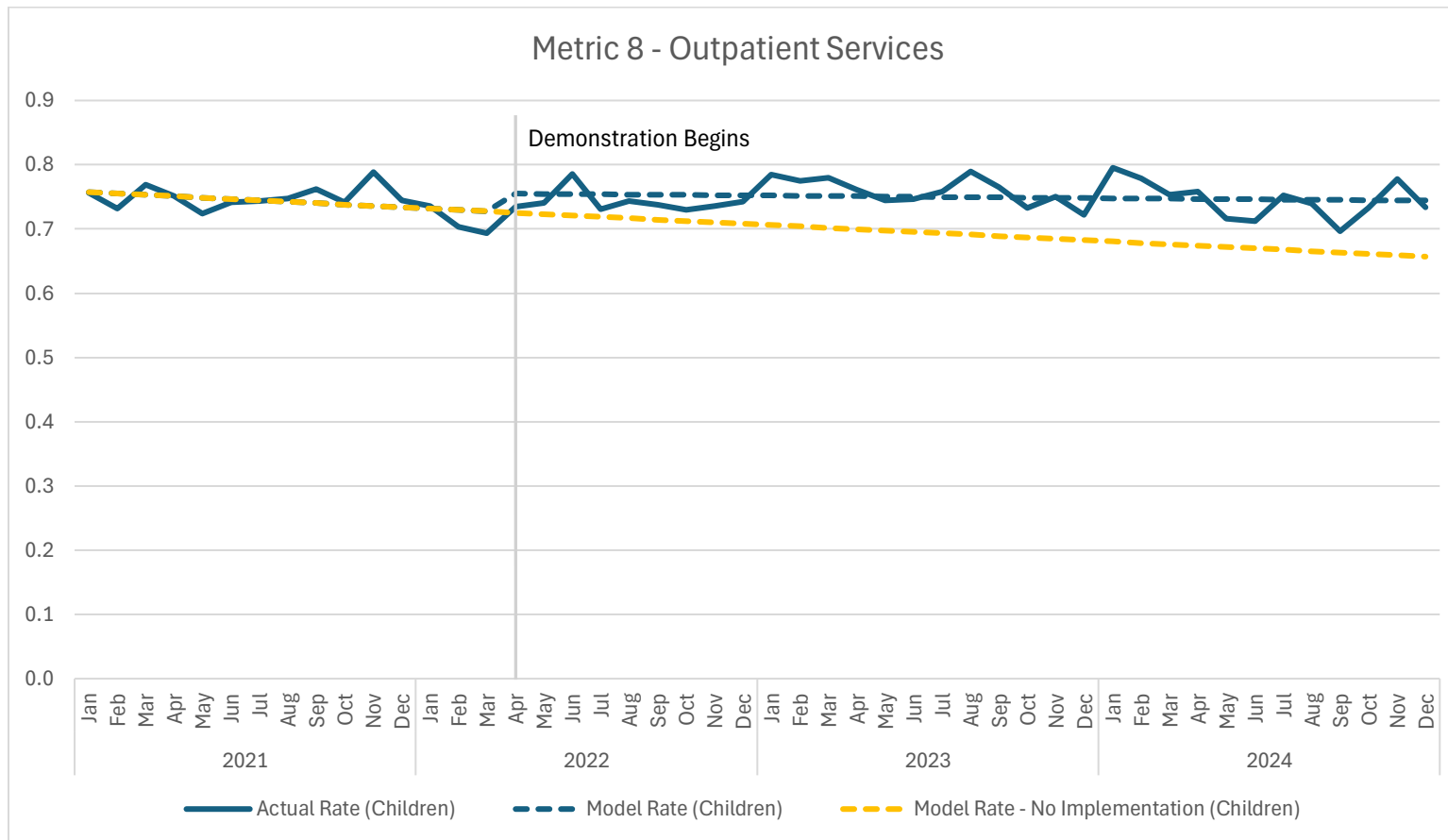
Metric 8 – Total Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	51.951438	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	1,812.46	1,319.16	2,305.75



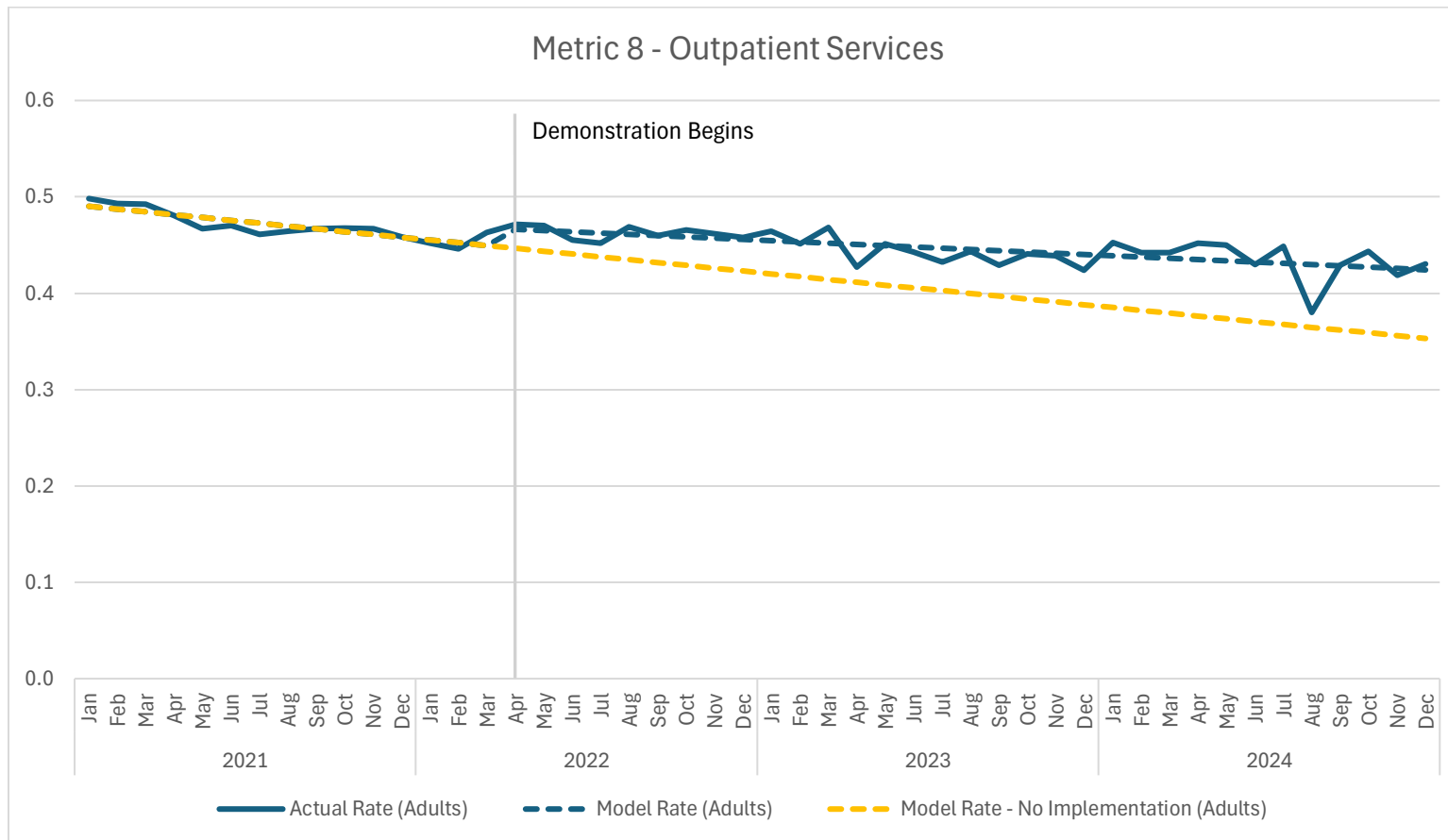
Metric 8 Rate – Medicaid Only Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	41.464289	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.048	0.031	0.064



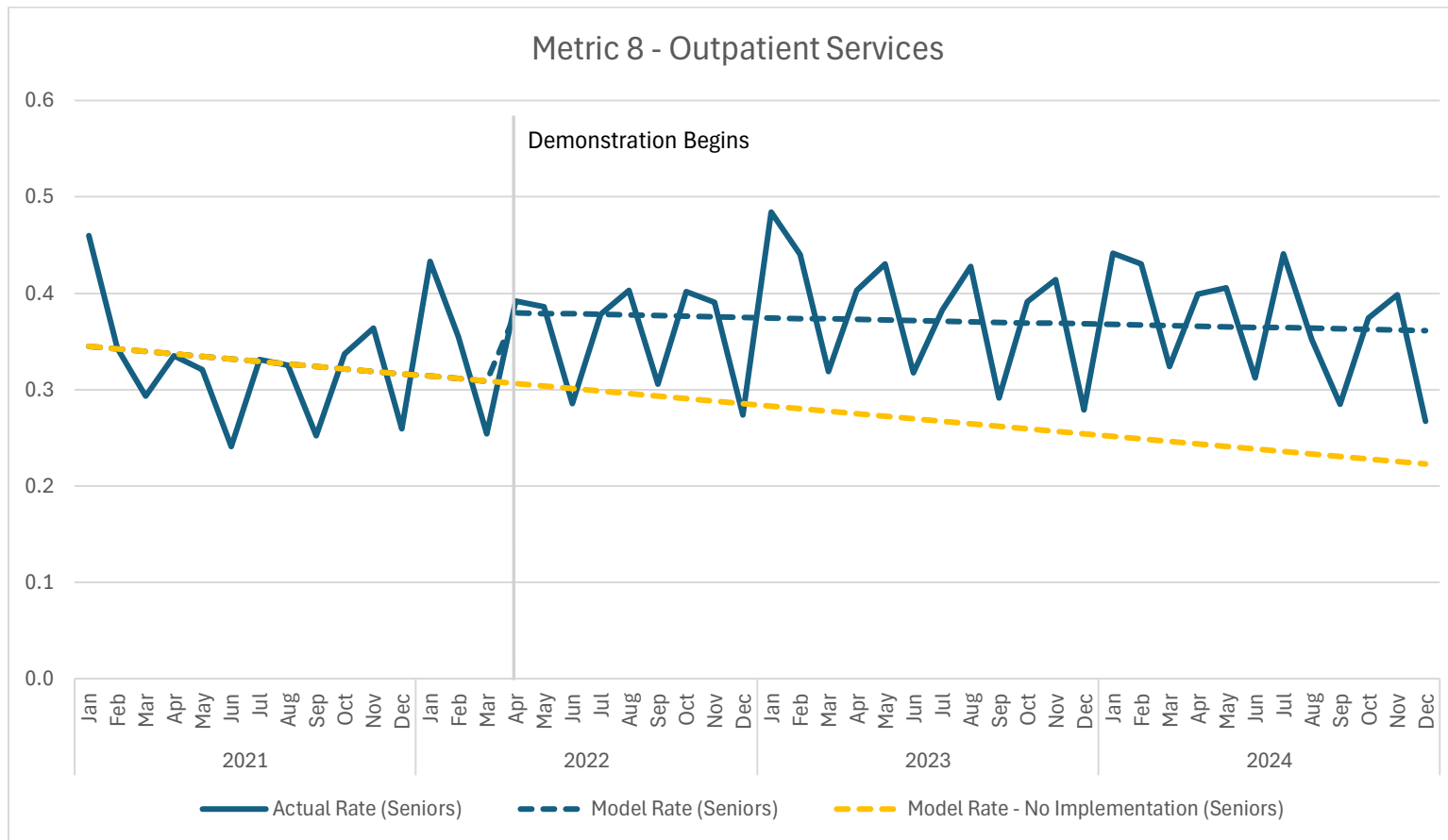
Metric 8 Rate – Dual Eligible Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	11.328344	-2	0.003
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.037	-0.102	0.177



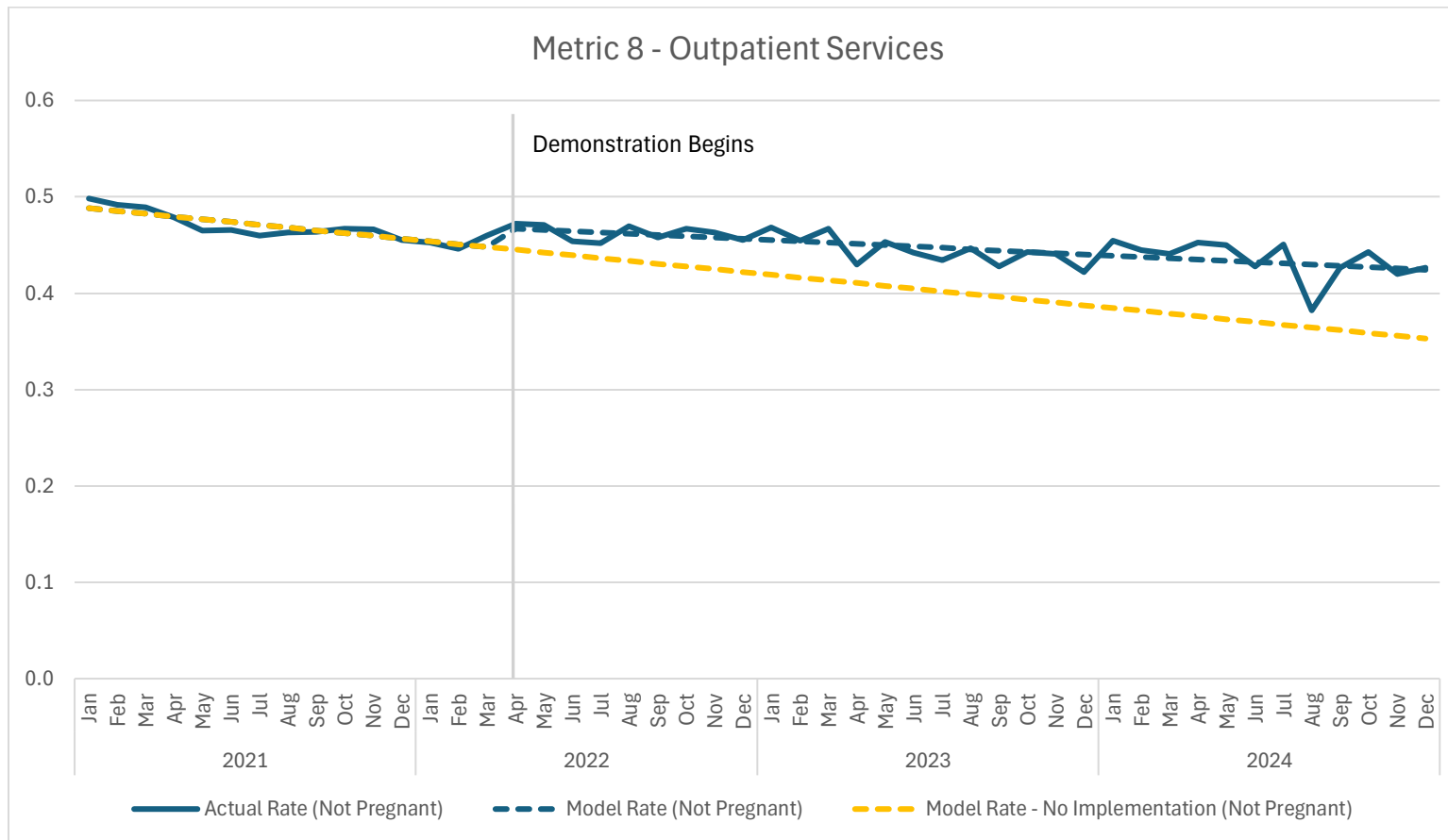
Metric 8 Rate – Children Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	8.6948488	-2	0.013
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.058	0.001	0.116



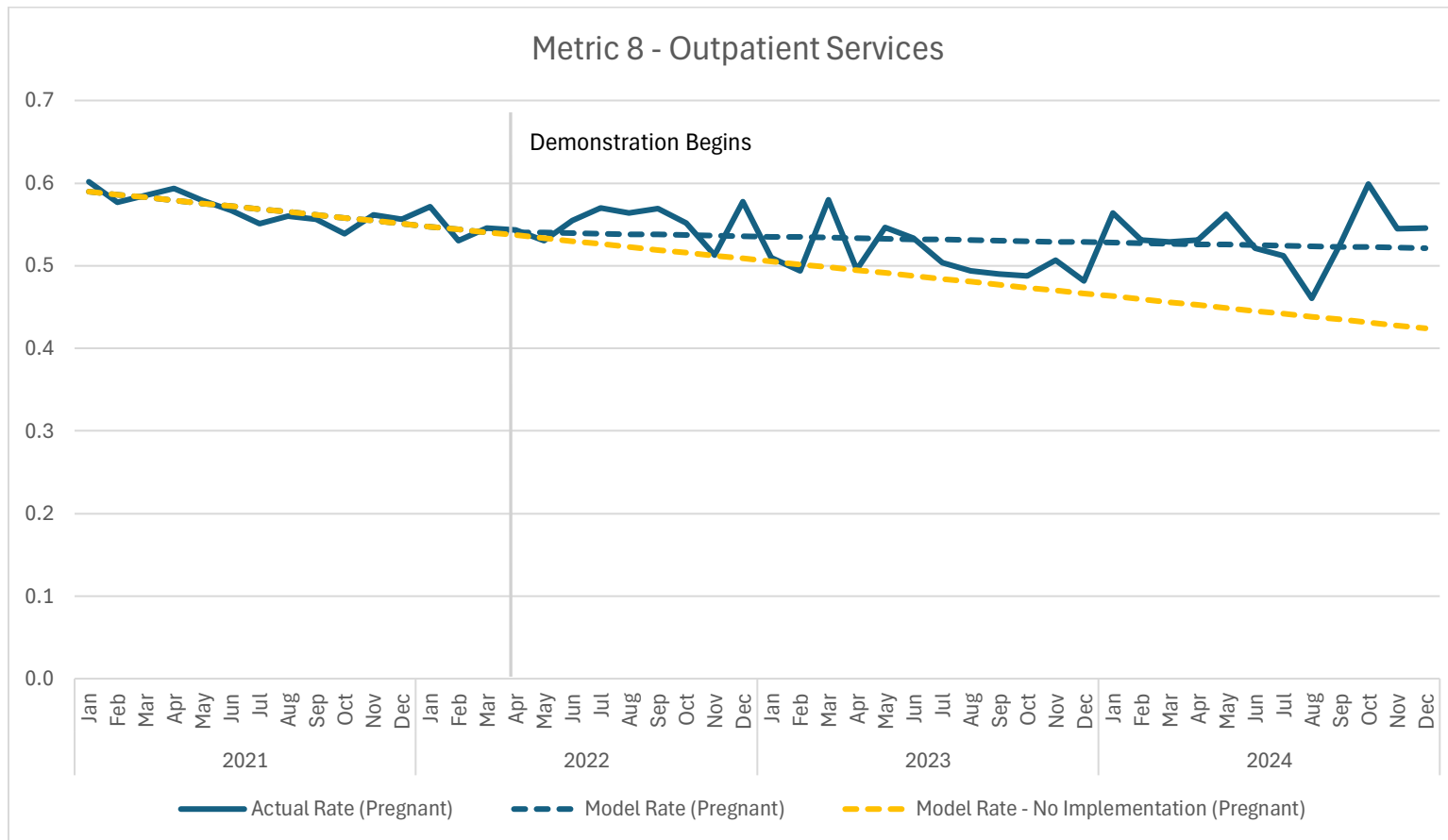
Metric 8 Rate – Adults Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	28.786475	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.046	0.026	0.065



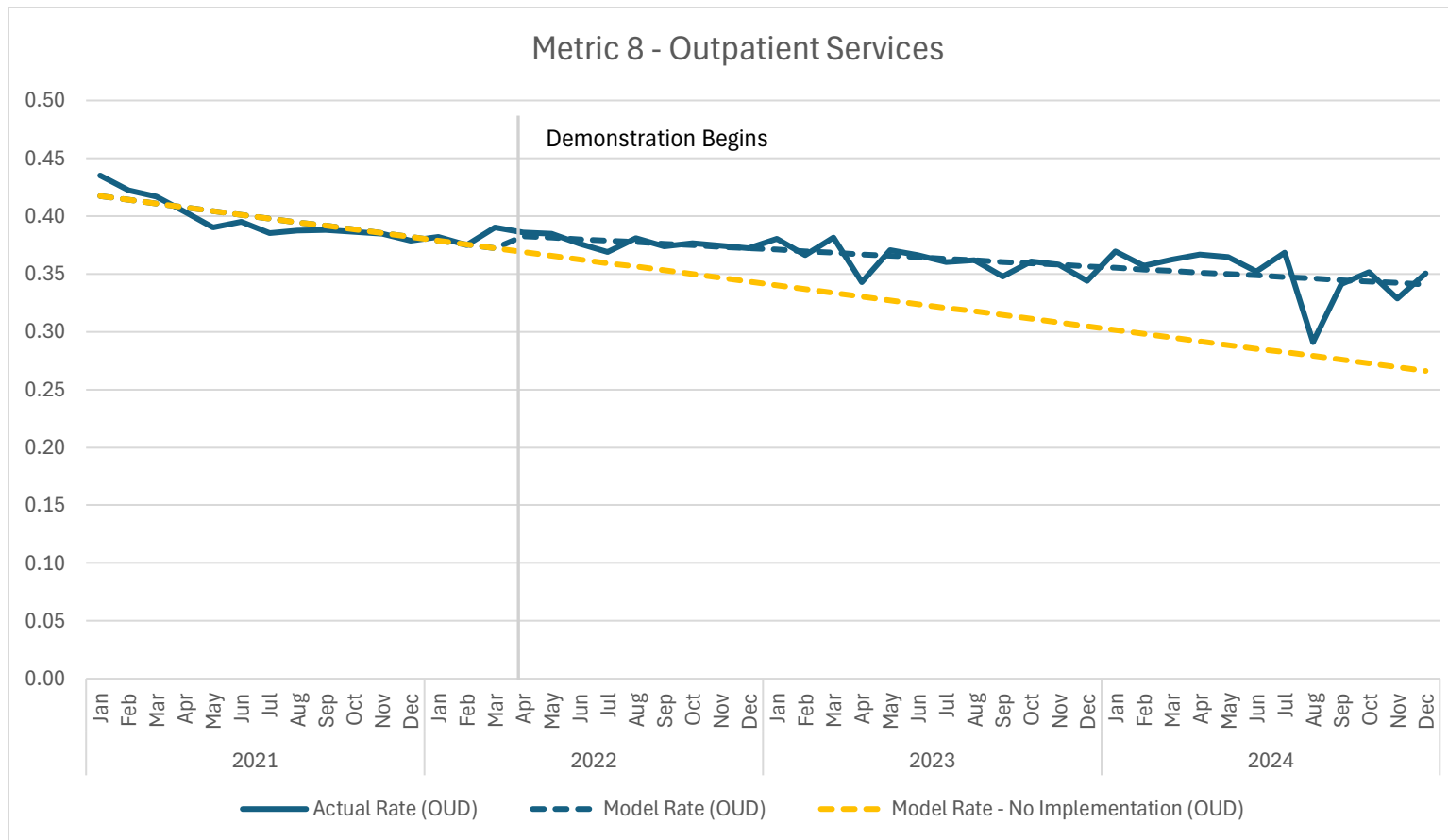
Metric 8 Rate – Seniors Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	9.3726337	-2	0.009
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.106	-0.028	0.240



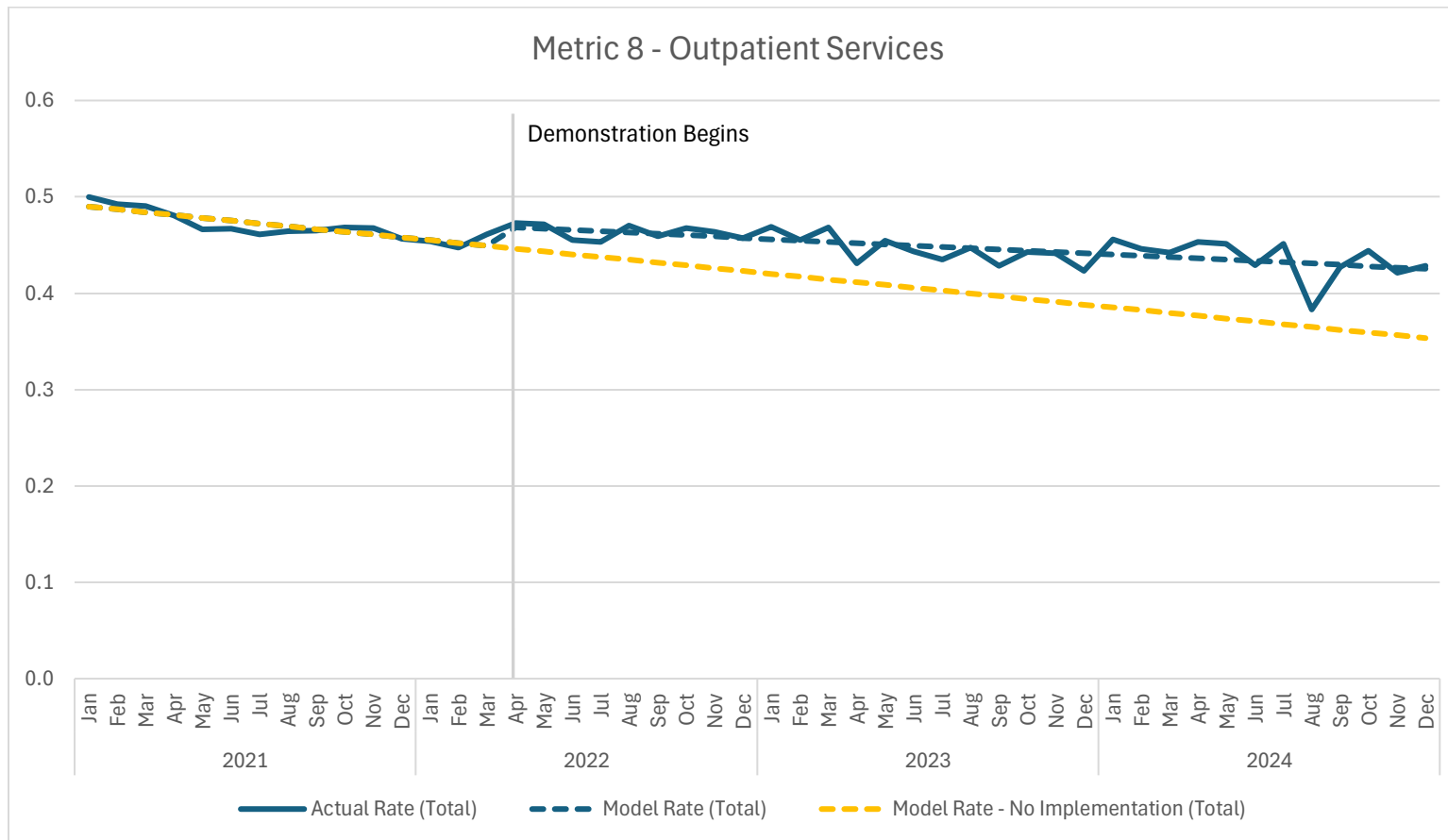
Metric 8 Rate – Not Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	29.378547	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.047	0.025	0.068



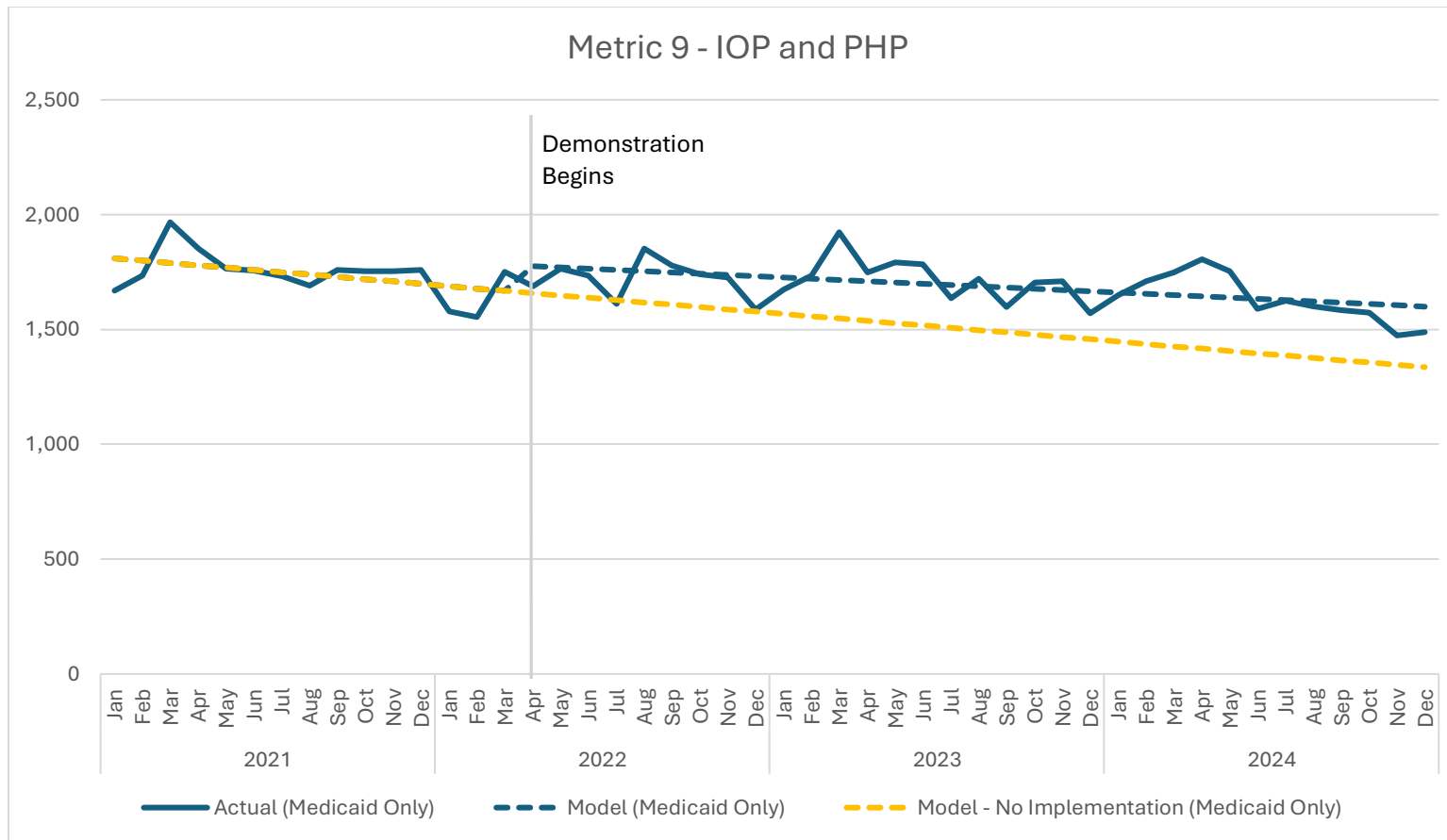
Metric 8 Rate – Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	17.36775	-2	0.000
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.050	0.026	0.075



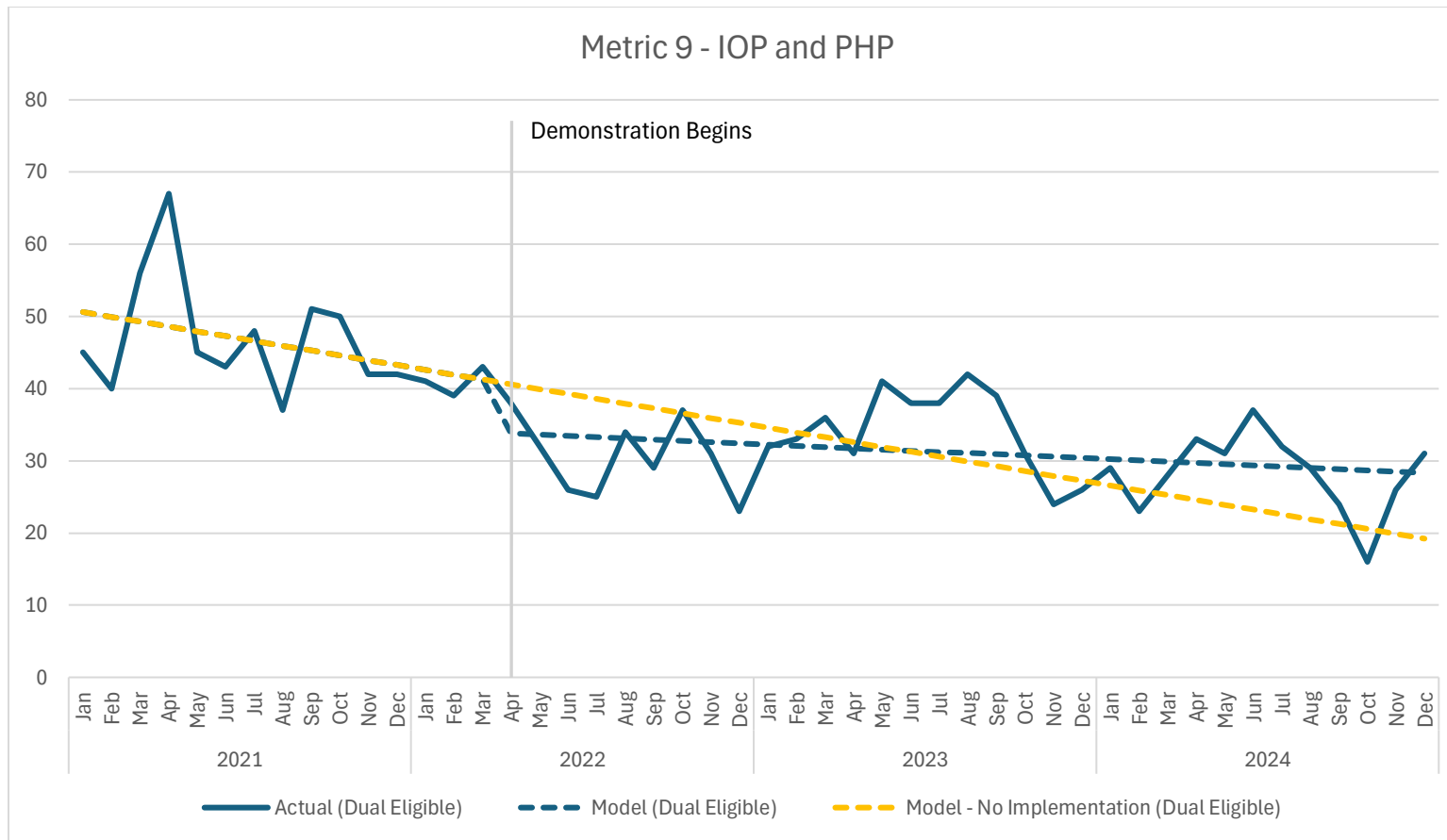
Metric 8 Rate – OUD Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	6.3945414	-2	0.041
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.044	0.009	0.079



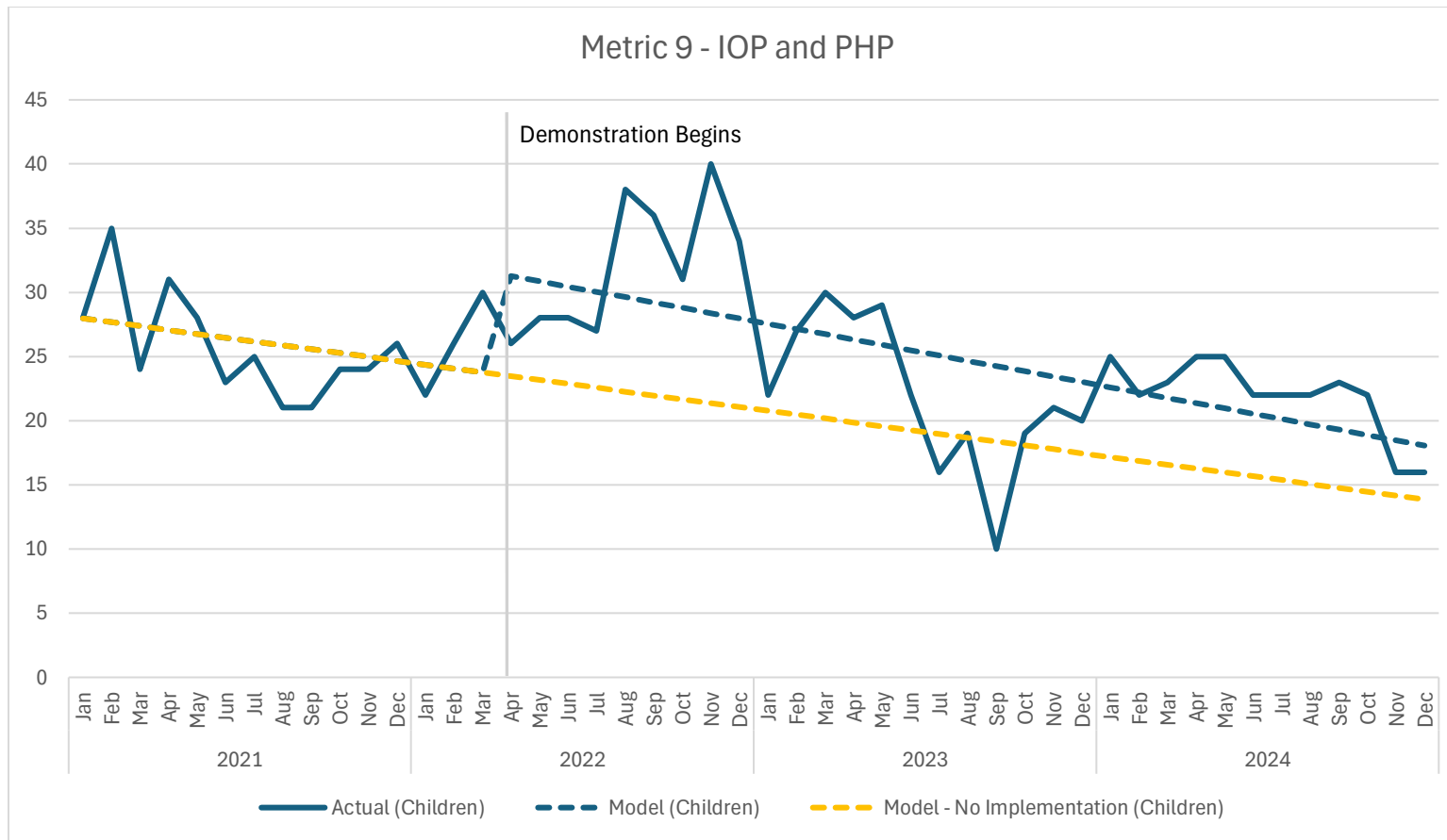
Metric 8 Rate – Total Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	29.552898	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.047	0.026	0.068



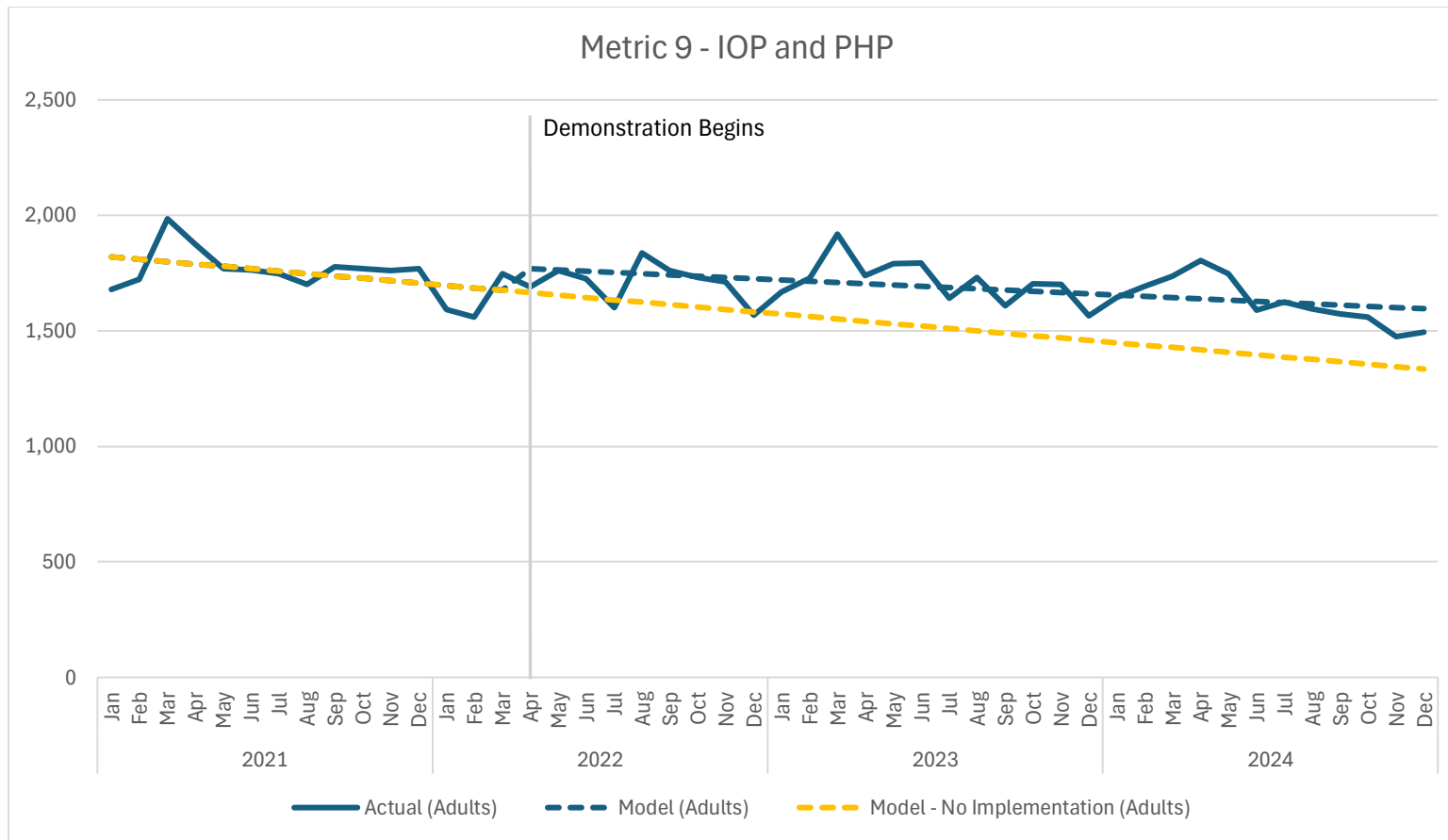
Metric 9 – Medicaid Only Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	11.468695	-2	0.003
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	190.27	46.61	333.92



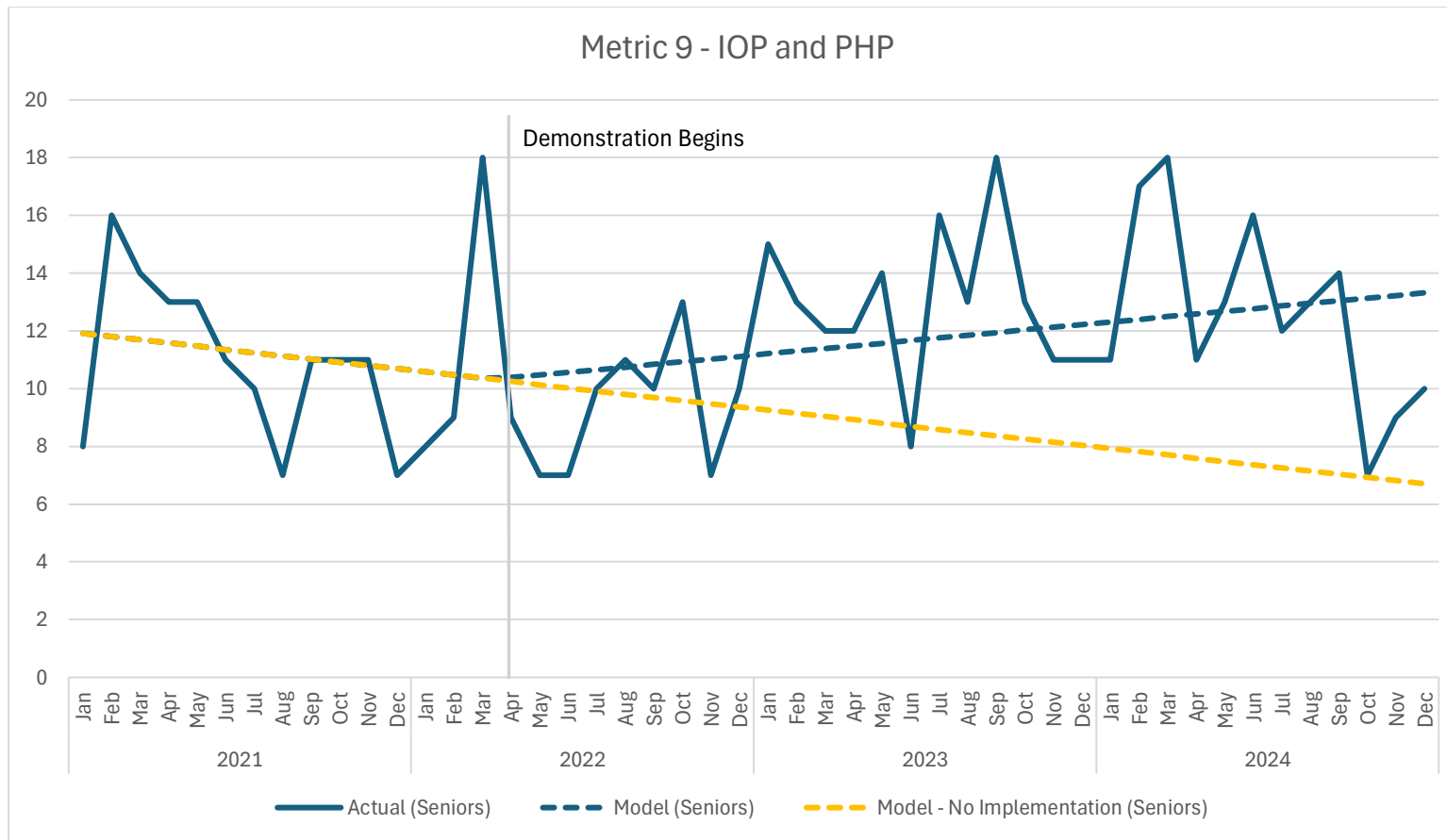
Metric 9 – Dual Eligible Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	12.552529	-2	0.002
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	1.16	-7.90	10.21



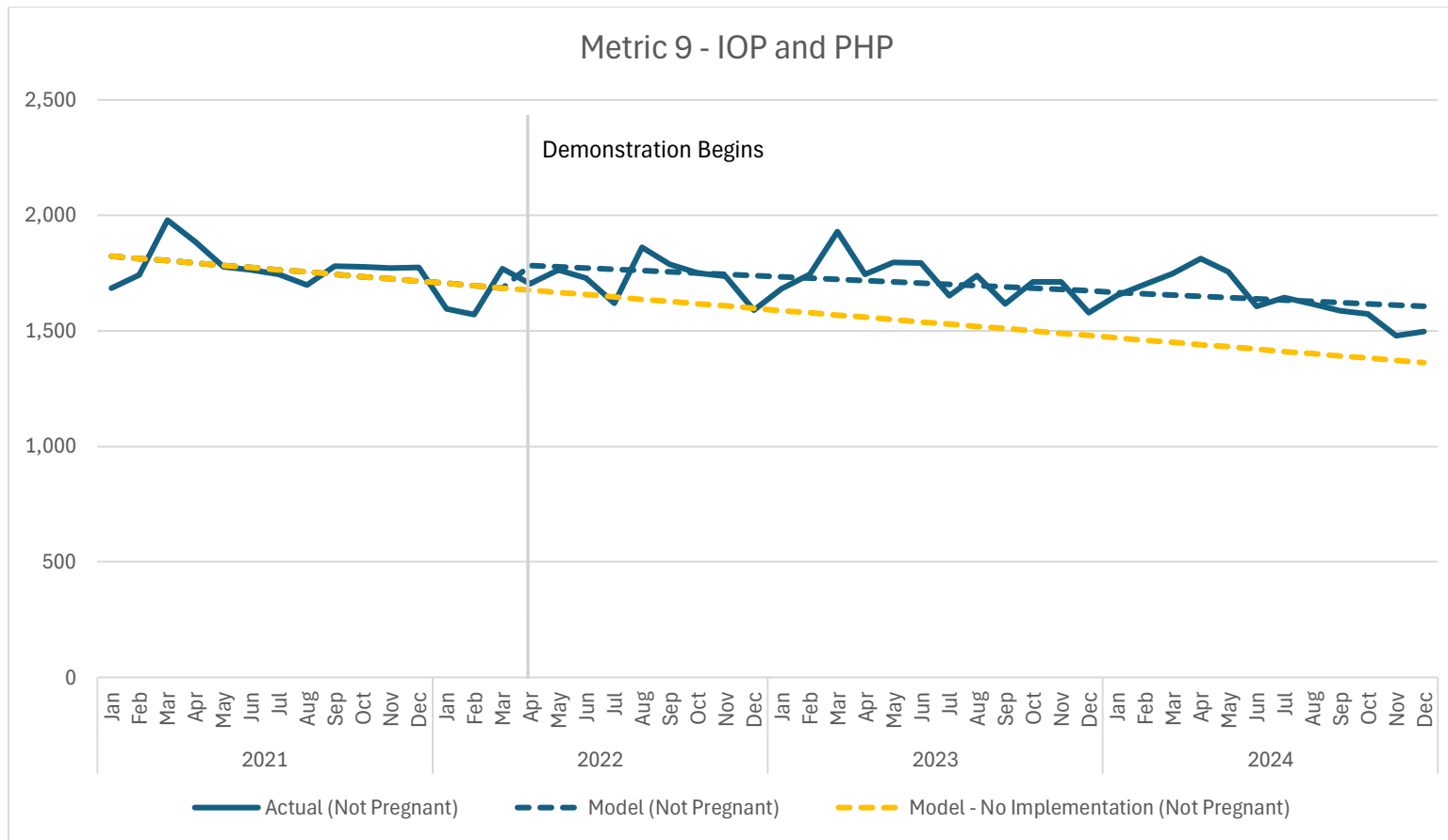
Metric 9 – Children Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	9.6268525	-2	0.008
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	6.00	-5.15	17.15



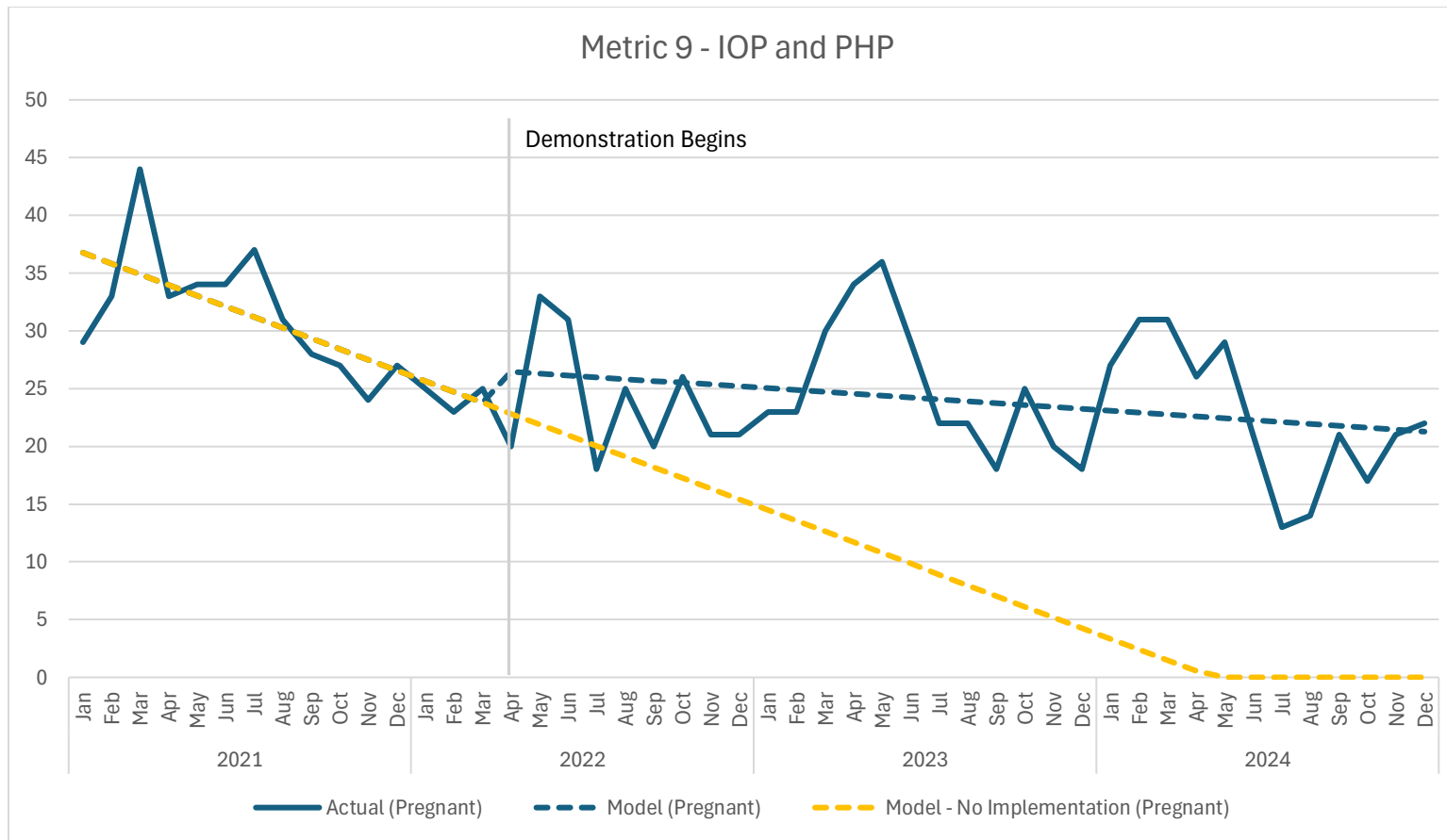
Metric 9 – Adults Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	8.5135476	-2	0.014
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	182.05	27.16	336.94



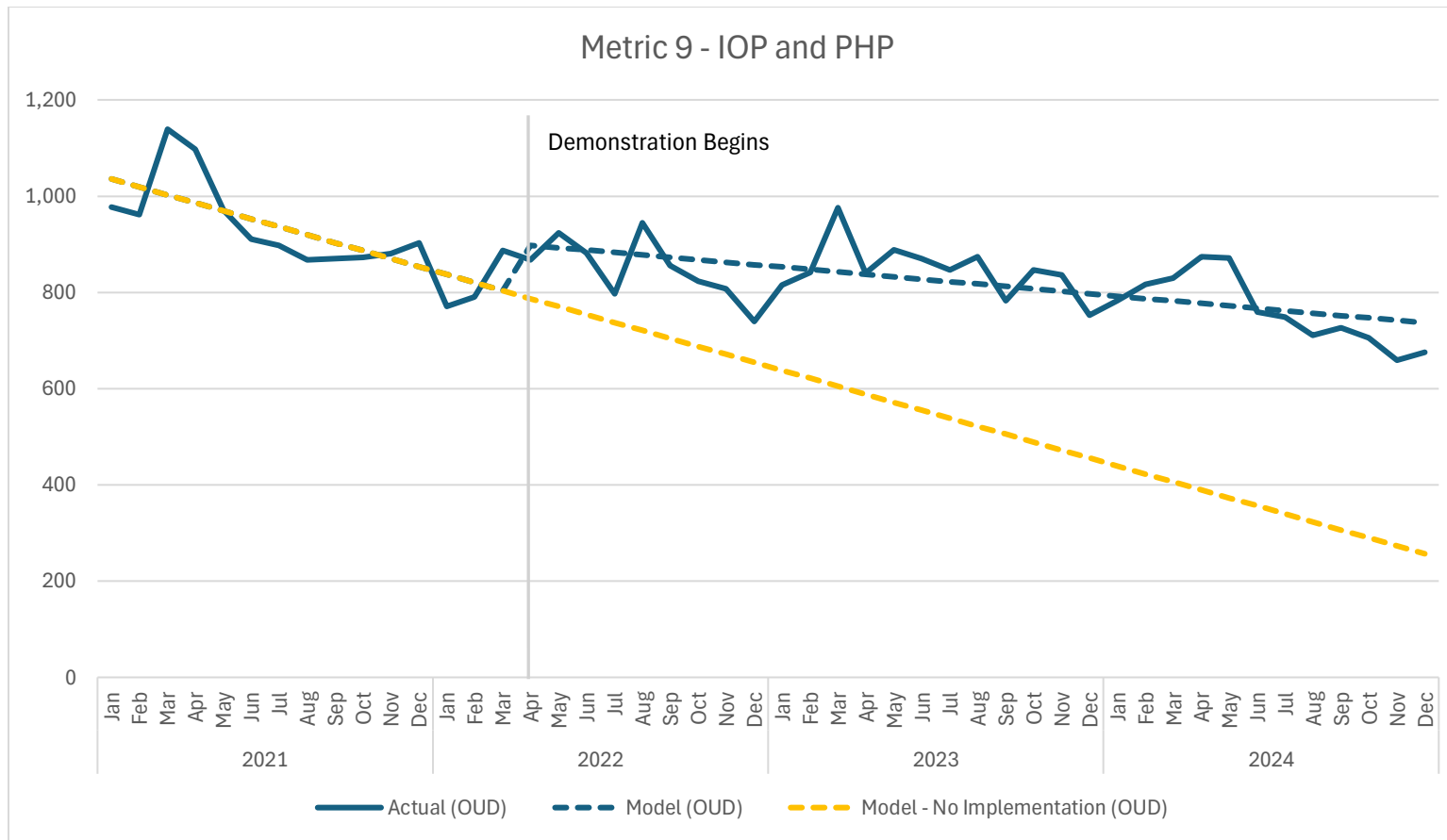
Metric 9 – Seniors Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	2.4769789	-2	0.290
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	3.37	-4.67	11.41



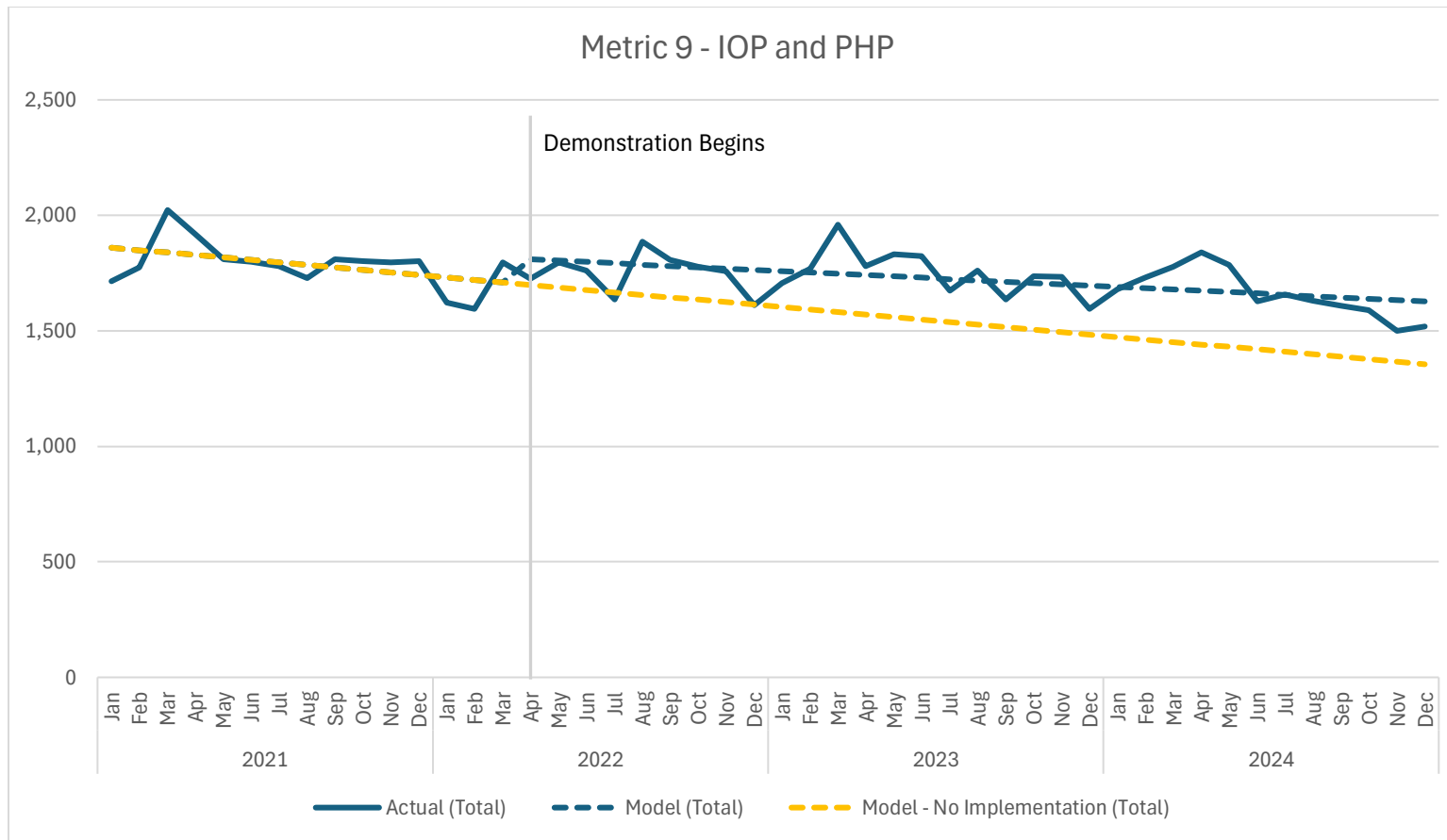
Metric 9 – Not Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	9.2482692	-2	0.010
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	175.52	30.06	320.99



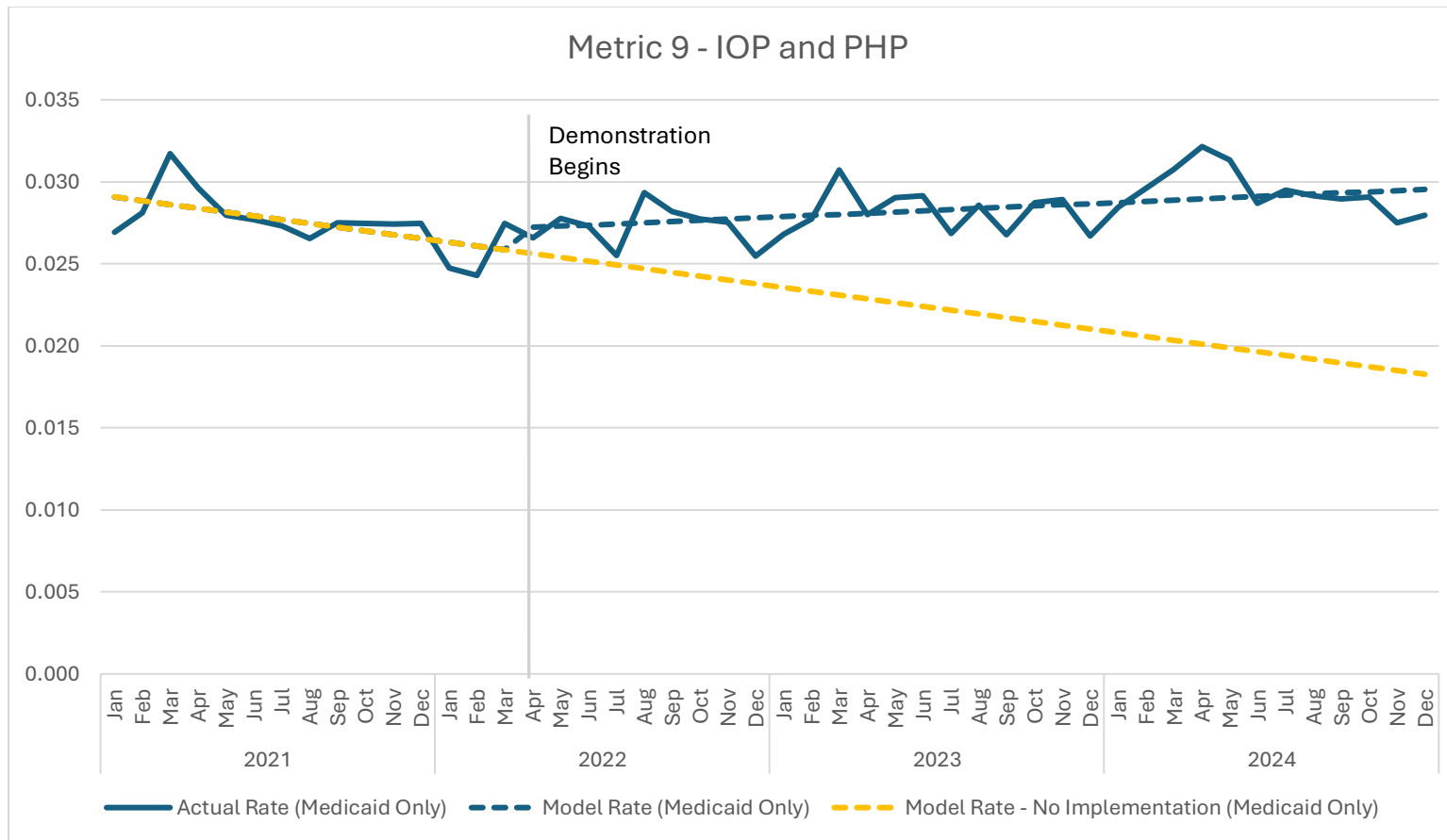
Metric 9 – Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	16.525236	-2	0.000
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	15.90	8.07	23.72



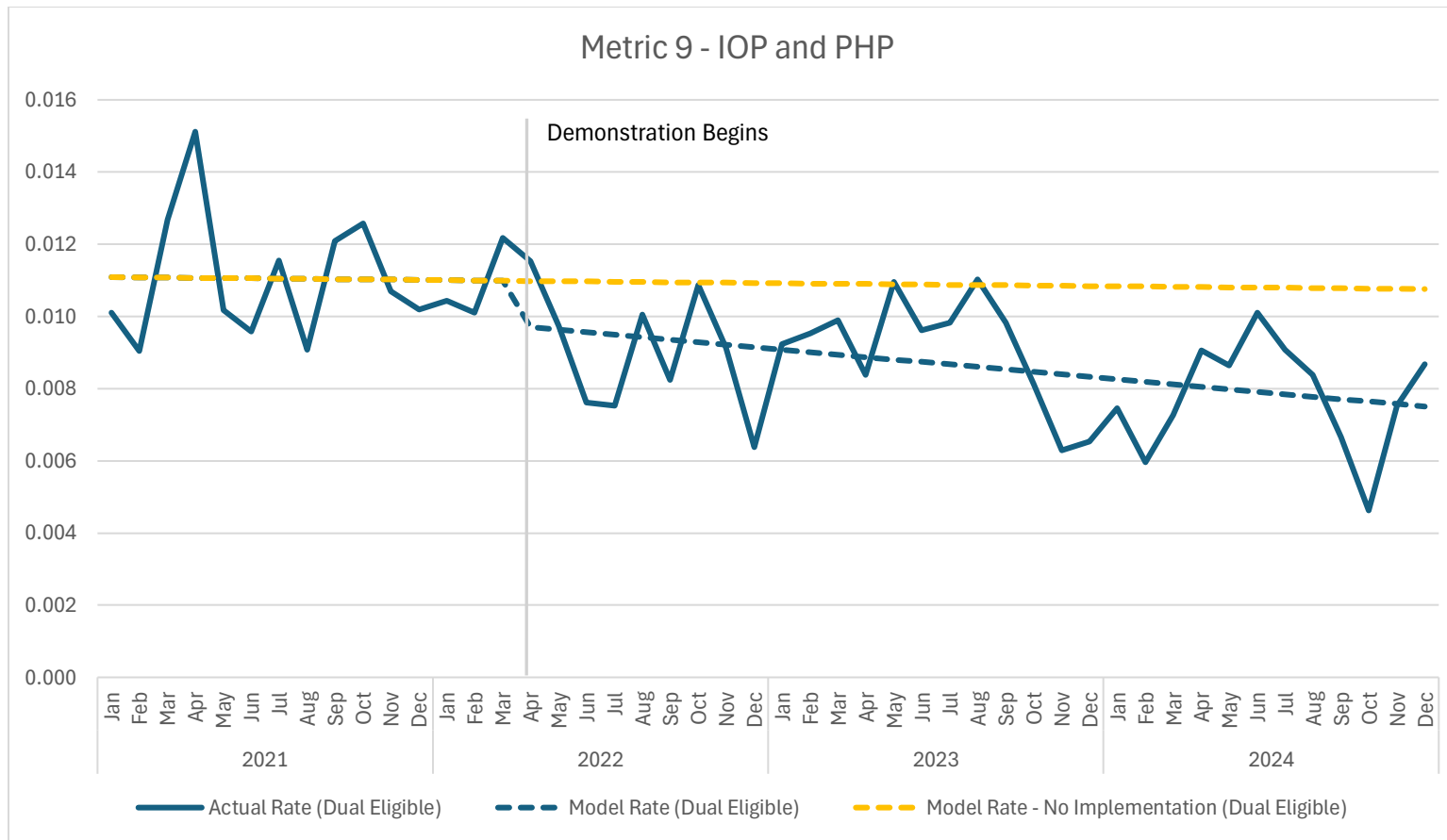
Metric 9 – OUD Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	24.620255	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	295.26	178.39	412.13



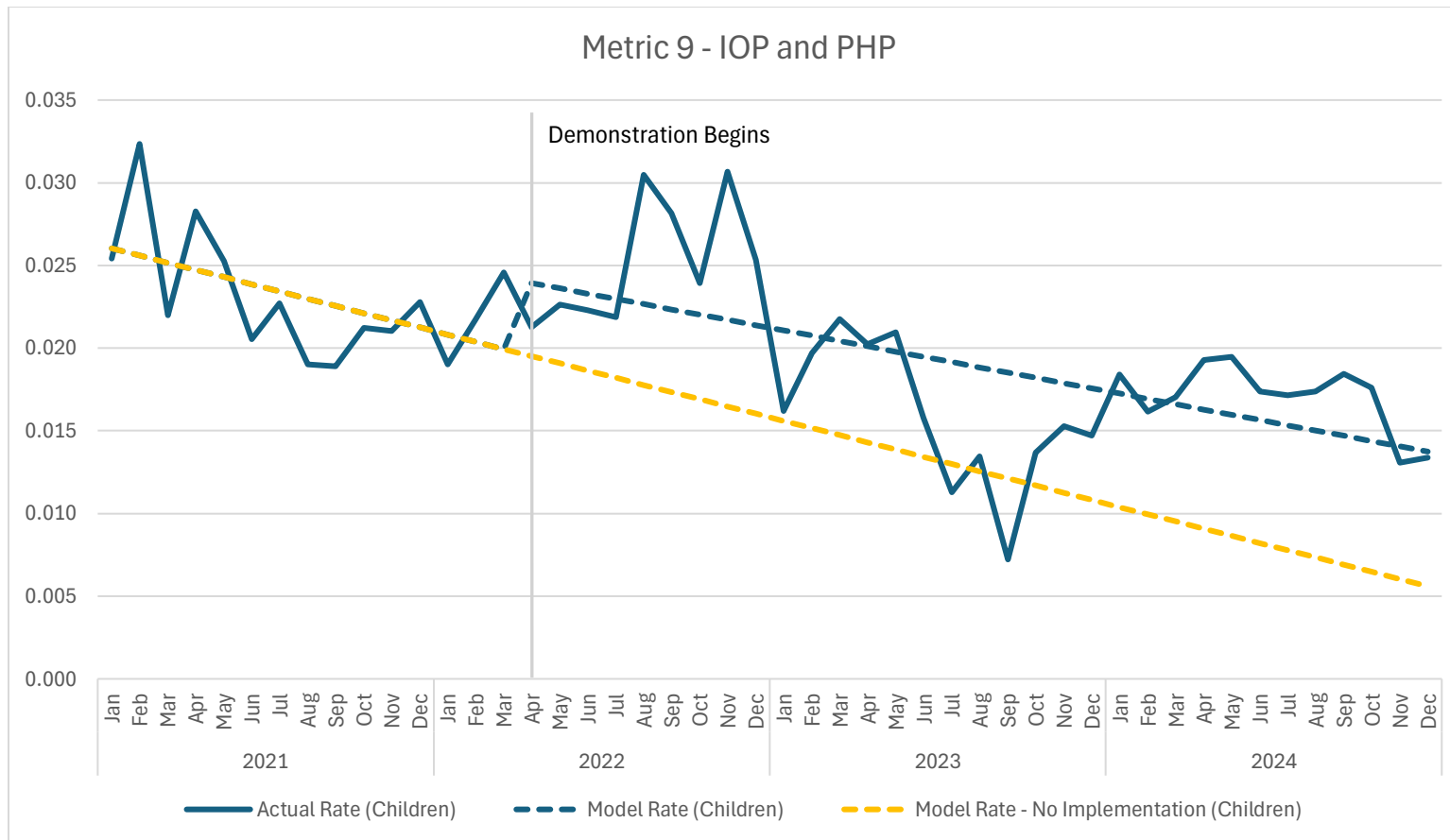
Metric 9 – Total Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	9.4632375	-2	0.009
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	191.42	39.61	343.23



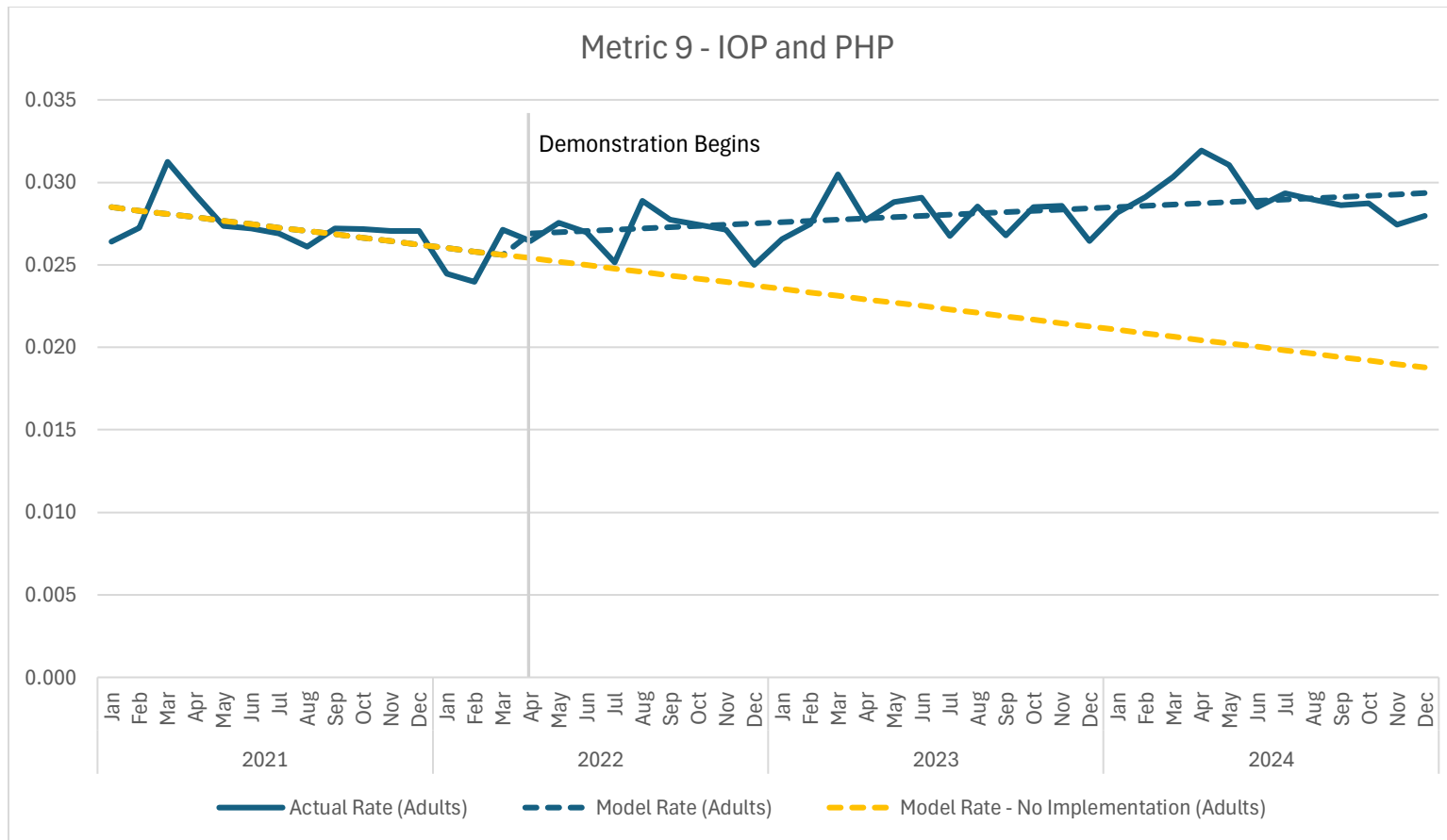
Metric 9 Rate – Medicaid Only Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	39.64666	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.006	0.004	0.008



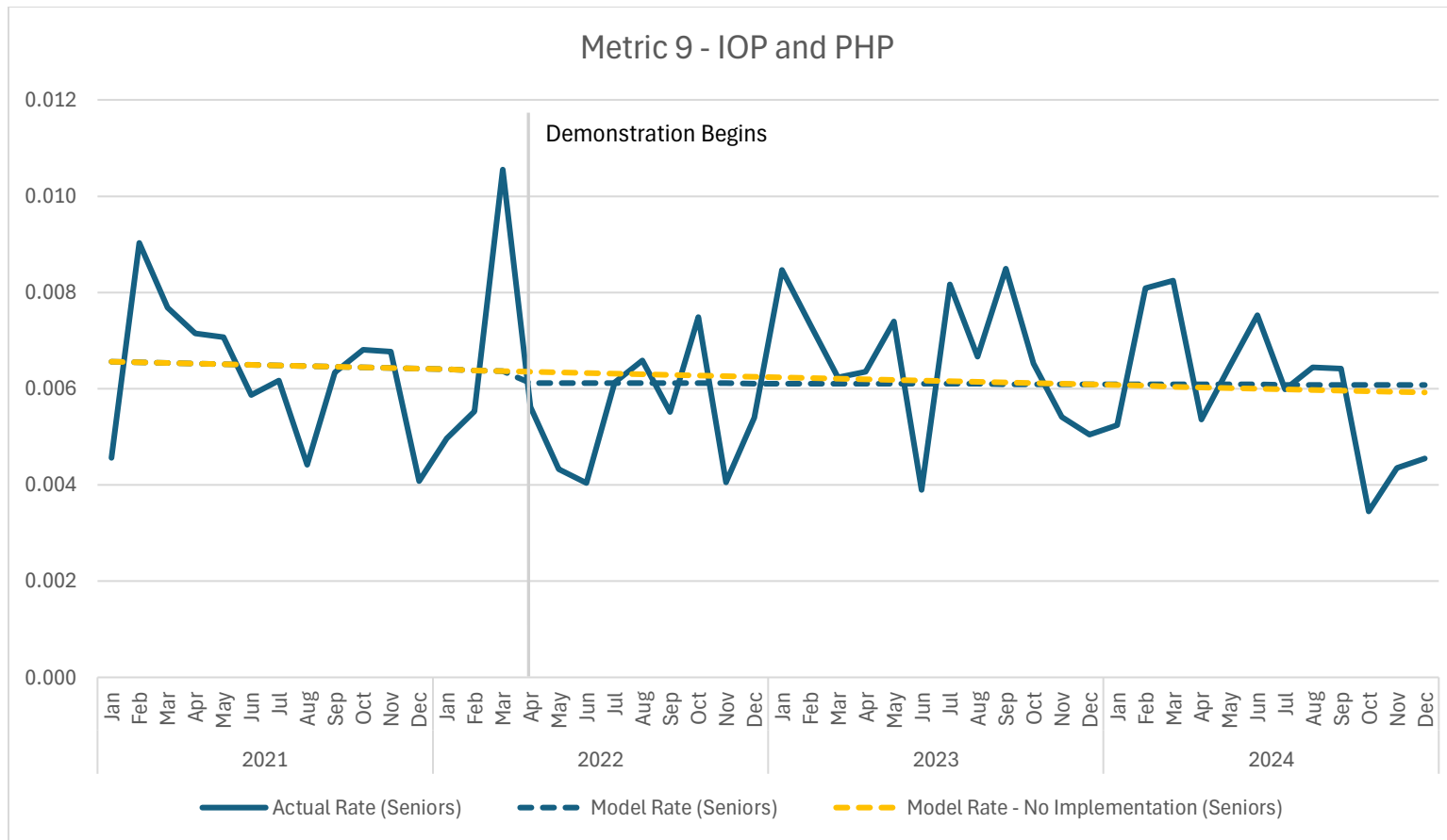
Metric 9 Rate – Dual Eligible Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	6.7837099	-2	0.034
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-0.002	-0.004	-0.0002



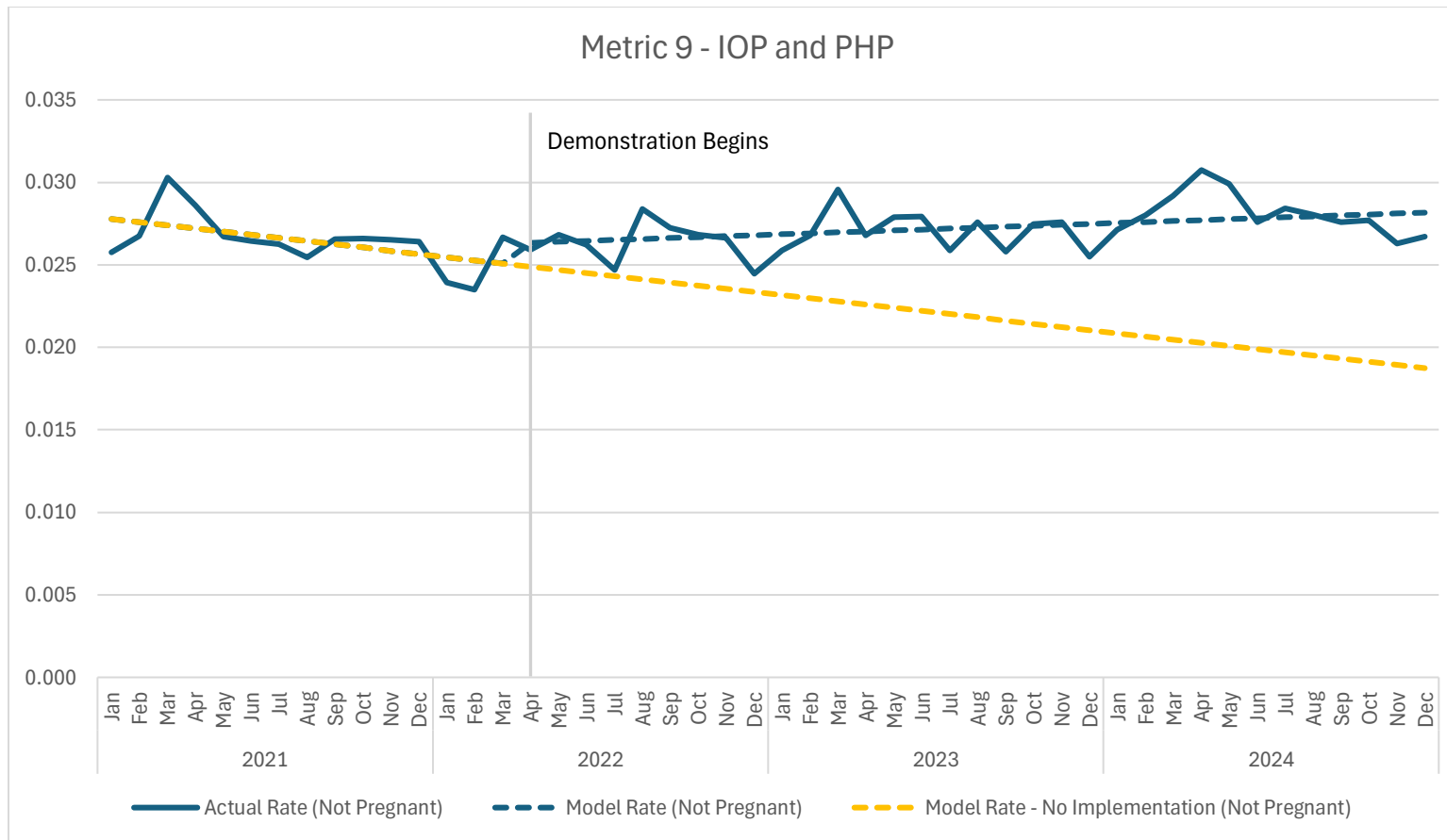
Metric 9 Rate – Children Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	4.0557568	-2	0.132
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.006	-0.002	0.015



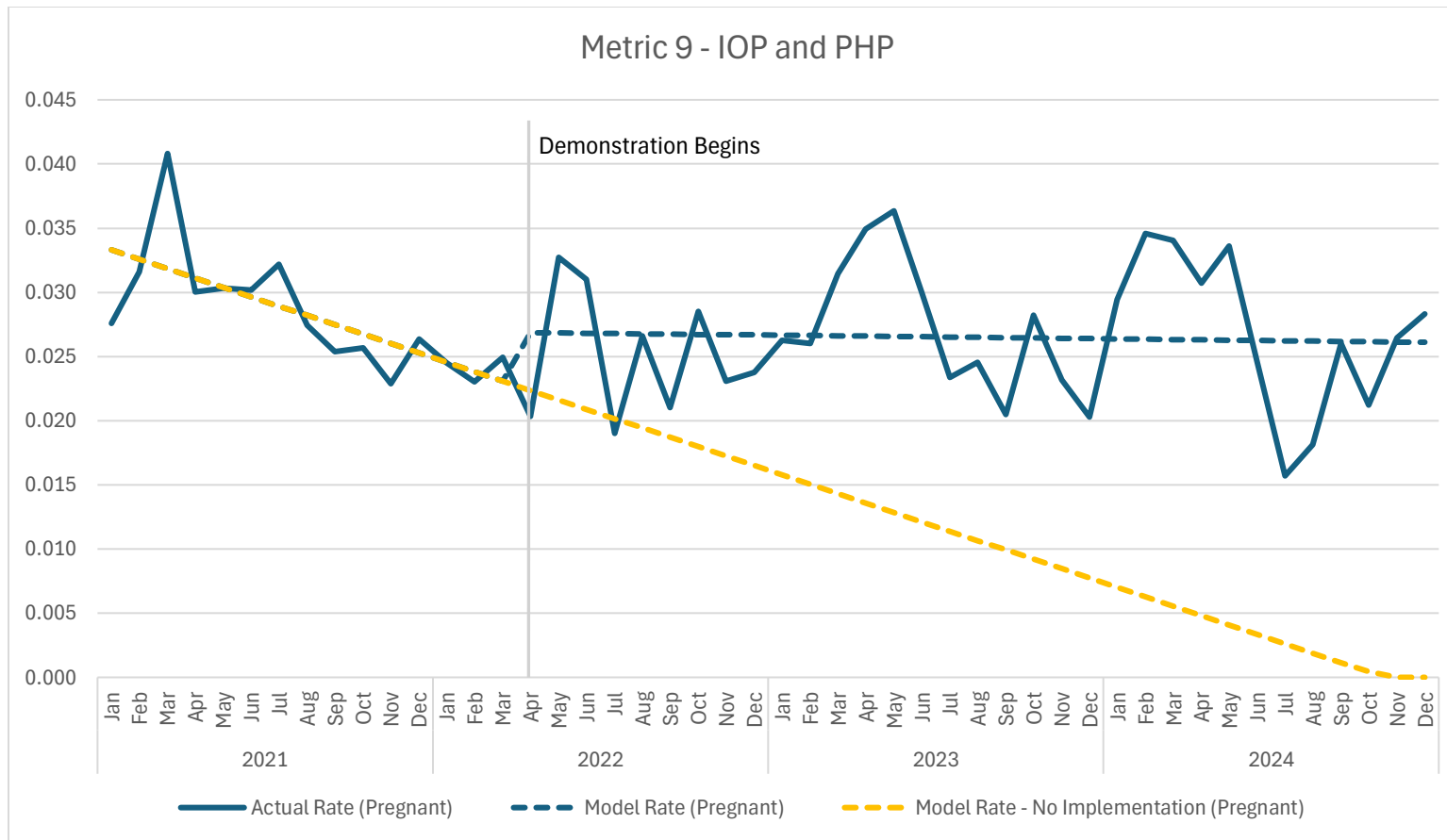
Metric 9 Rate – Adults Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	32.829308	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.006	0.004	0.008



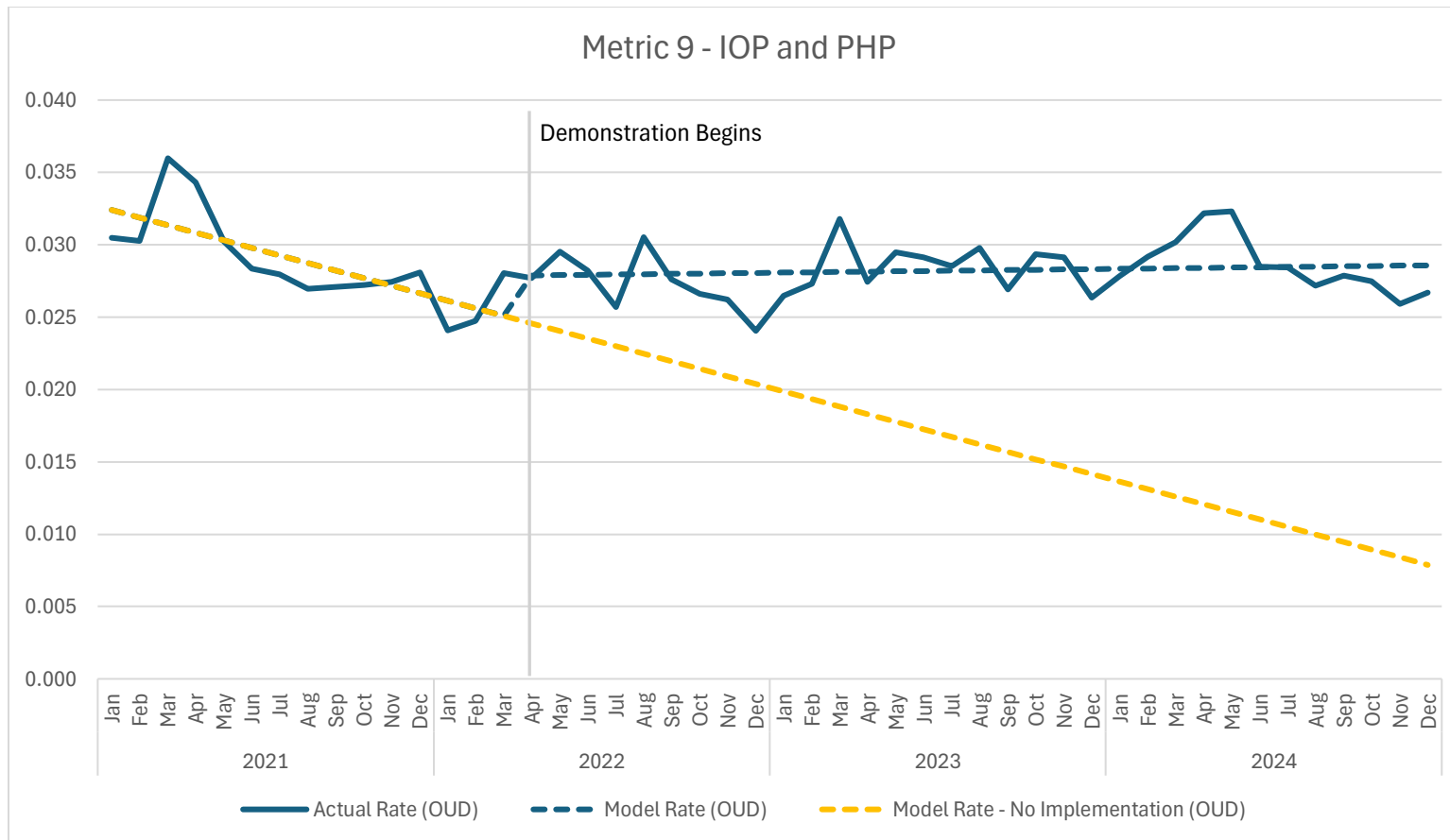
Metric 9 Rate – Seniors Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	0.1932416	-2	0.908
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-0.00004	-0.004	0.004



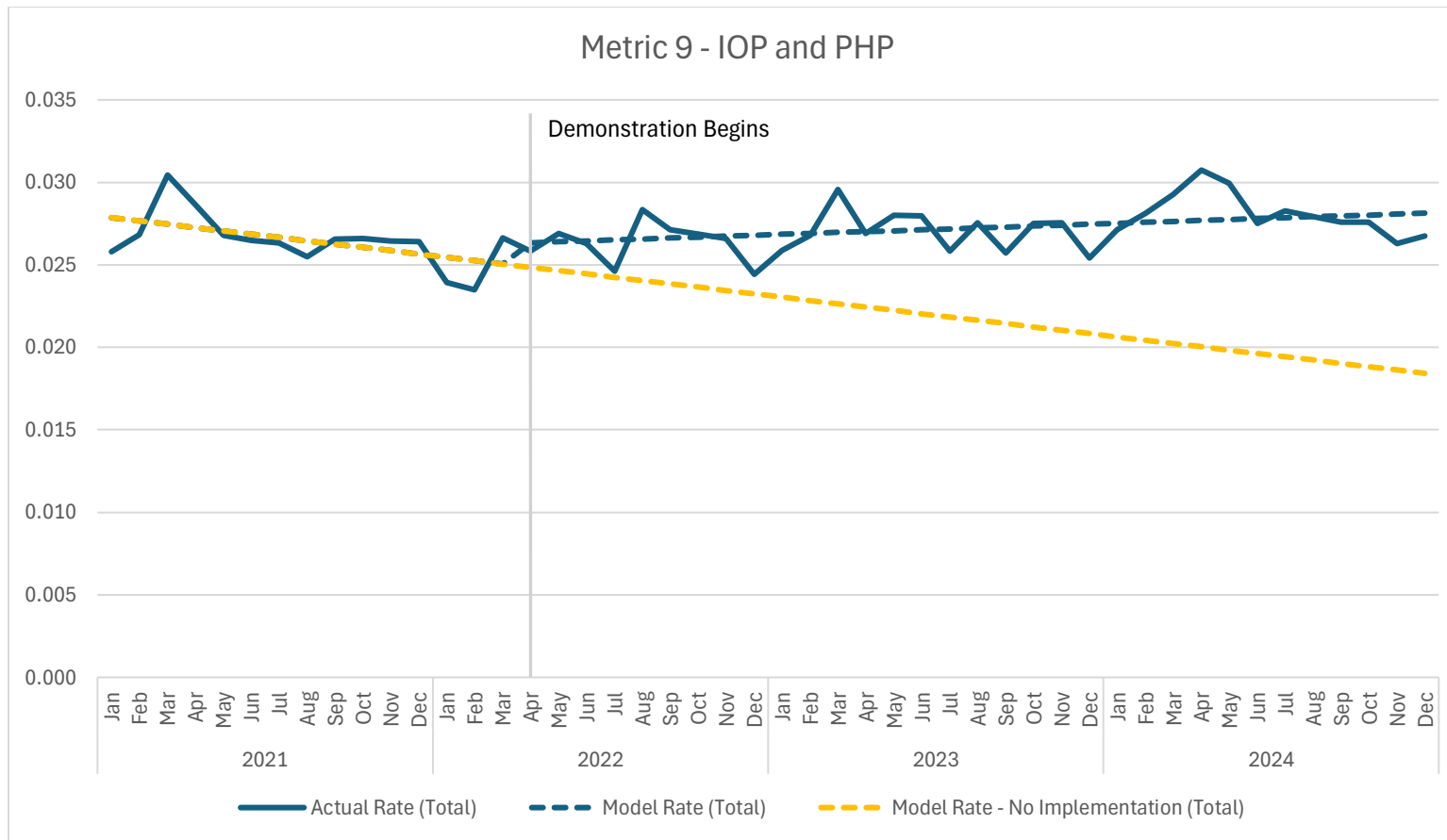
Metric 9 Rate – Not Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	29.181005	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.005	0.003	0.007



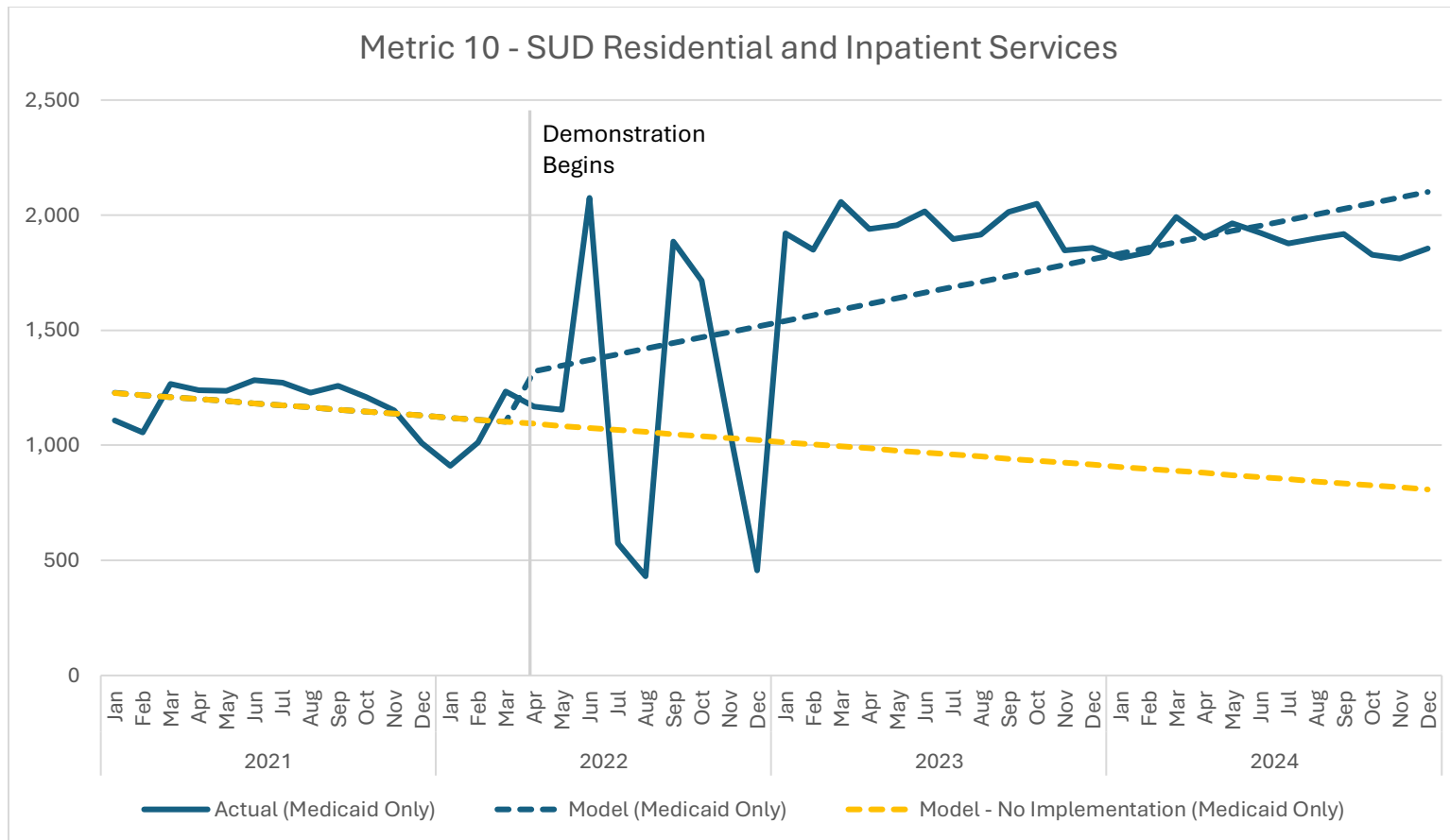
Metric 9 Rate – Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	36.680238	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.016	0.011	0.021



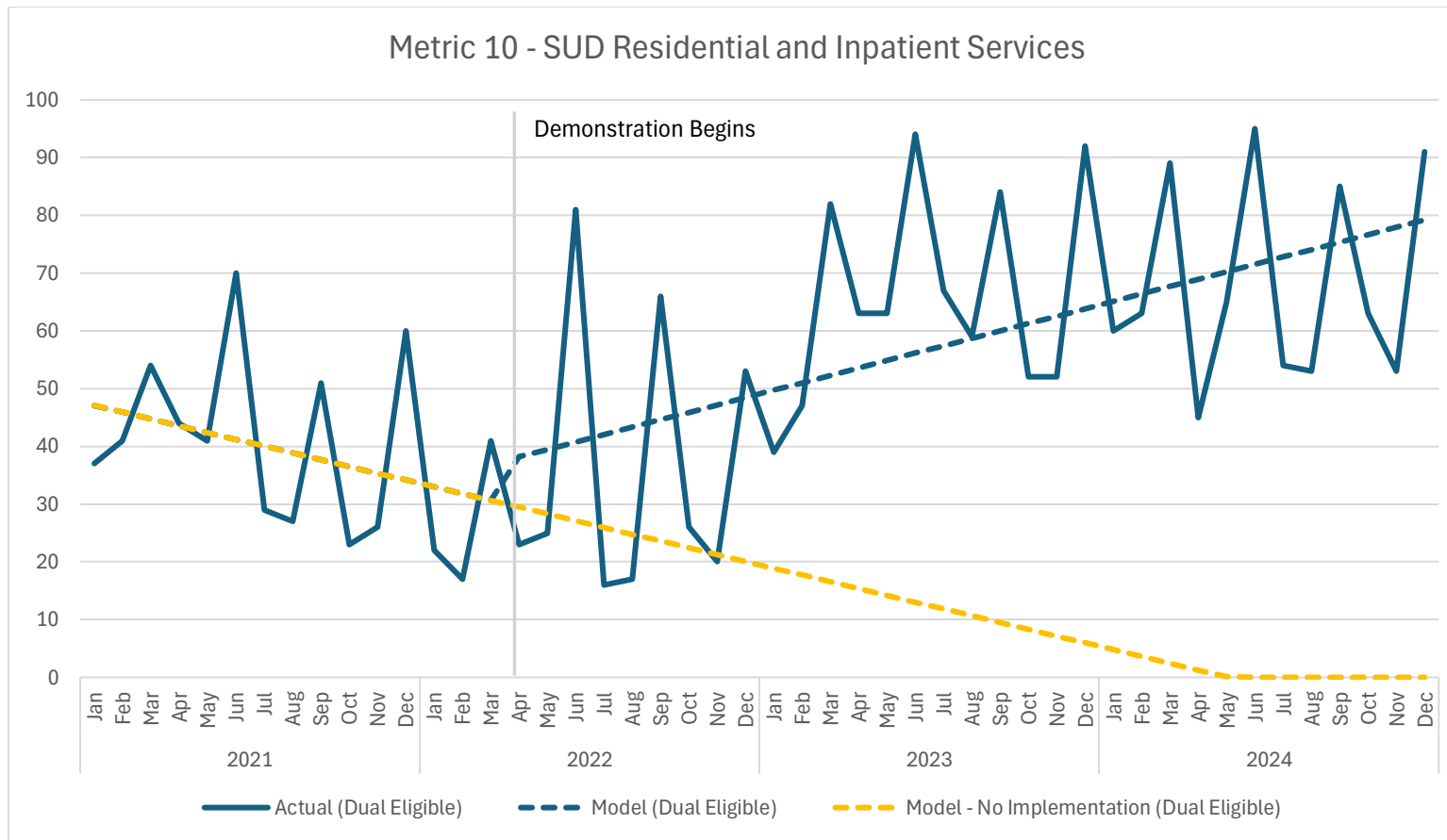
Metric 9 Rate – OUD Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	36.389277	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.012	0.008	0.016



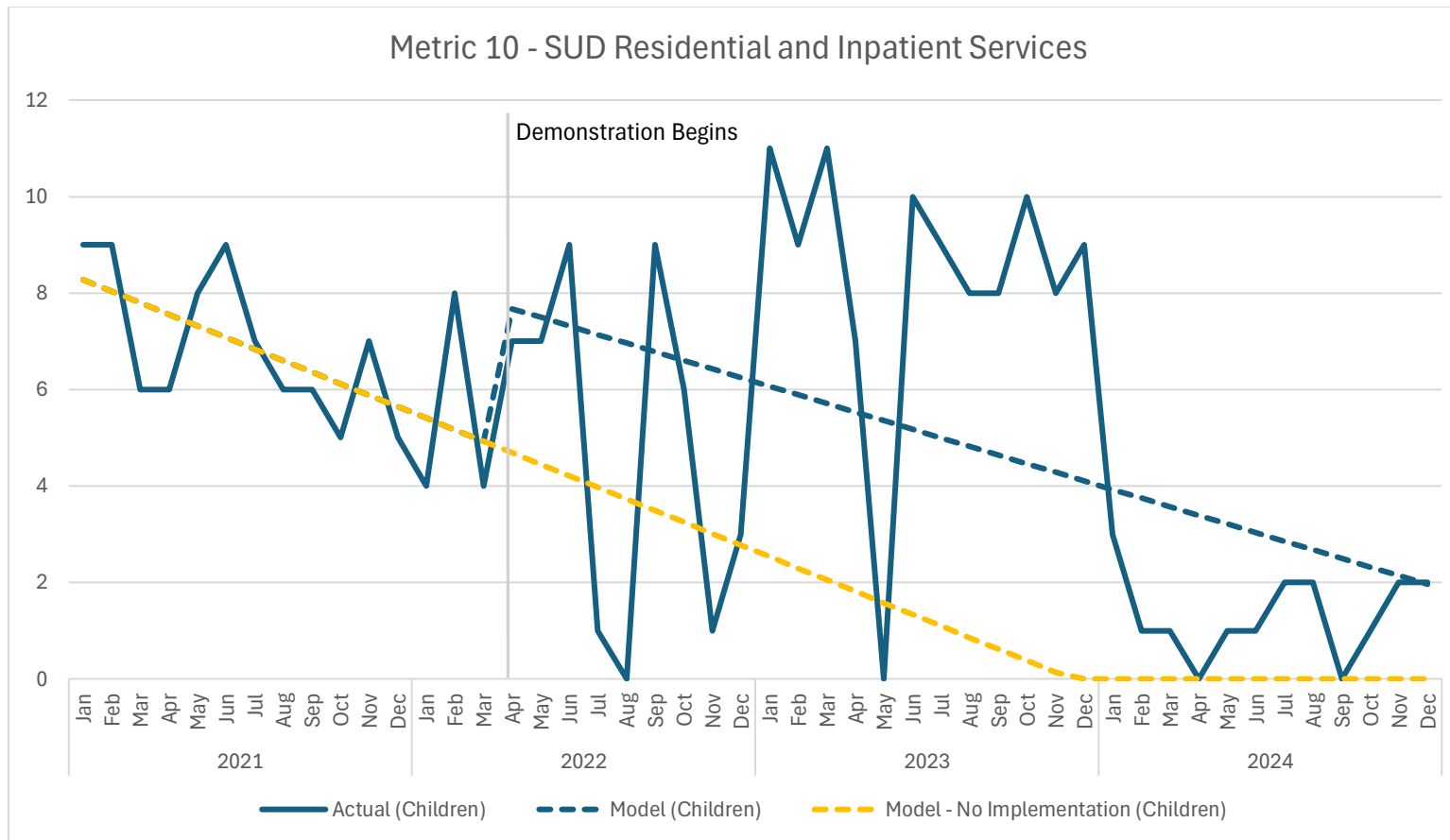
Metric 9 Rate – Total Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	30.055911	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.006	0.004	0.008



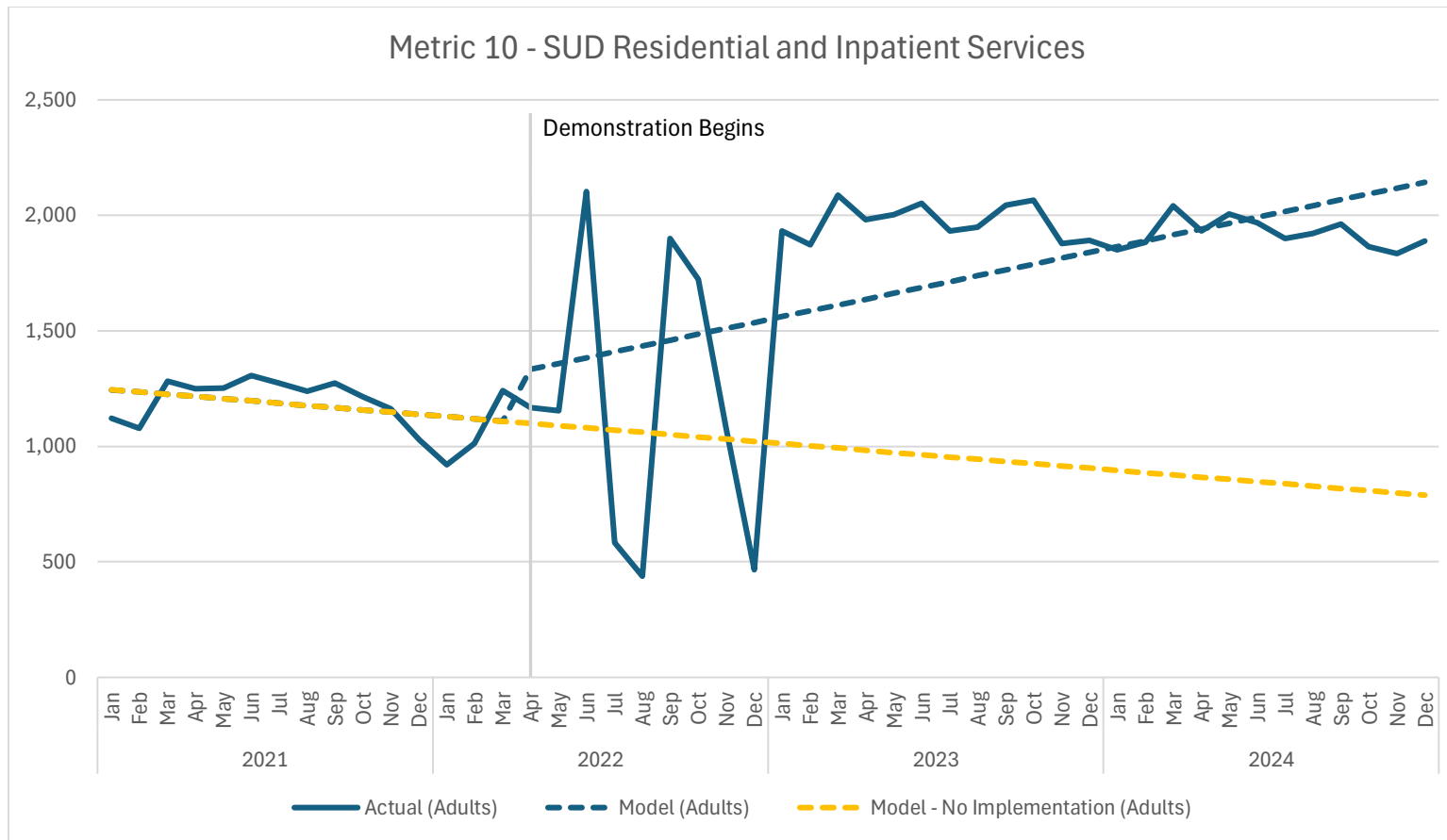
Metric 10 – Medicaid Only Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	18.109793	-2	0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	760.57	402.93	1,118.22



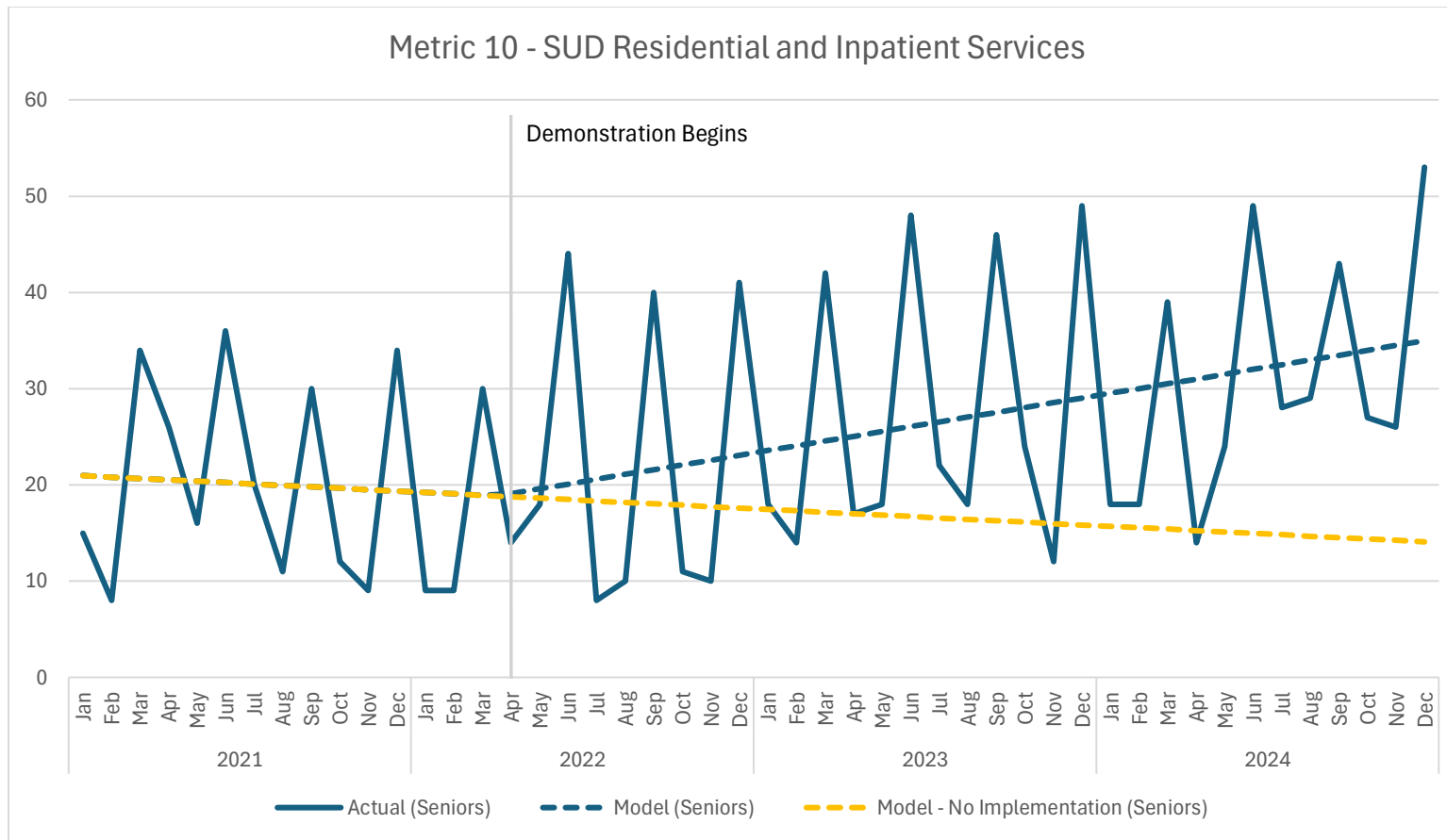
Metric 10 – Dual Eligible Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	45.762631	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	48.03	32.87	63.19



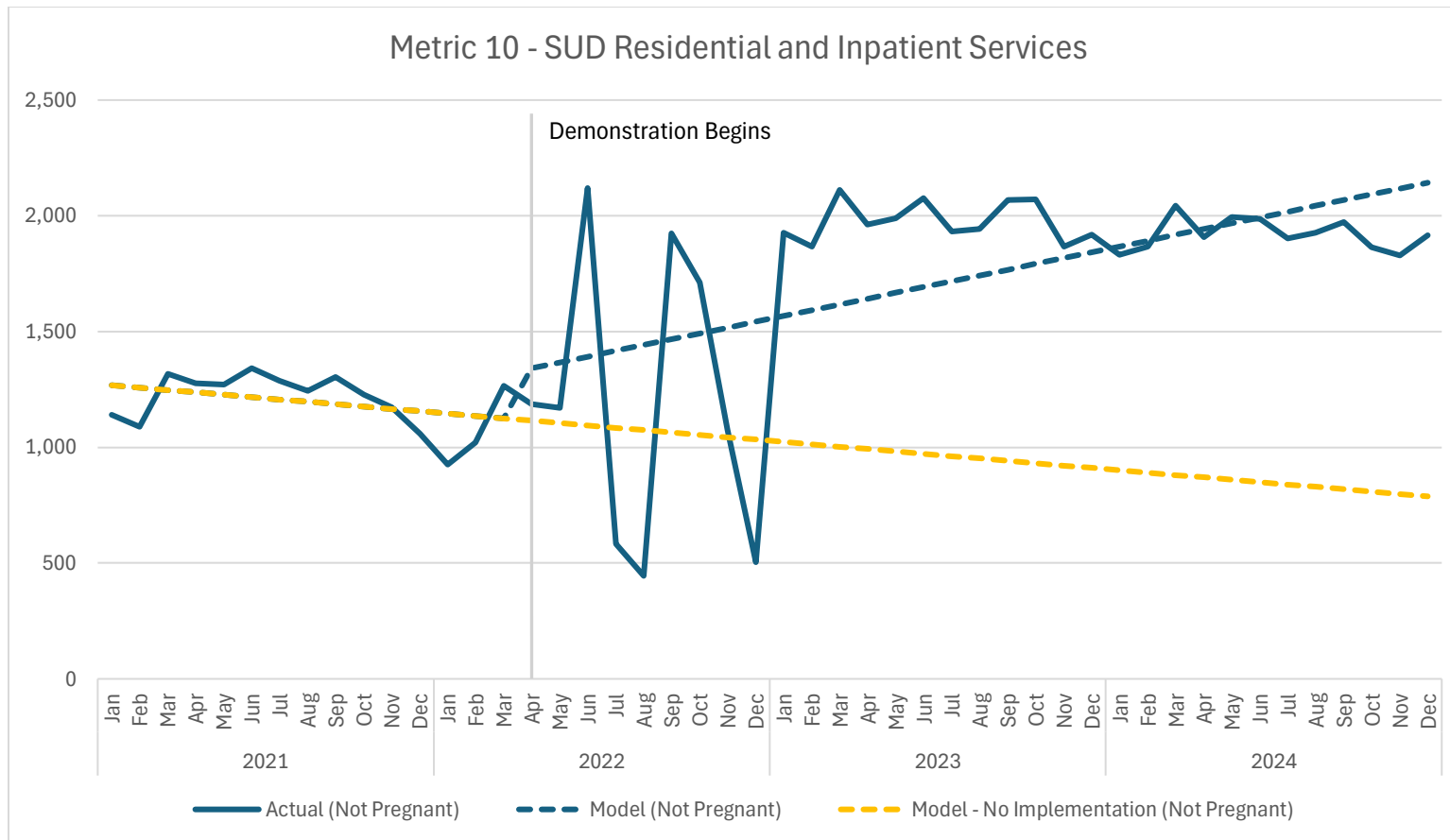
Metric 10 – Children Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	12.283702	-2	0.002
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	3.96	1.68	6.24



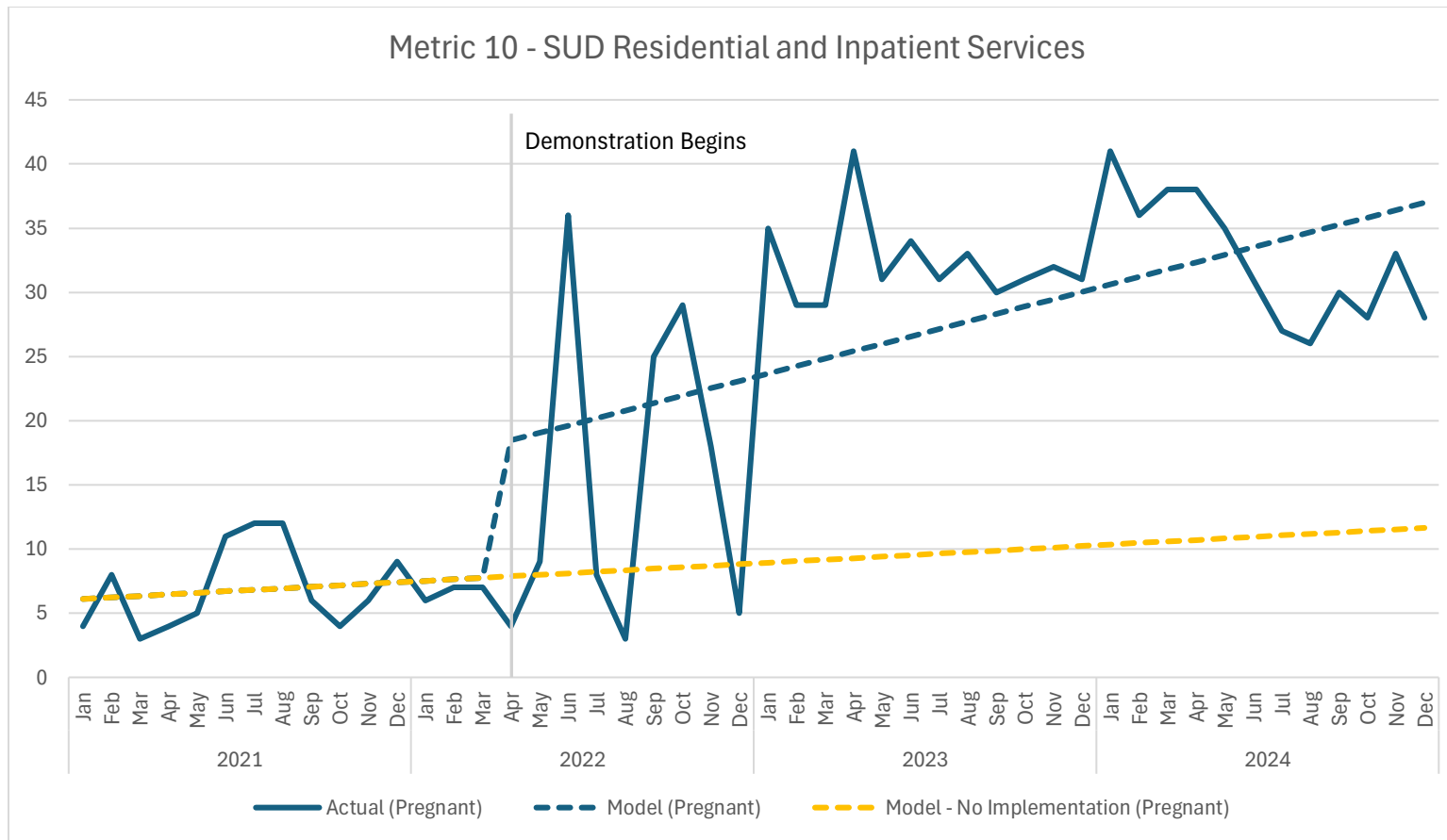
Metric 10 – Adults Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	19.668245	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	794.03	435.37	1,152.69



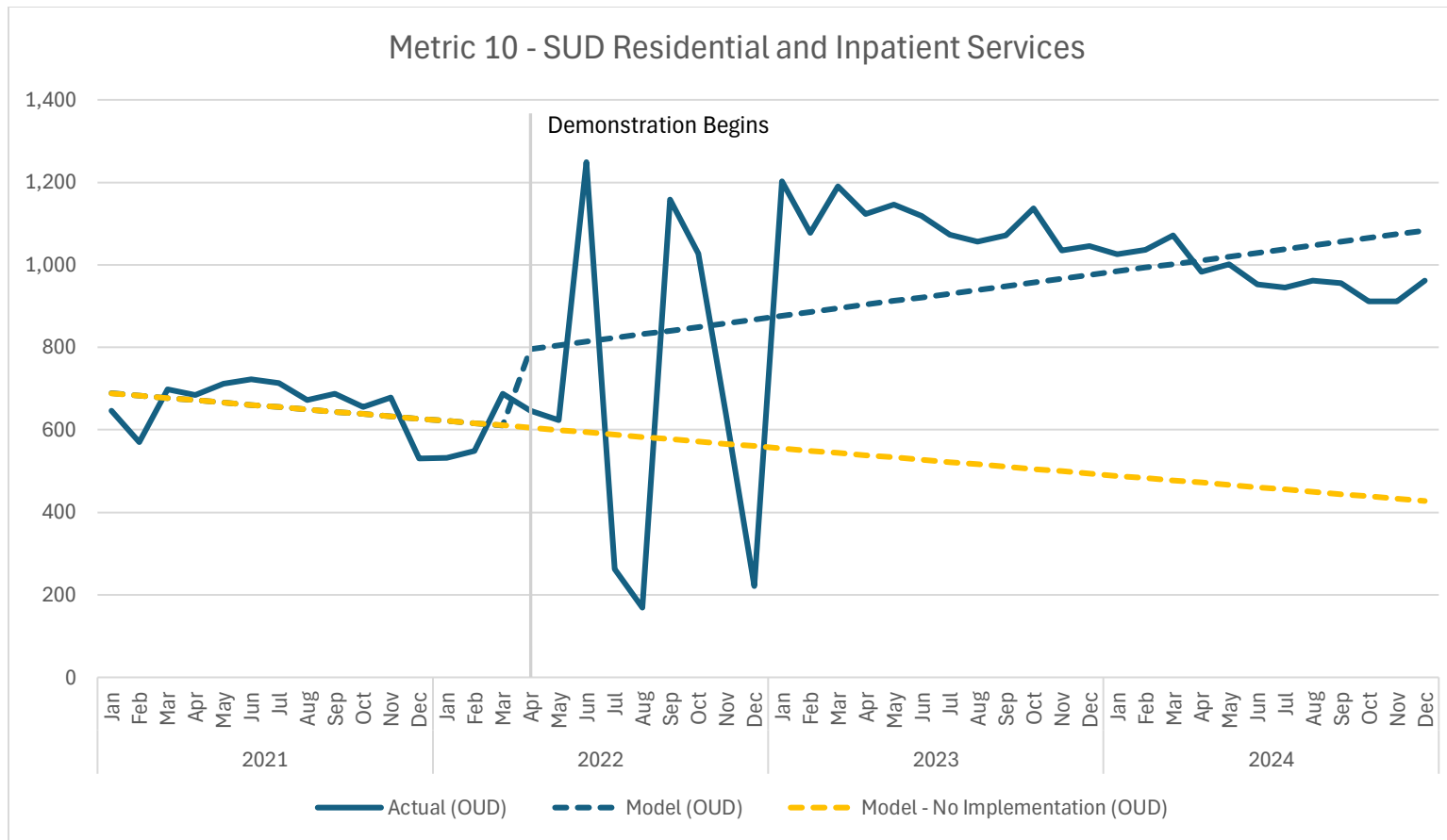
Metric 10 – Seniors Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	6.034091	-2	0.049
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	10.61	-3.23	24.45



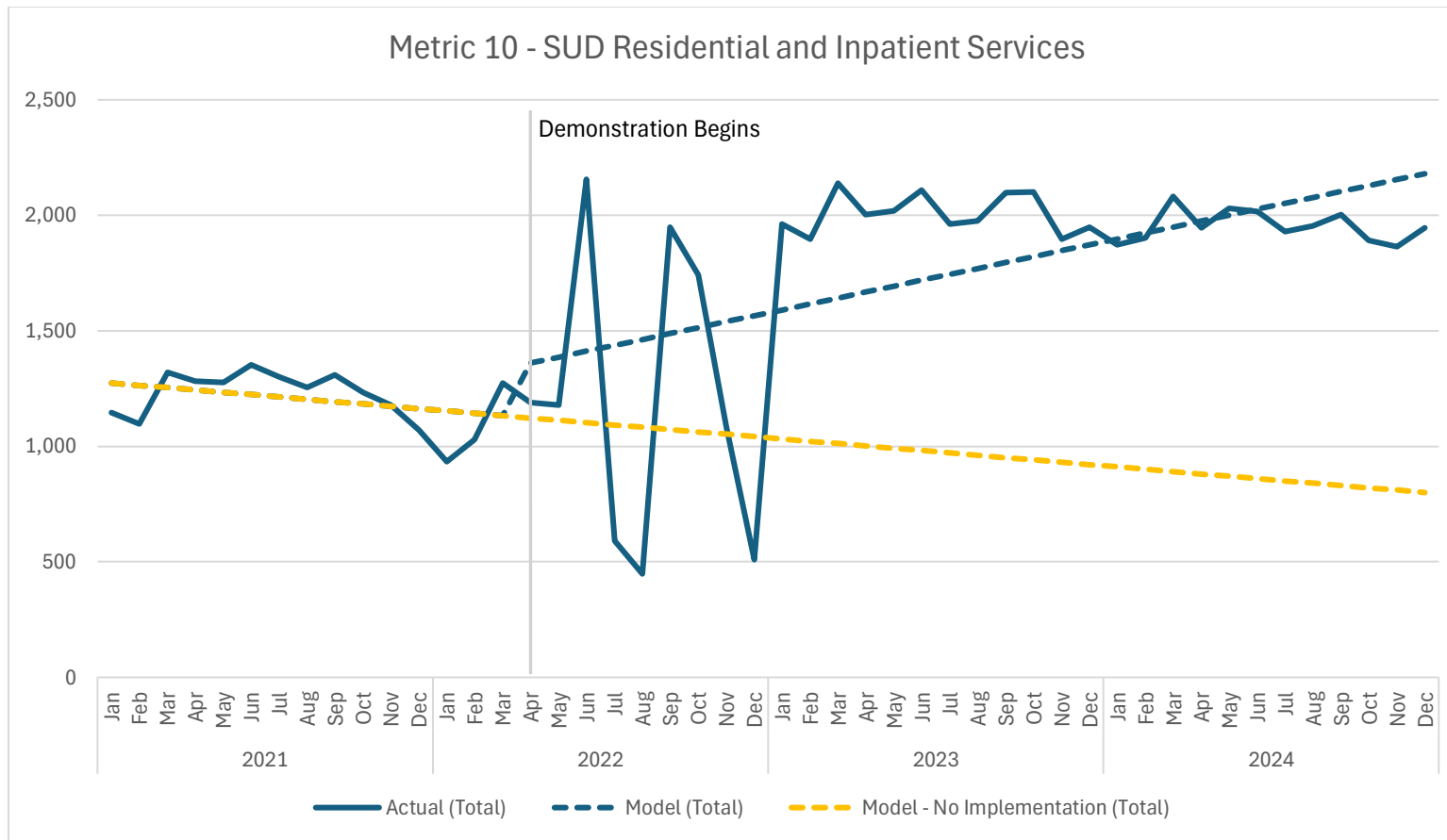
Metric 10 – Not Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	19.067649	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	790.64	426.38	1,154.89



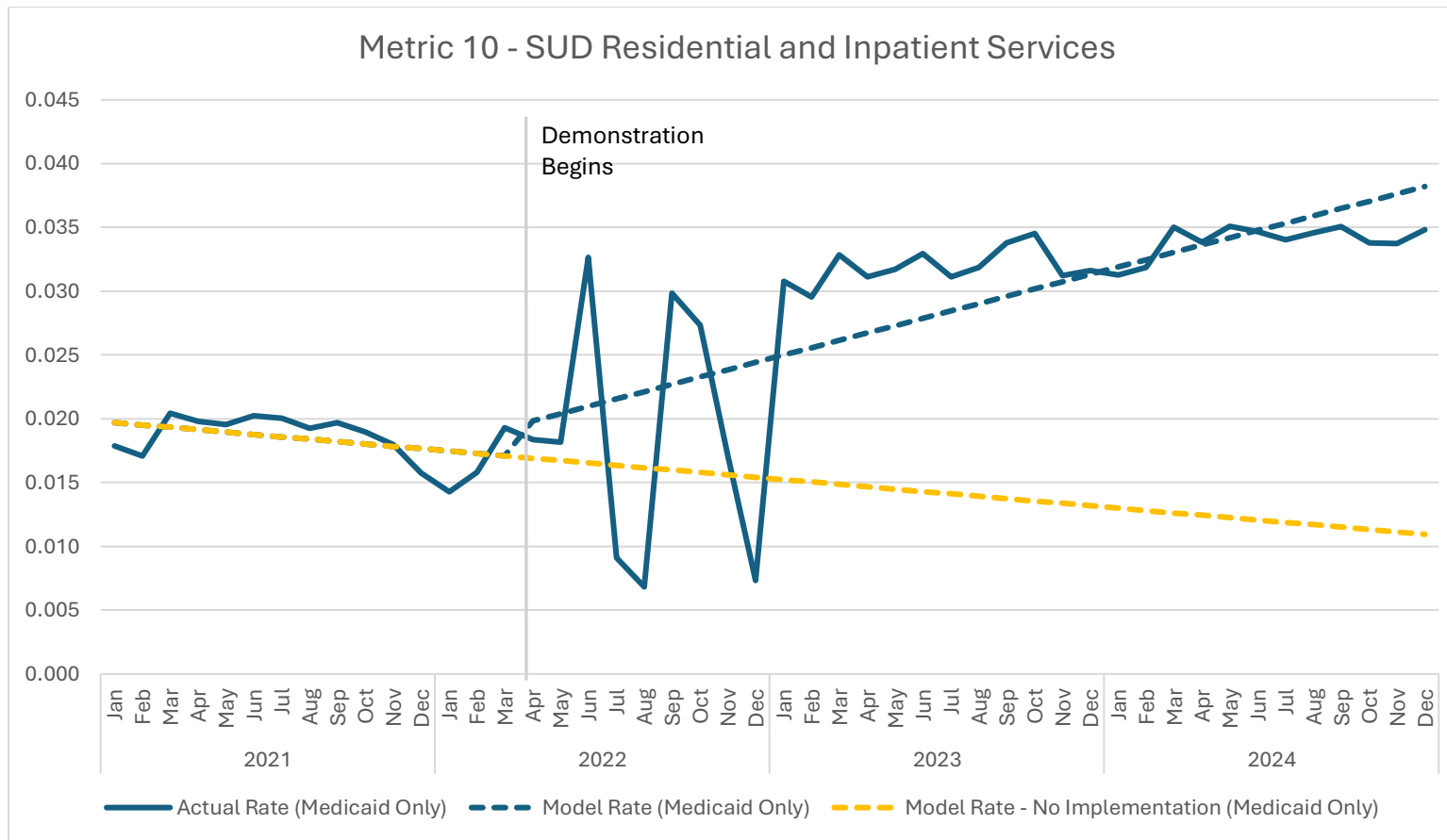
Metric 10 – Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	36.463945	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	17.97	11.91	24.02



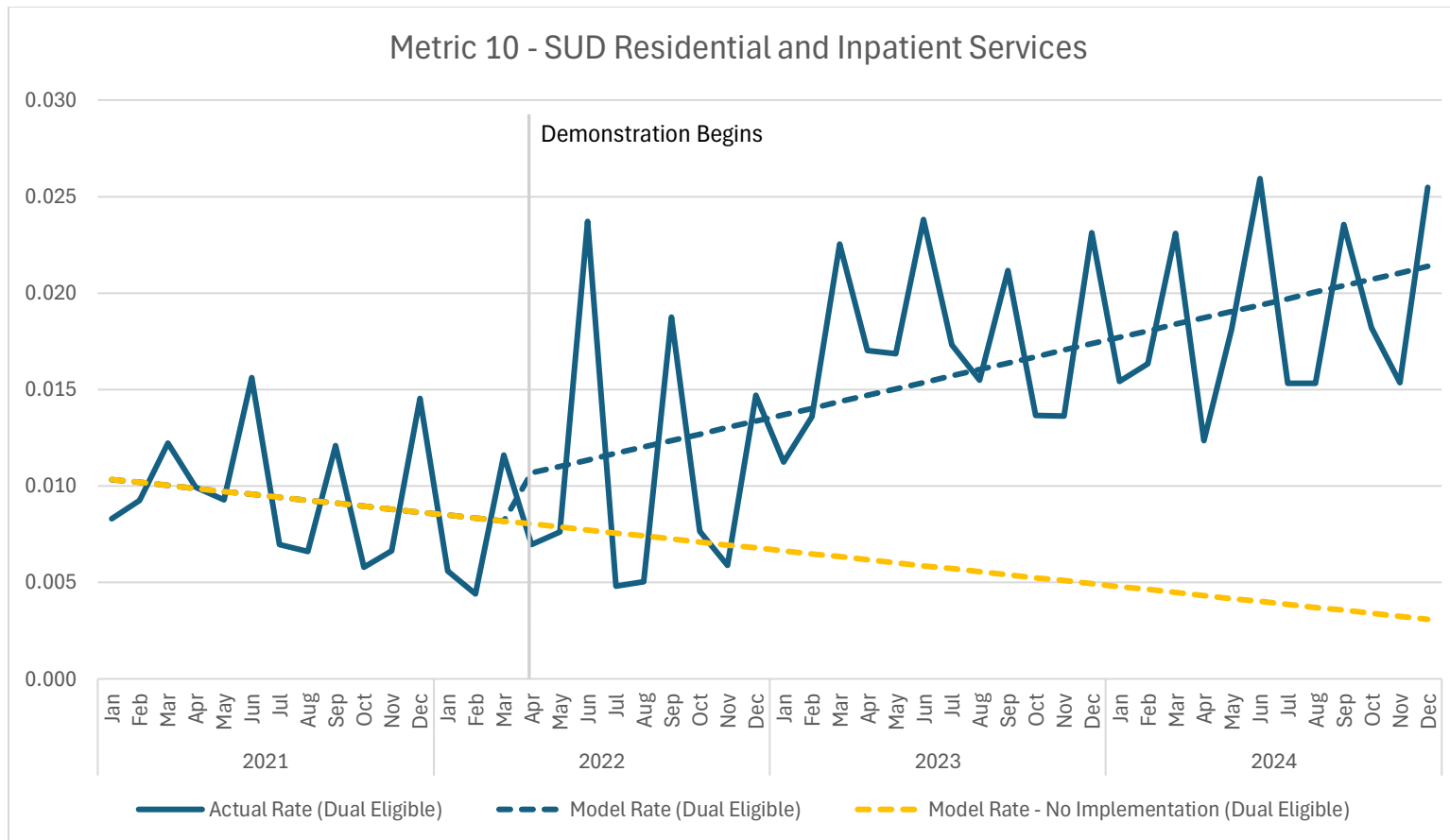
Metric 10 – OUD Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	16.916537	-2	0.0002
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	422.86	221.01	624.71



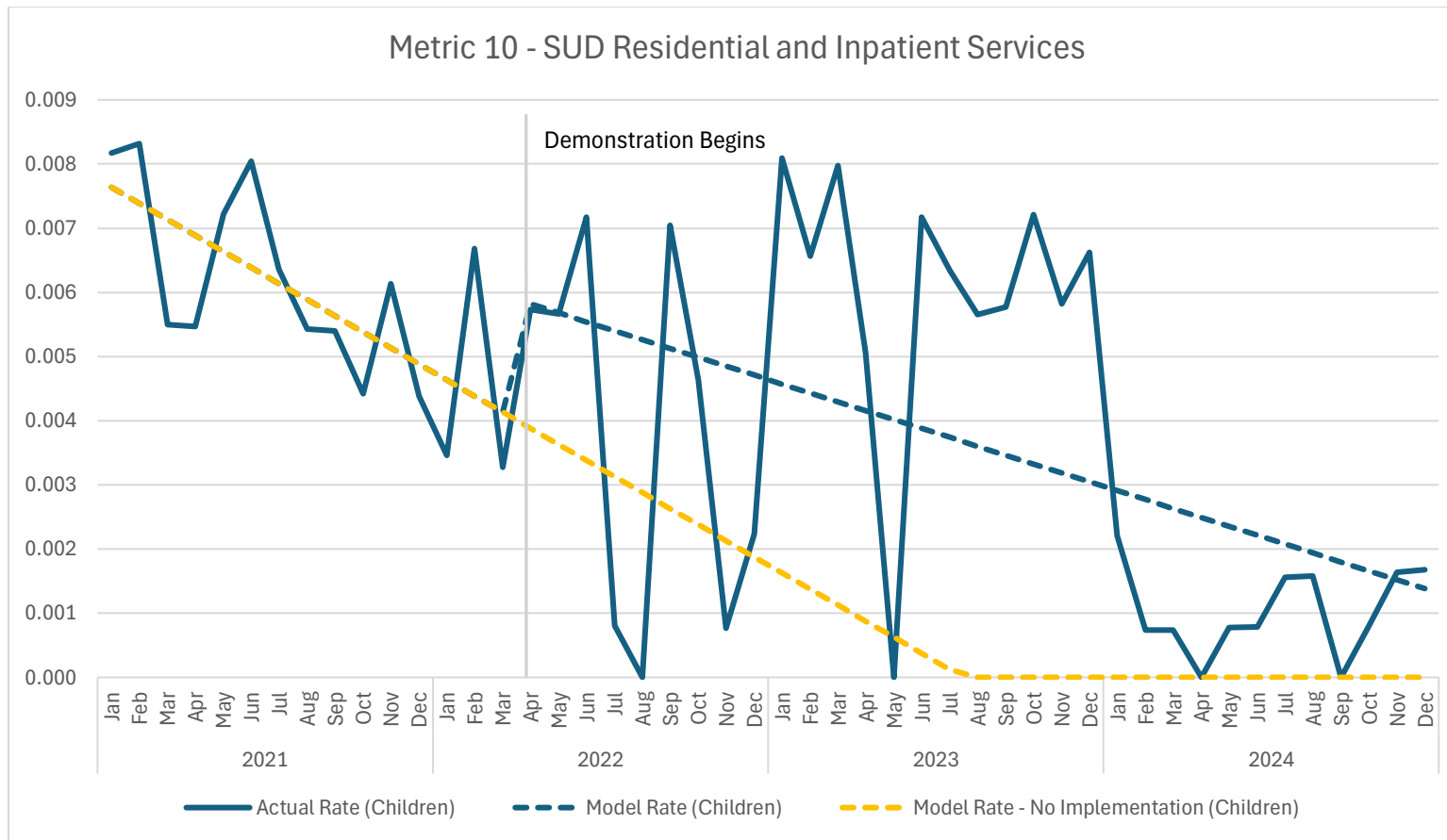
Metric 10 – Total Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	19.313687	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	808.60	439.61	1,177.60



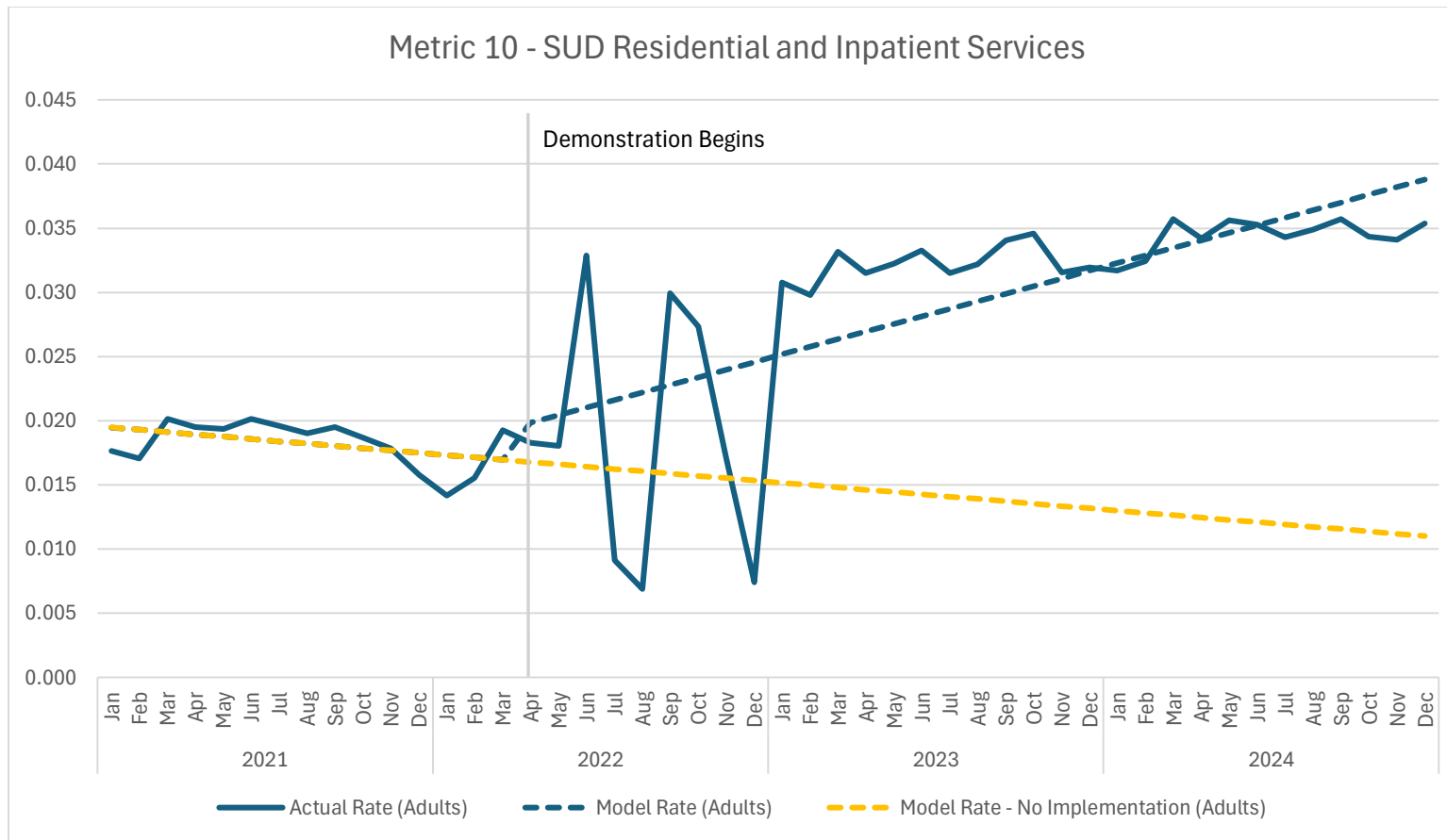
Metric 10 Rate – Medicaid Only Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	36.397648	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.015	0.010	0.020



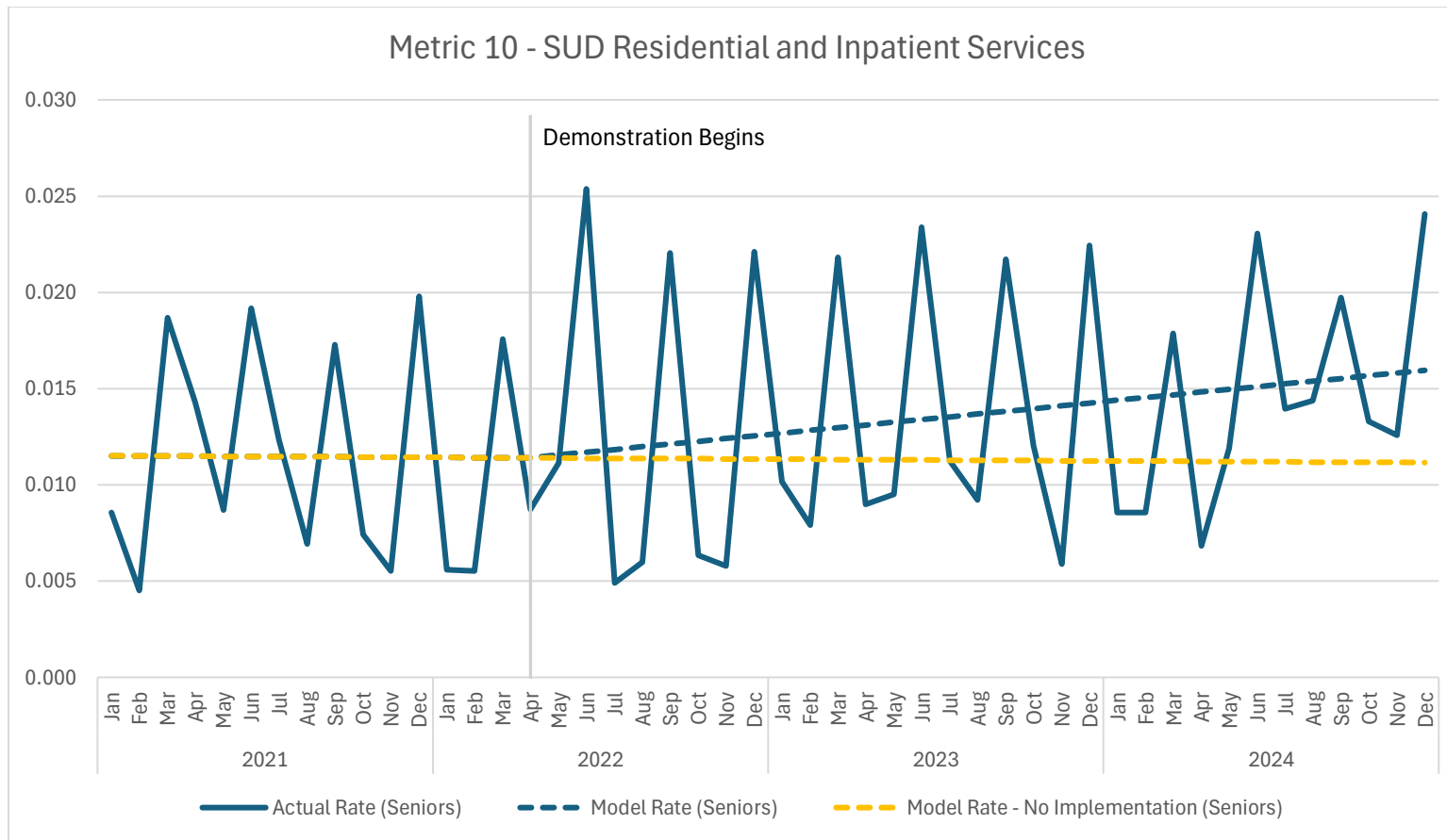
Metric 10 Rate – Dual Eligible Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	41.429938	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.010	0.007	0.014



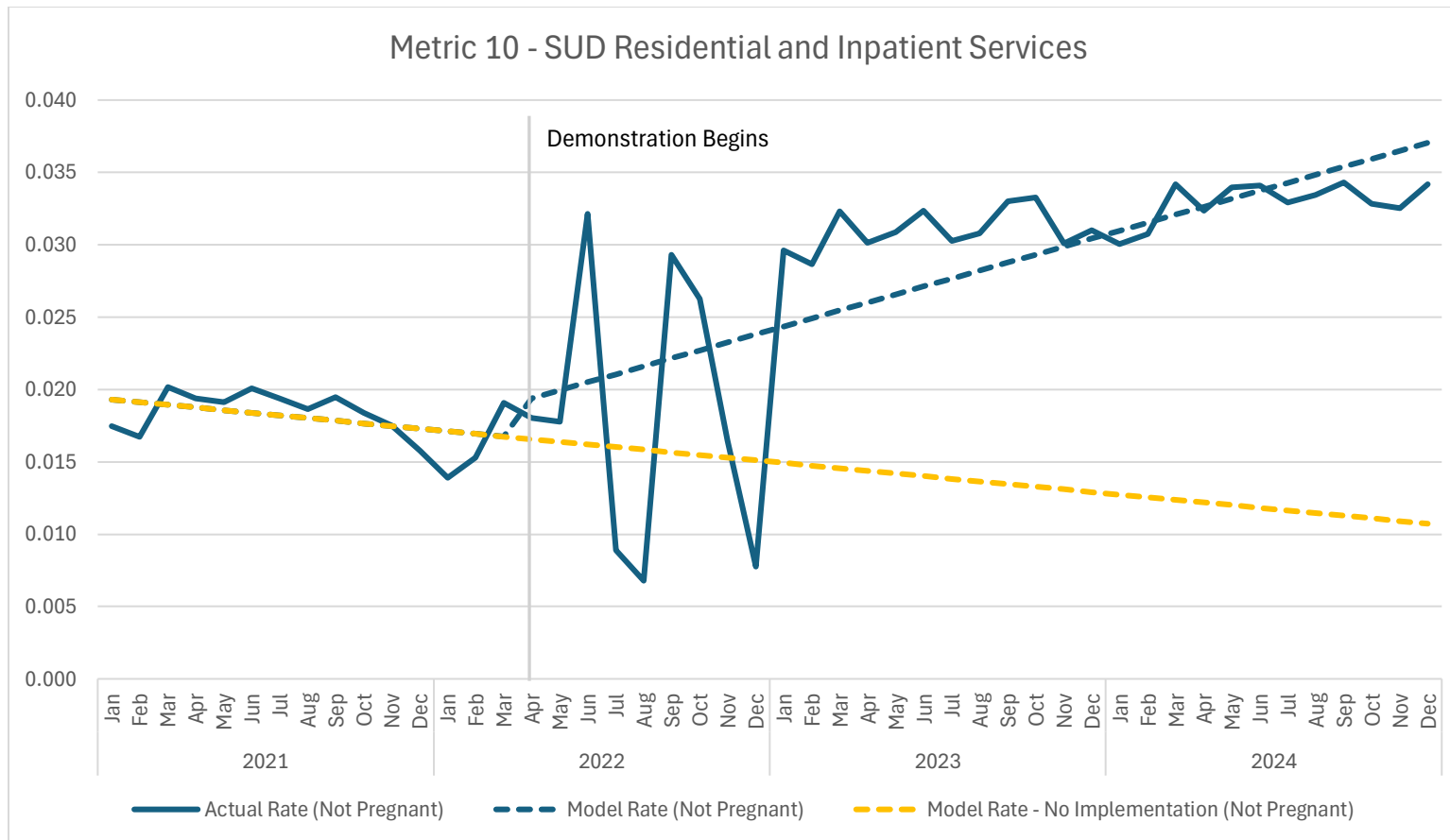
Metric 10 Rate – Children Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	23.922279	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.004	0.002	0.005



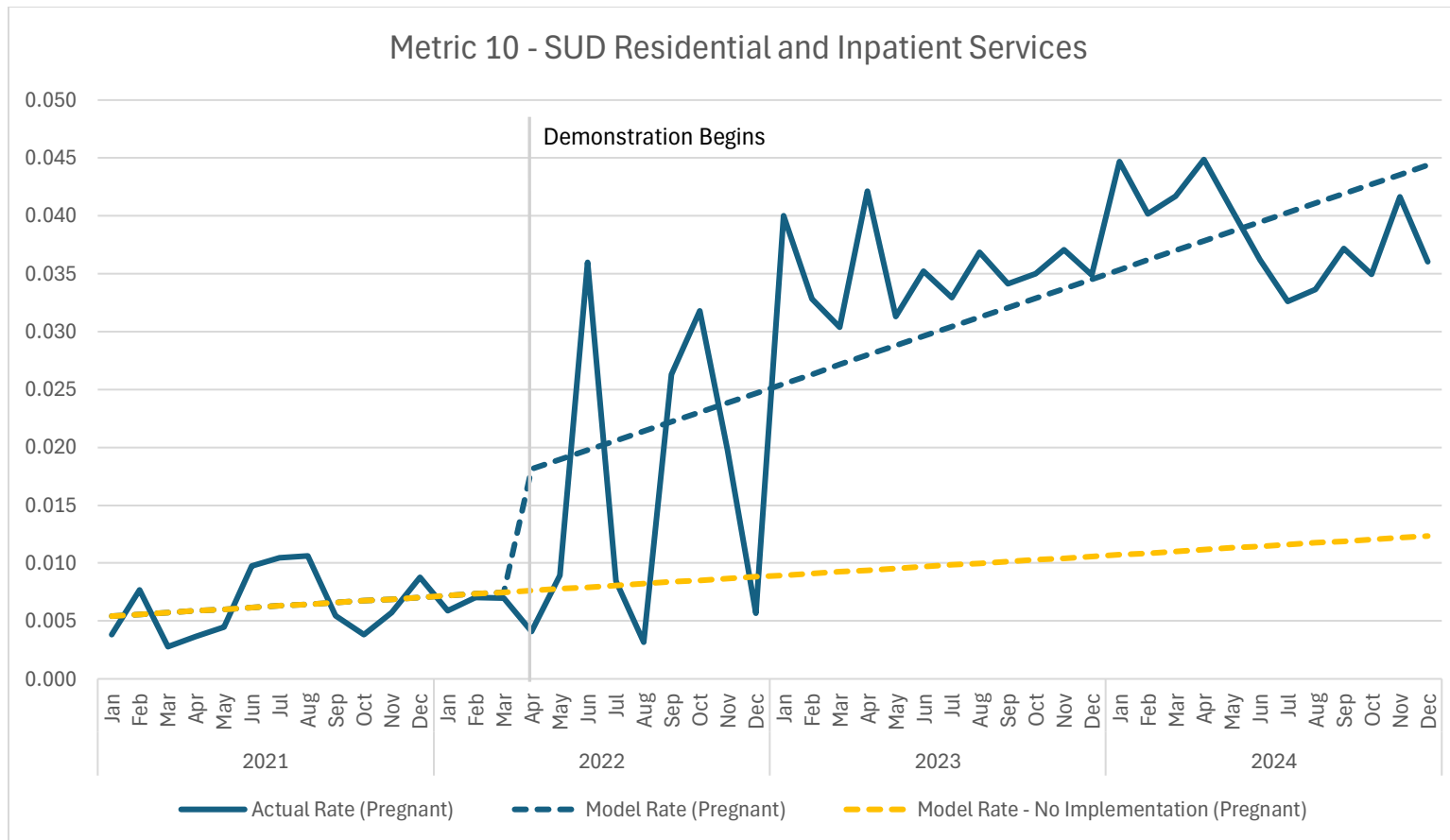
Metric 10 Rate – Adults Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	39.573037	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.015	0.010	0.021



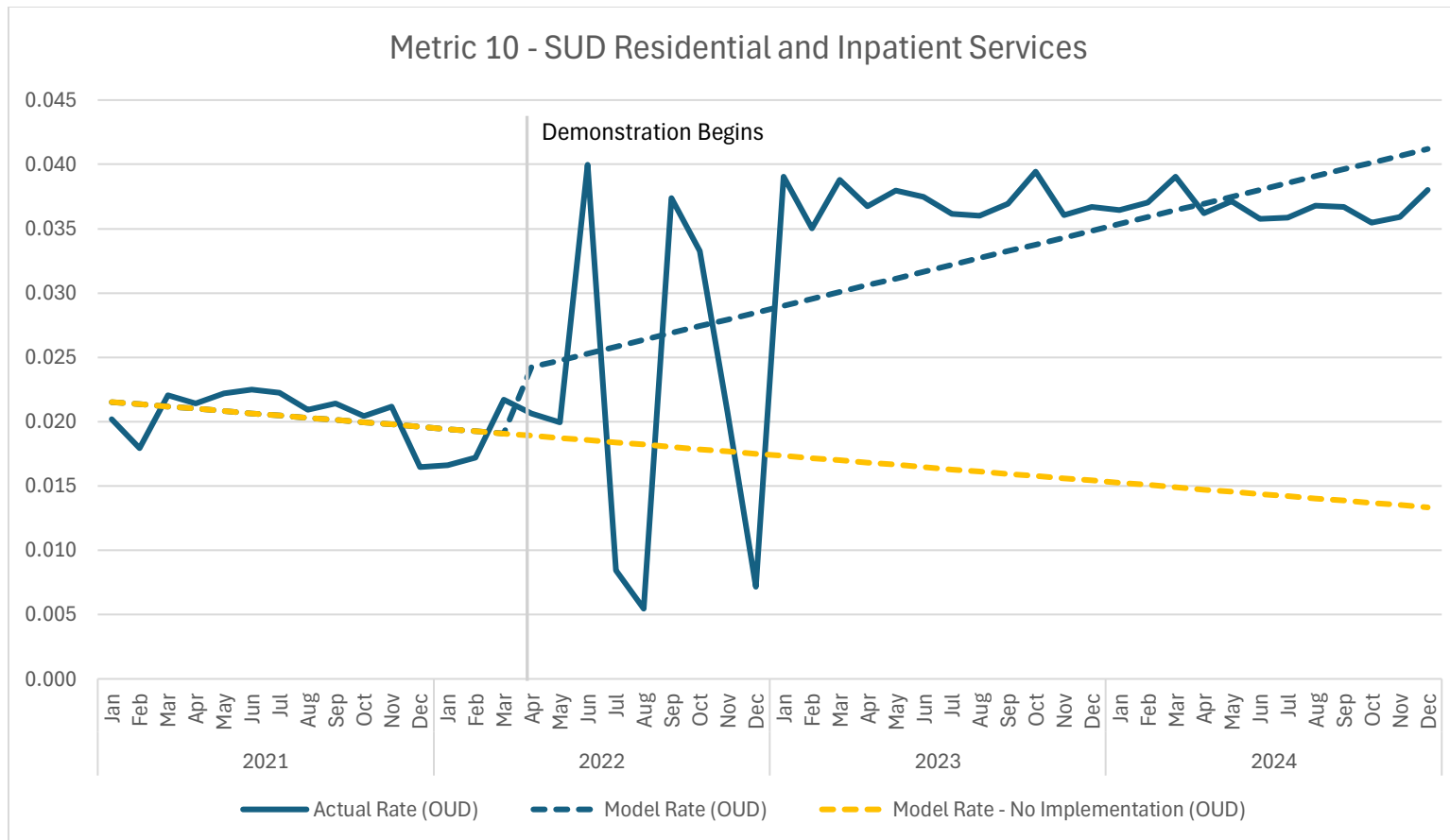
Metric 10 Rate – Seniors Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	1.1555464	-2	0.561
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.002	-0.005	0.010



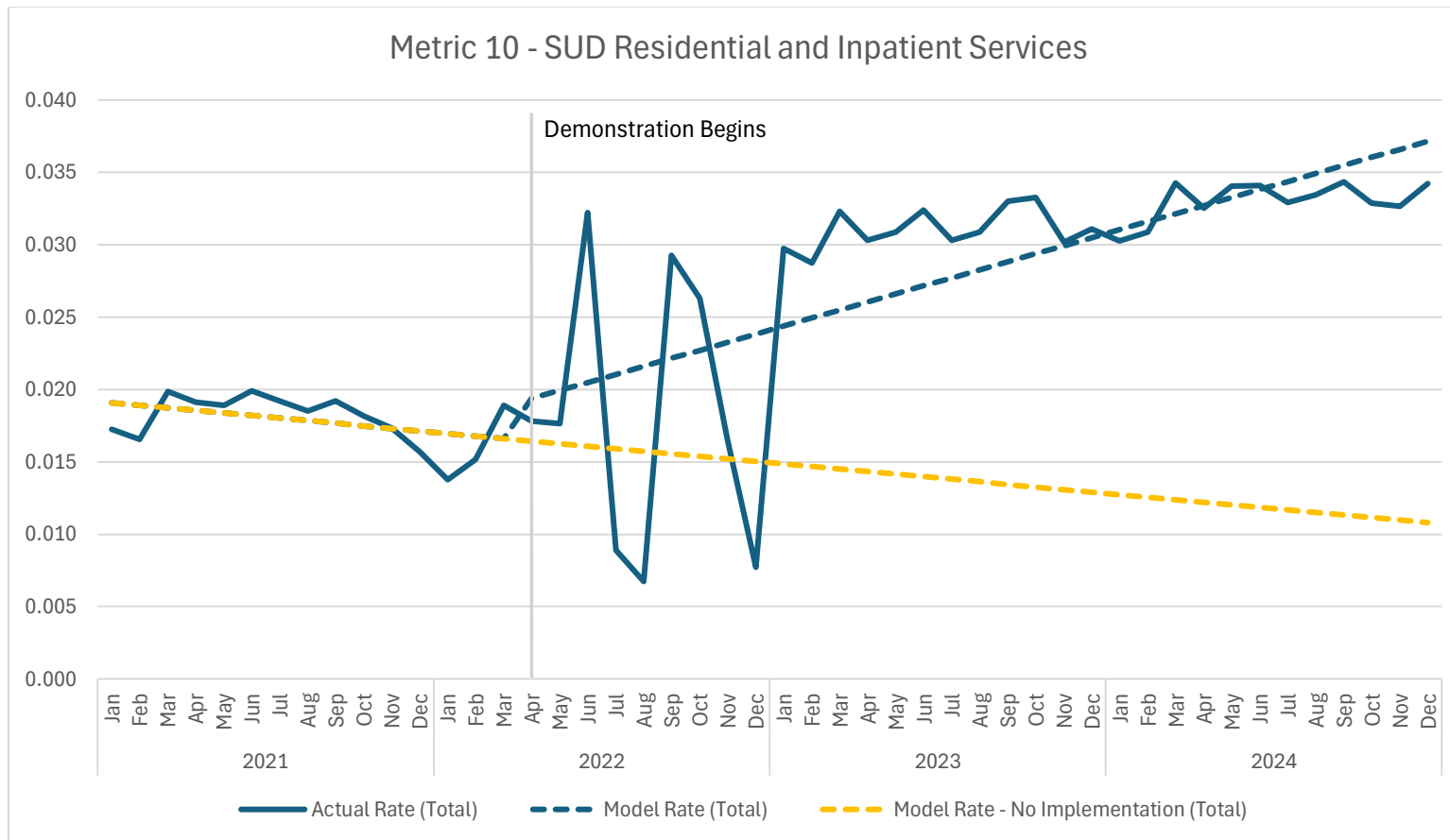
Metric 10 Rate – Not Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	36.088089	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.015	0.009	0.020



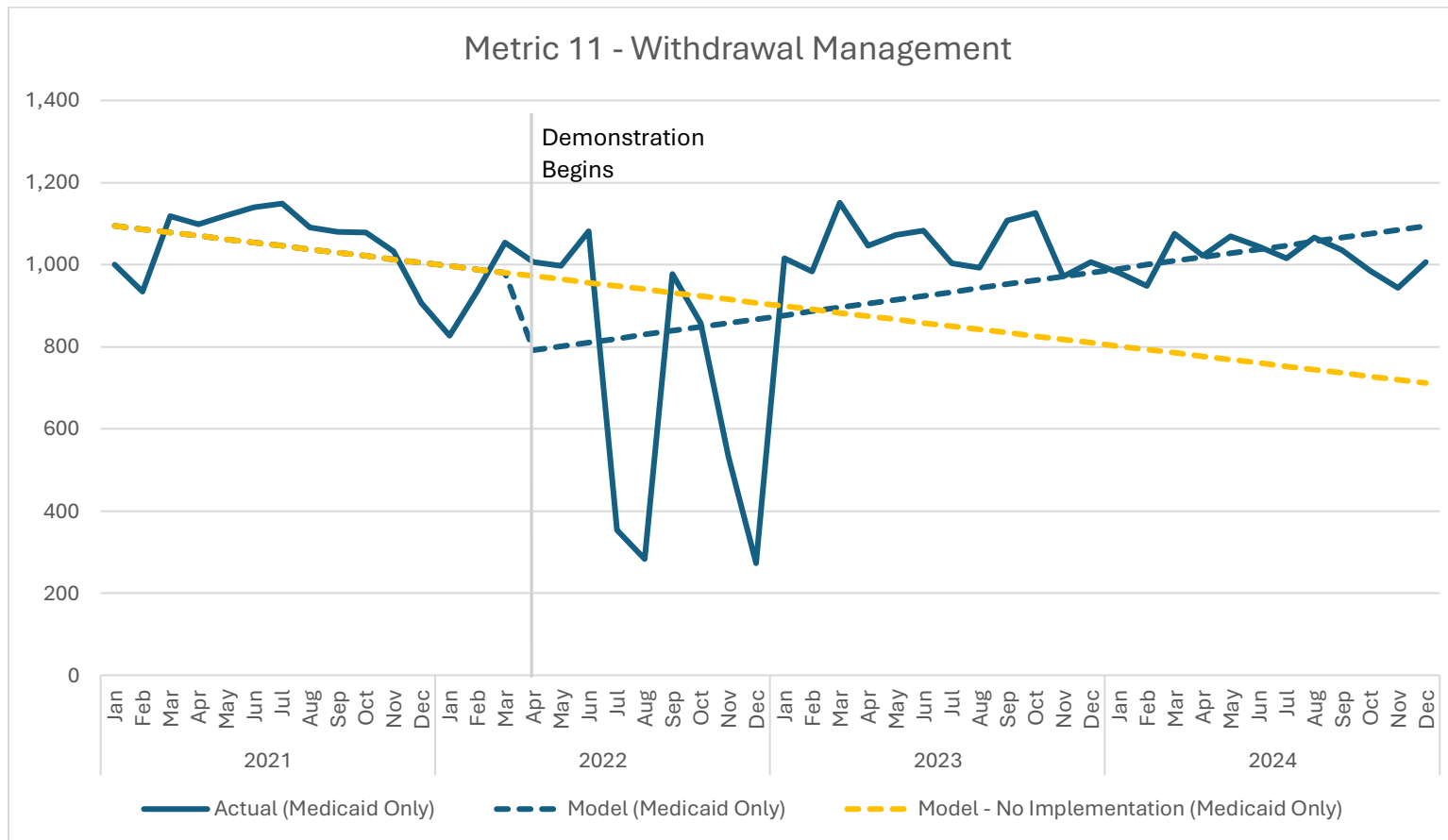
Metric 10 Rate – Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	74.051473	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.021	0.016	0.026



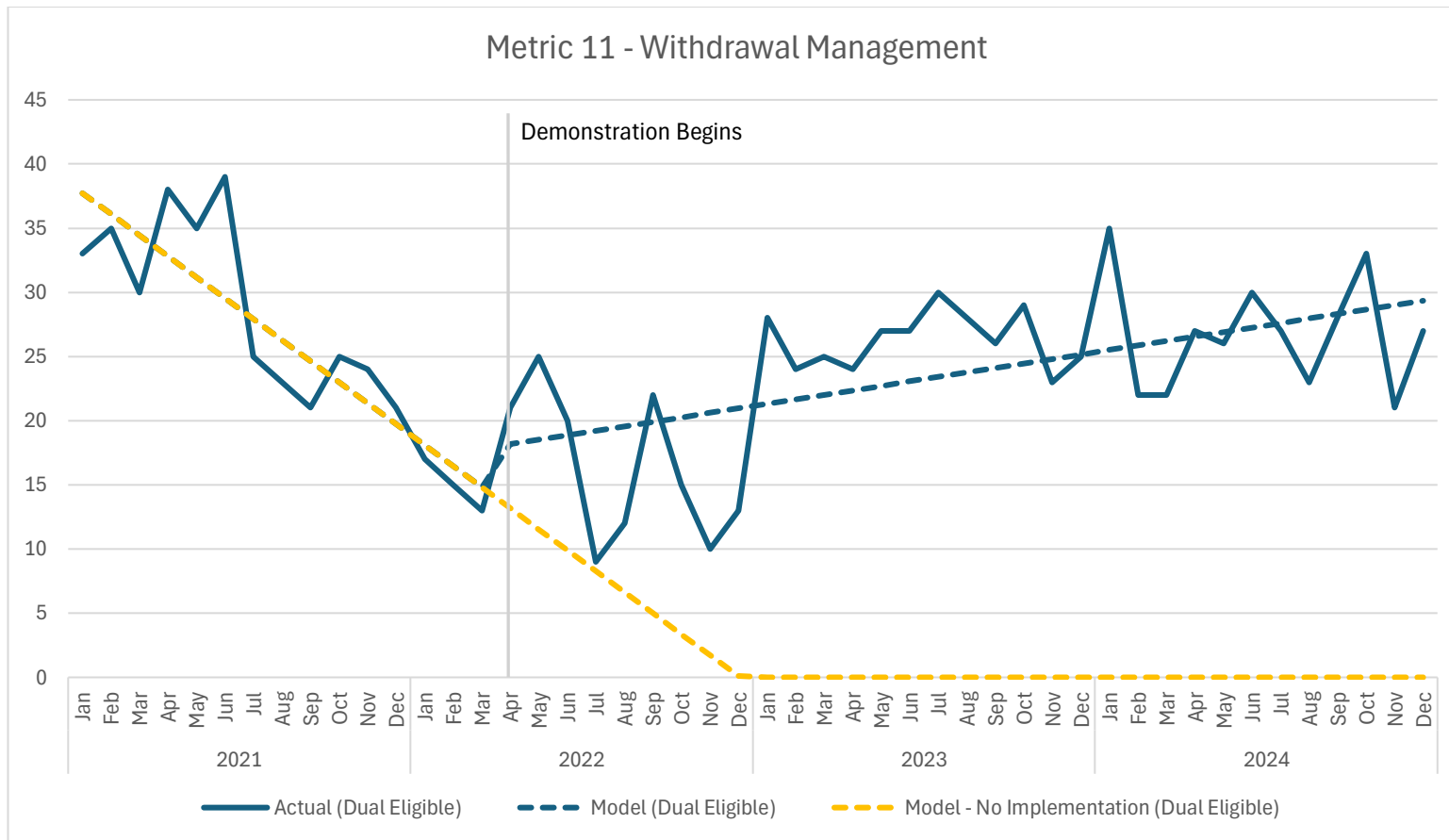
Metric 10 Rate – OUD Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	29.9945	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.017	0.011	0.023



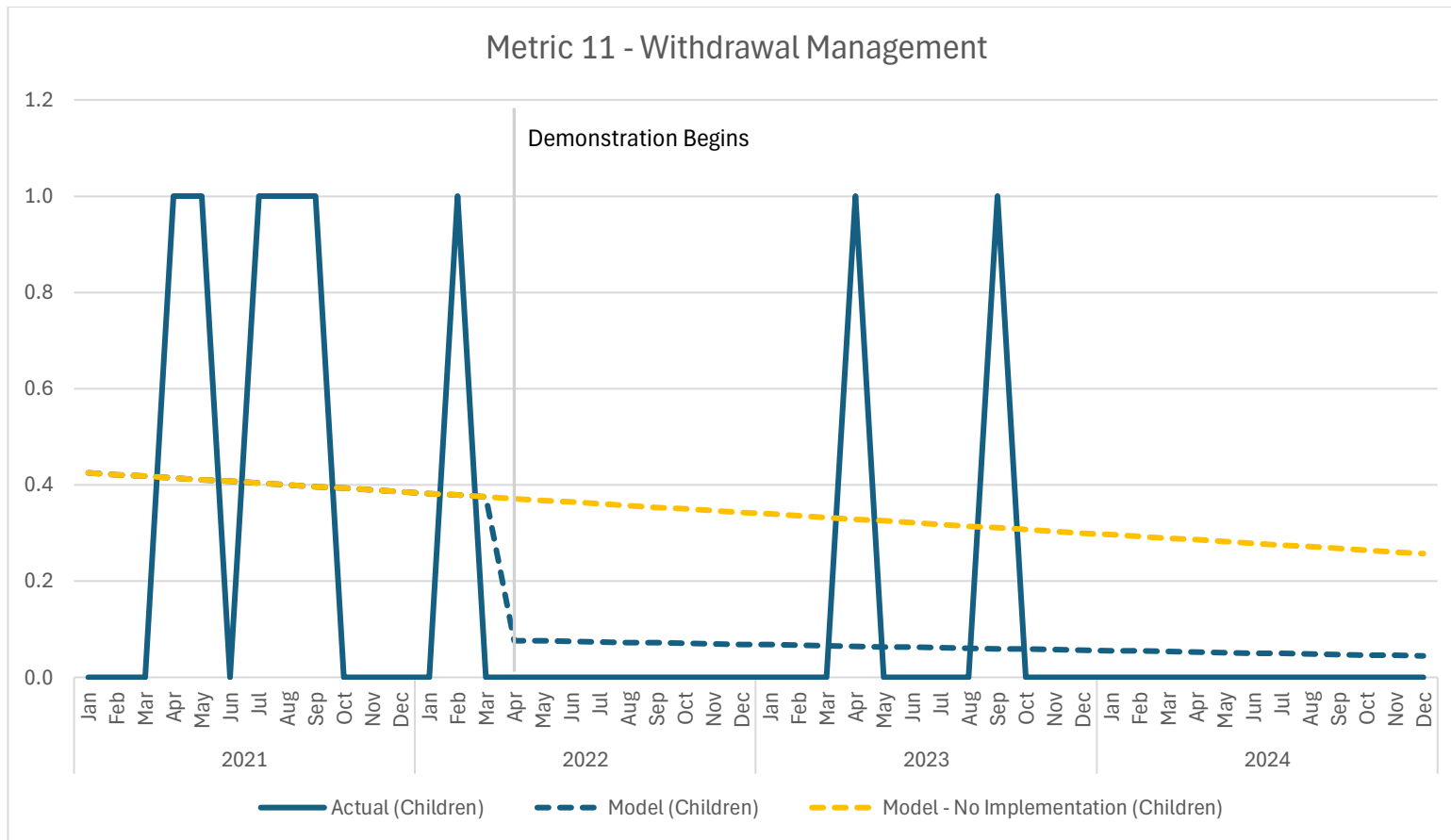
Metric 10 Rate – Total Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	36.64597	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.015	0.010	0.020



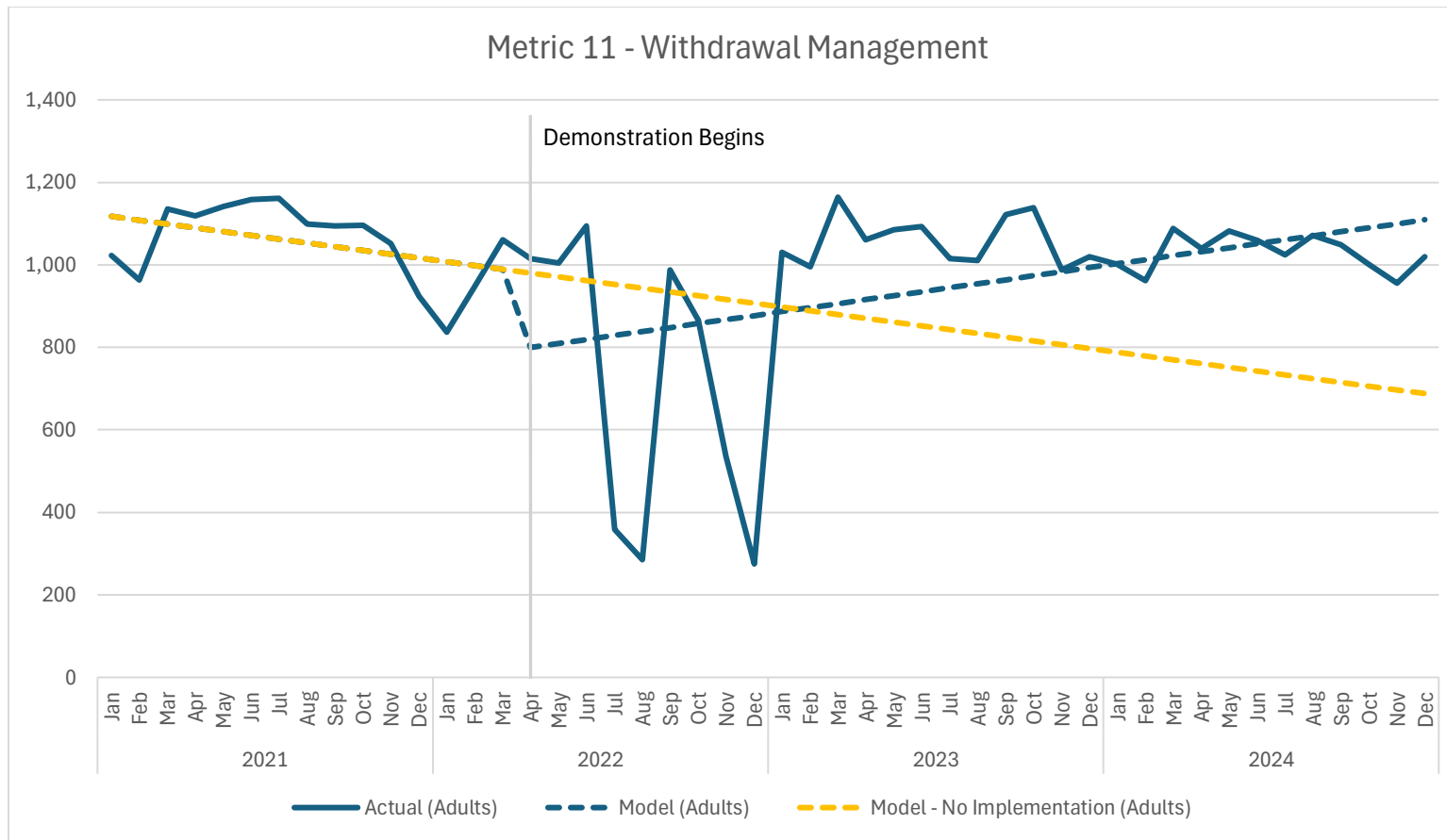
Metric 11 – Medicaid Only Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	10.788185	-2	0.005
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	100.78	-190.82	392.38



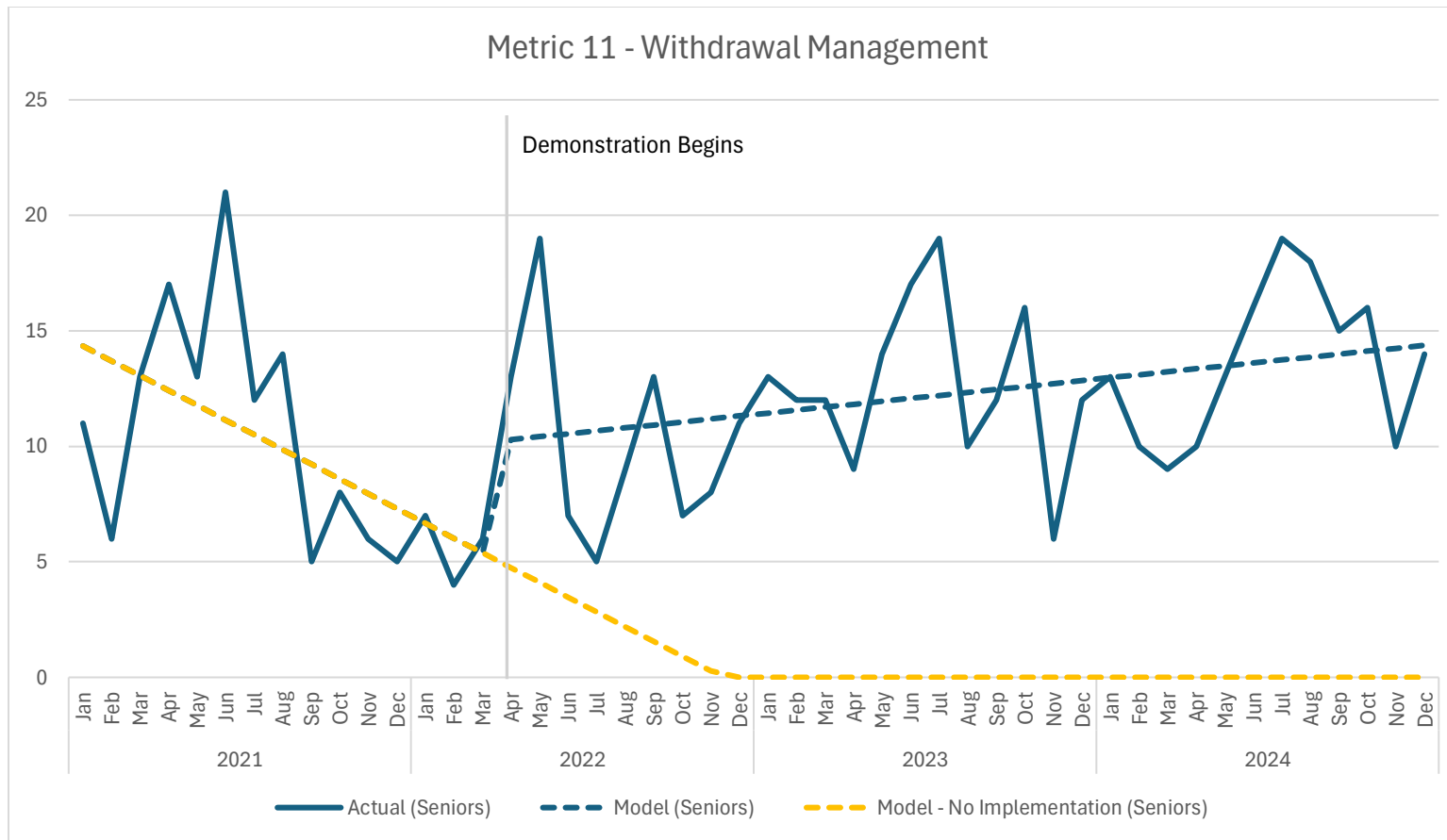
Metric 11 – Dual Eligible Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	127.85812	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	36.75	29.93	43.56



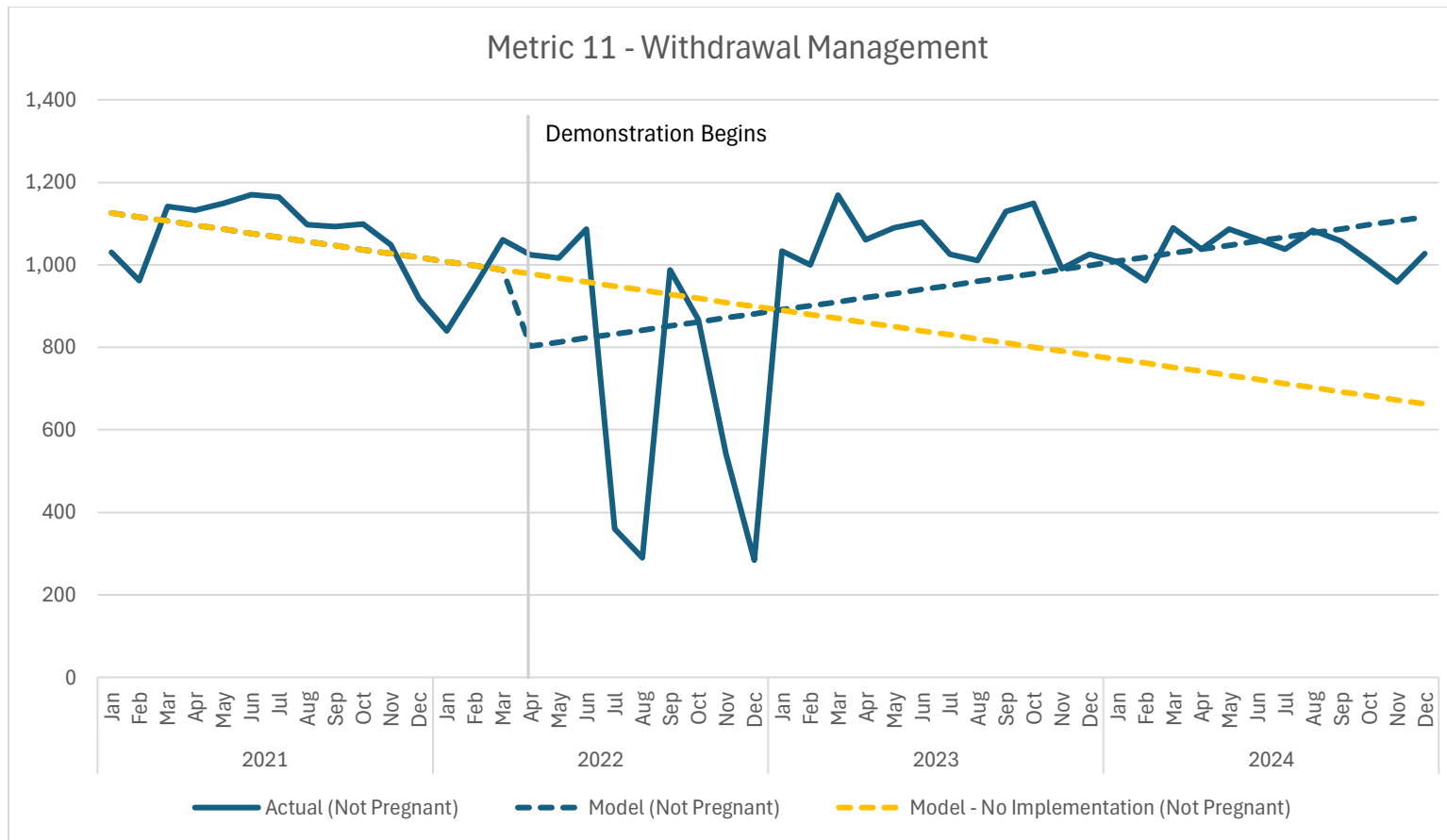
Metric 11 – Children Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	9.7365052	-2	0.008
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-0.25	-1.32	0.81



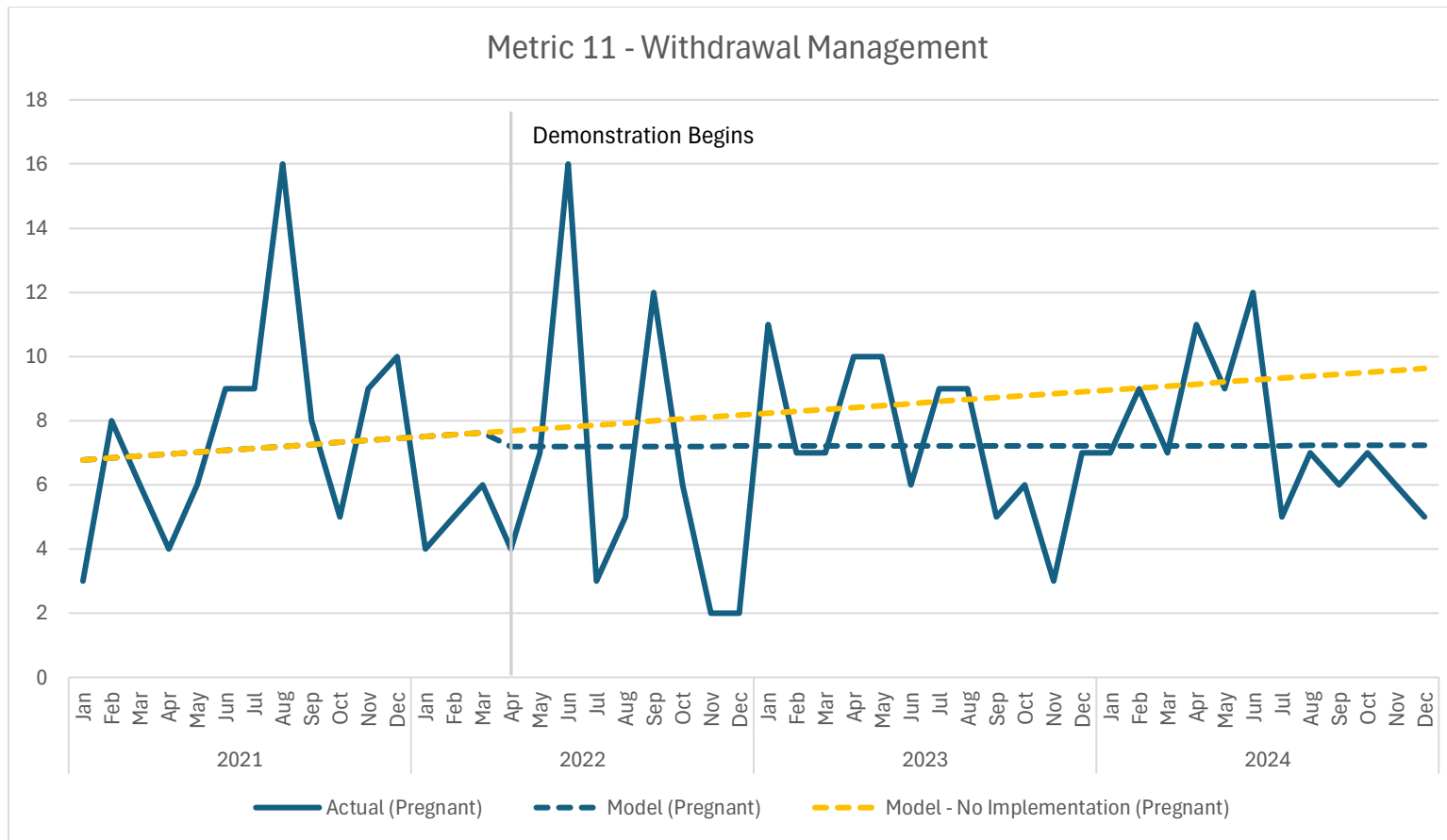
Metric 11 – Adults Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	11.570909	-2	0.003
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	119.97	-167.65	407.60



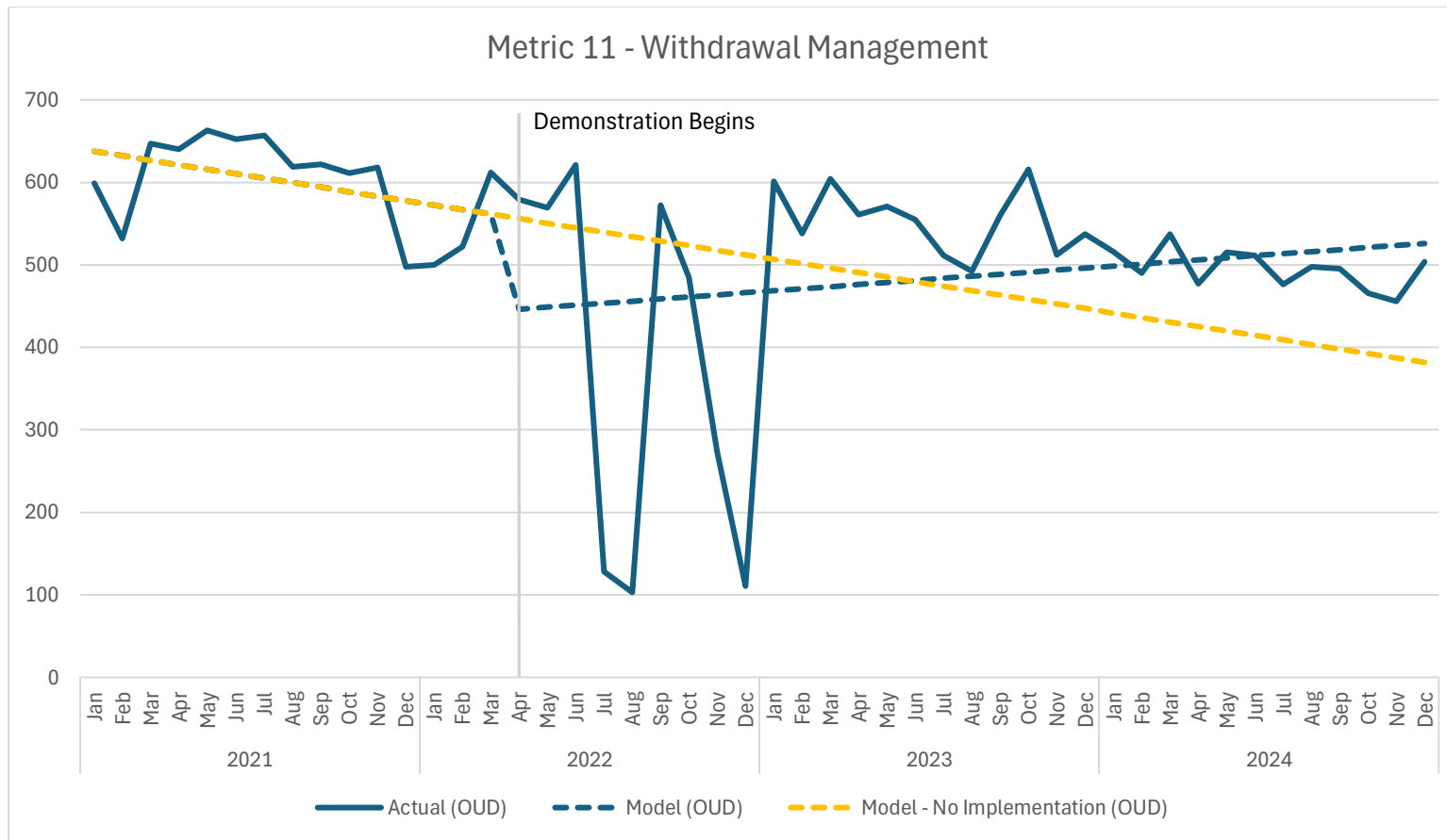
Metric 11 – Seniors Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	13.113912	-2	0.001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	17.81	8.04	27.58



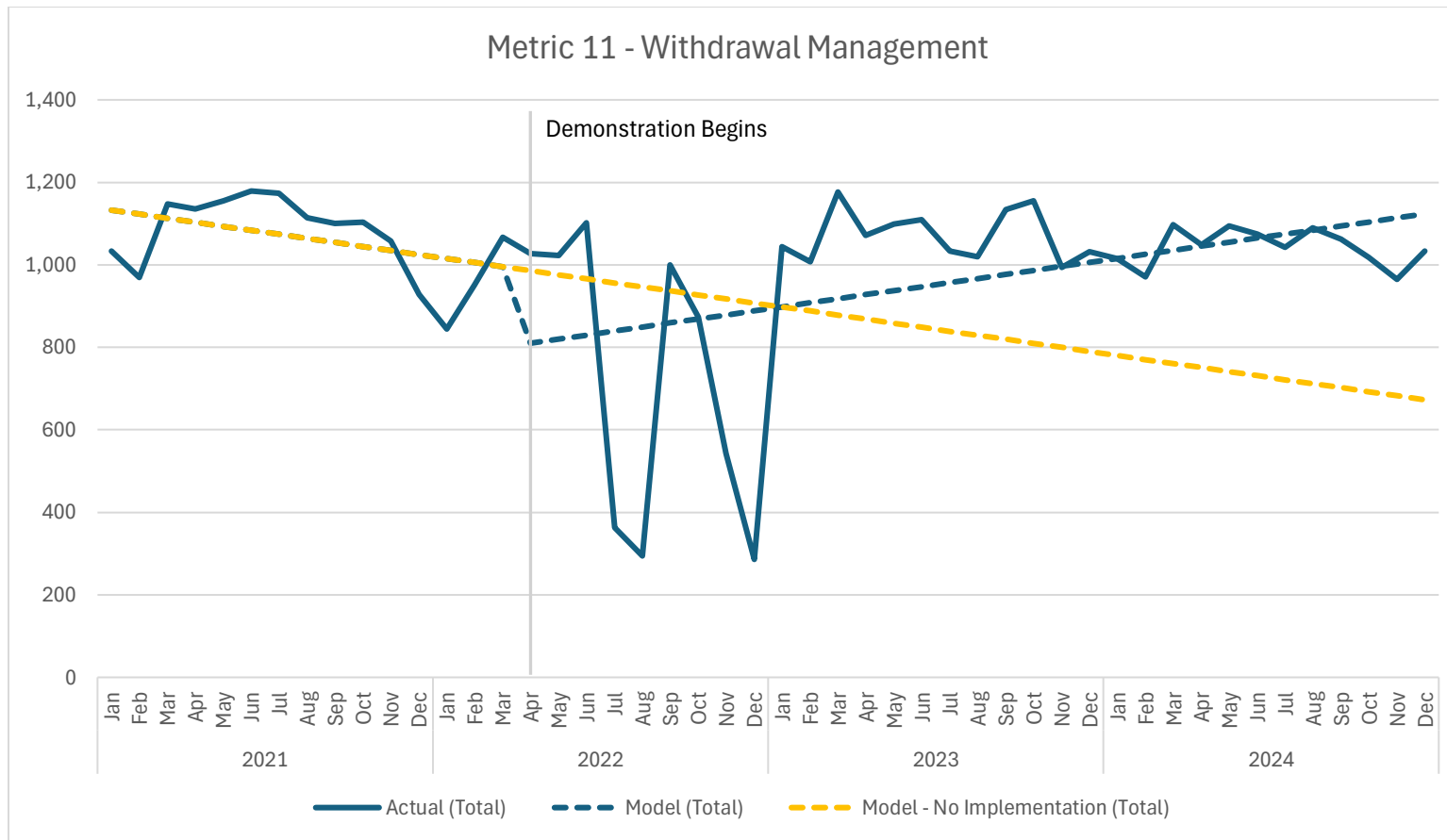
Metric 11 – Not Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	11.944587	-2	0.003
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	138.97	-152.43	430.37



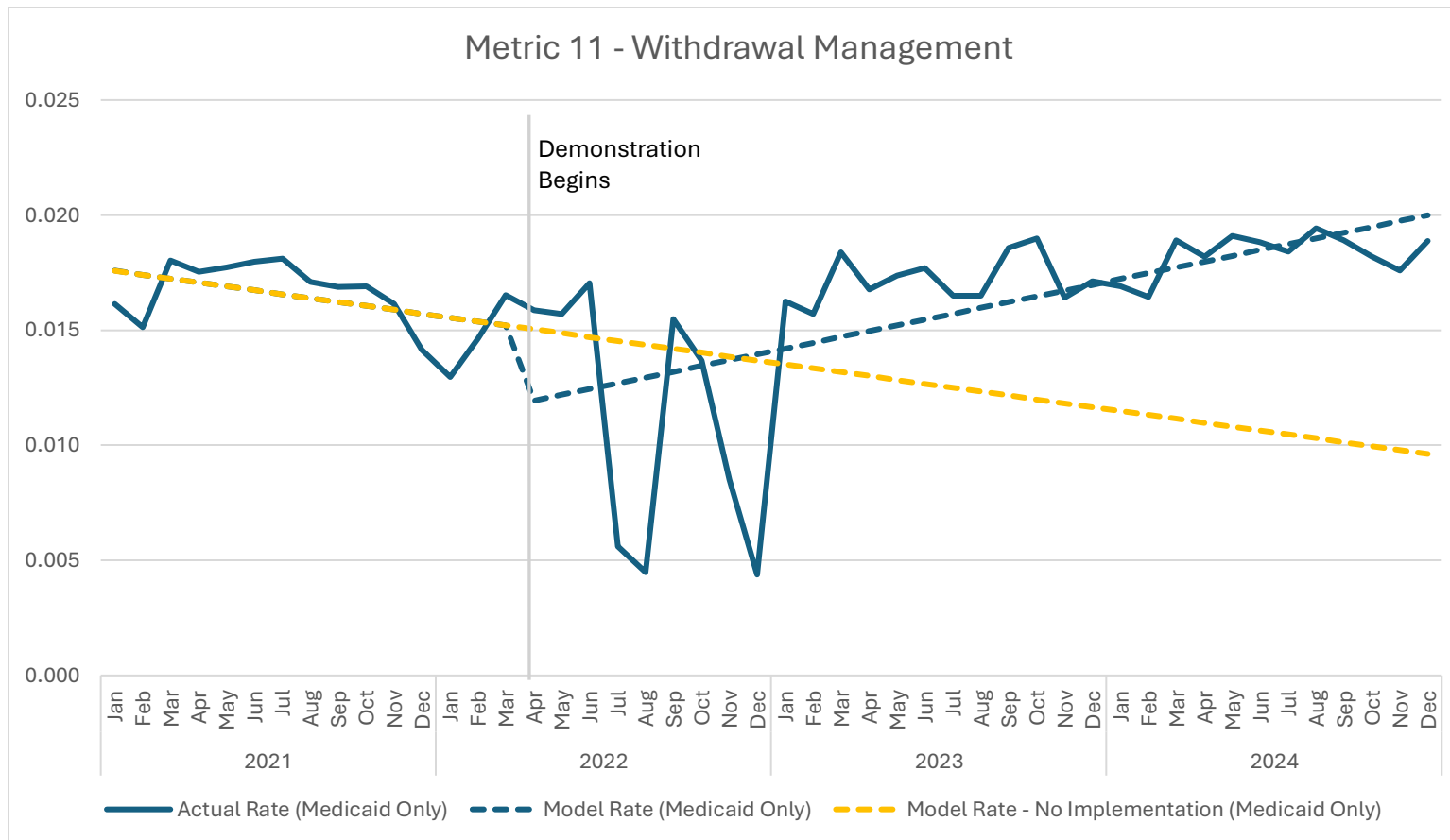
Metric 11 – Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	0.1187255	-2	0.942
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-1.45	-9.67	6.78



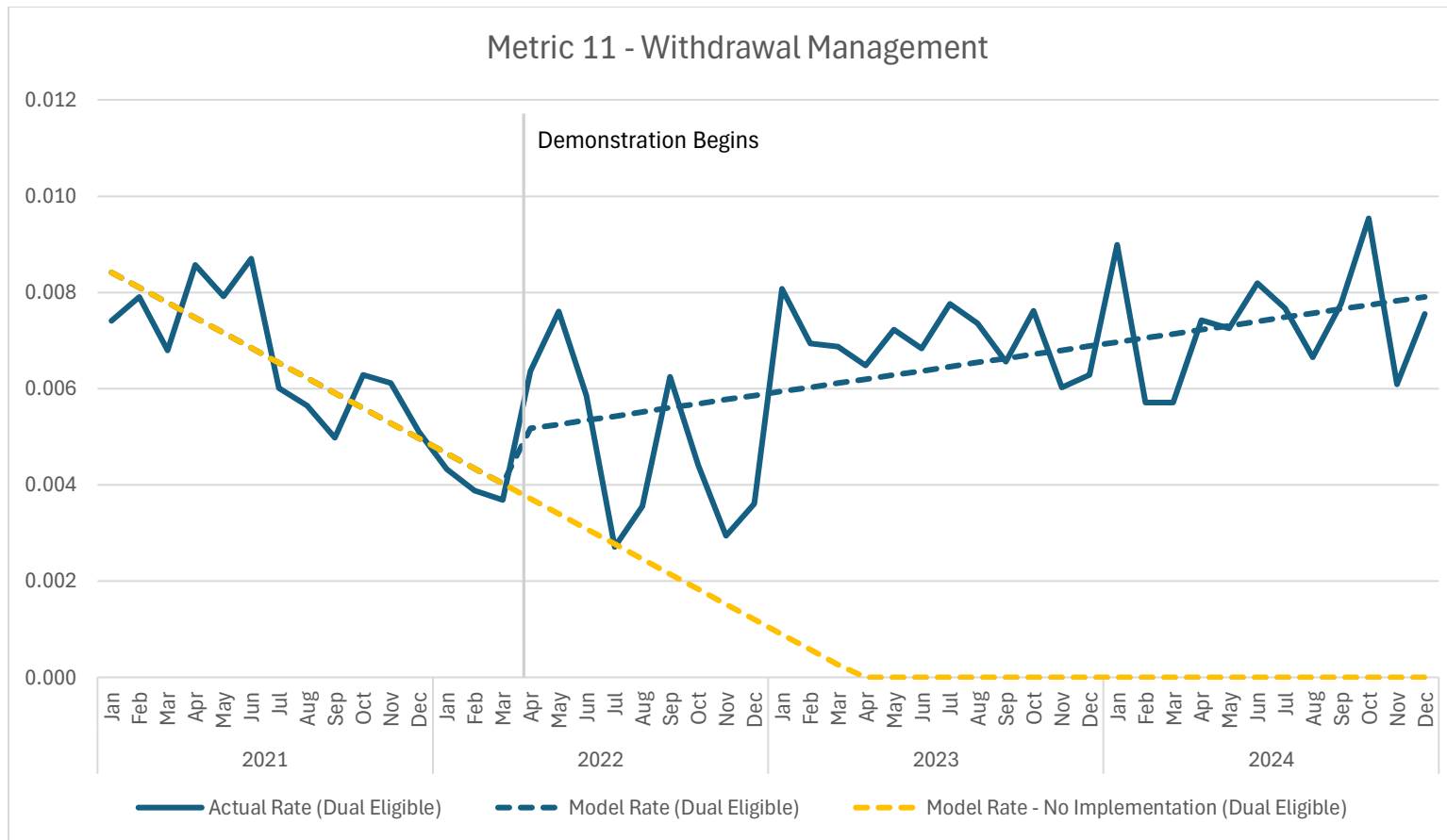
Metric 11 – OUD Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	8.1113571	-2	0.017
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	17.22	-140.57	175.01



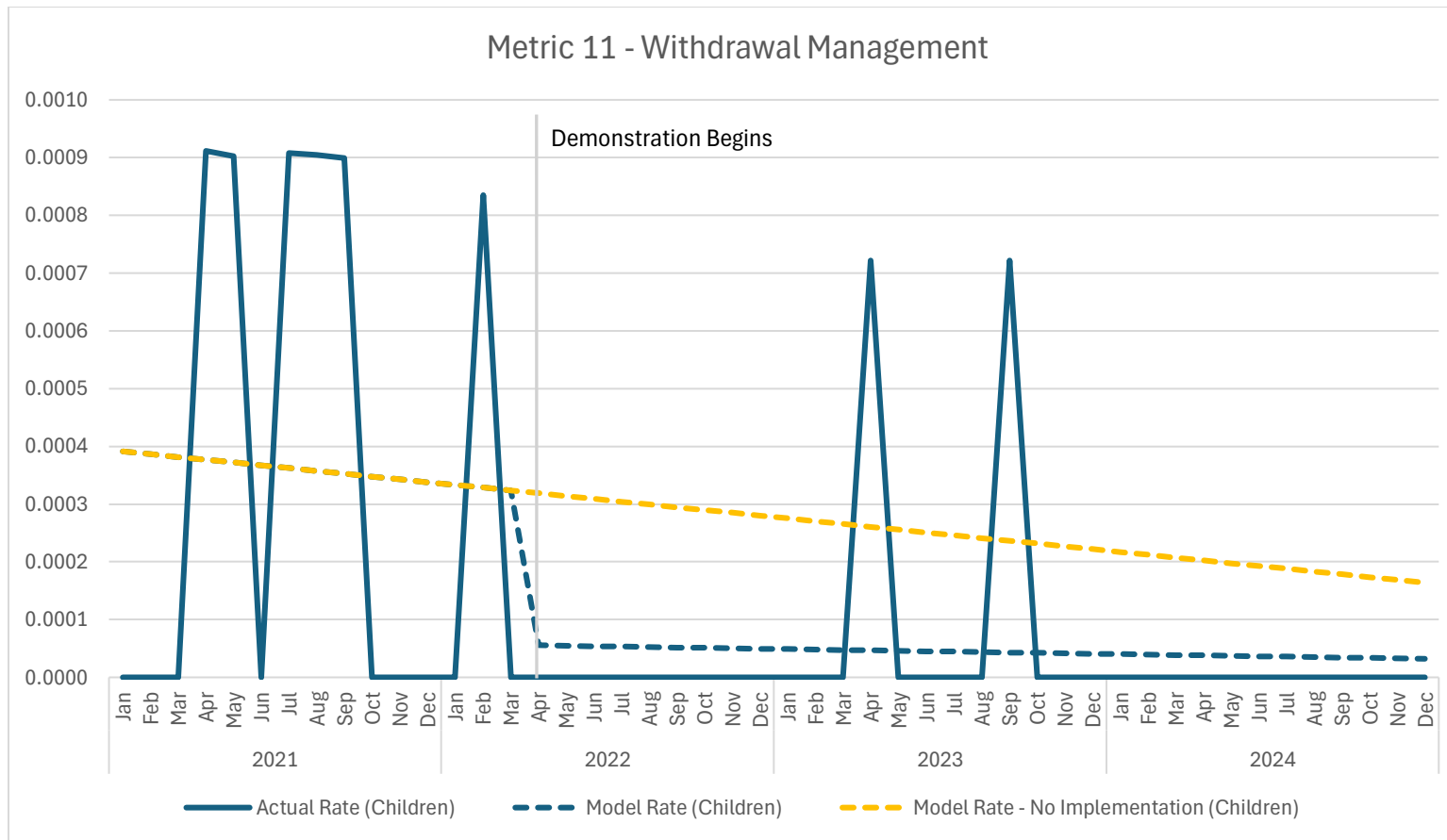
Metric 11 – Total Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	11.695289	-2	0.003
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	137.53	-159.95	435.01



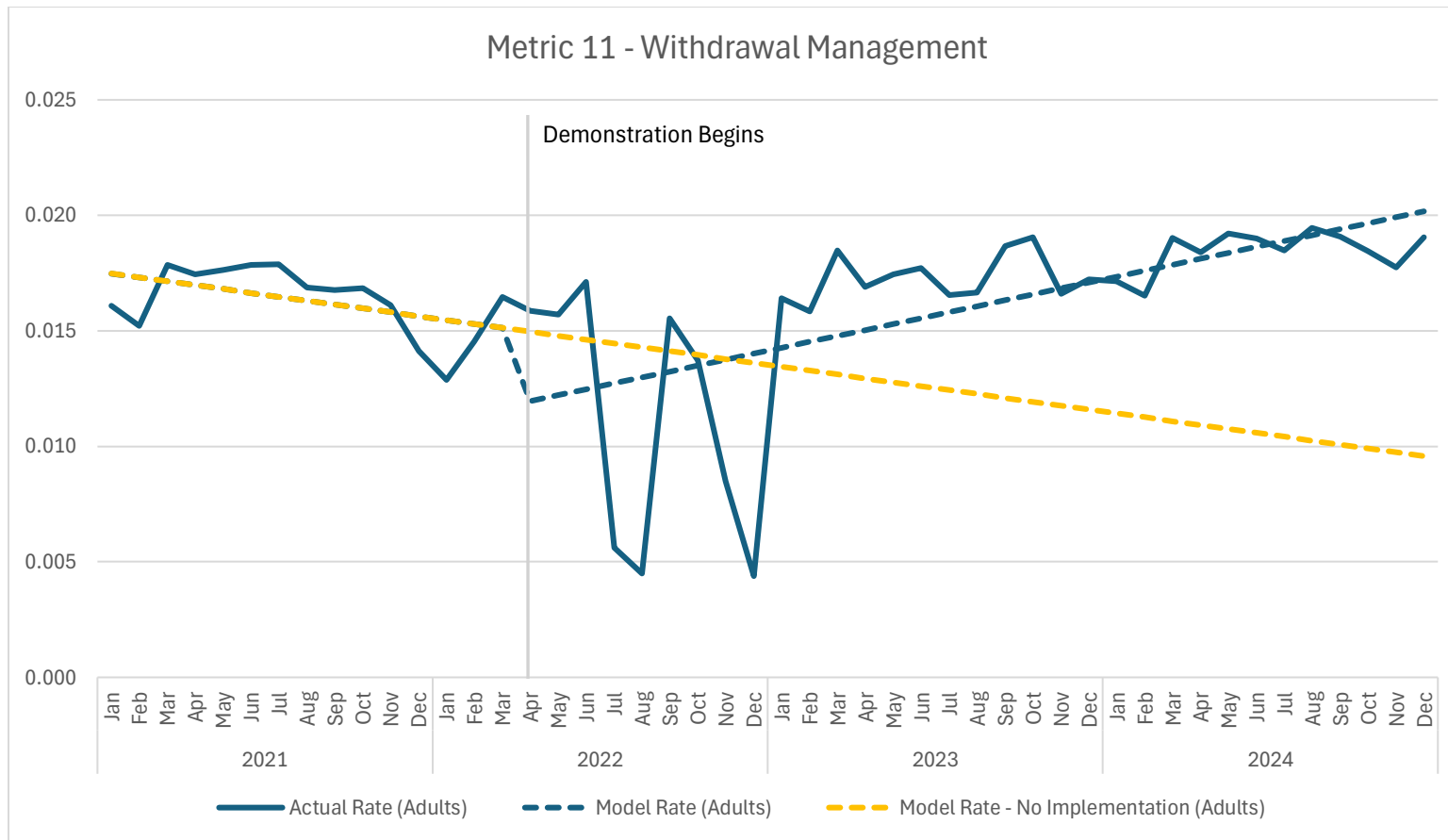
Metric 11 Rate – Medicaid Only Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	24.420023	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.004	-0.001	0.008



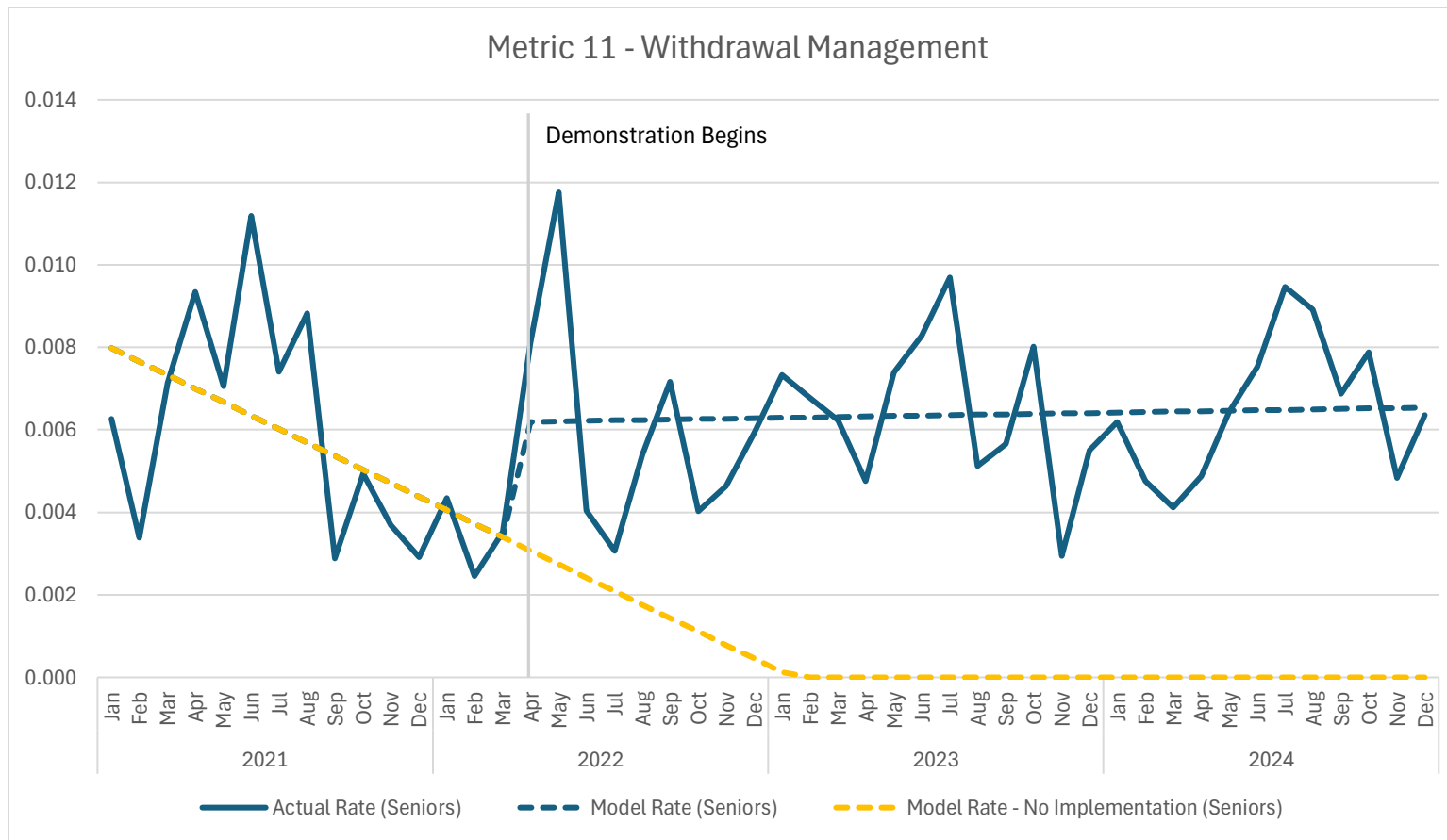
Metric 11 Rate – Dual Eligible Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	116.54315	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.008	0.006	0.009



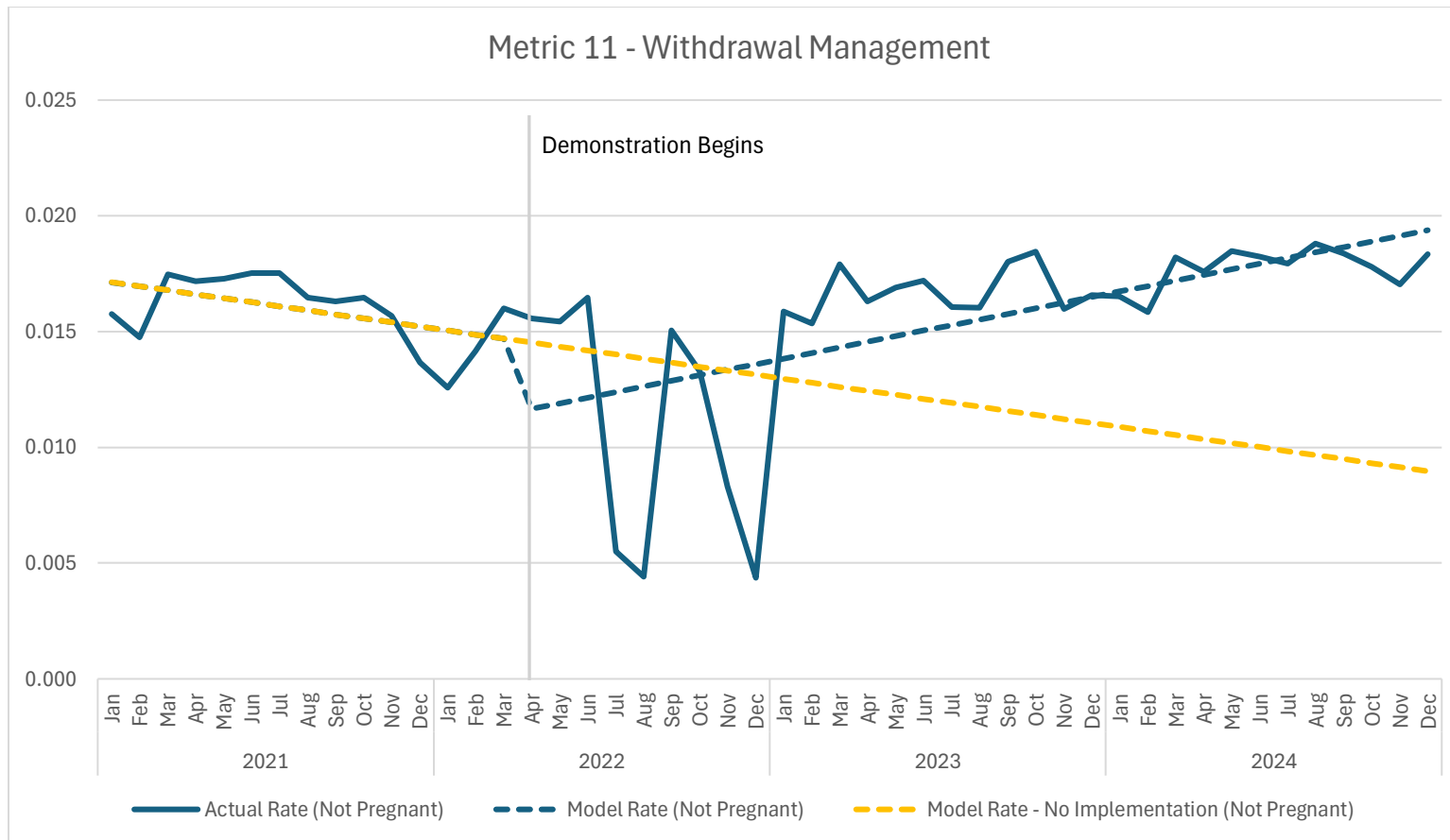
Metric 11 Rate – Children Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	12.816873	-2	0.002
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-0.0002	-0.001	0.001



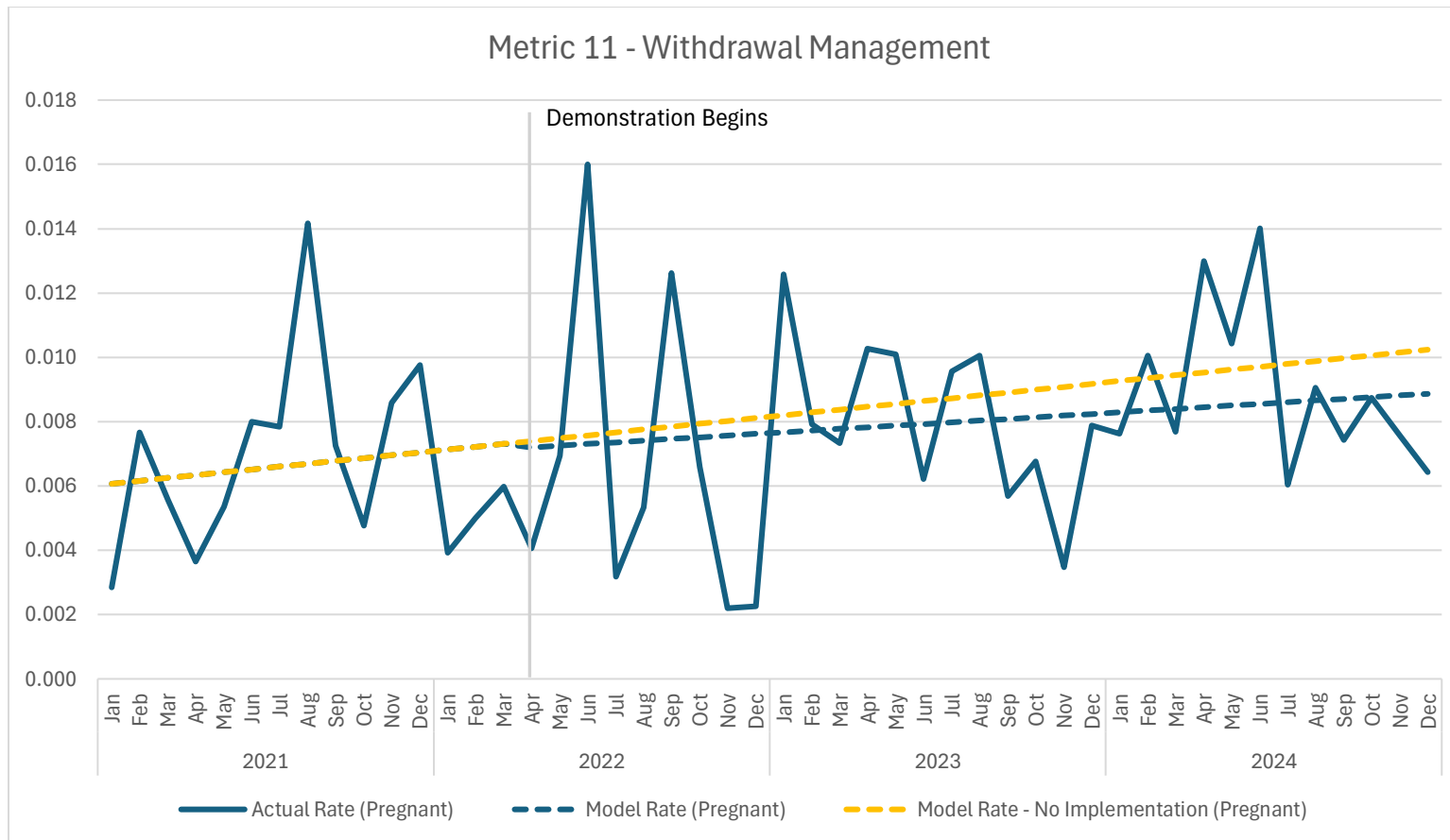
Metric 11 Rate – Adults Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	25.336437	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.004	-0.0003	0.008



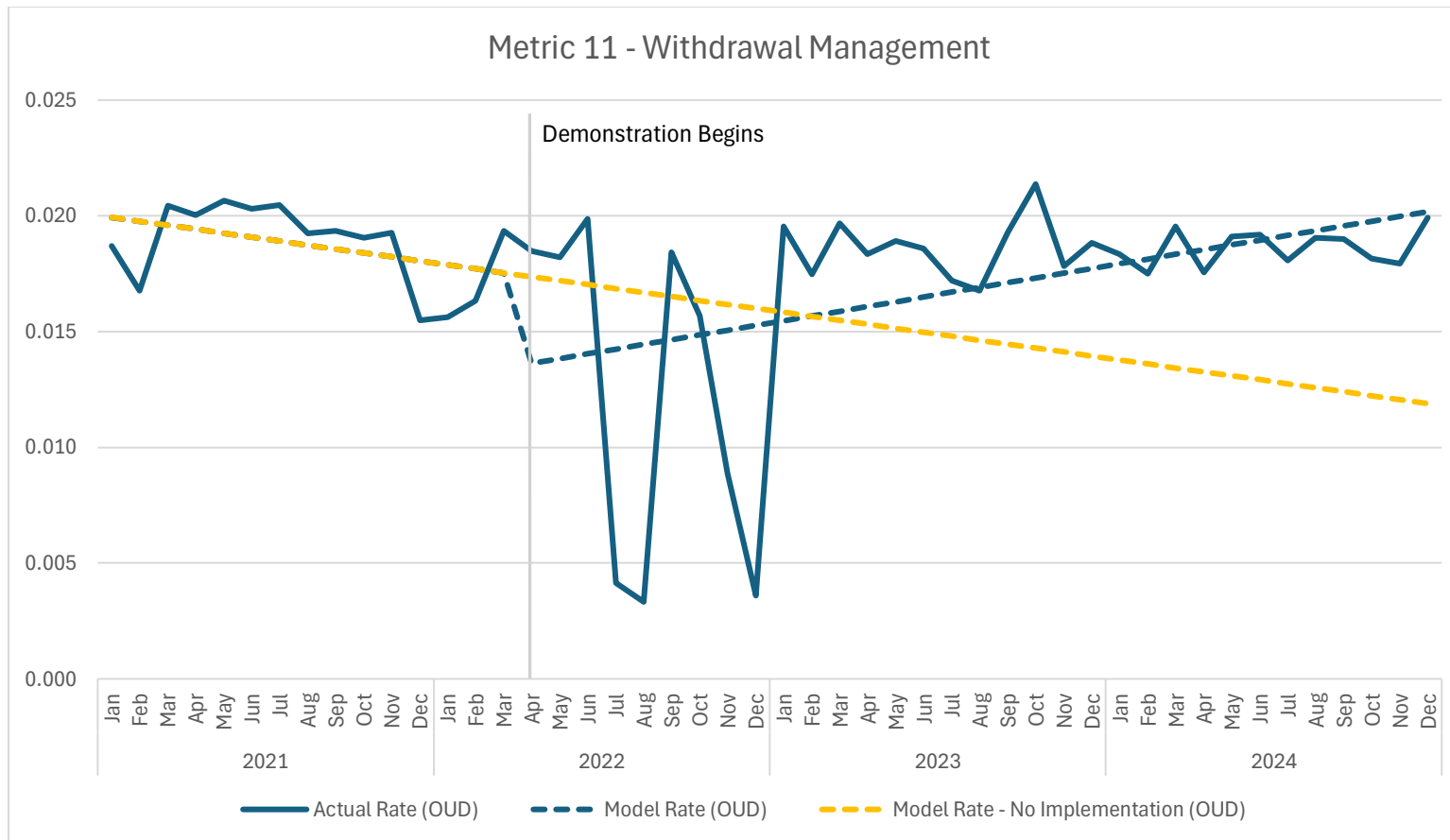
Metric 11 Rate – Seniors Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	8.8939069	-2	0.012
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.009	0.003	0.014



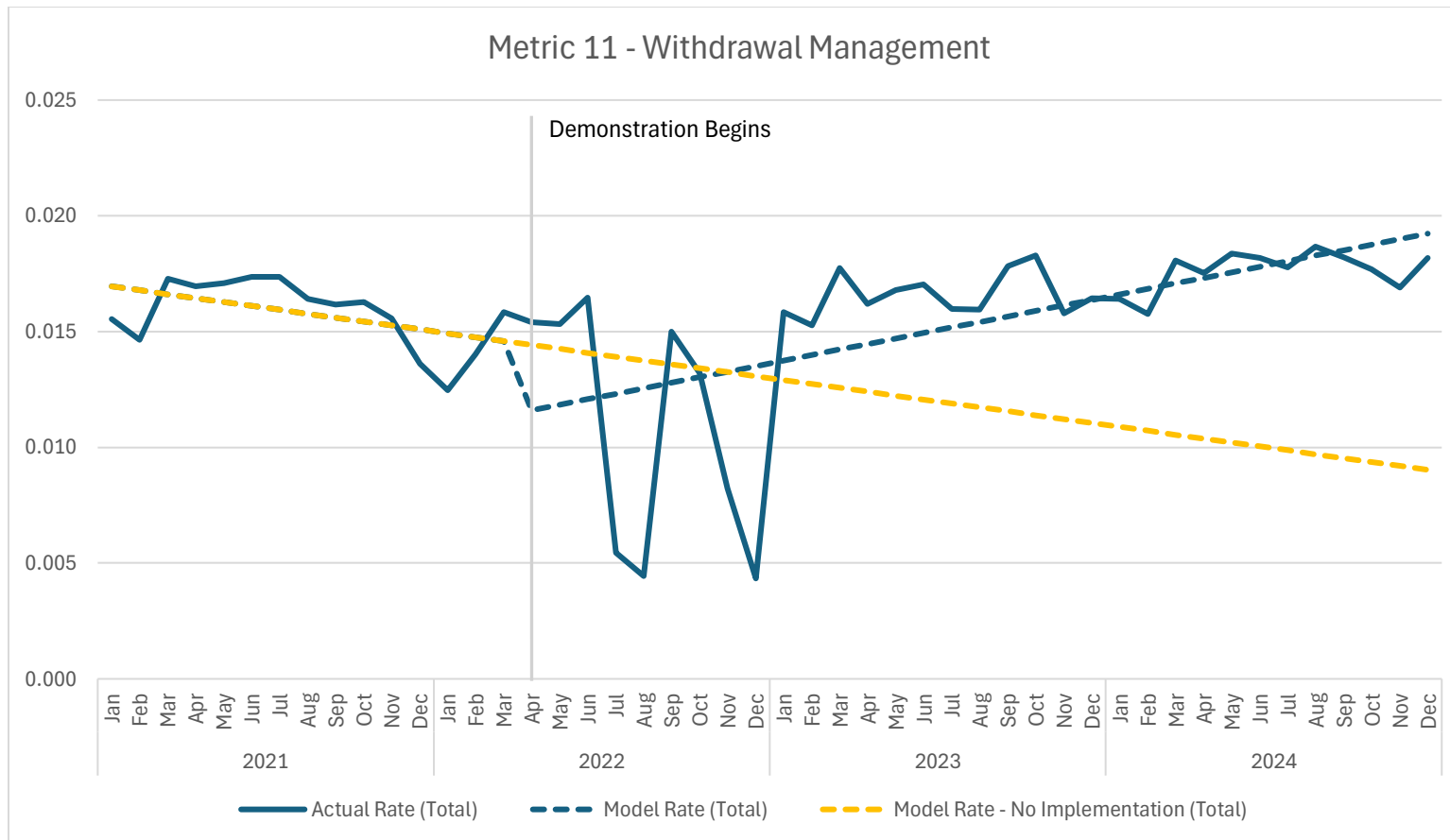
Metric 11 Rate – Not Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	24.857171	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.004	-0.0004	0.008



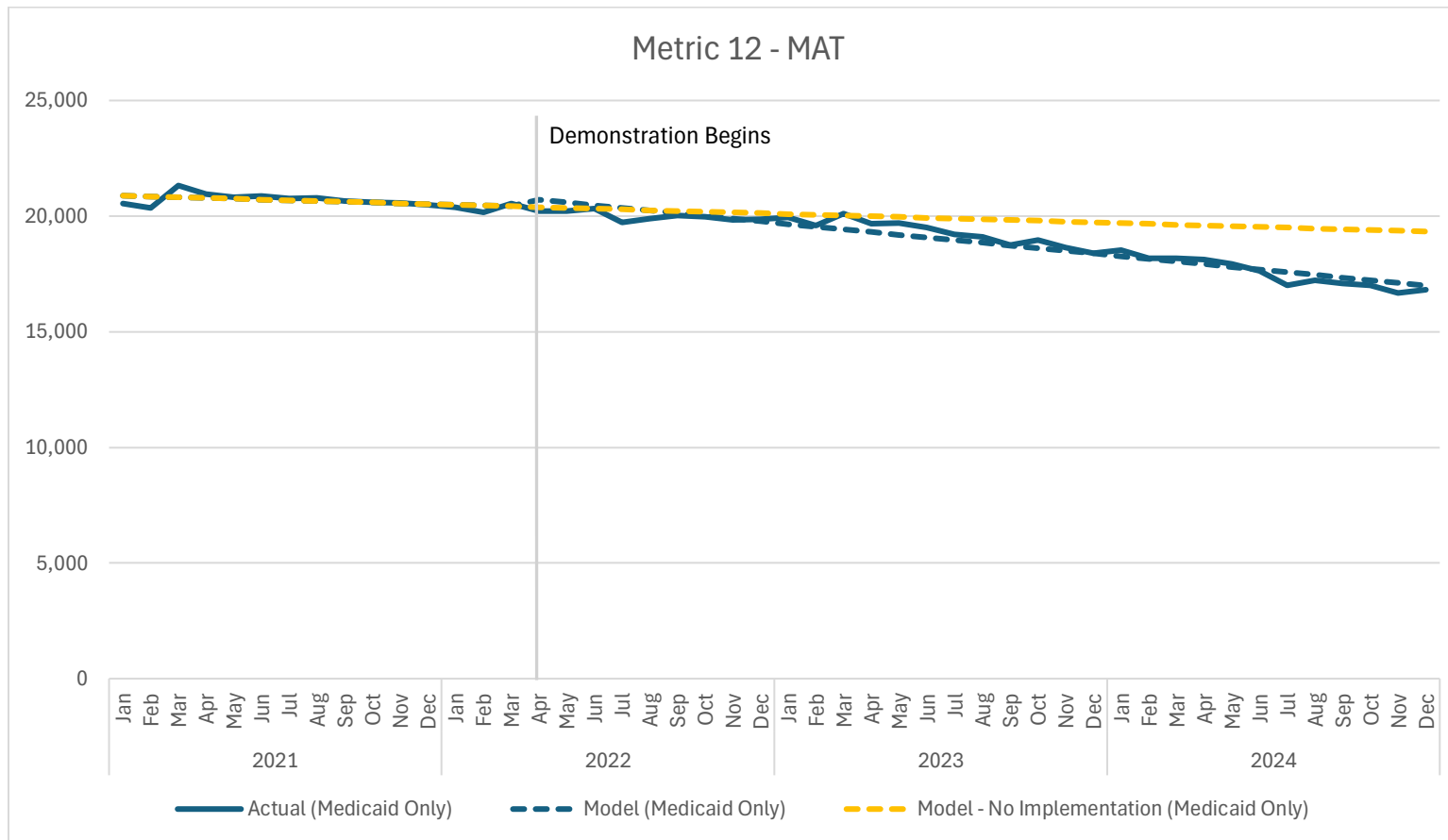
Metric 11 Rate – Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	0.0683999	-2	0.966
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-0.001	-0.007	0.006



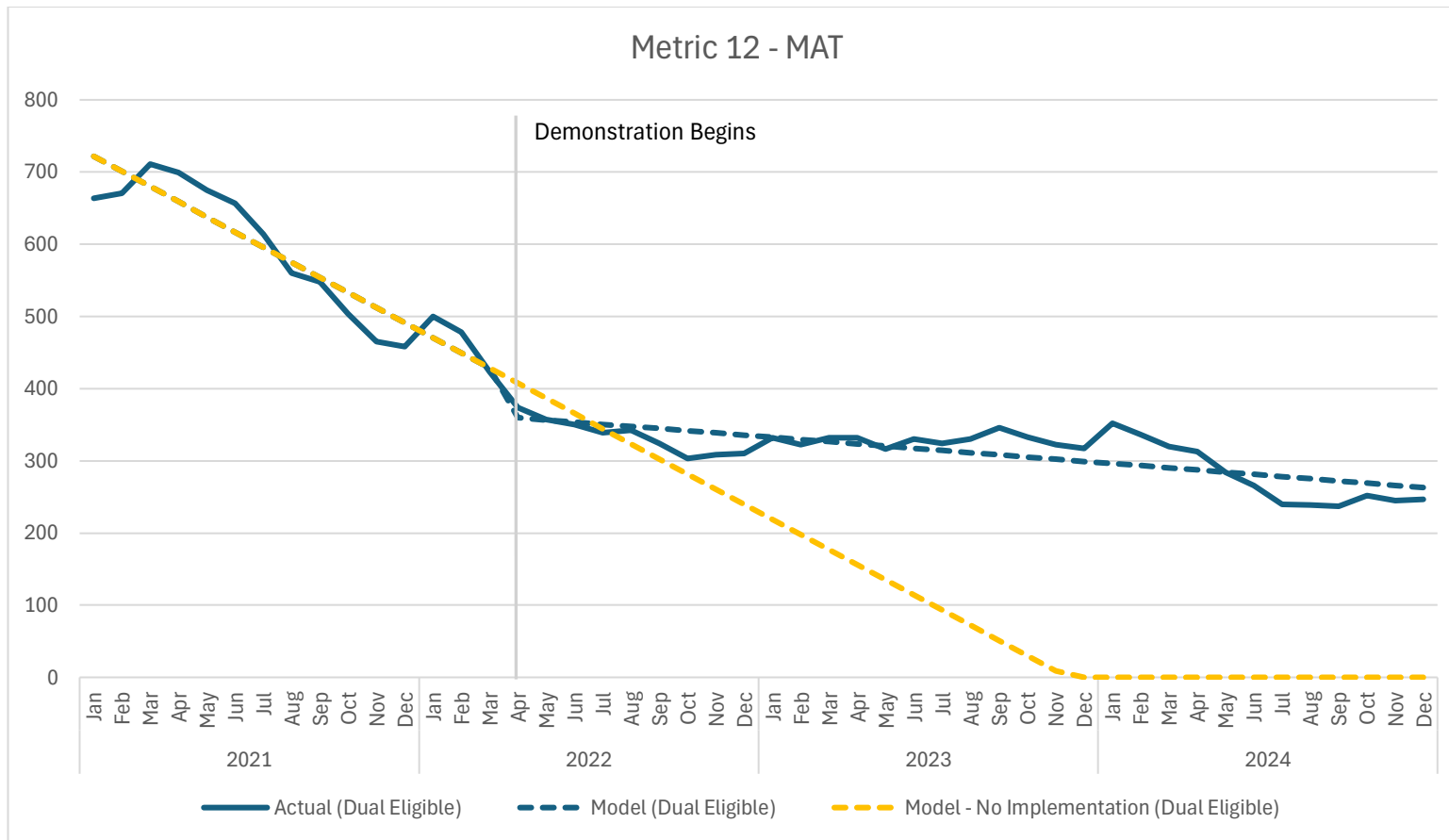
Metric 11 Rate – OUD Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	16.0746	-2	0.0003
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.002	-0.003	0.007



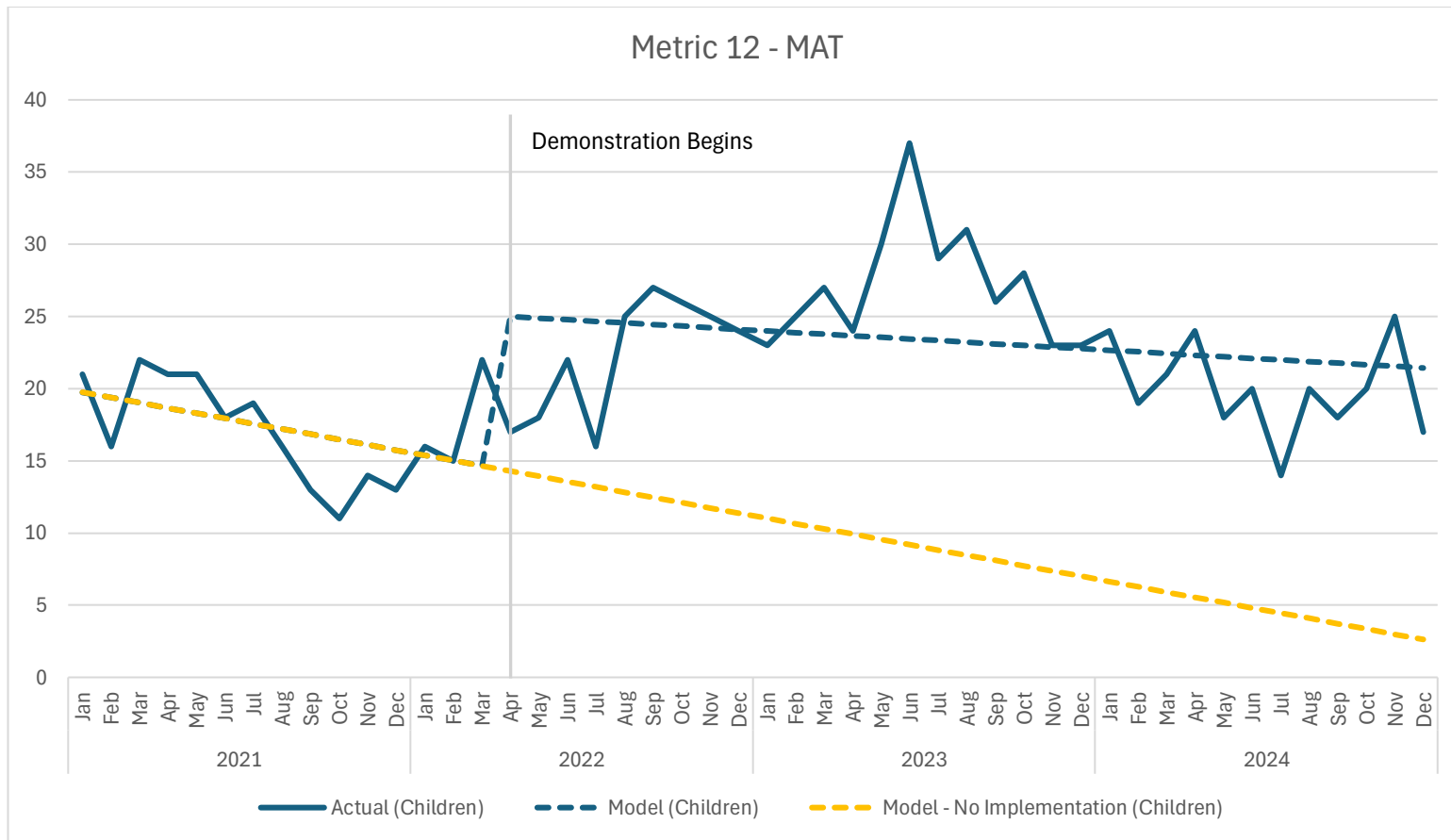
Metric 11 Rate – Total Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	24.371364	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.004	-0.0004	0.008



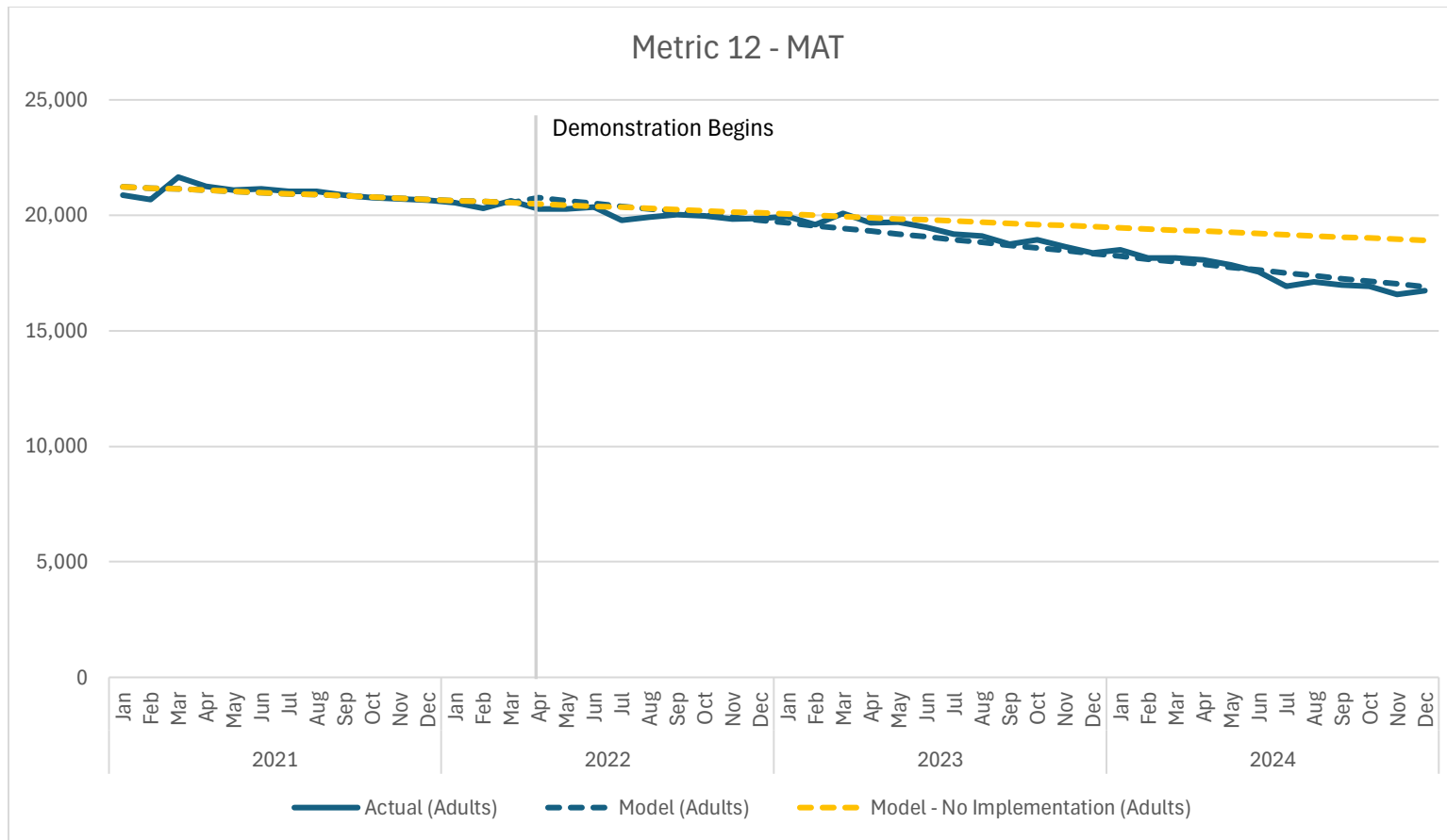
Metric 12 – Medicaid Only Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	19.147223	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-1,014.72	-1,588.15	-441.30



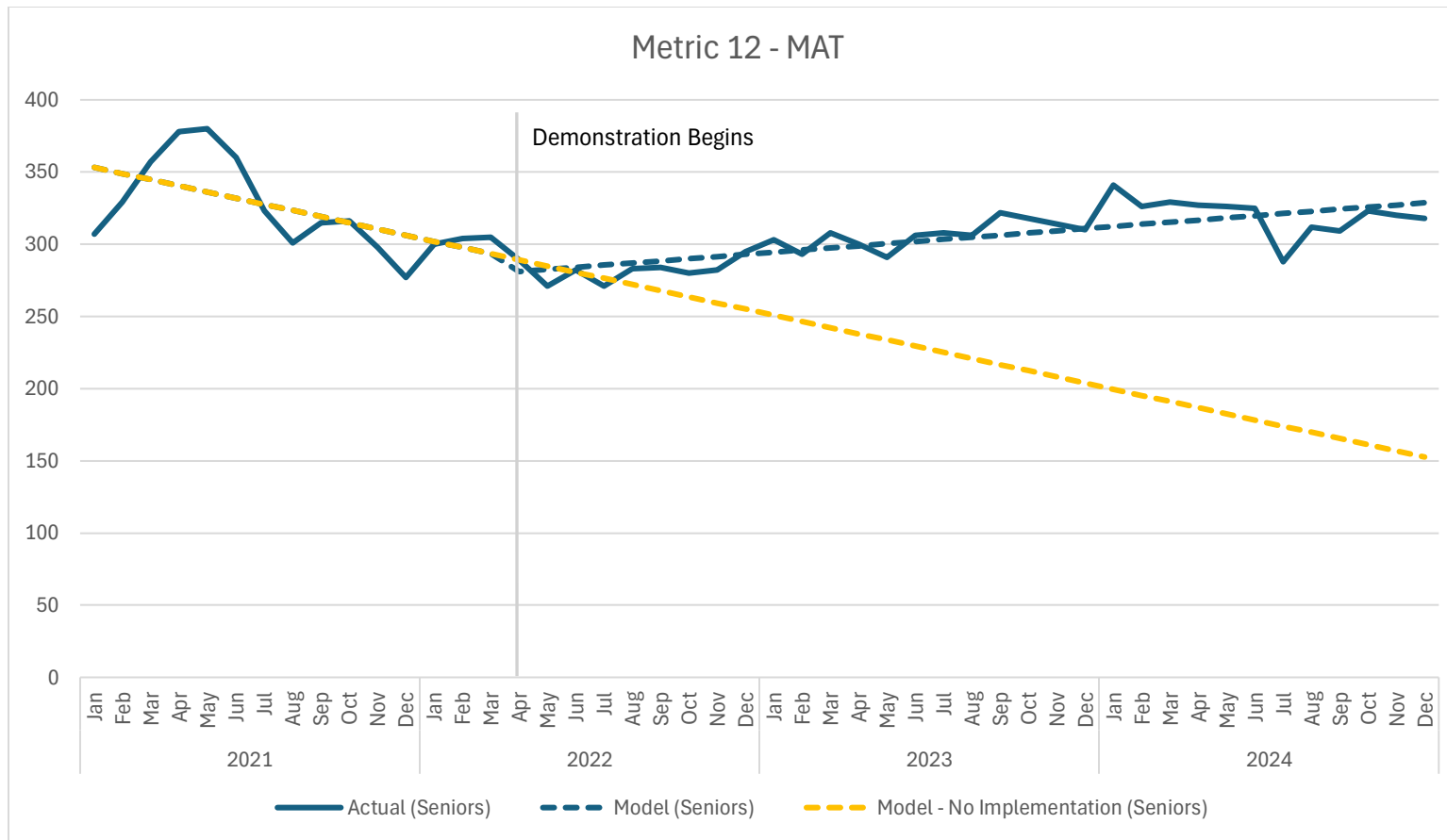
Metric 12 – Dual Eligible Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	152.5509	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	239.24	160.92	317.56



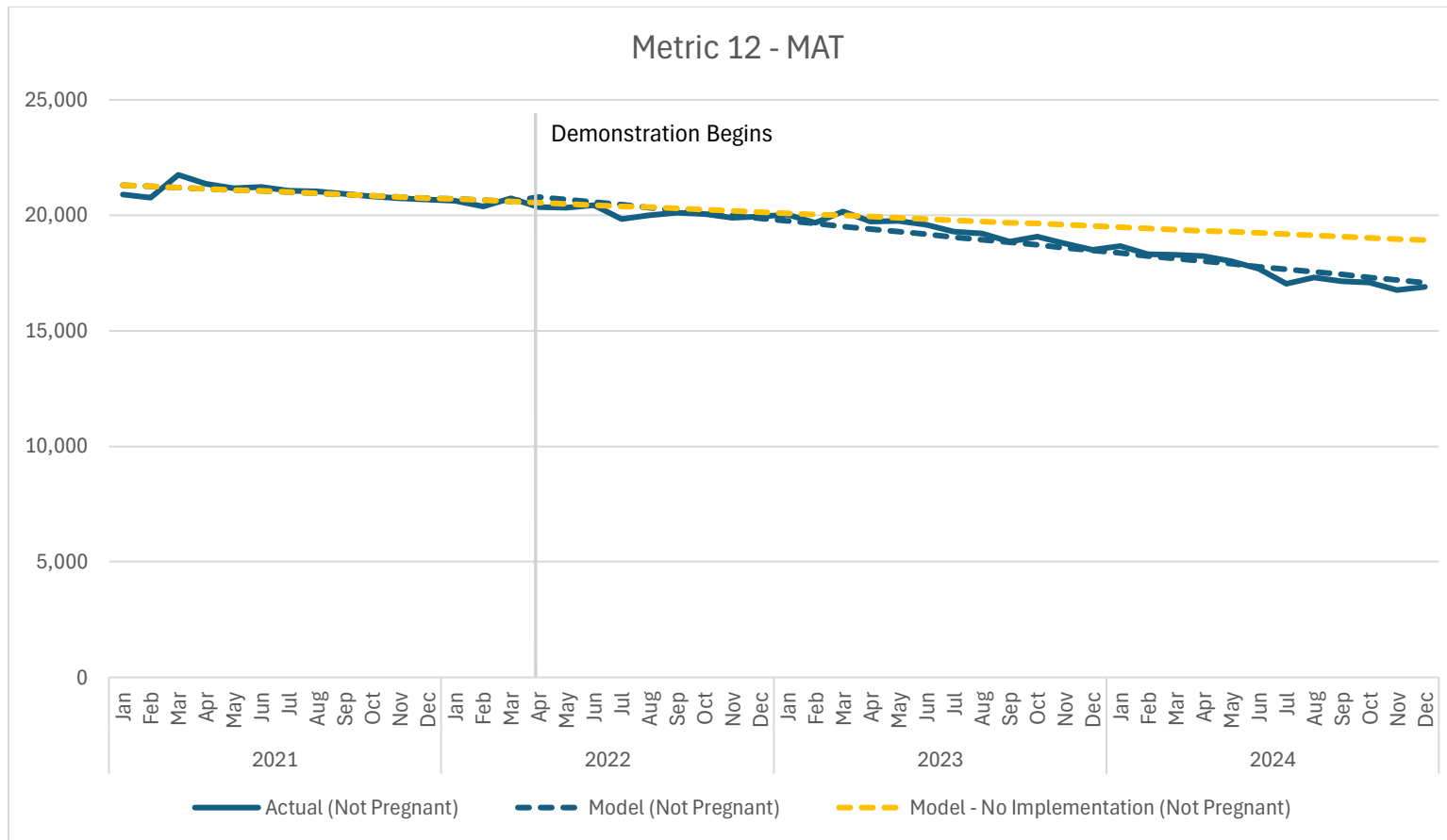
Metric 12 – Children Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	7.5365363	-2	0.023
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	14.75	4.09	25.42



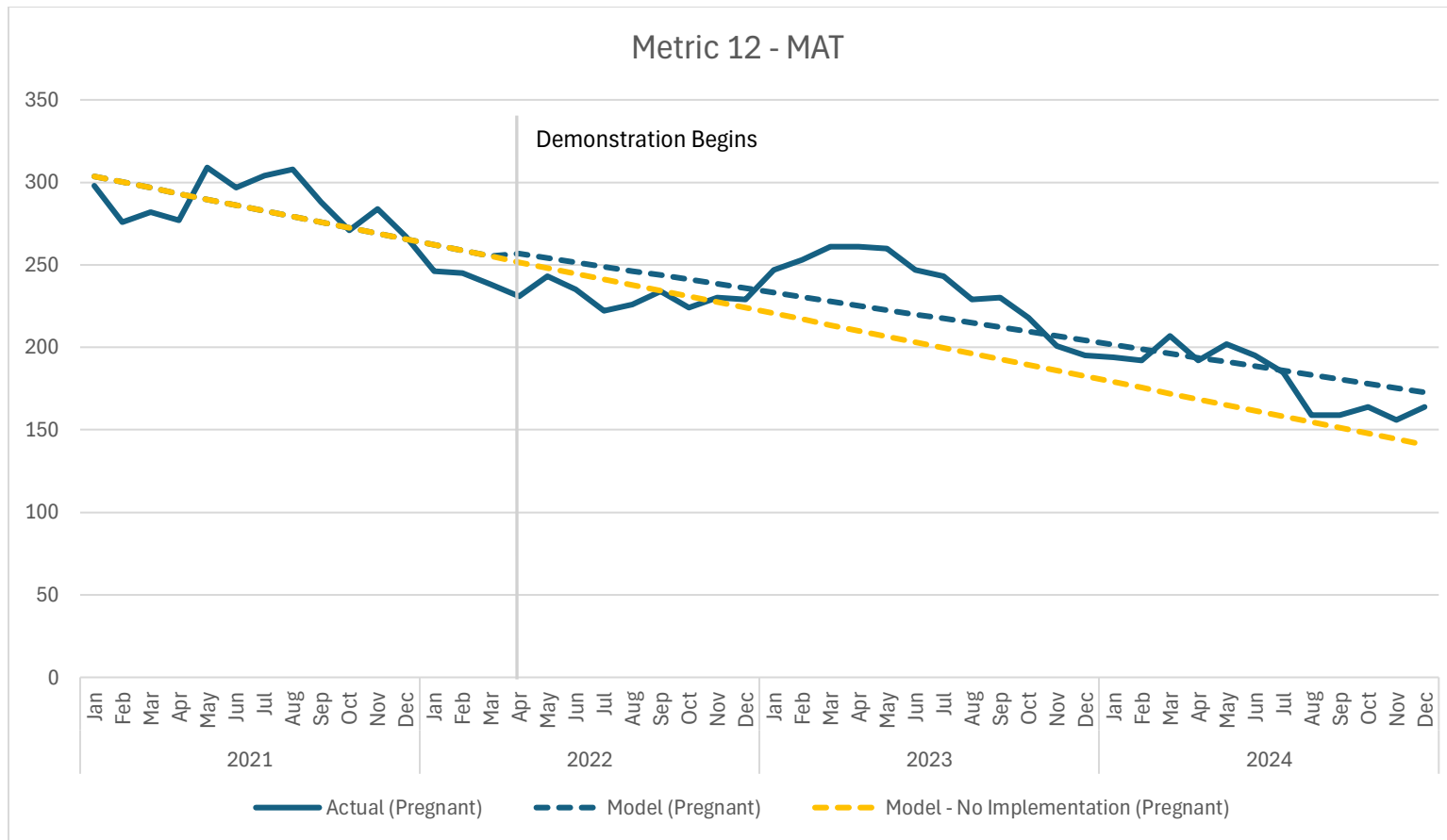
Metric 12 – Adults Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	13.785848	-2	0.001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-874.19	-1,454.09	-294.28



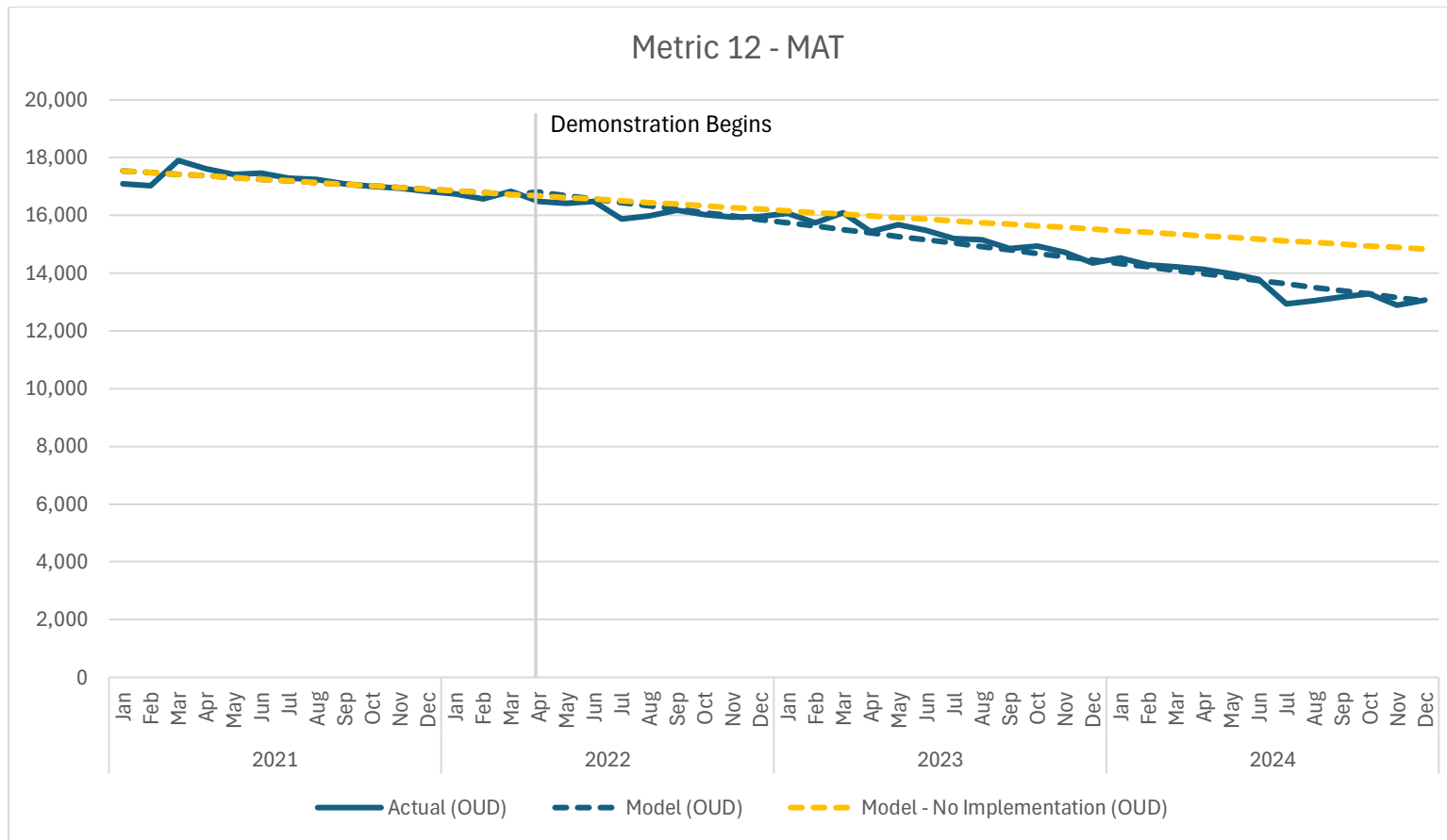
Metric 12 – Seniors Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	53.923959	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	83.94	25.51	142.38



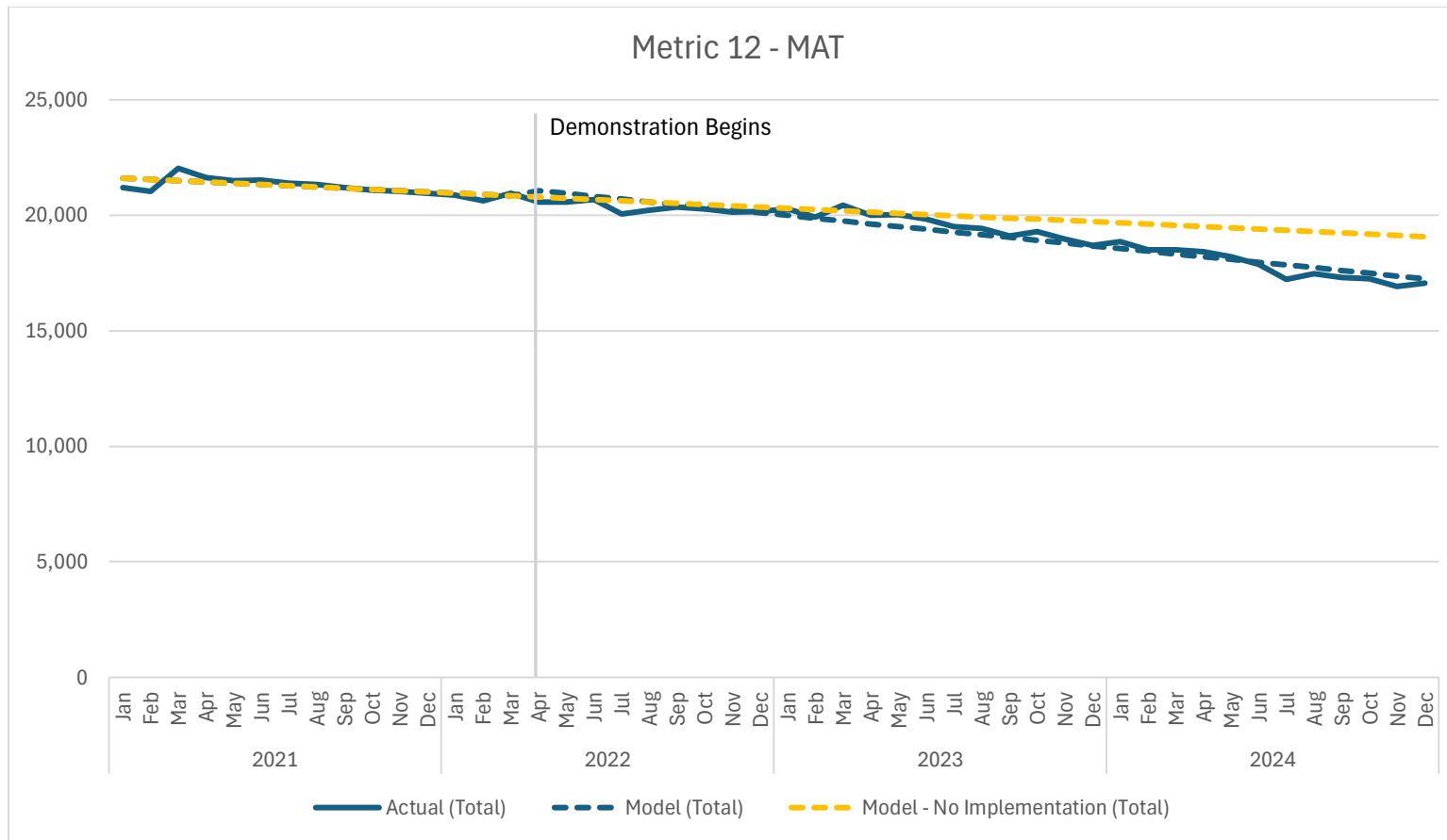
Metric 12 – Not Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	12.288076	-2	0.002
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-794.00	-1,384.80	-203.20



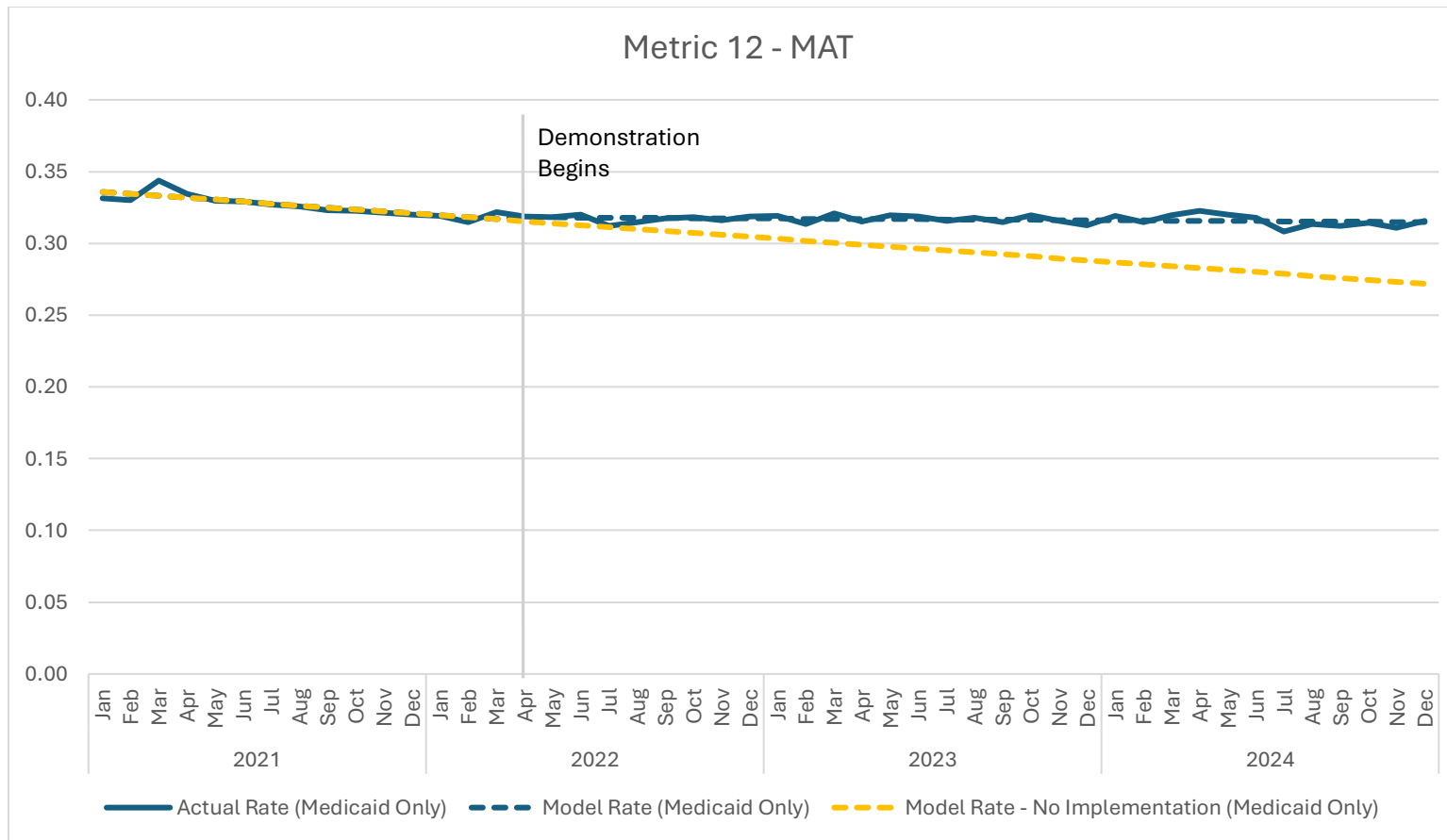
Metric 12 – Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	0.3923896	-2	0.822
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	18.51	-40.60	77.62



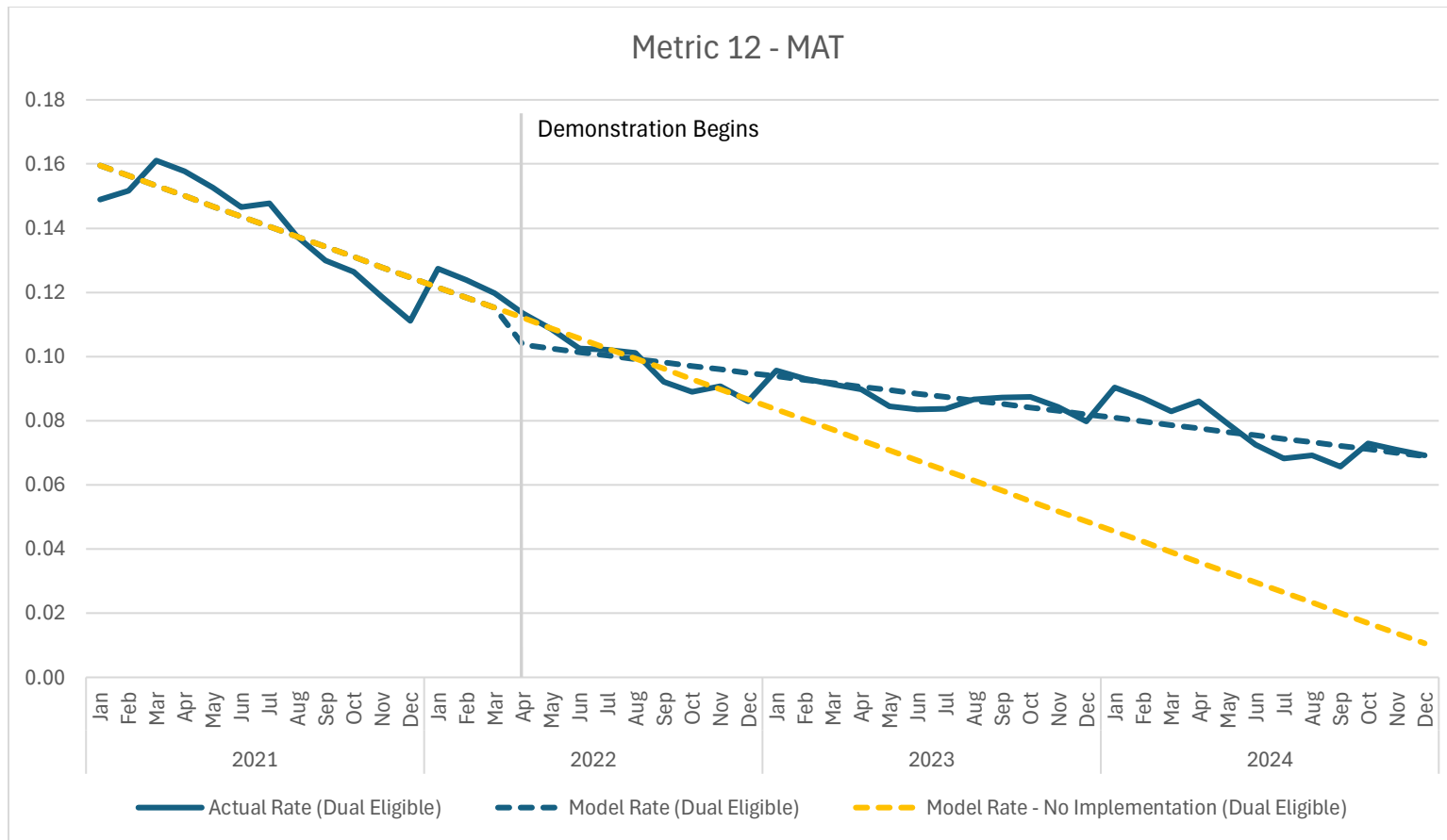
Metric 12 – OUD Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	11.198333	-2	0.004
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-833.64	-1,459.97	-207.31



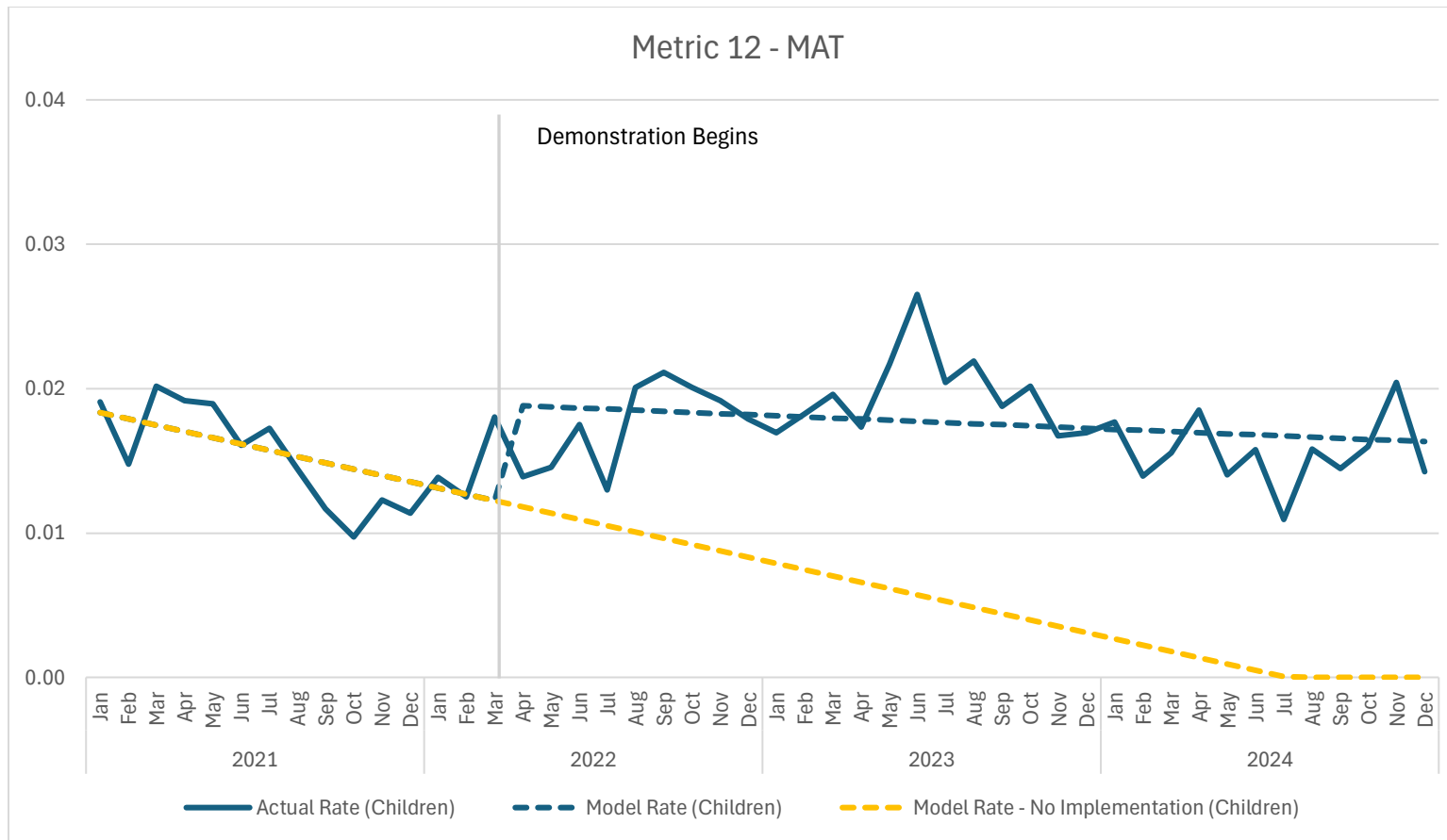
Metric 12 – Total Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	10.395222	-2	0.006
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-775.49	-1,403.71	-147.26



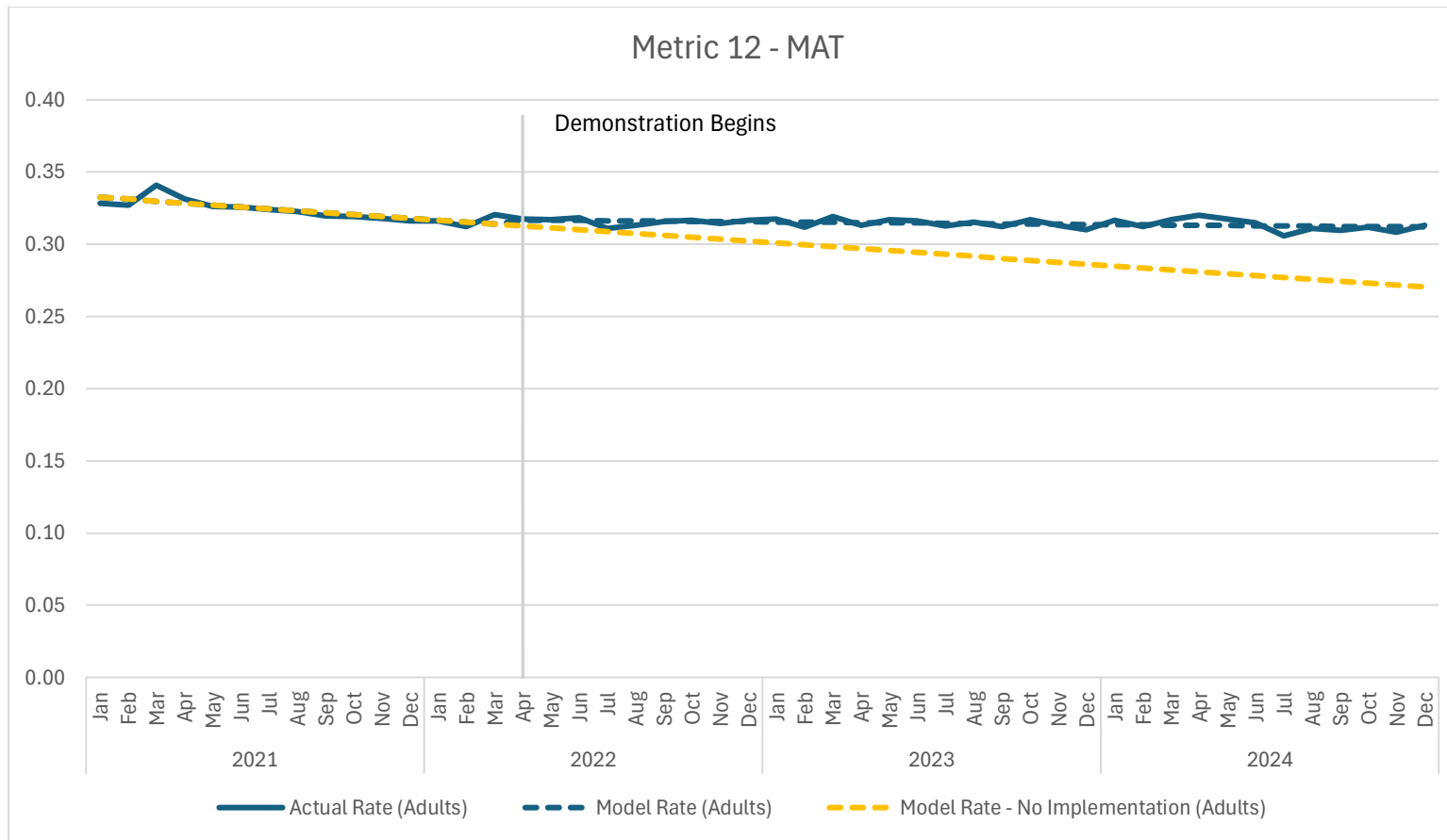
Metric 12 Rate – Medicaid Only Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	86.320232	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.023	0.016	0.029



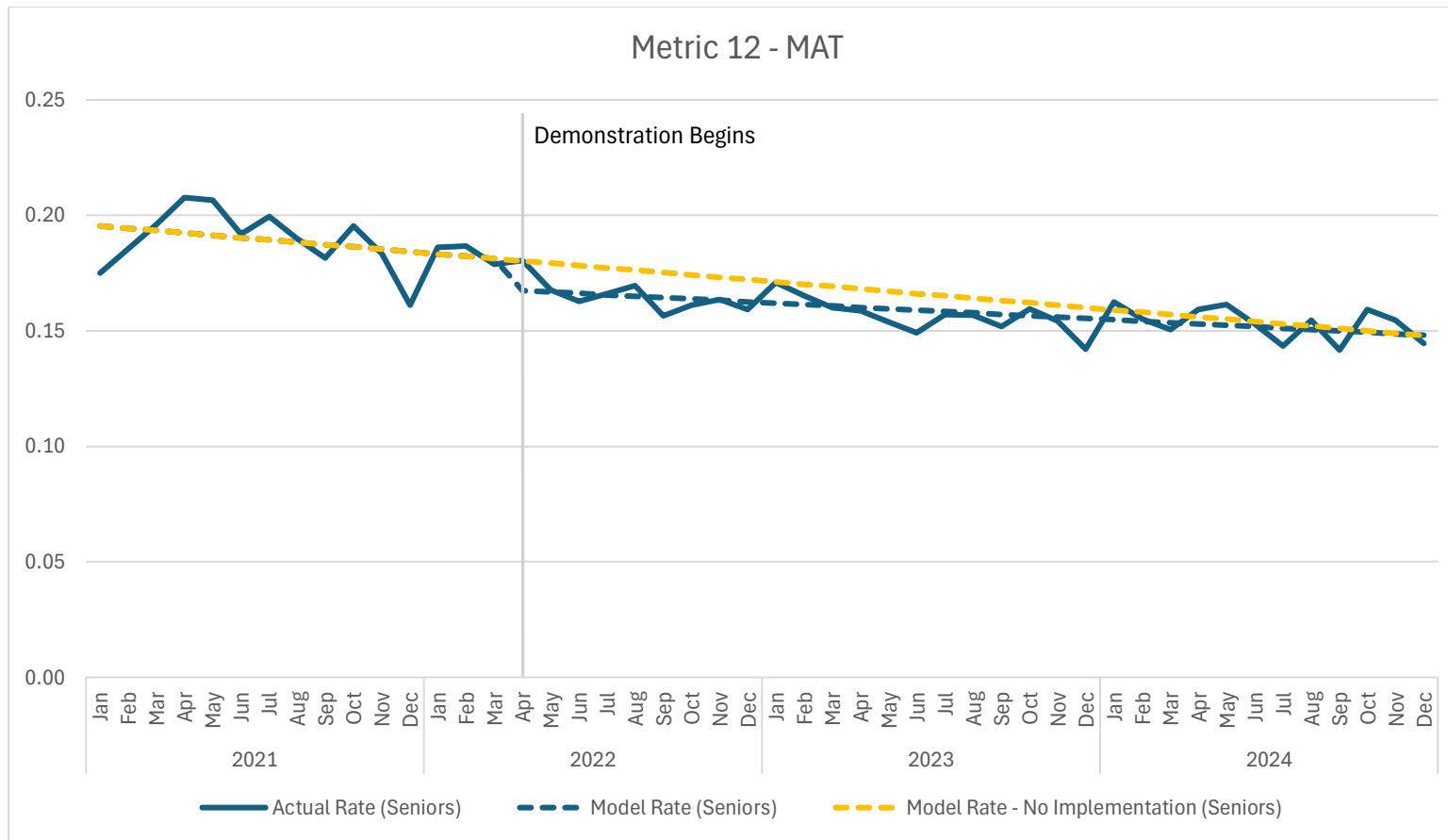
Metric 12 Rate – Dual Eligible Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	60.655927	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.025	0.008	0.042



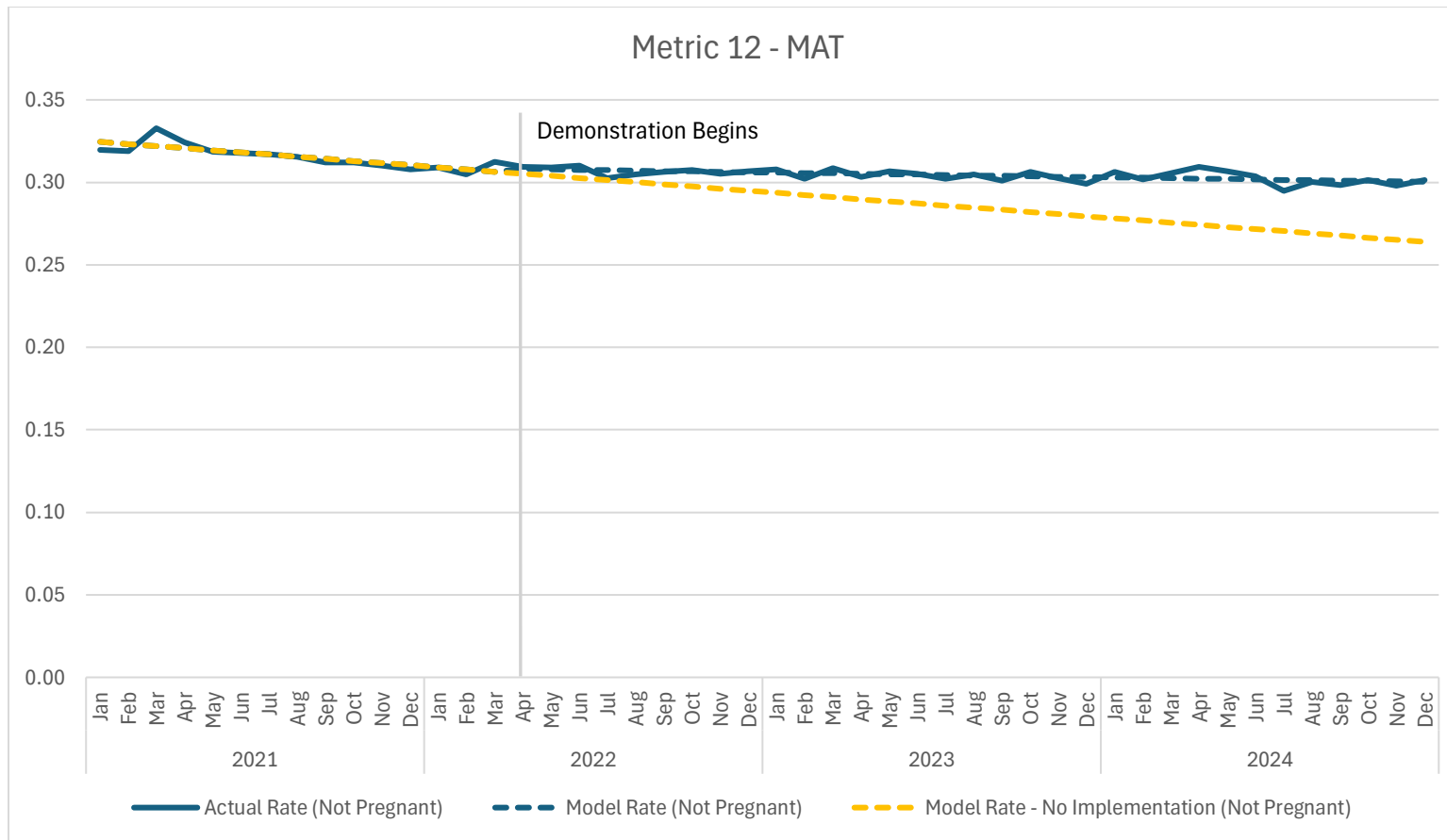
Metric 12 Rate – Children Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	9.6214127	-2	0.008
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.013	0.005	0.021



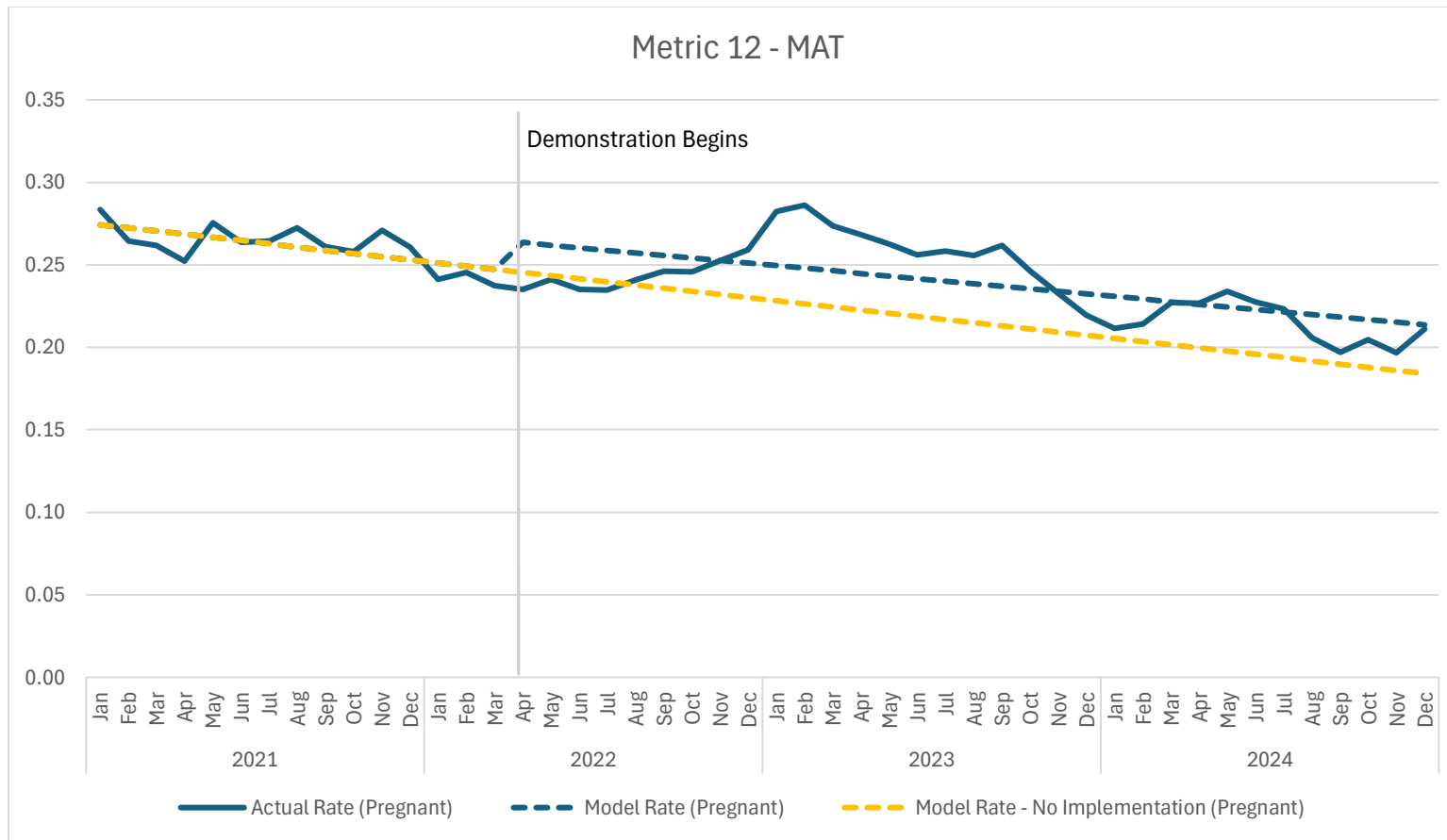
Metric 12 Rate – Adults Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	63.240678	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.023	0.015	0.030



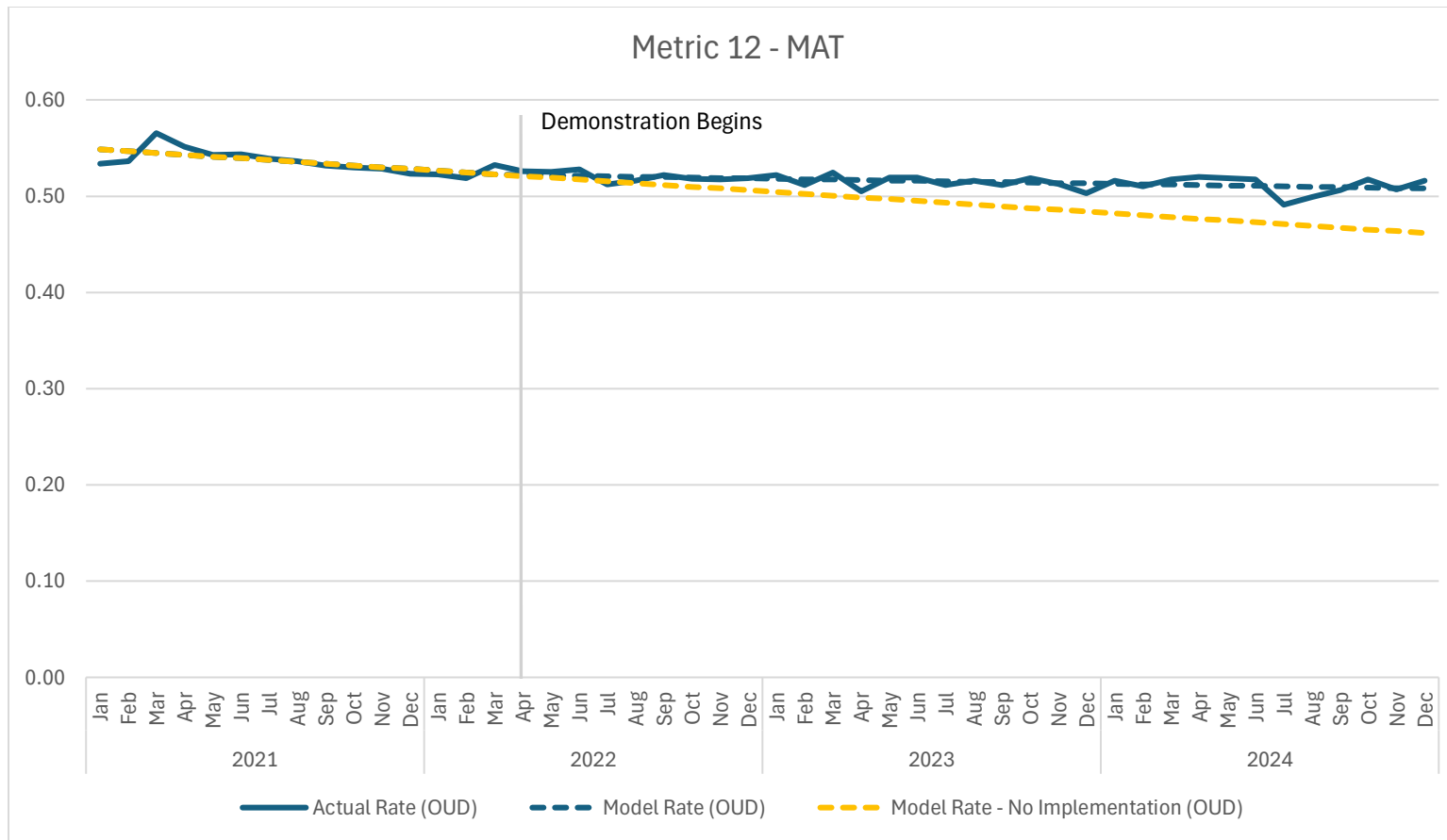
Metric 12 Rate – Seniors Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	26.843613	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-0.006	-0.034	0.021



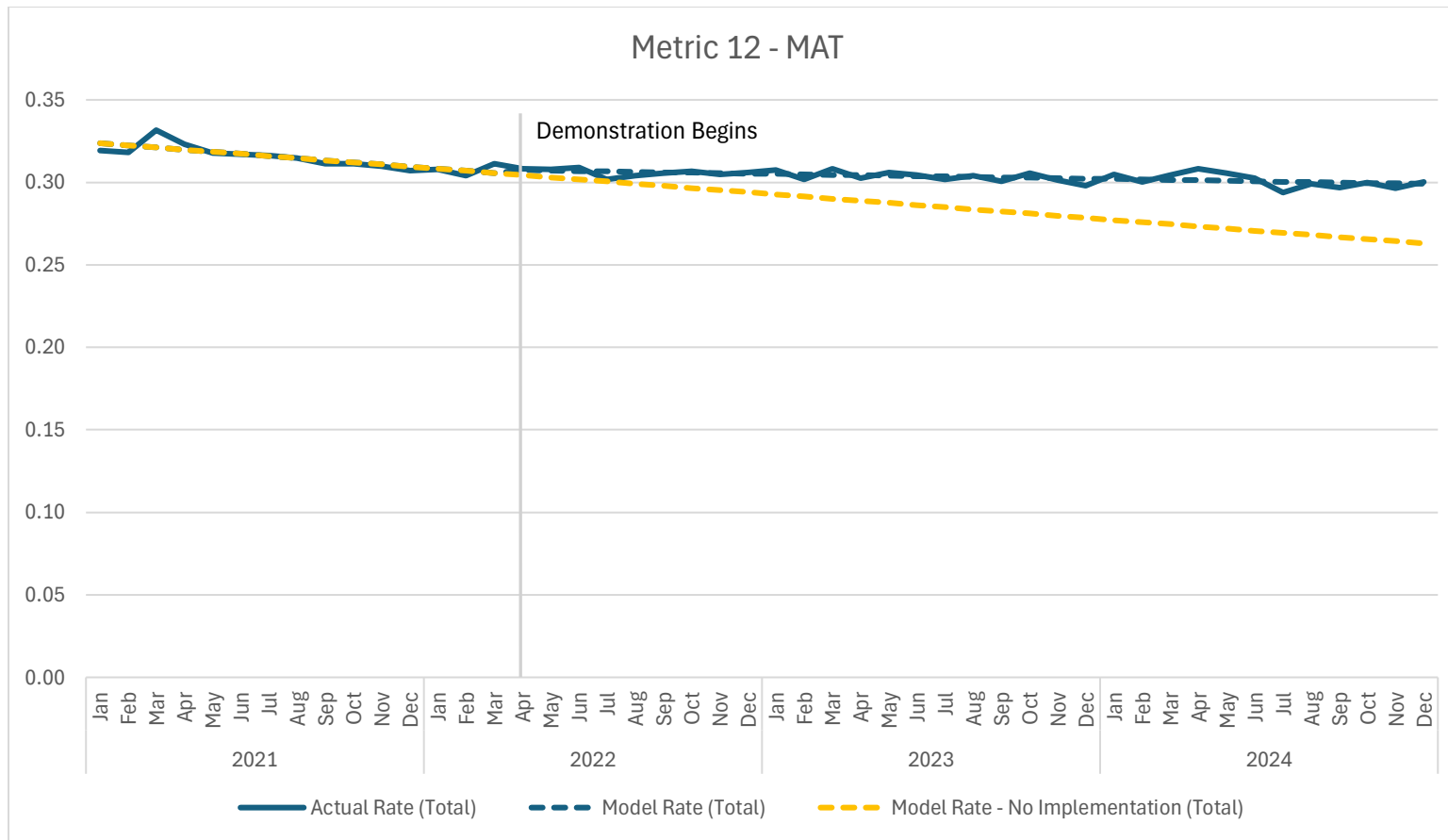
Metric 12 Rate – Not Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	60.832708	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.020	0.012	0.027



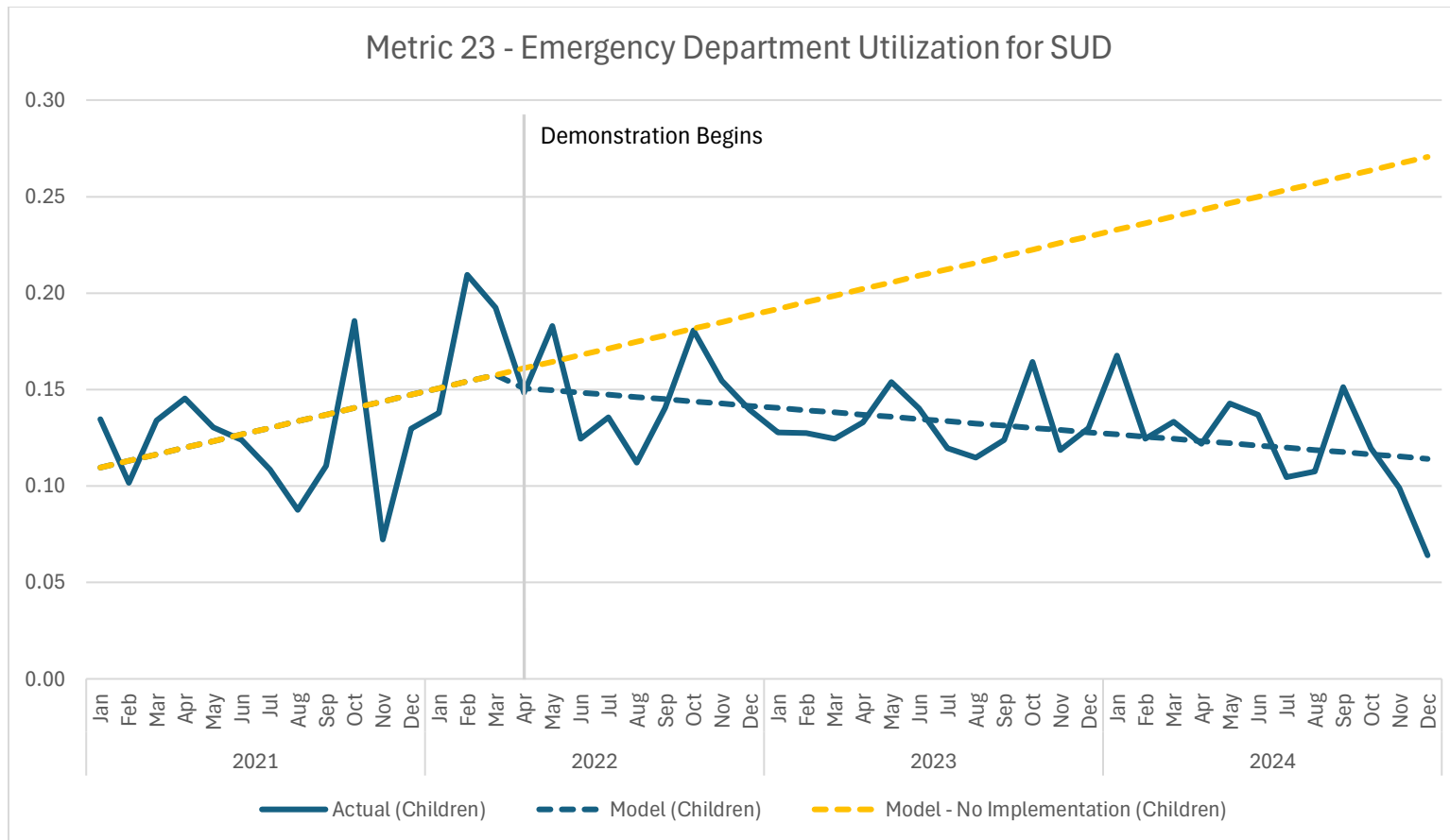
Metric 12 Rate – Pregnant Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	4.7728526	-2	0.092
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.024	0.000	0.047



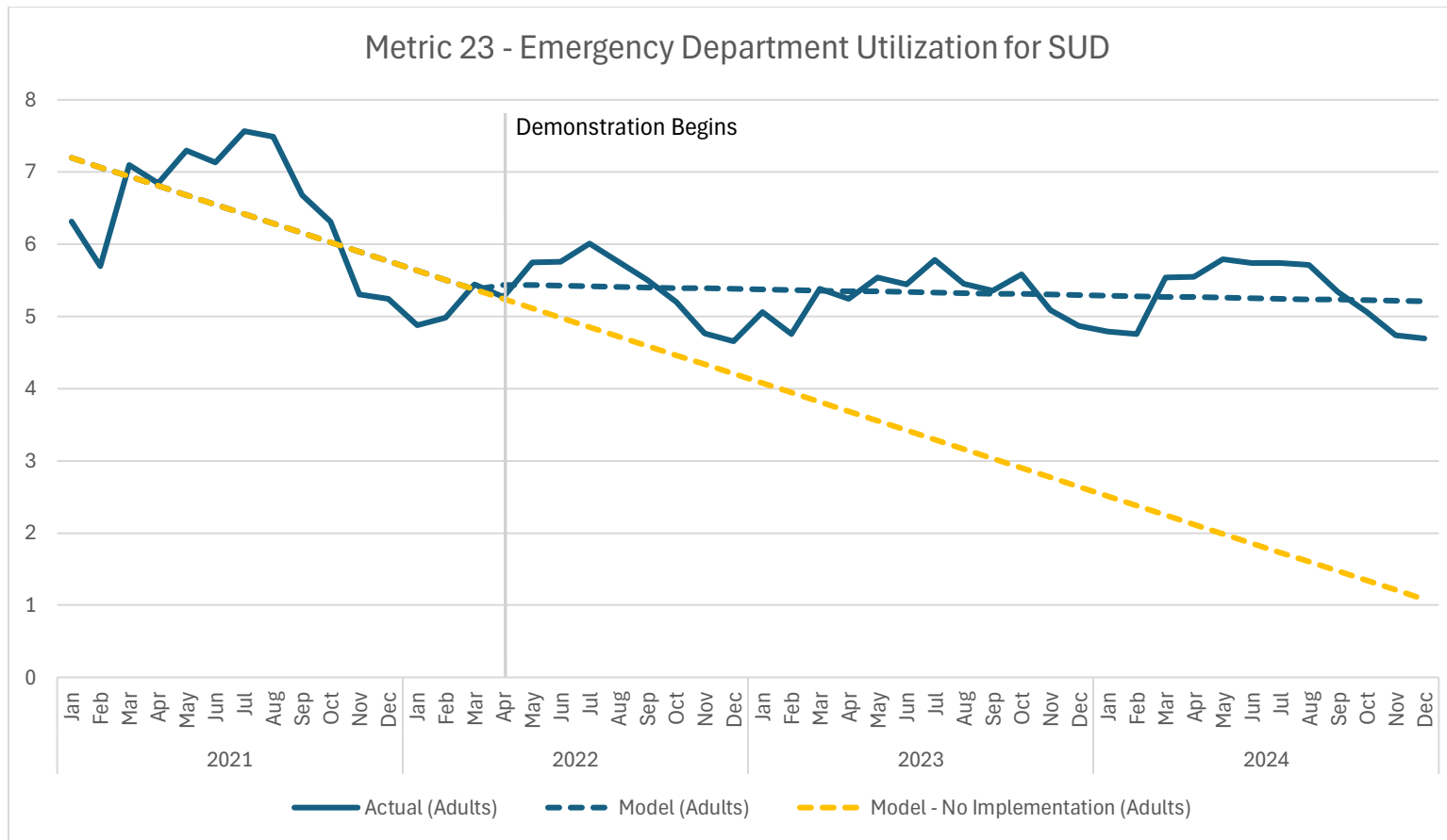
Metric 12 Rate – OUD Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	28.447575	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.024	0.006	0.041



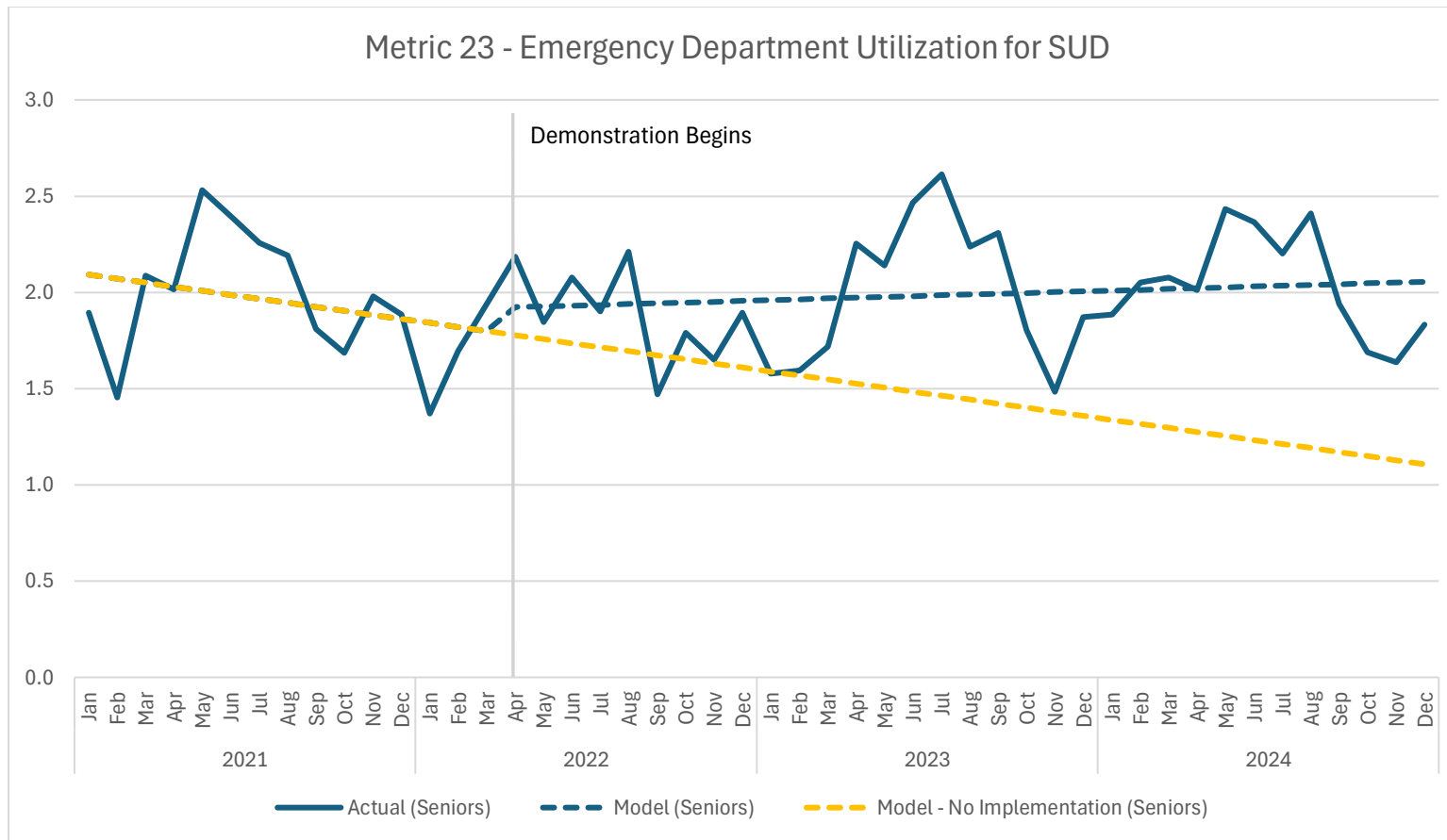
Metric 12 Rate – Total Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	60.672821	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.020	0.012	0.027



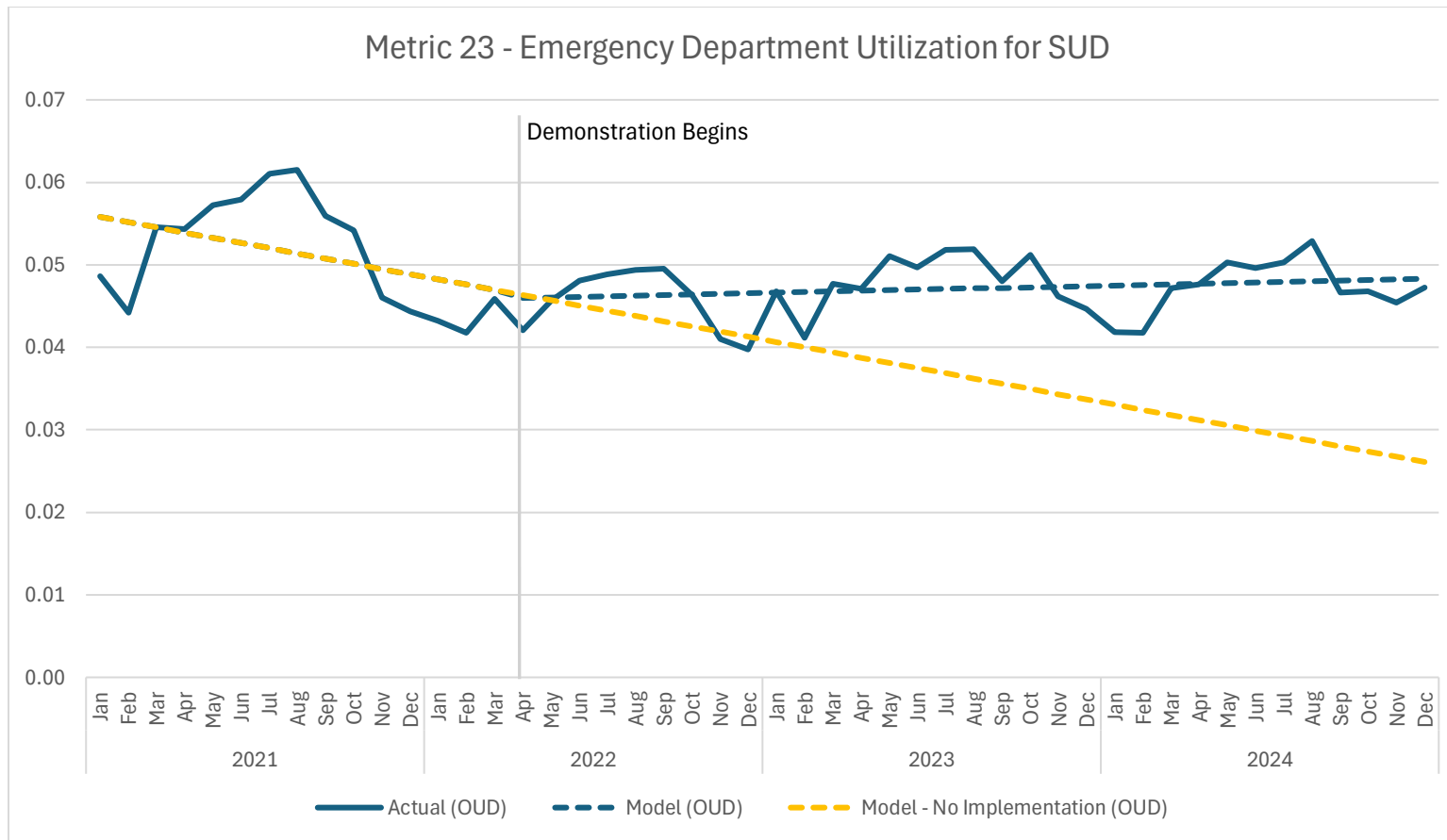
Metric 23 Rate – Children Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	14.930519	-2	0.001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-0.08	-0.17	0.01



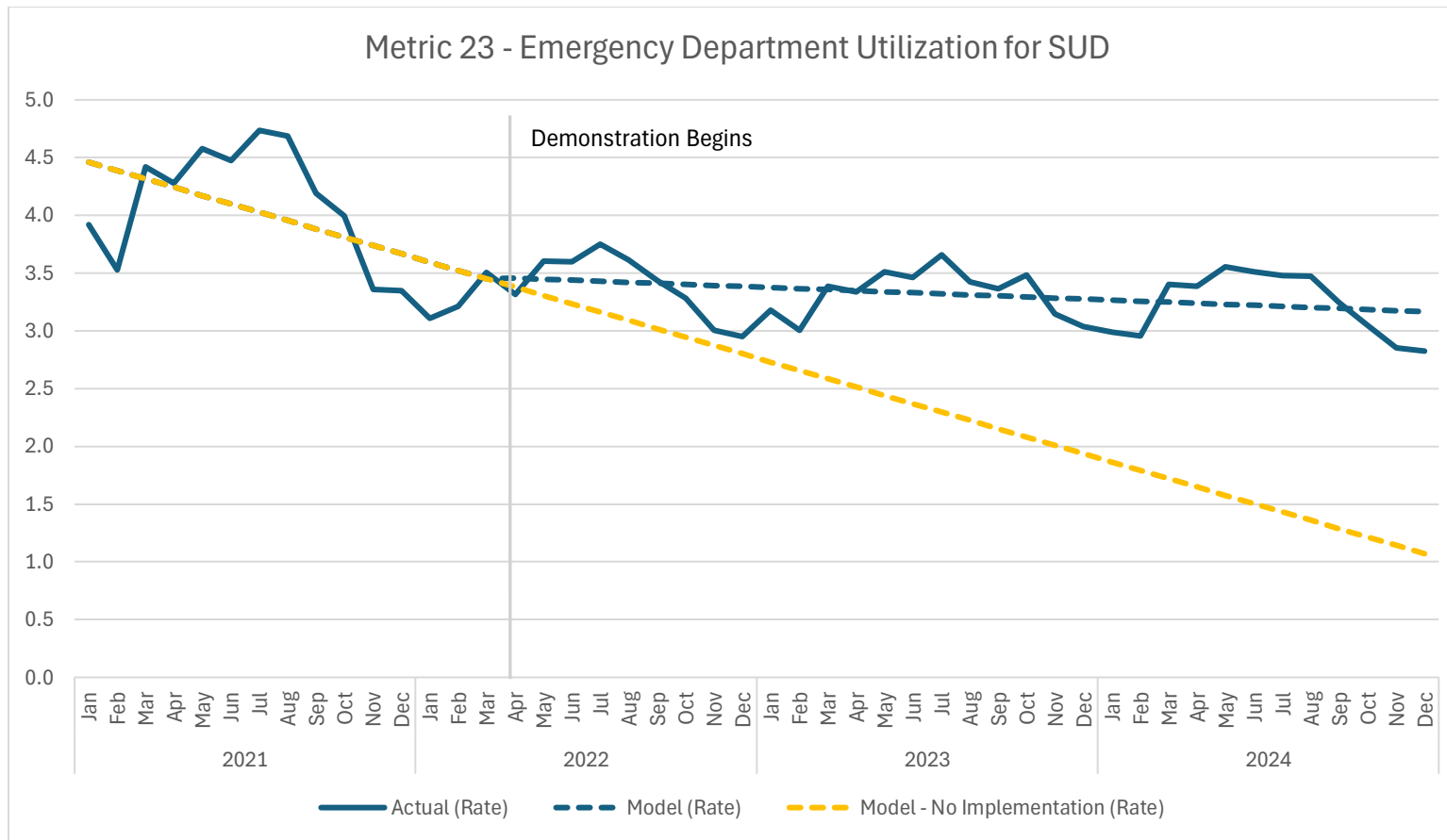
Metric 23 Rate – Adults Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	11.258004	-2	0.004
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	2.16	-0.50	4.82



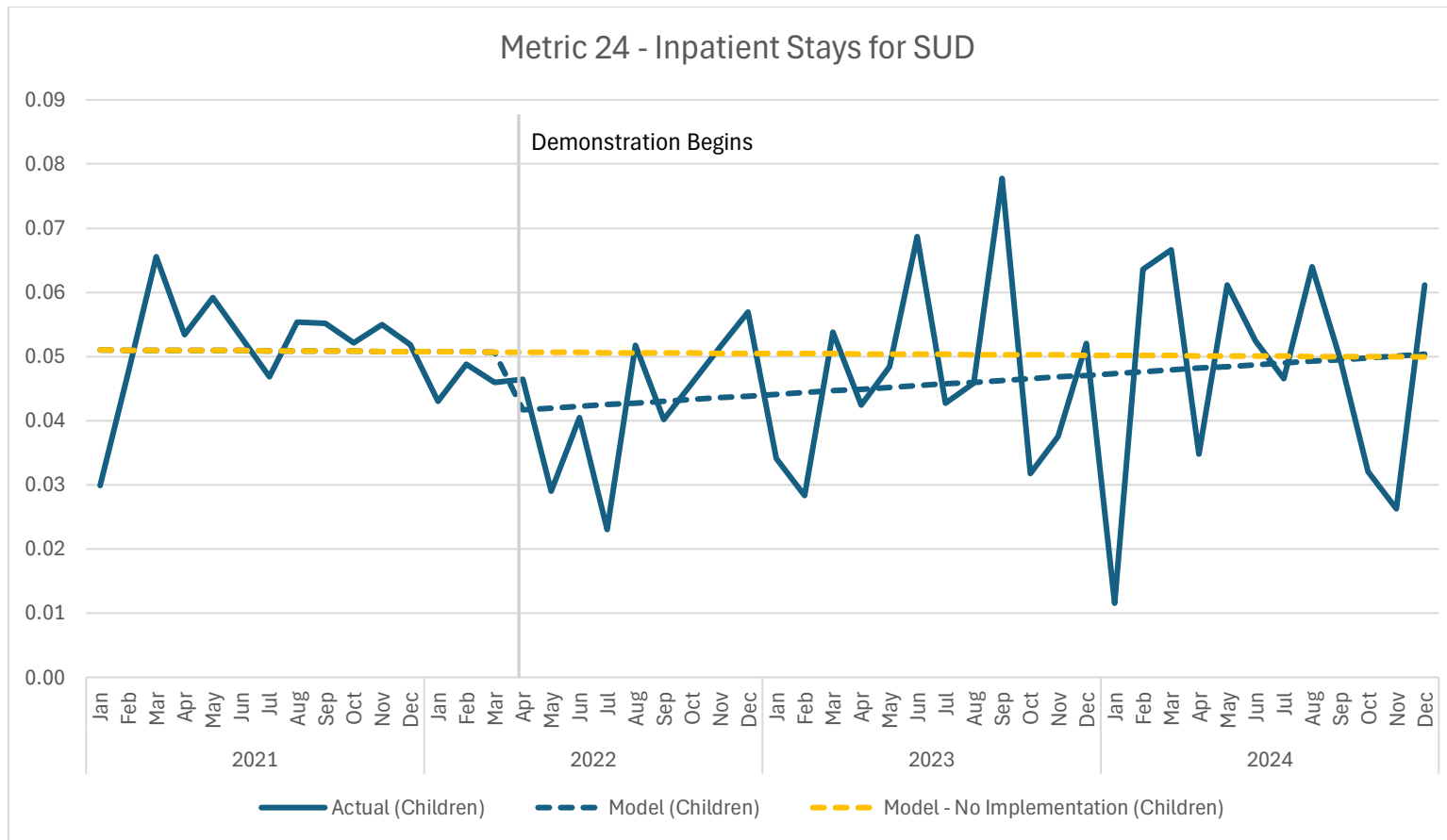
Metric 23 Rate – Seniors Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	1.9220912	-2	0.382
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.55	-0.28	1.37



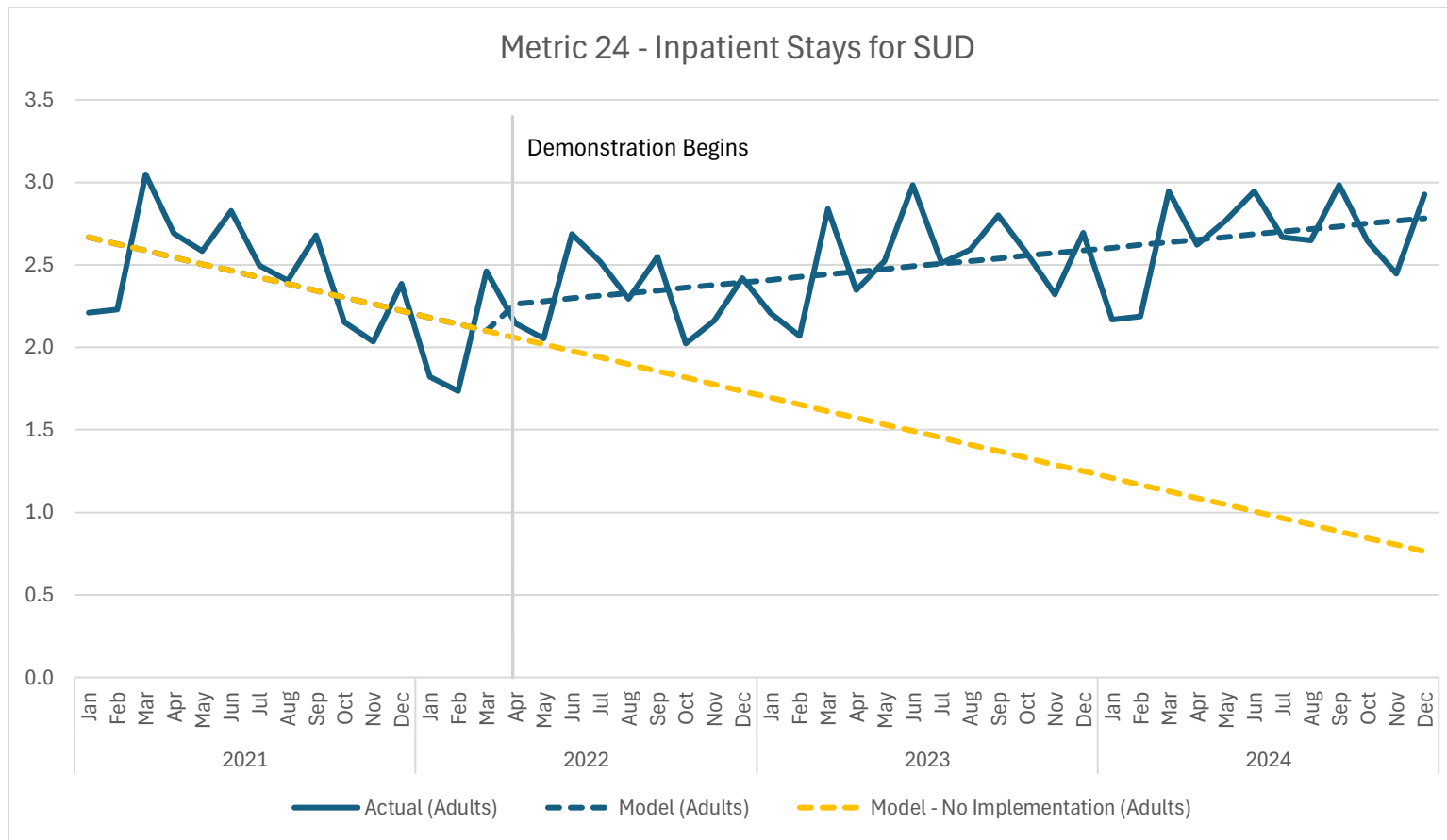
Metric 23 Rate – OUD Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	9.8414184	-2	0.007
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.01	-0.01	0.03



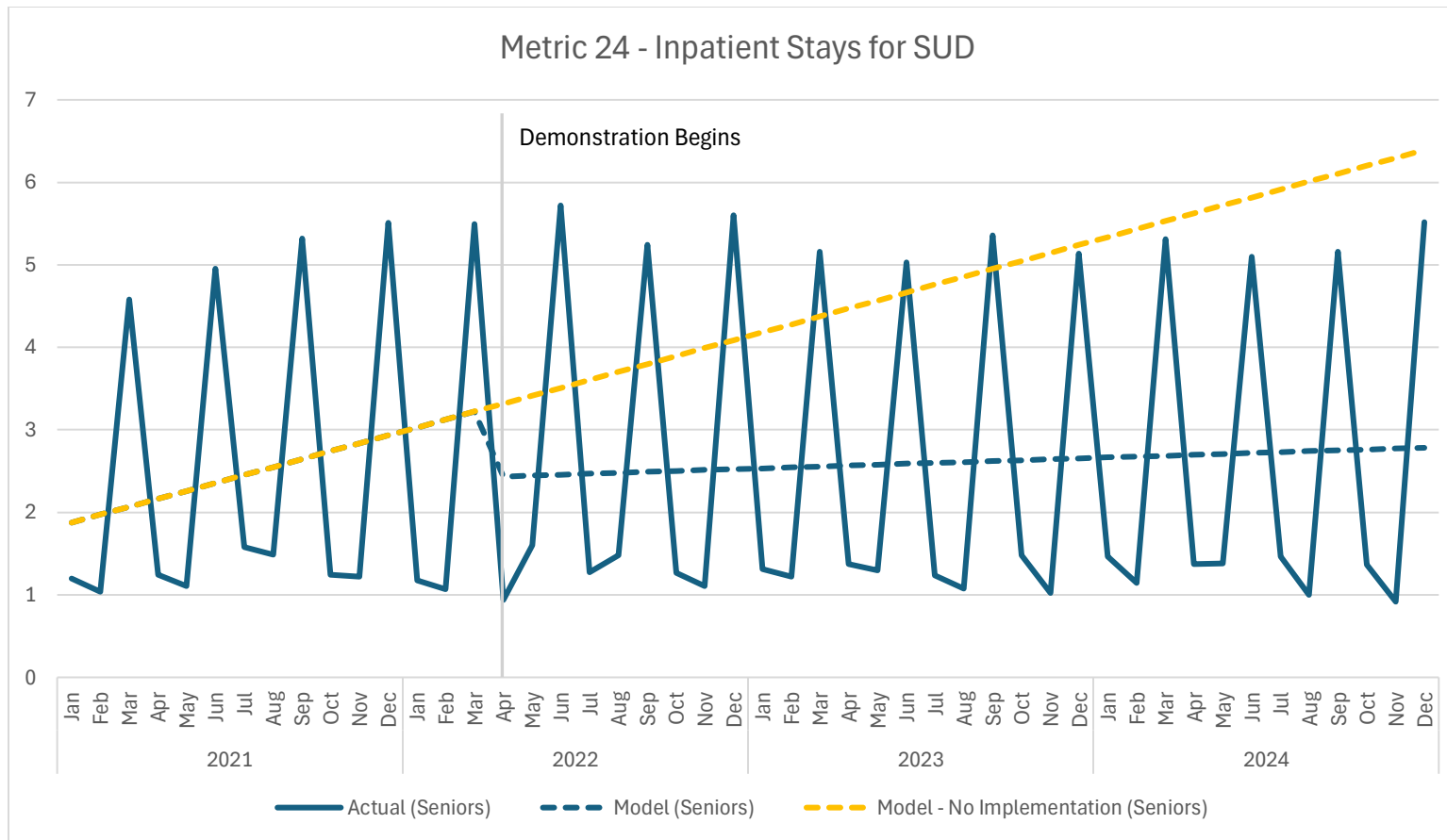
Metric 23 Rate – Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	8.7273747	-2	0.013
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	1.09	-0.55	2.73



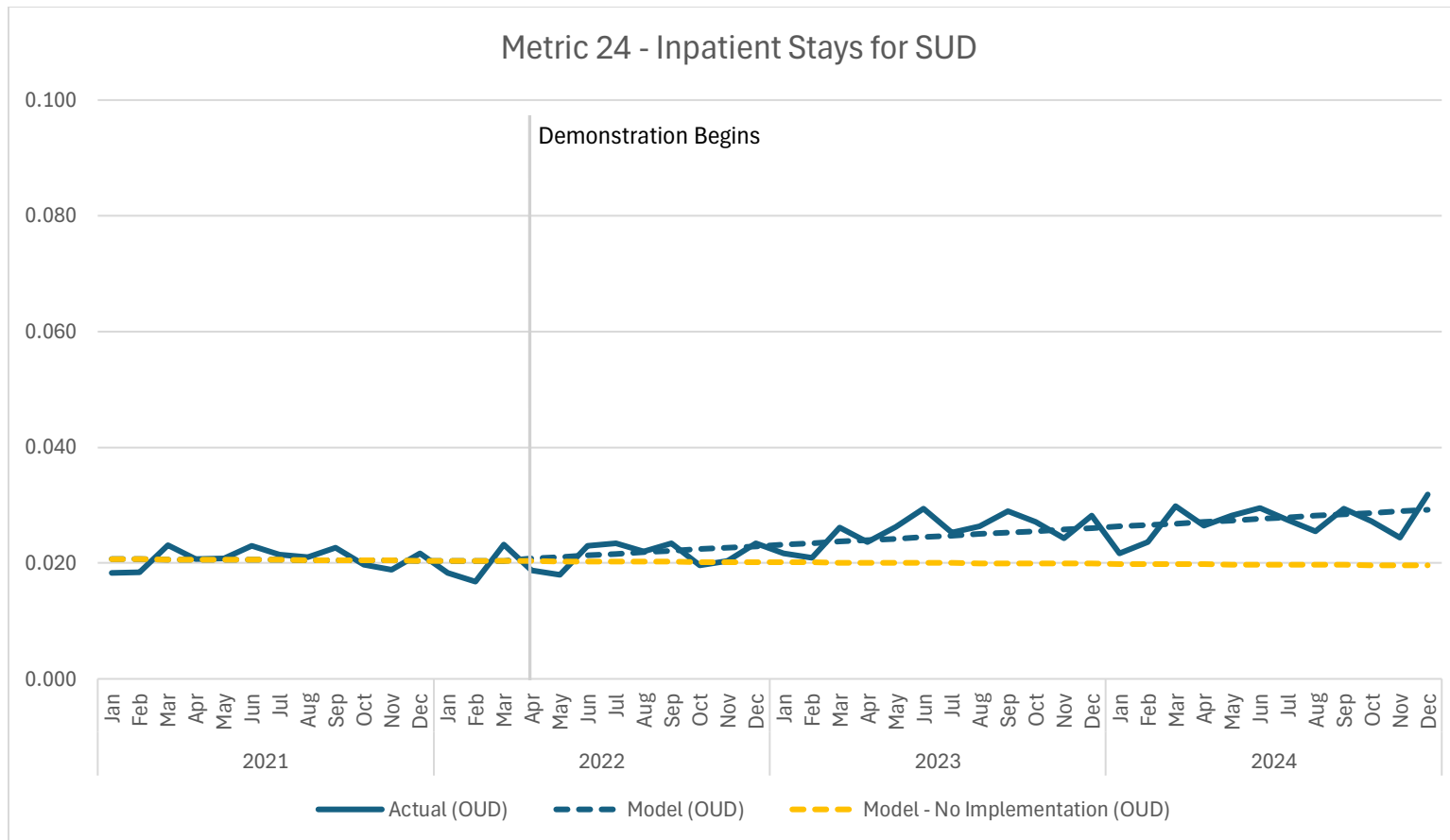
Metric 24 Rate – Children Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	10.954204	-2	0.004
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-0.004	-0.02	0.02



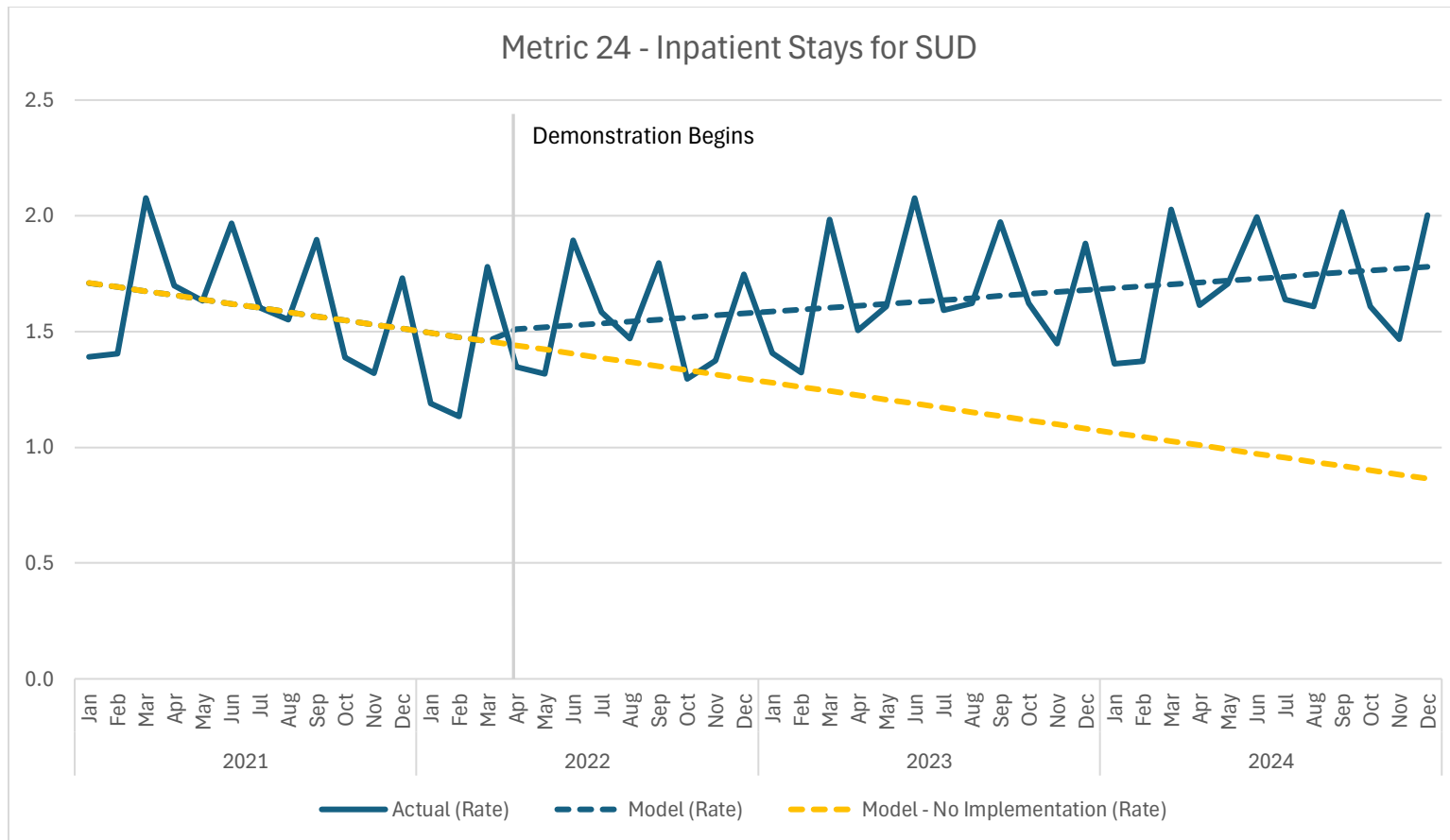
Metric 24 Rate – Adults Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	20.038514	-2	<0.0001
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	1.11	0.39	1.83



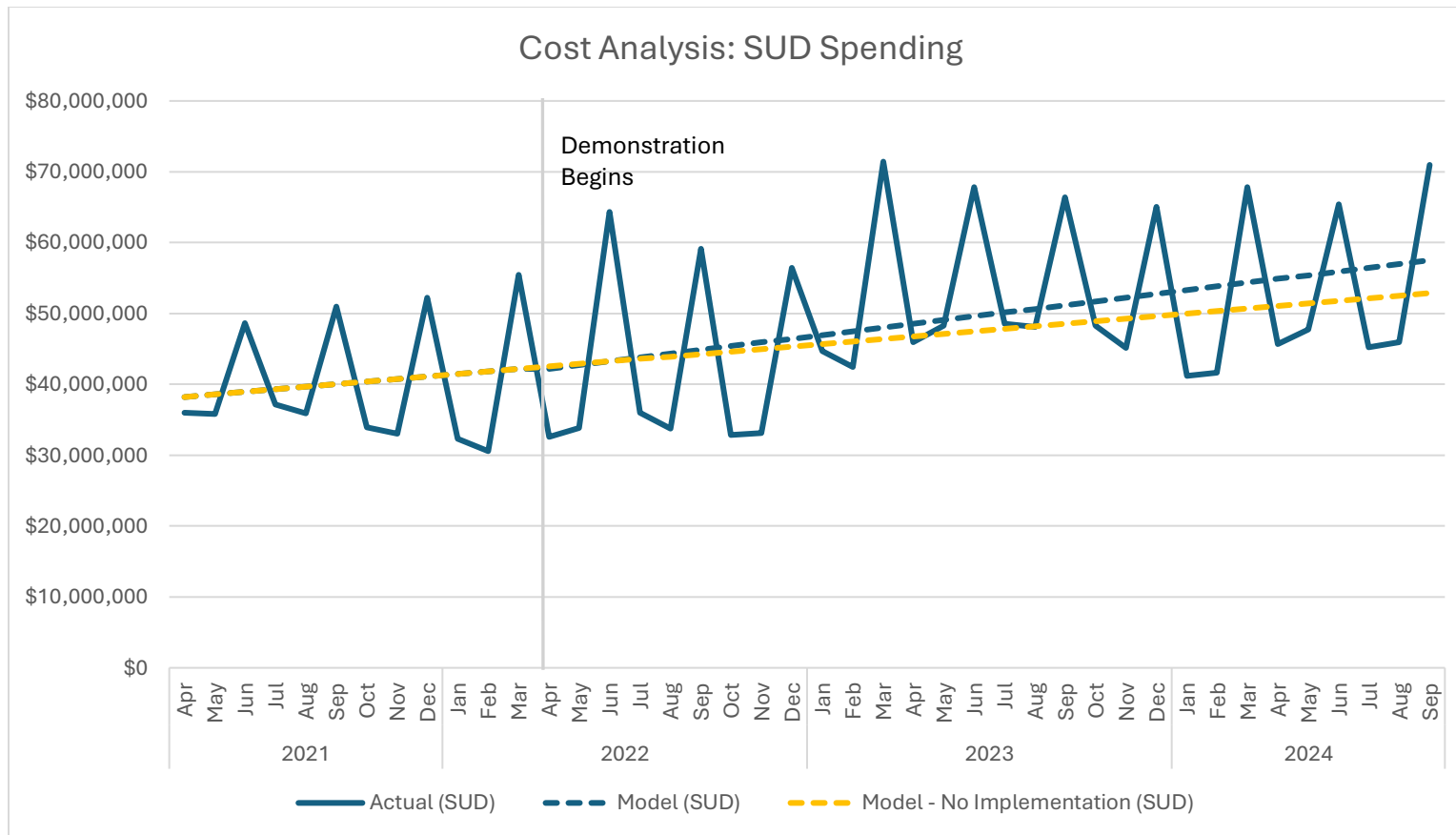
Metric 24 Rate – Seniors Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	6.7411734	-2	0.034
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-2.25	-3.95	-0.54



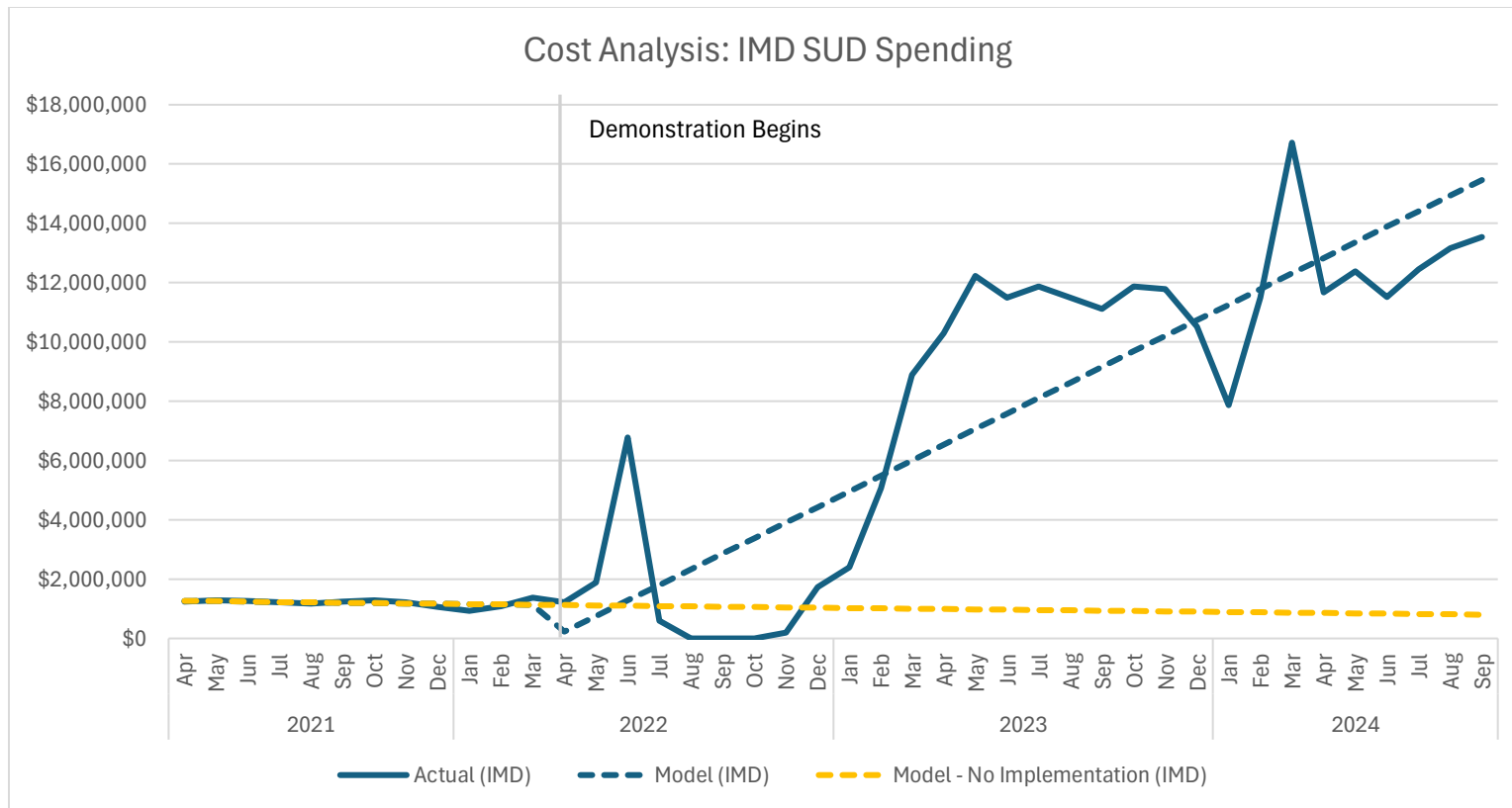
Metric 24 Rate – OUD Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	8.6113476	-2	0.013
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.005	0.001	0.010



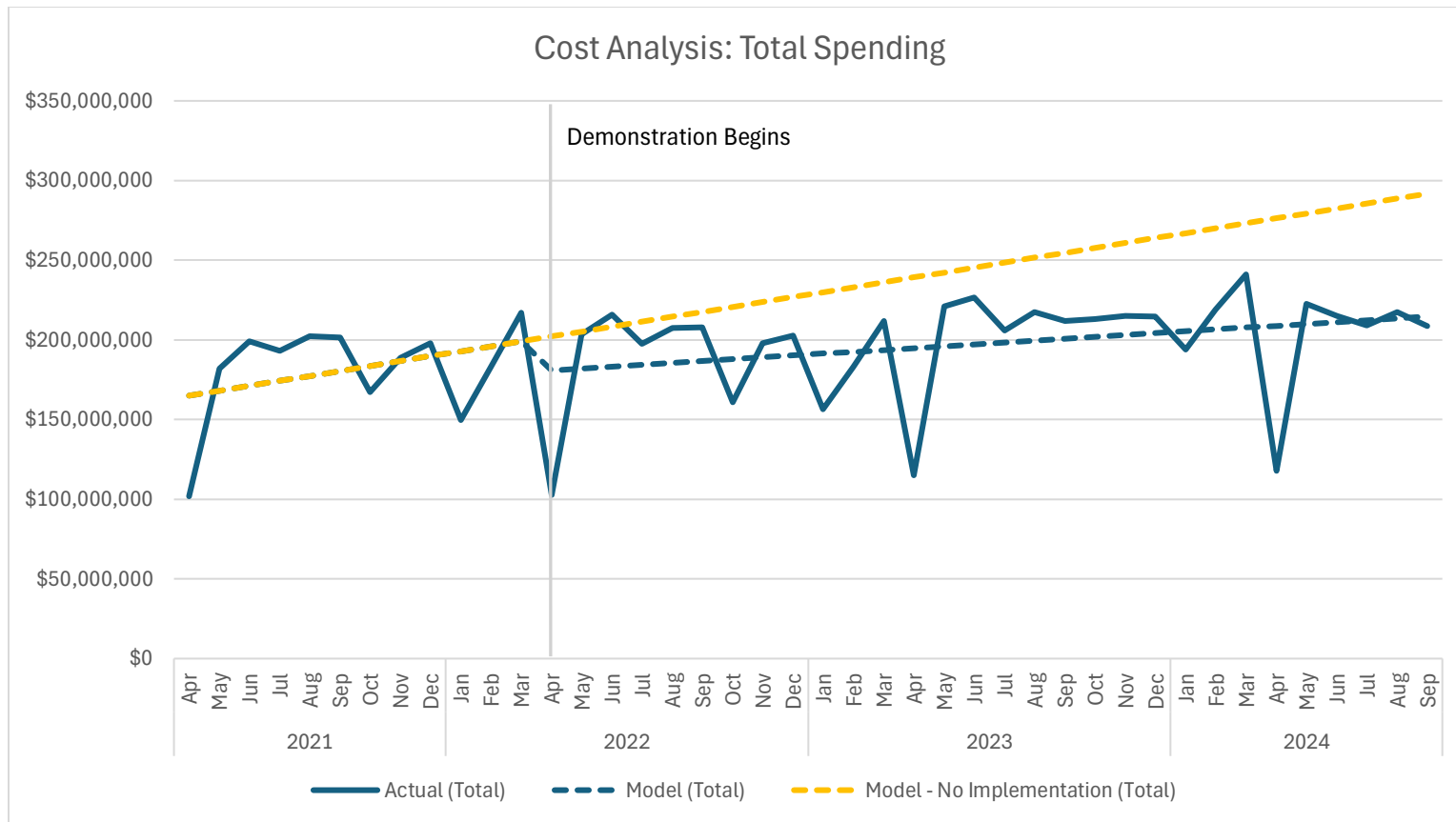
Metric 24 Rate – Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	10.073395	-2	0.006
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	0.49	-0.01	1.00



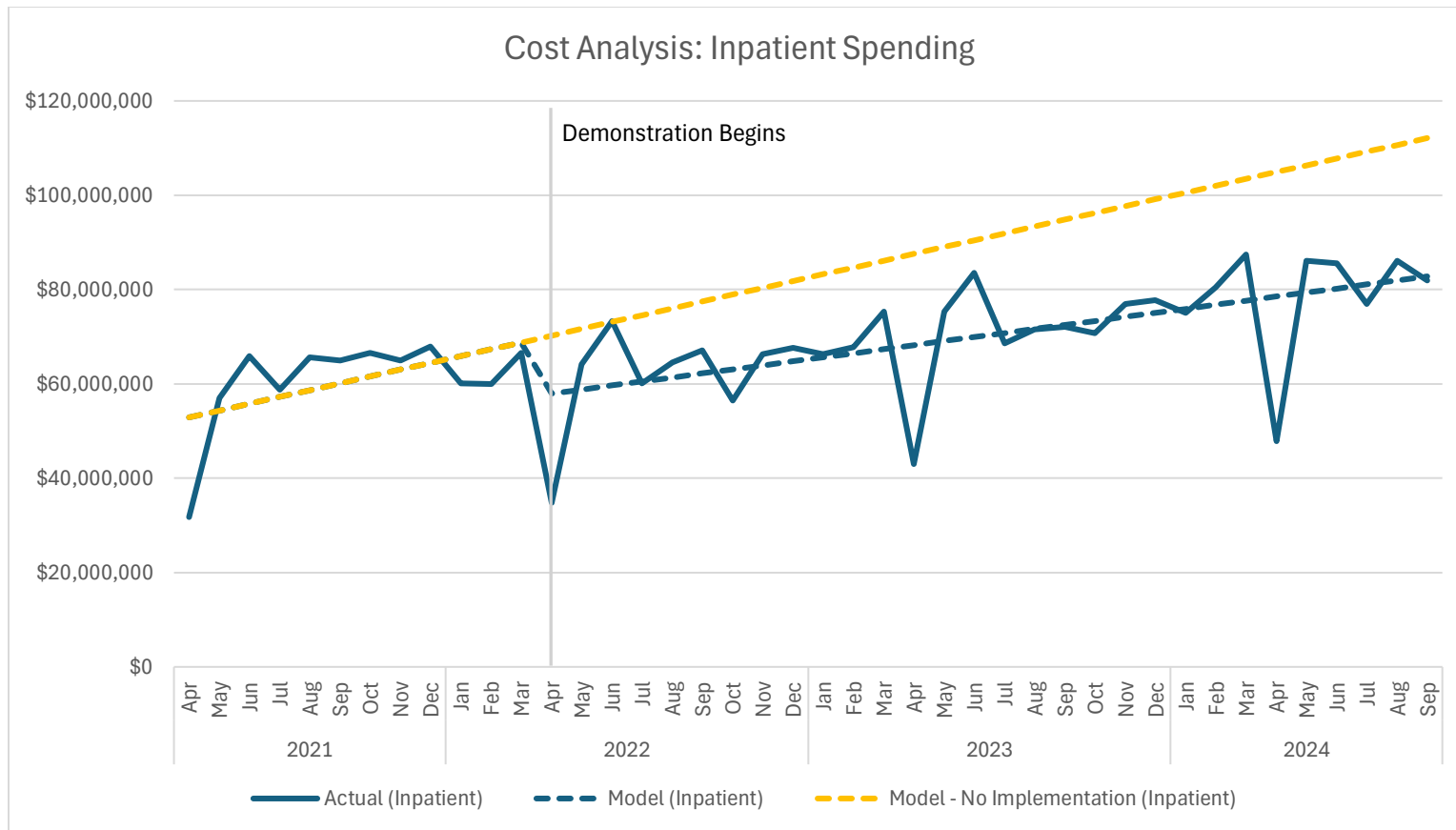
Cost Analysis: SUD Spending Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	0.52321433	-2	0.76981337
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	2,174,188.67	-10,258,633.48	14,607,010.81



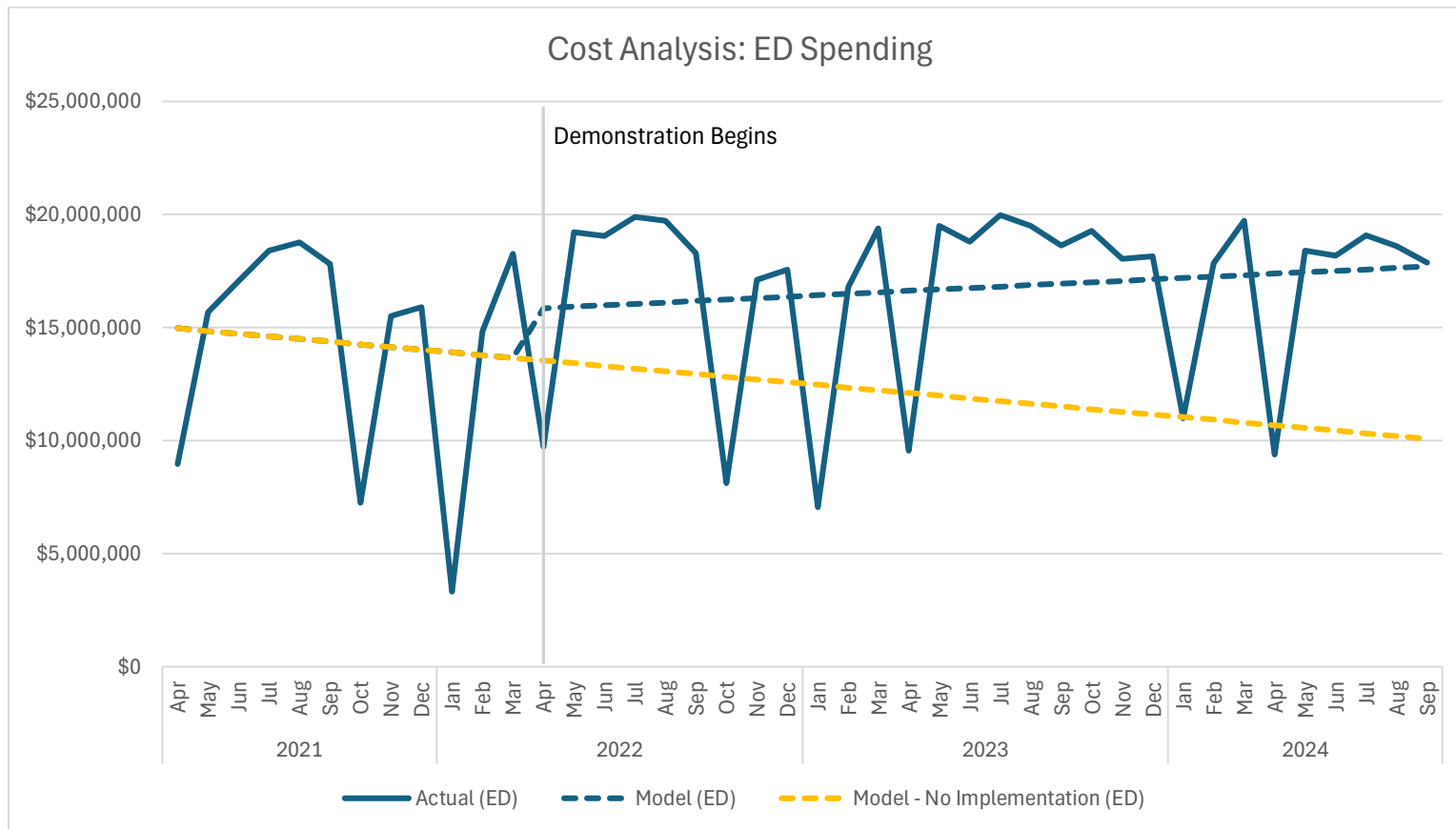
Cost Analysis: IMD SUD Spending Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	127.261797	-2	2.3198E-28
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	6,882,355.96	5,136,615.41	8,628,096.51



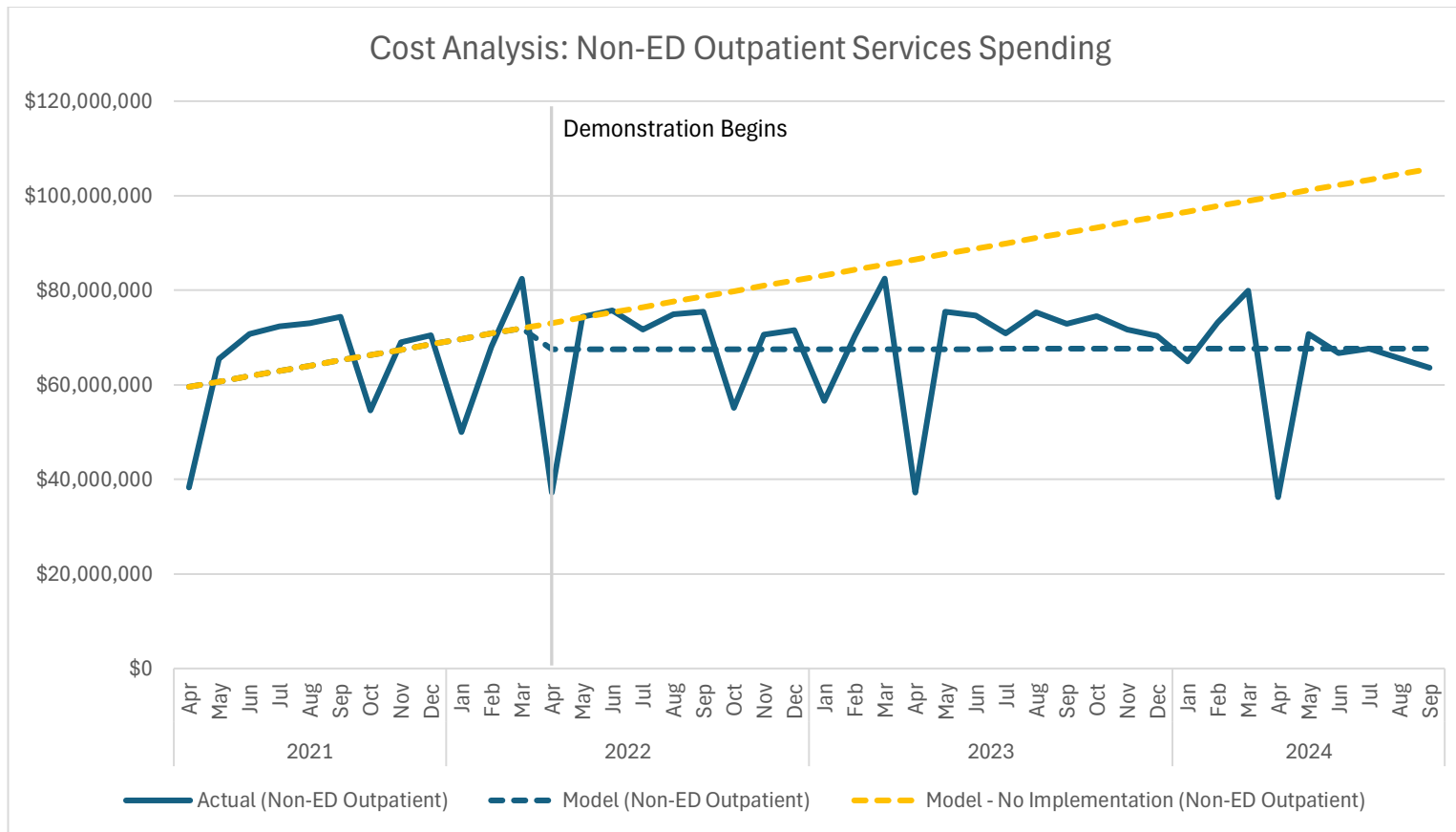
Cost Analysis: Total Spending Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	3.9673293	-2	0.13756419
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-49,127,345.82	-118,159,984.43	19,905,292.79



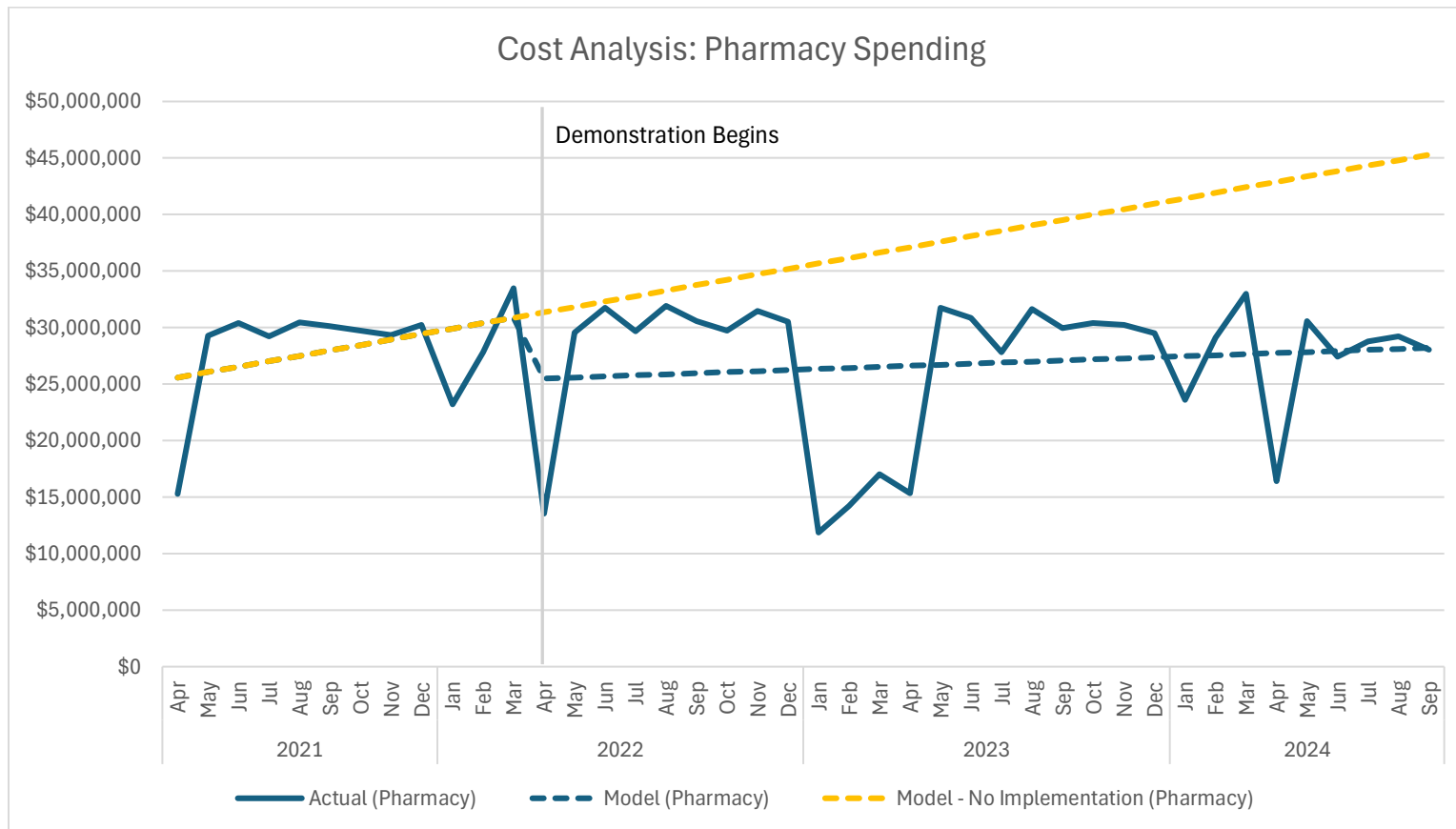
Cost Analysis: Inpatient Spending Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	14.0886662	-2	0.00087234
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-20,820,734.51	-49,300,707.16	7,659,238.15



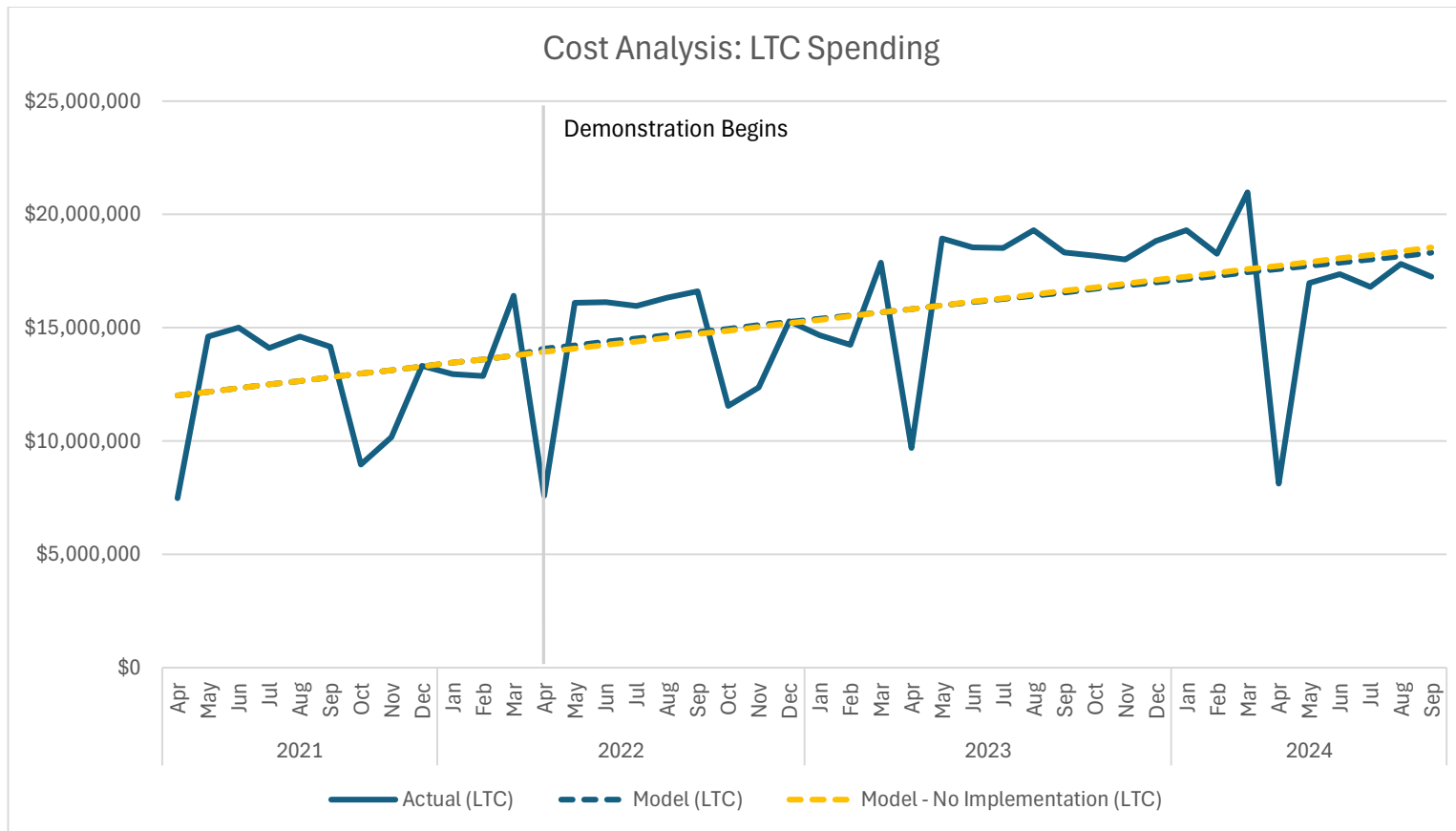
Cost Analysis: ED Spending Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	1.94232699	-2	0.37864223
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	4,969,460.10	-3,464,017.86	13,402,938.07



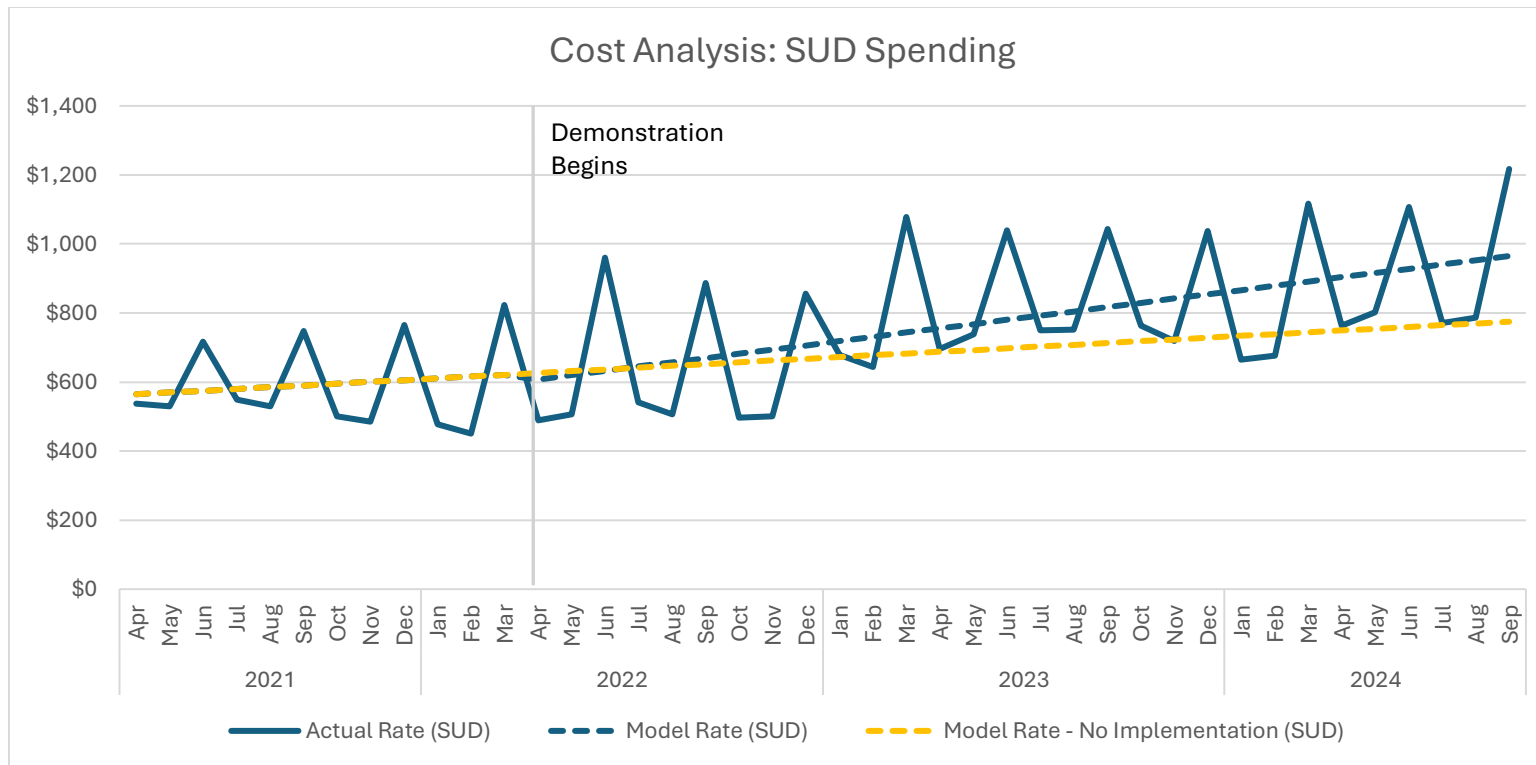
Cost Analysis: Non-ED Outpatient Services Spending Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	3.26689965	-2	0.19525482
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-21,776,020.93	-45,425,166.54	1,873,124.69



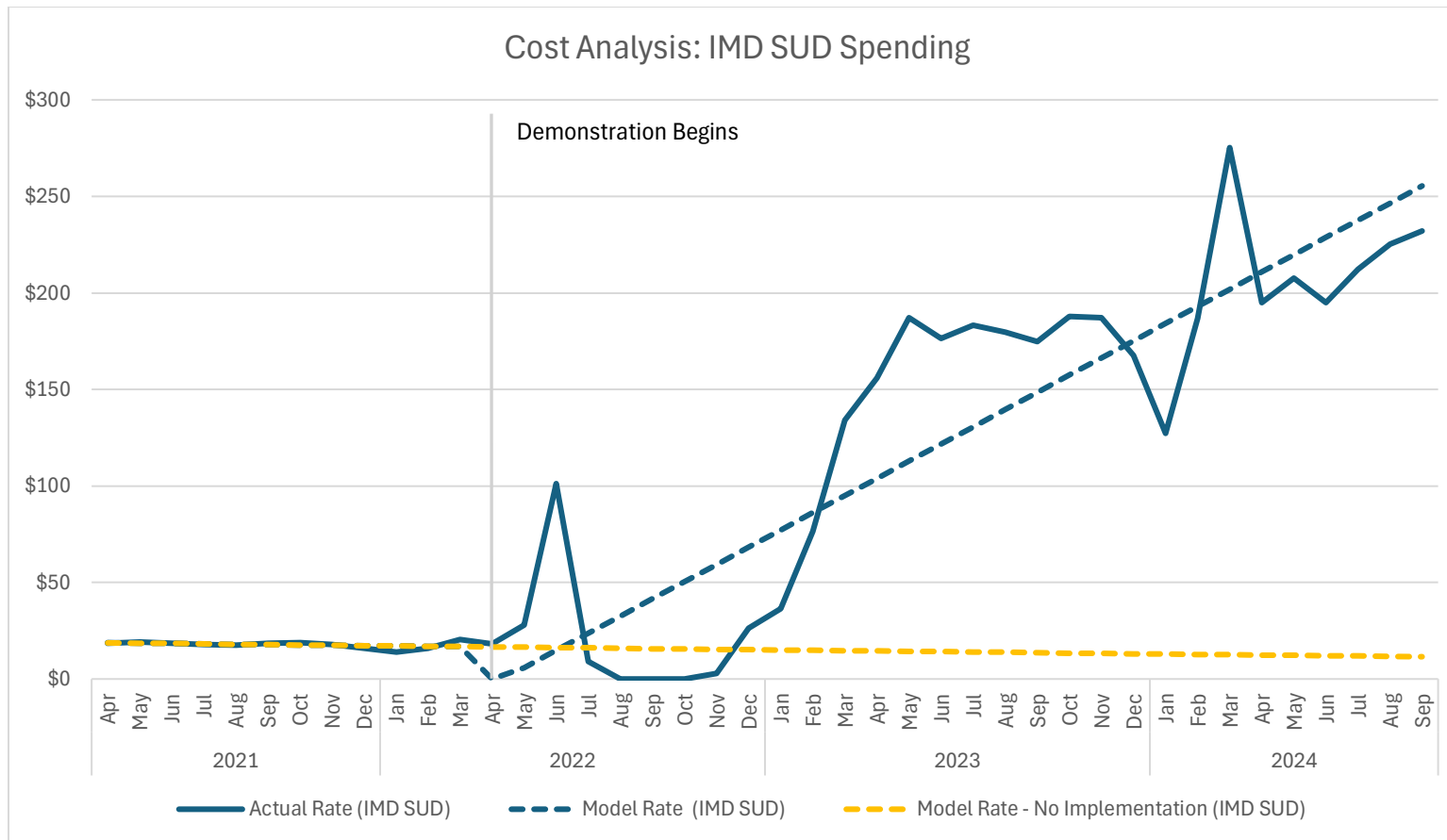
Cost Analysis: Pharmacy Spending Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	5.08293808	-2	0.07875063
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-11,466,688.47	-23,017,828.77	84,451.83



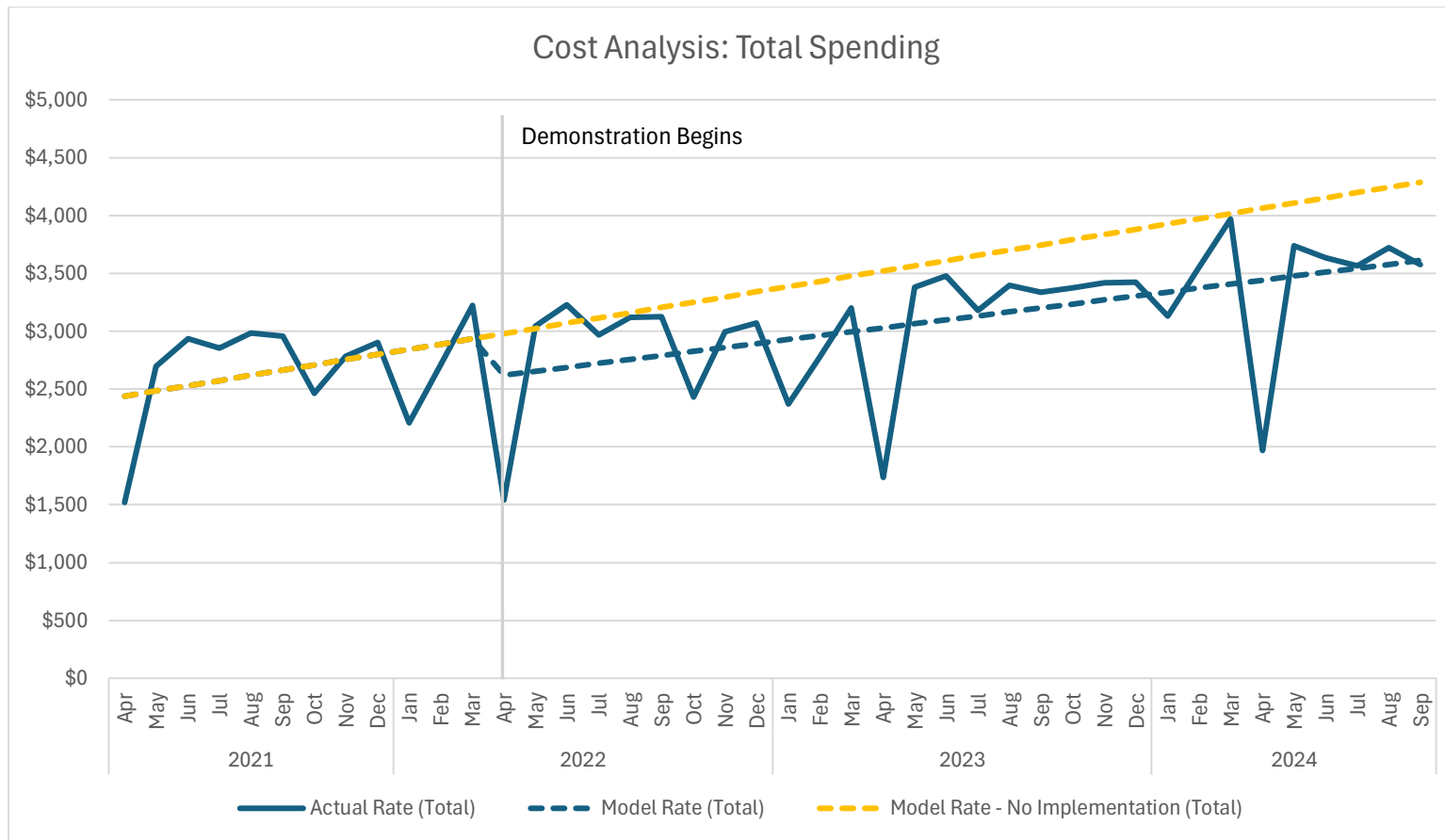
Cost Analysis: LTC Spending Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	0.05785229	-2	0.97148821
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-33,362.02	-4,856,946.96	4,790,222.92



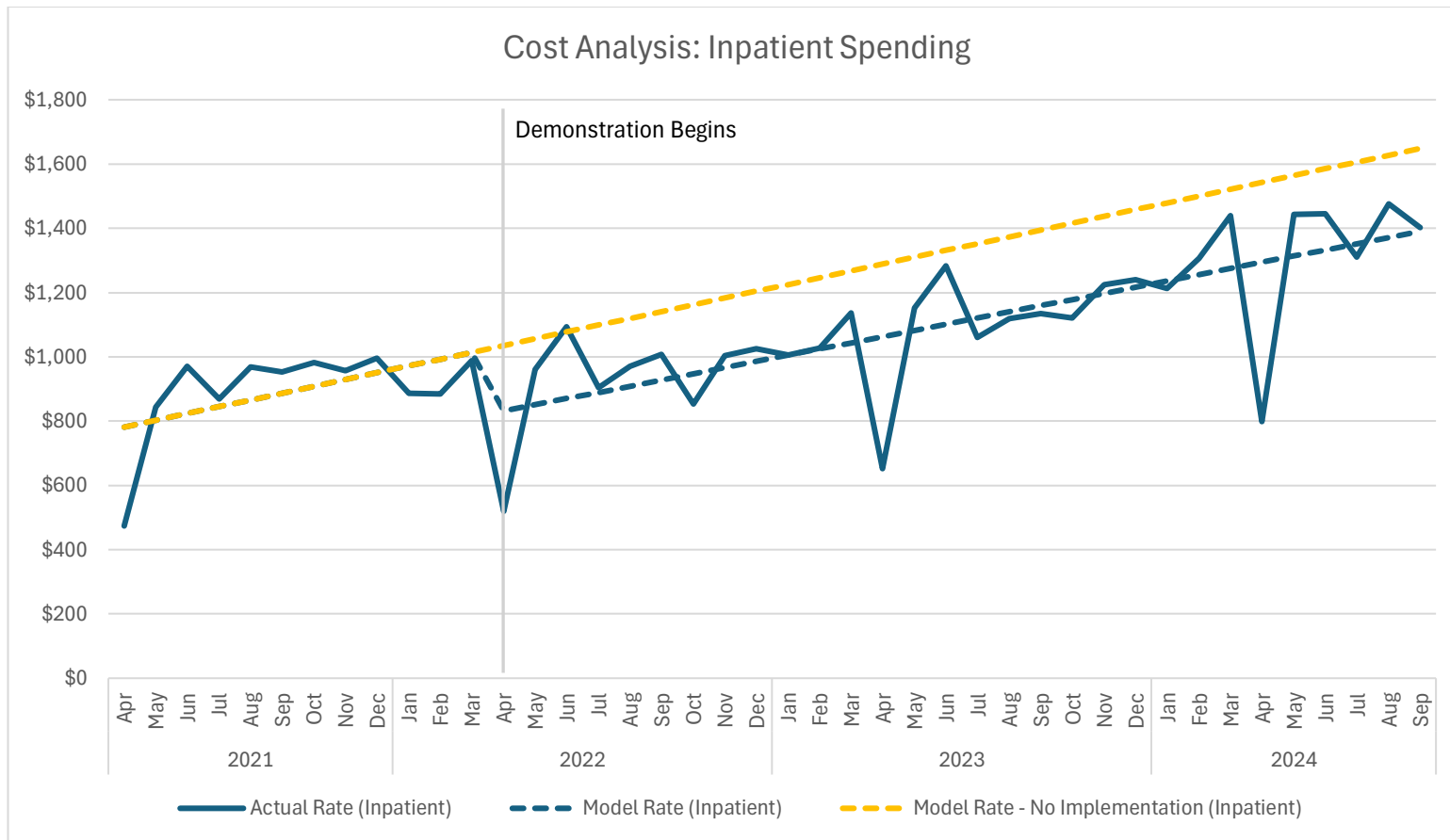
Cost Analysis: SUD Spending Rate Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	5.58202026	-2	0.0613592
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	85.86	-99.97	271.70



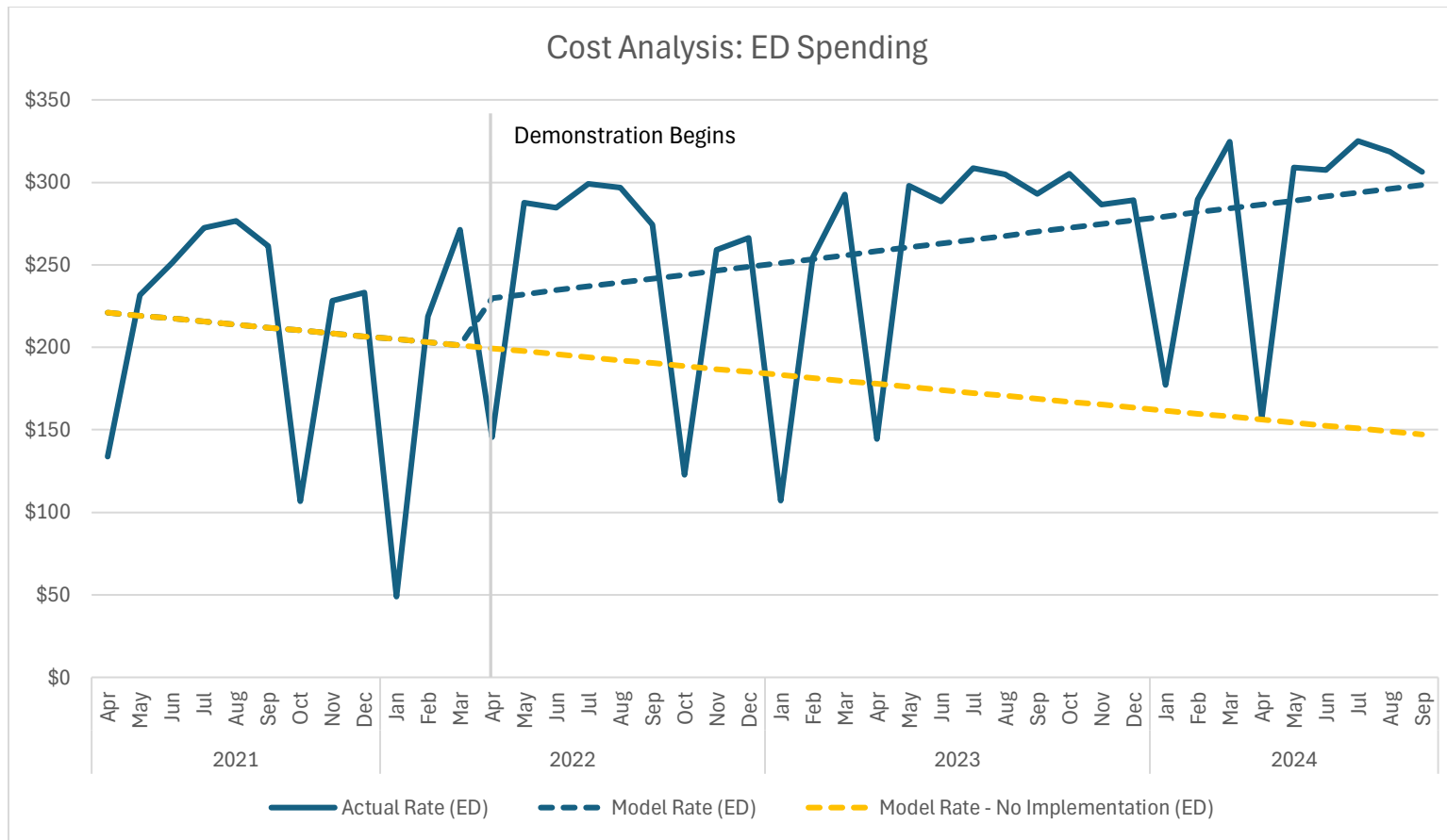
Cost Analysis: IMD SUD Spending Rate Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	196.281061	-2	2.3884E-43
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	112.11	87.86	136.35



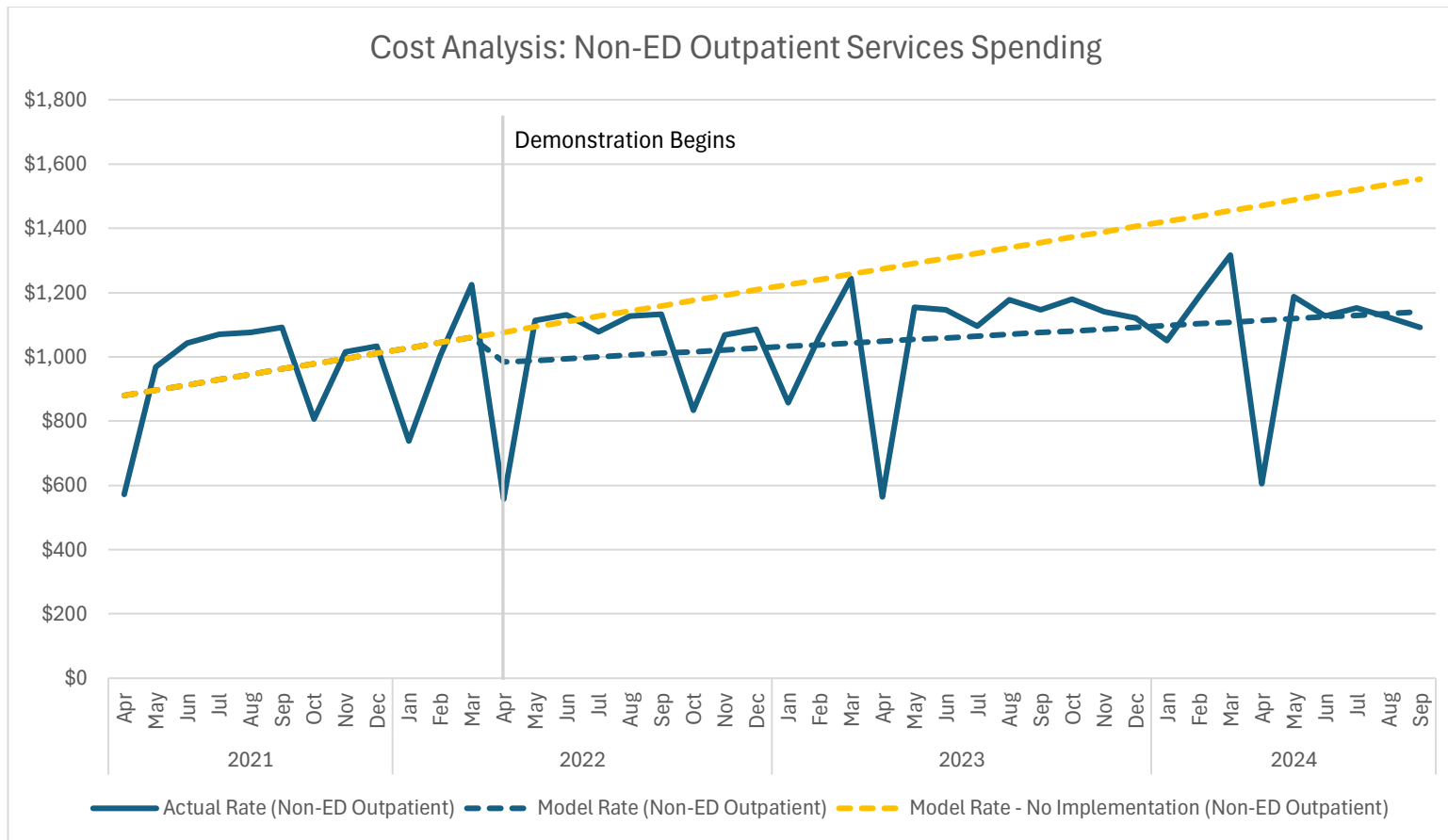
Cost Analysis: Total Spending Rate Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	5.51413018	-2	0.0634778
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-517.51	-1,516.83	481.81



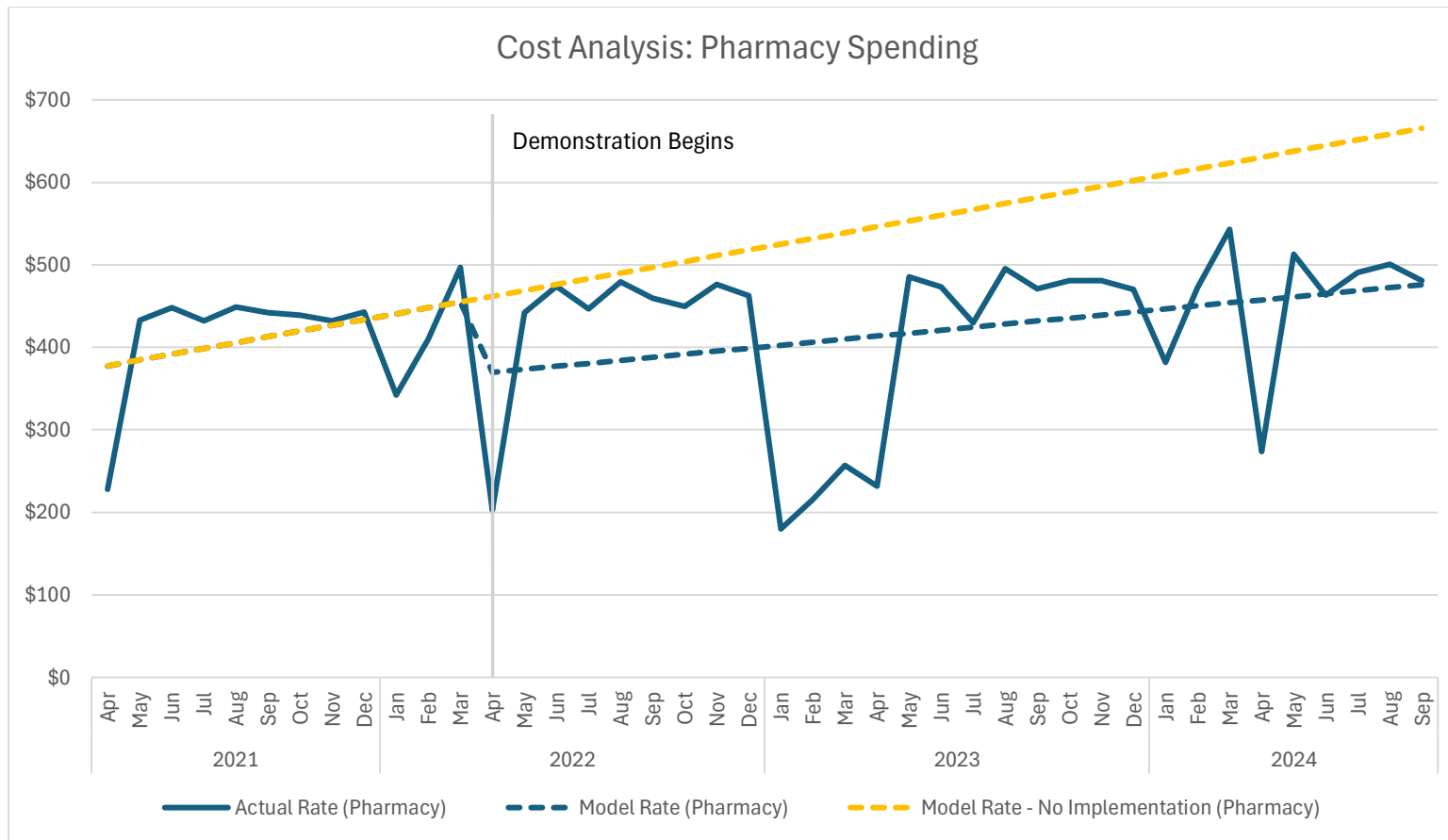
Cost Analysis: Inpatient Spending Rate Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	17.8560794	-2	0.00013262
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-230.73	-643.01	181.56



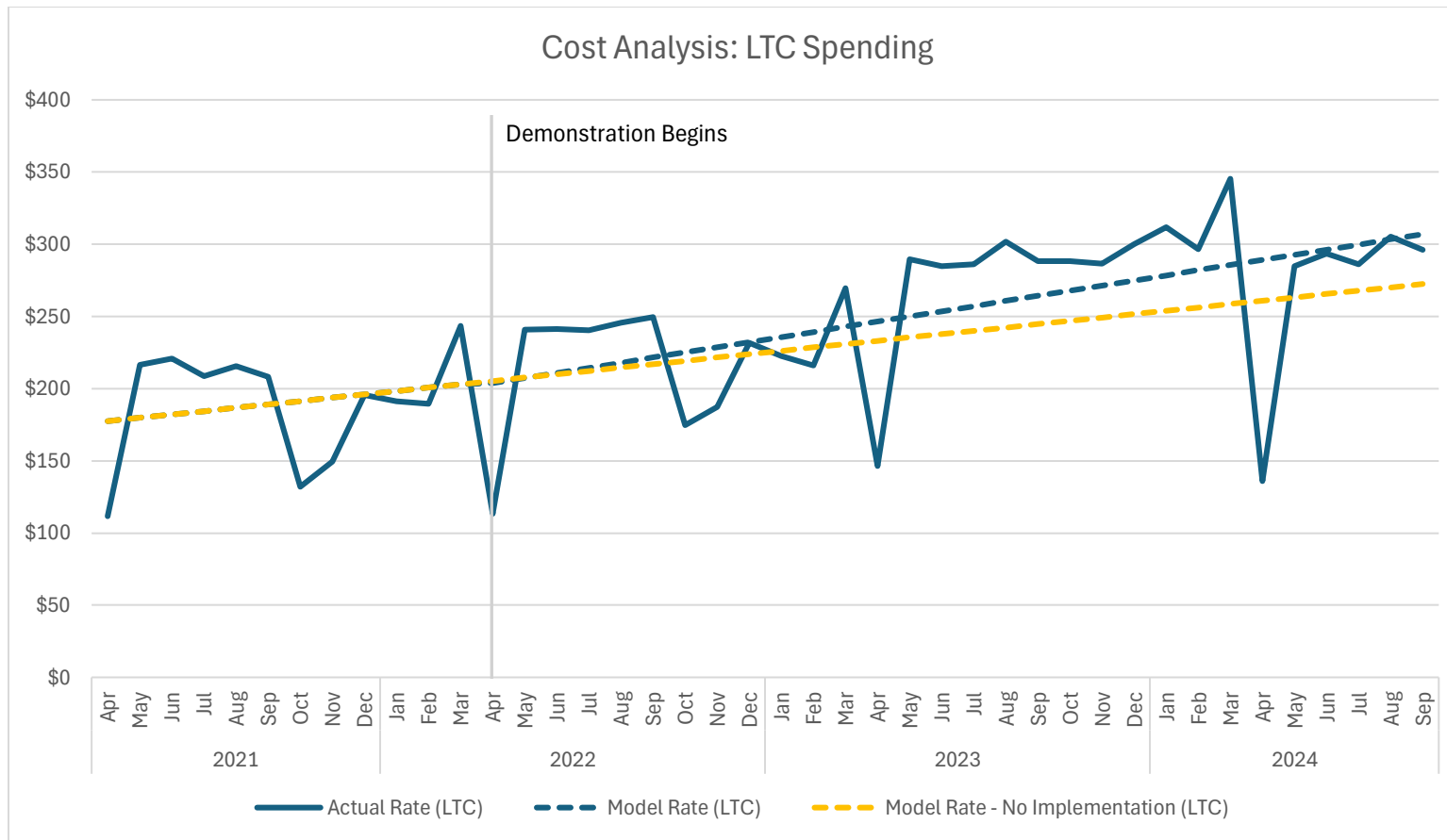
Cost Analysis: ED Spending Rate Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	2.06015733	-2	0.35697888
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	90.76	-33.39	214.92



Cost Analysis: Non-ED Spending Rate Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	2.71347817	-2	0.25749909
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-253.00	-597.13	91.14



Cost Analysis: Pharmacy Spending Rate Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	4.61834755	-2	0.0993433
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	-140.99	-308.50	26.53



Cost Analysis: LTC Spending Rate Coefficients			
	t	df	p-value
Wald Test for Joint Significance (Level and Slope)	0.64813984	-2	0.72319967
	Average Effect	Lower 95% CI	Upper 95% CI
Effect Summary	16.44	-54.97	87.85



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Appendix D

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

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

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

Connecticut Behavioral Health Partnership

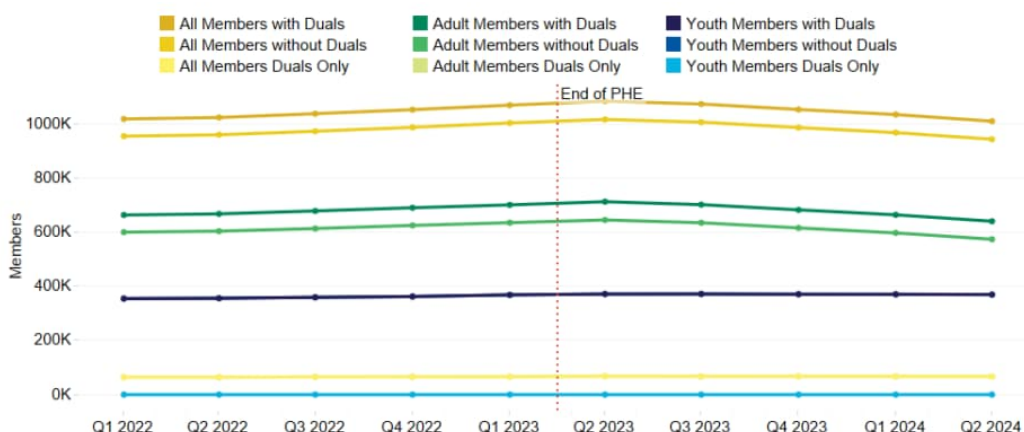
The Connecticut Behavioral Health Partnership (CT BHP) was established to provide a multi-agency approach to streamline and build collaboration in the behavioral health system. Its goals are to promote positive outcomes and to improve access to care for all individuals. The partnership is a collaboration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

Utilization Management

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

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

Figure D.1. Total HUSKY Health Membership by Quarter

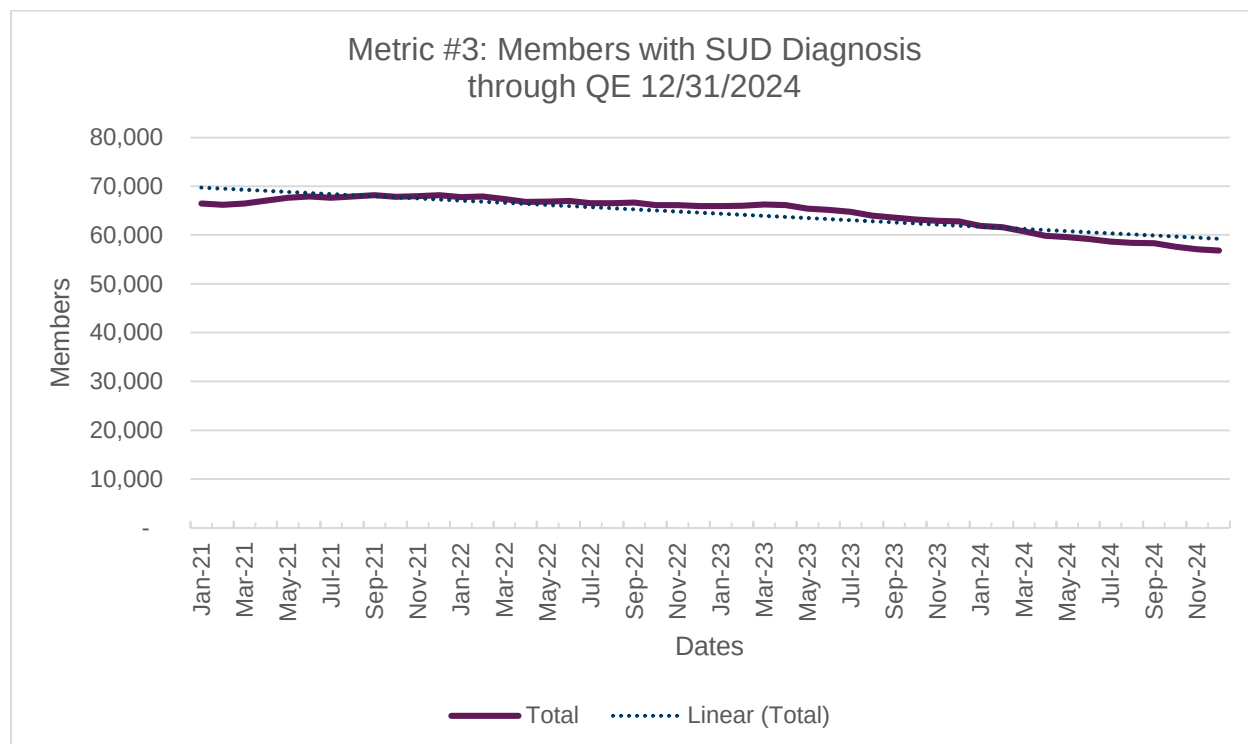


Carelon performs Utilization Management according to the population (youth, adult, pregnant and parenting women) and American Society of Addiction Medicine (ASAM) level of care standards. Provider support and technical assistance are provided as needs are identified.

Medicaid Individuals with SUD Diagnosis

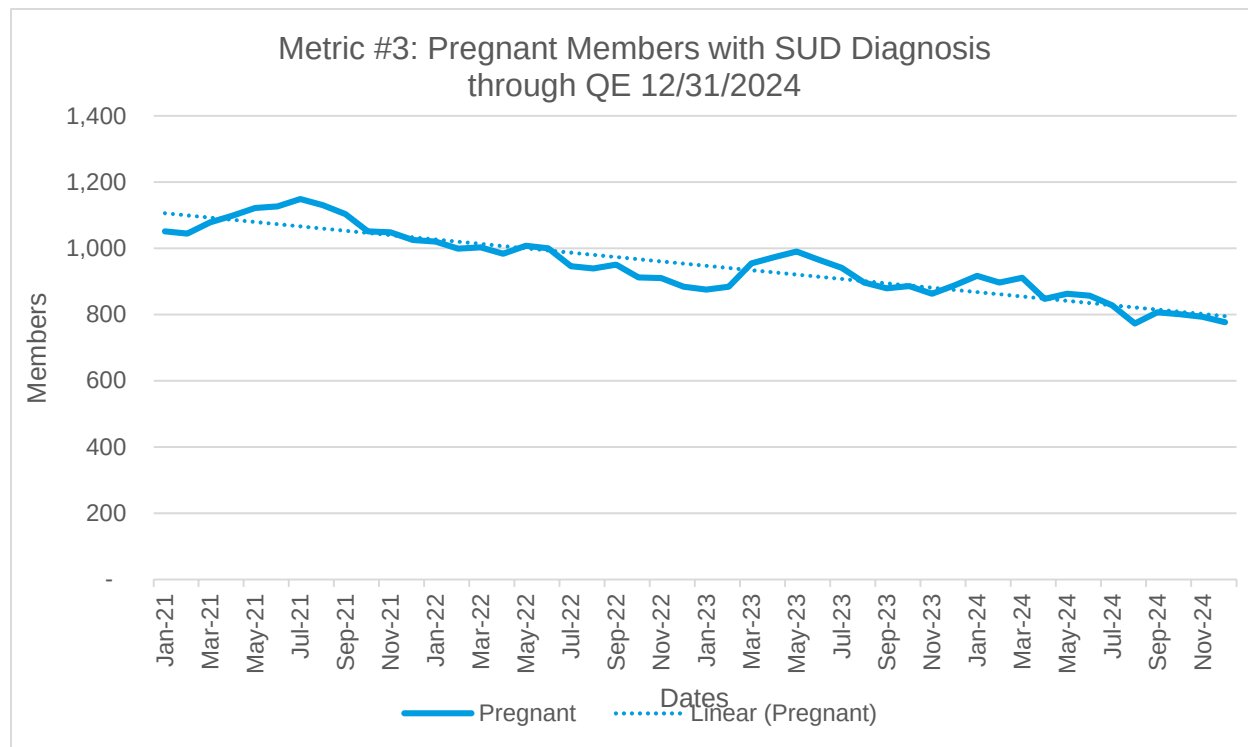
The overall number of individuals with SUD diagnoses under the Demonstration have declined. This is likely related to the end of the PHE and the eligibility unwinding.

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



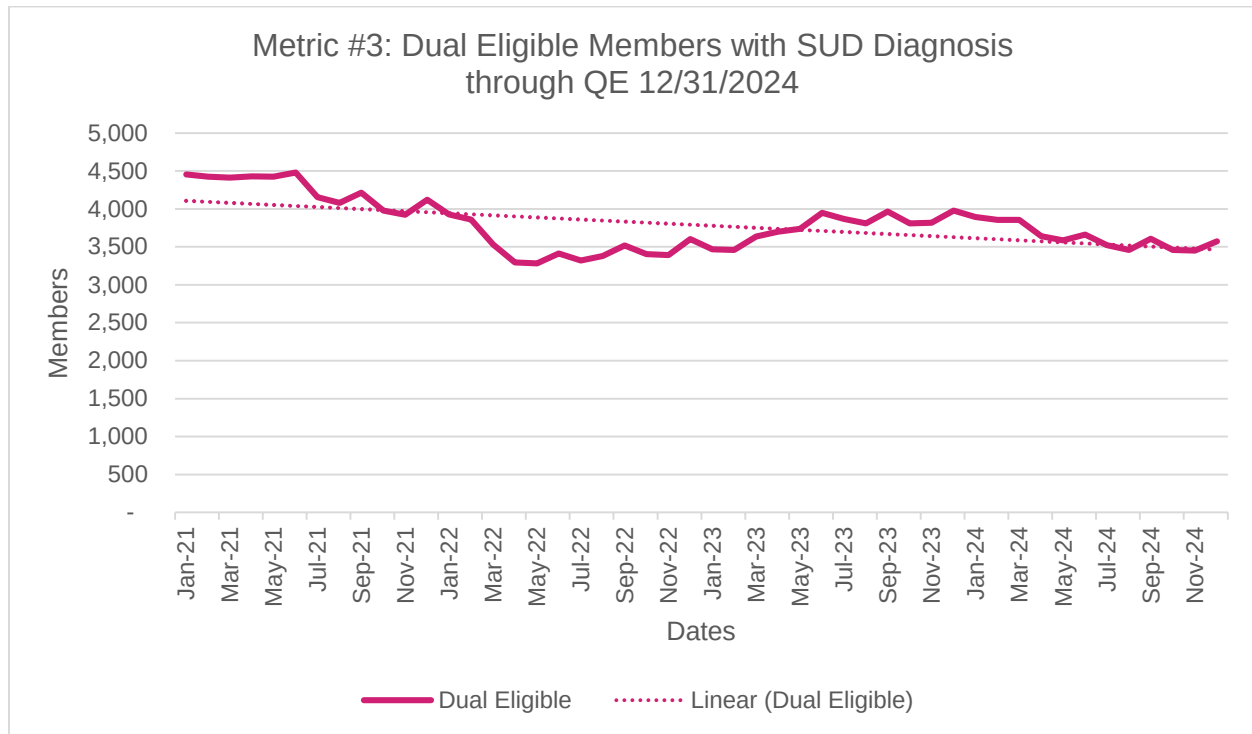
Several subpopulations exhibit this declining trend. See Pregnant Women below which has declined steadily since the Demonstration's inception.

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



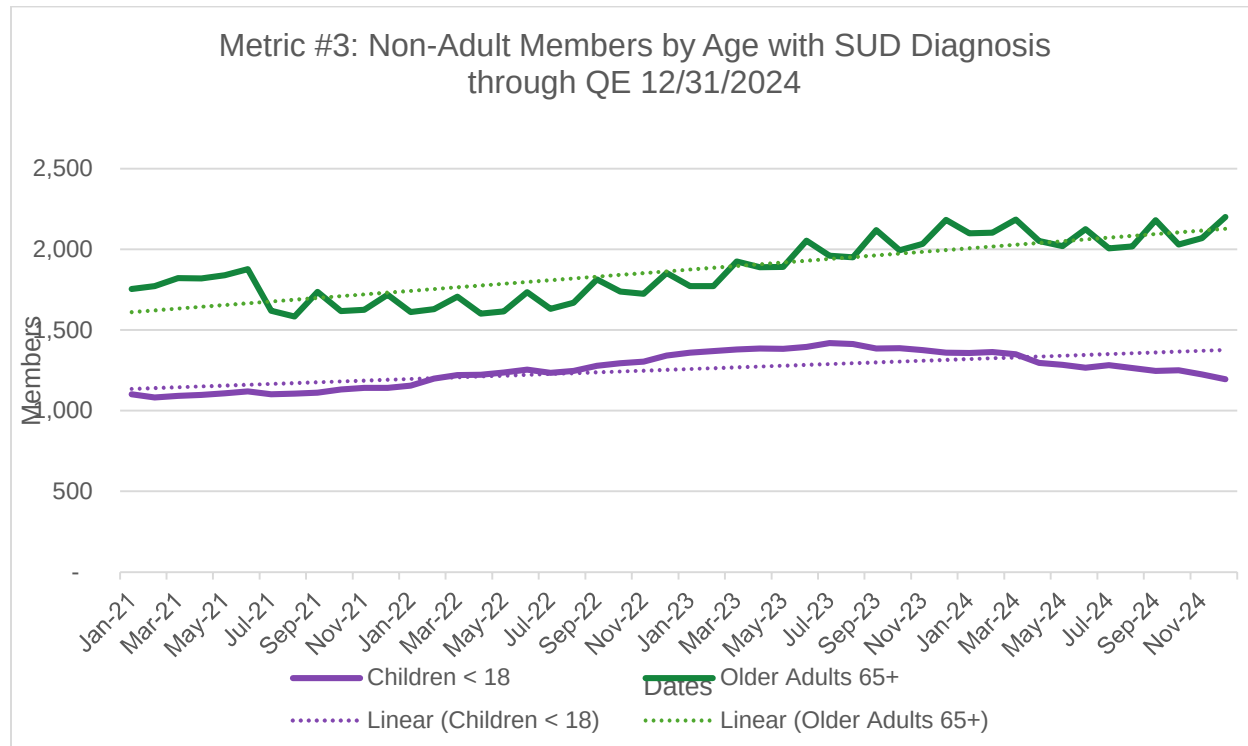
Dual eligible members declined with the inception of the Demonstration, but increased through the end of 2023. The decline in 2024 is probably due to the eligibility unwinding at the end of the PHE.

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



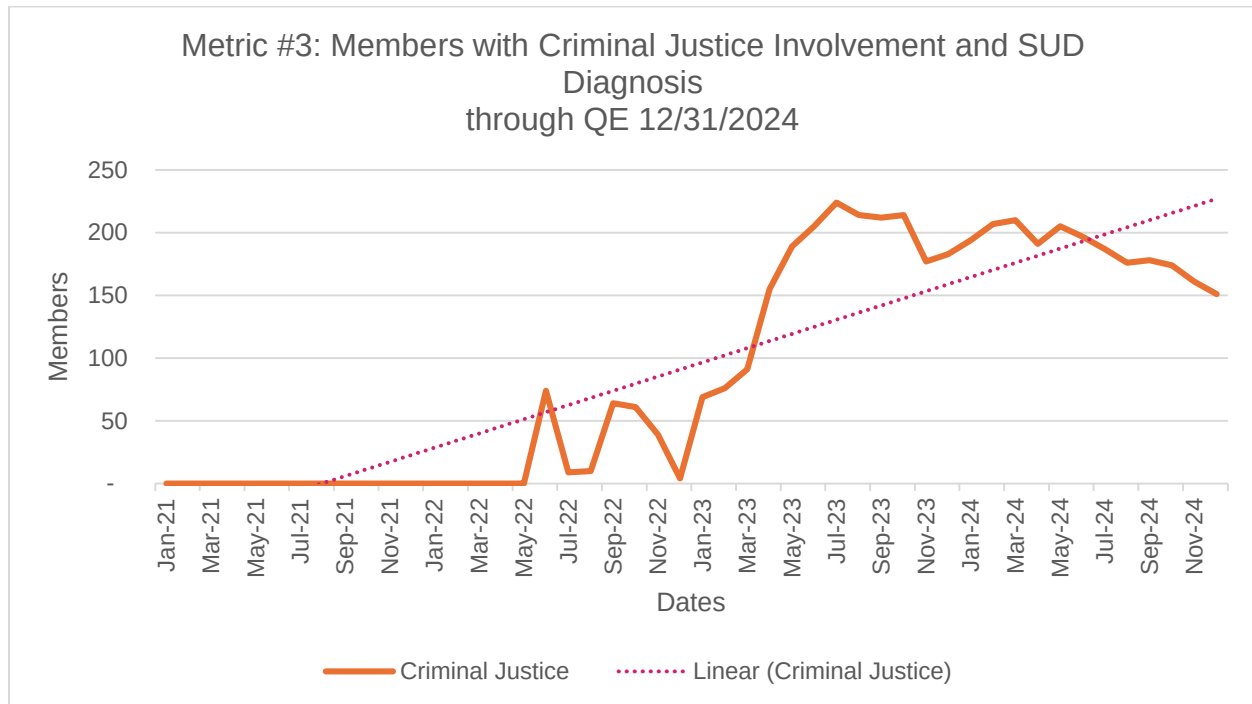
Older adults age 65 years and older with an SUD diagnosis have steadily increased under the Demonstration while the number of youth increased until the end of the PHE when eligibility unwinding began.

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



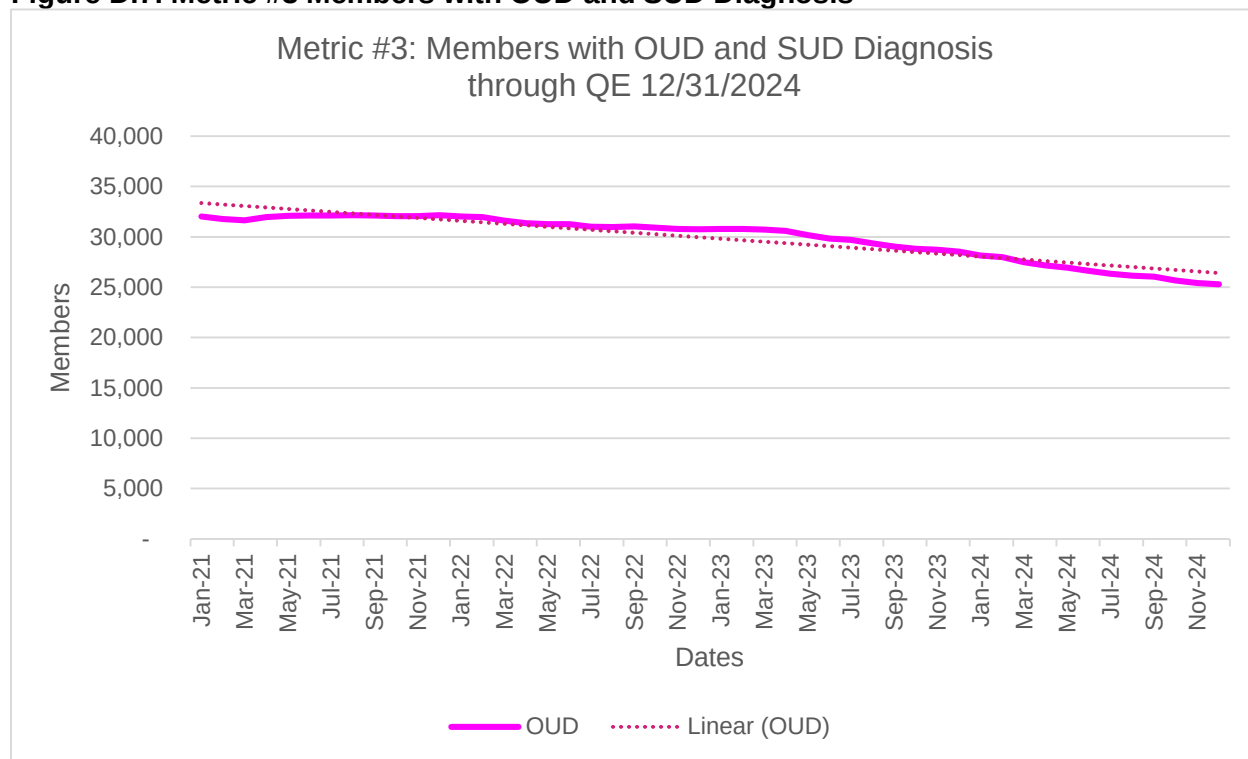
Prior to the Demonstration, Connecticut did not track Medicaid members with criminal involvement and SUD diagnosis. Beginning in June 2022, Connecticut was able to track individuals with the Department of Correction or Judicial Branch Court Support Services Division involvement post release from prison.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

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



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

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



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

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

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

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

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

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

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

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

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

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

Annual System Evaluation

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

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

PAR activities for various levels of care included:

- On a semiannual basis, RNMs applied a multi-systems approach to promote health care, strengthen care connections, improve documentation, and cultivate a cohesive Statewide strategy among inpatient, ambulatory, and community-based programs. The goal was to improve the delivery of MOUD and alcohol use disorder (MAUD) services throughout Connecticut's Medicaid behavioral health care system. These behavioral health partners were engaged in PAR discussions to capture actionable insights, explore next steps, and improve the flow of communication.
- Throughout 2024, the PAR program remained the primary platform for promoting, replicating, and sustaining the Changing Pathways model across alcohol and drug treatment centers (ADTCs) offering ASAM 3.7 withdrawal management (3.7 WM) level of care. The shift from traditional withdrawal management to the initiation of MOUD was a central theme during PAR meetings.
- RNMs continued to leverage medications for substance use disorder data as part of the PAR meeting process to gain critical insights and inform practice changes at both the provider and system levels. PAR discussions focused on the initiation of MOUD and its associated impact on related quality measures, including members leaving treatment AMA, readmissions, opioid poisoning pre/post-discharge, and connections to MOUD. To promote standardization of the Changing Pathways model and sustain the practice of initiating MOUD during treatment, RNMs conducted regular quality and performance improvement activities with all 3.7 WM providers. These activities included documentation training and the use of ad hoc system enhancement meetings to foster collaboration among community providers and establish a deeper understanding of referral pathways. Additionally, monthly data on MOUD initiations was made available to providers.
- In preparation for the launch of the 2025 inpatient and residential PAR program, Carelon focused on several key activities in 2024 to support the system of care including: (1) developing data analytic capabilities to report on the utilization of inpatient and residential levels of care for SUD treatment, (2) fostering better relationships among providers across the continuum of care through a series of connect-to-care meetings, and (3) educating providers on the ASAM levels of care to assist in determining the appropriate level of care for HUSKY Health members. These activities not only support the expansion of access to vital SUD services, but also promote a more integrated, collaborative approach to the delivery of care. By strengthening provider relationships, employing data analytics to track utilization trends, enhancing education on ASAM Quality Management and Clinical Program Evaluation criteria, and offering training on the latest treatment best practices, Connecticut is making significant strides toward improving the quality and effectiveness of its SUD treatment system.¹¹

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

Utilization by Level of Care¹² — Adult

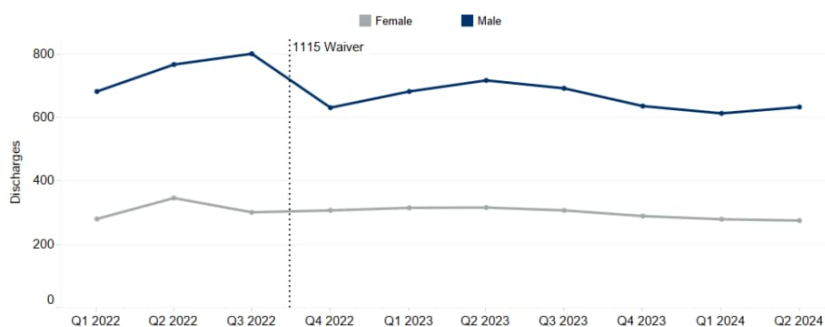
Carelon produces utilization reports used by DSS for monitoring utilization under the Demonstration.

ASAM 4.0-WM

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

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

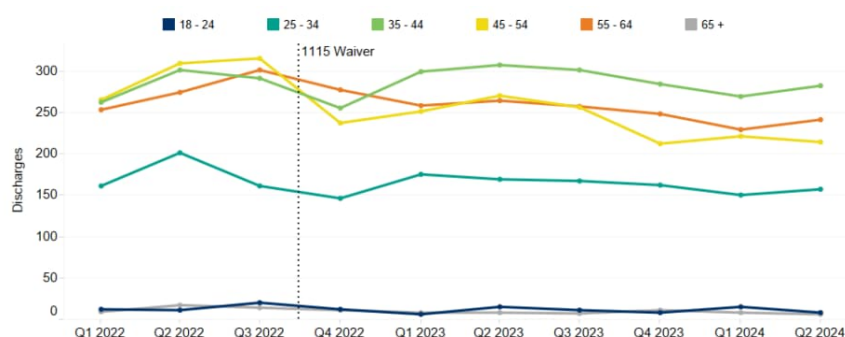
Figure D.8. Discharge Volume by Gender for ASAM 4.0-WM Medically Managed Intensive Inpatient Withdrawal Management



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

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

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



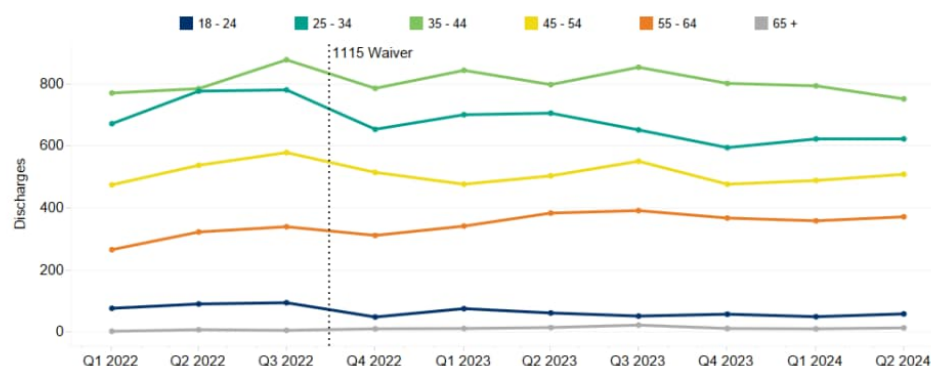
ASAM 3.7-WM

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

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

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

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



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

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

ASAM 3.7

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

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

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

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

IOP and Partial Hospitalization

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

Authorization and Utilization — Youth¹³

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

IOP and PHP

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

Improving Capacity and Access

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

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

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

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

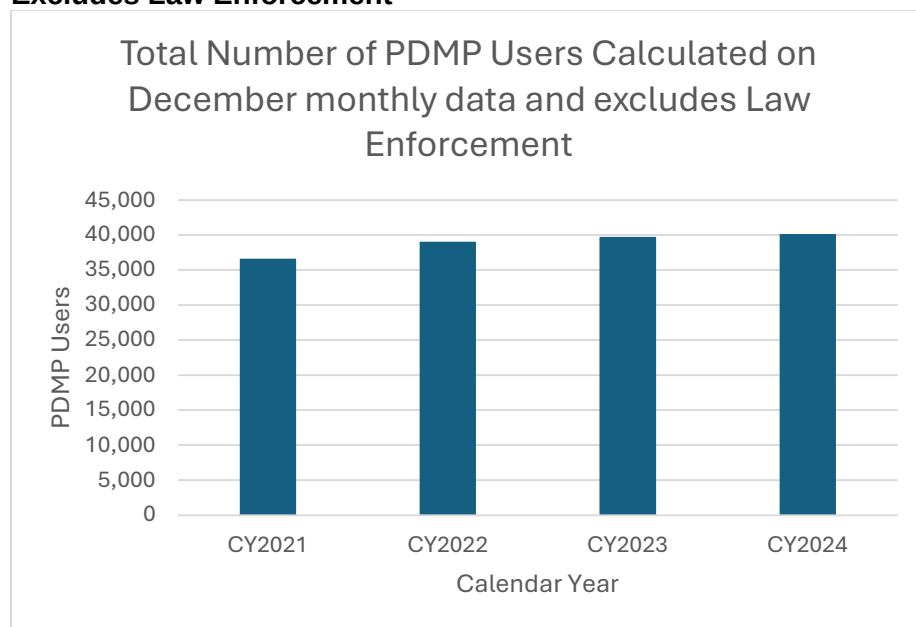
Carelon has a Provider Data Verification (PDV) form which serves as a resource for providers to refresh their referral details for the Provider Search website. This form enables Carelon to keep accurate records of essential practice information, such as identifying providers who are currently accepting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

Substance Use Disorder Health Information Technology Annual Metrics

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

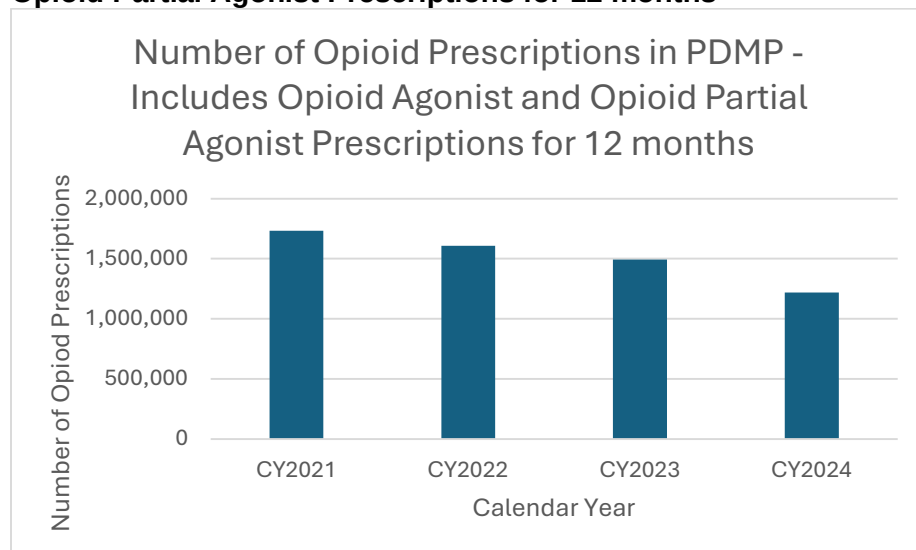
In the figure below, the number of PDMP users has increased since the beginning of the Demonstration (1.8% in calendar year 2023 [CY23] and 1.07% in CY24).

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



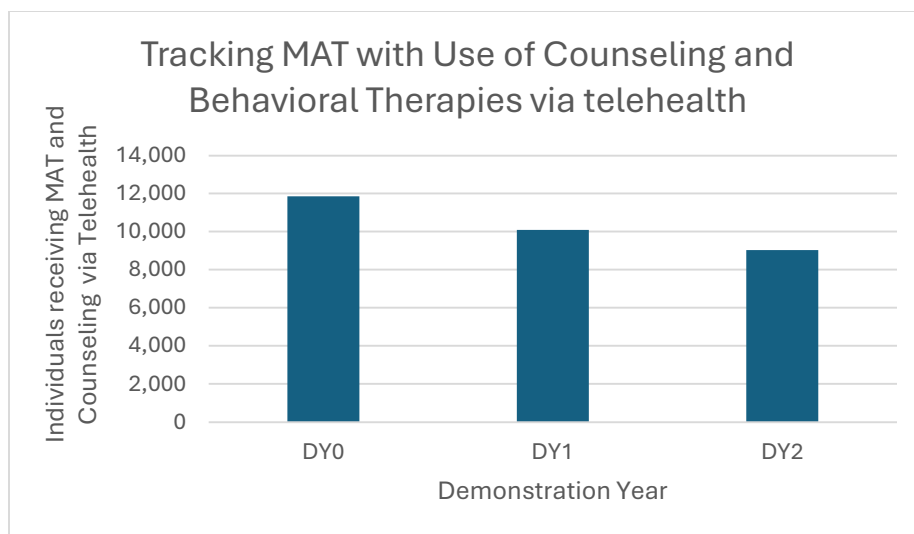
In the figure below, the number of opioid prescriptions in the PDMP has continued to decrease since the beginning of the Demonstration (-7.12% in CY23, and -18.47% in CY24).

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



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

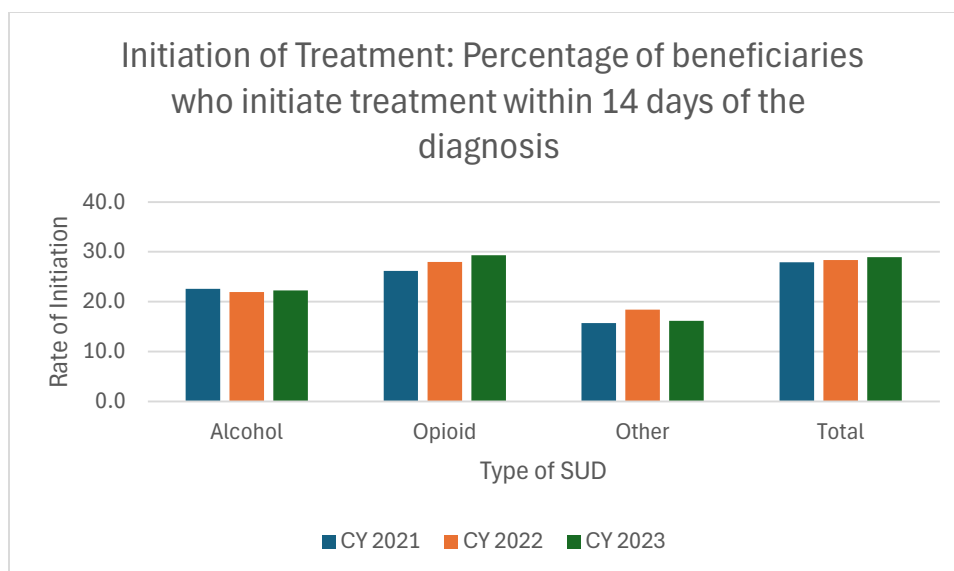
Figure D.13. Tracking MAT with Use of Counseling and Behavioral Therapies via Telehealth



Performance Metrics

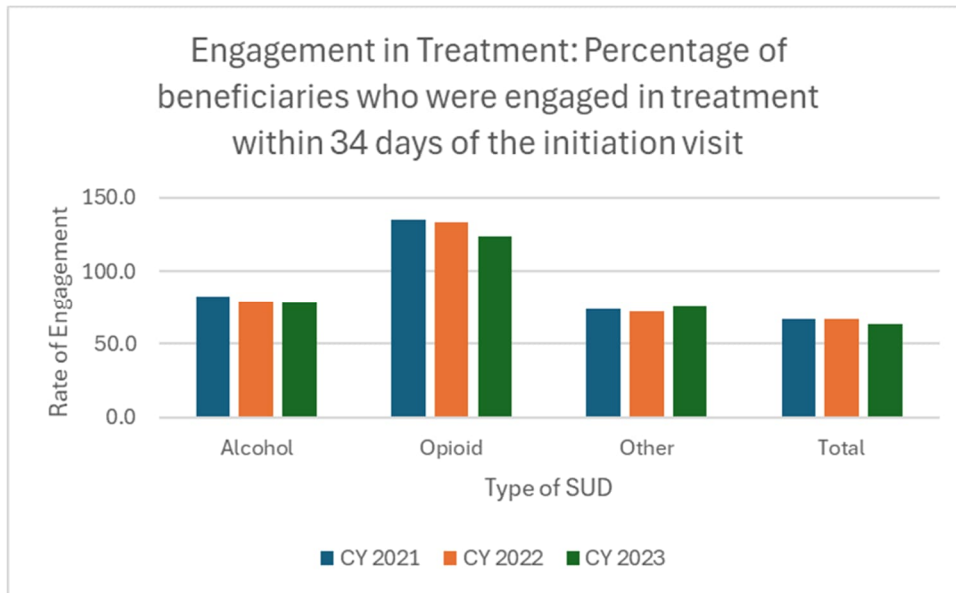
Connecticut routinely calculates SUD metrics using technical specifications from national stewards. In the second year of the Demonstration (CY23), Connecticut interventions under the Demonstration increased initiation of treatment for alcohol, opioids, and SUD overall, but initiation of treatment for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

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



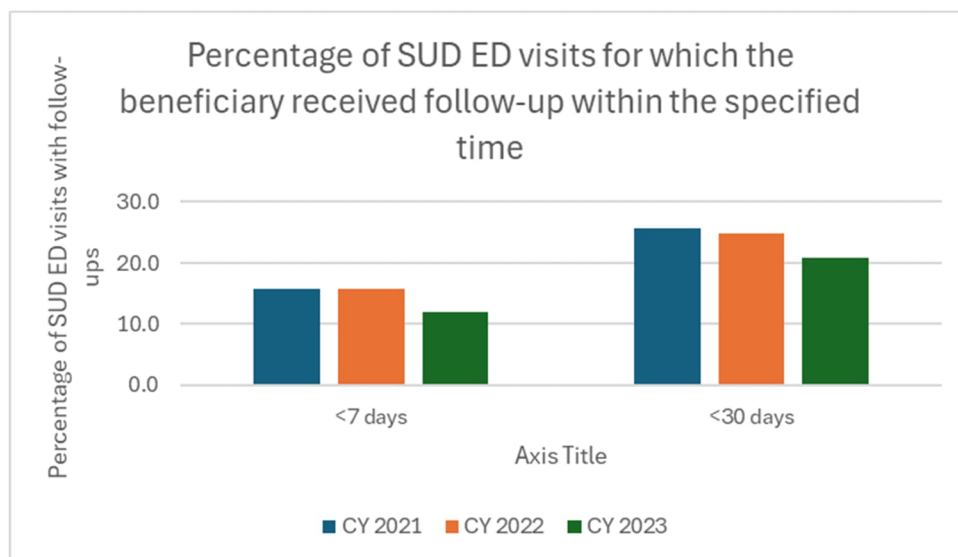
For Engagement in Treatment, the percentage of beneficiaries engaging in treatment within 34 days of the initiation visit increased for other SUD types from year one to year two by 4.4%, but decreased for alcohol, opioids, and SUDs overall (-1.2%, -7.2%, and -4.3%, respectively).

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



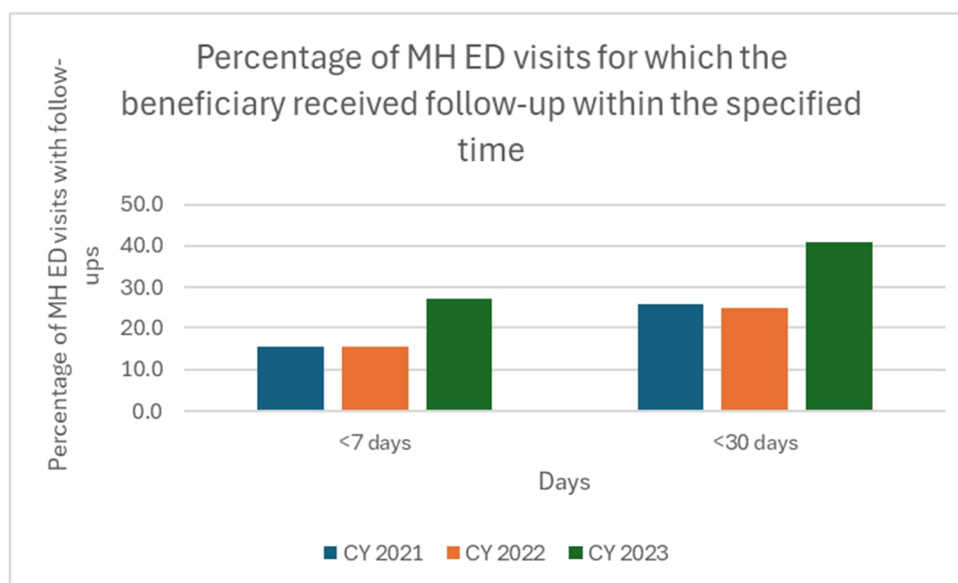
The Demonstration did not have a positive effect on follow-up after SUD emergency department (ED) visits for beneficiaries ages 18 years or older with a principal diagnosis of alcohol and other drug or other drug dependence: follow-up after seven days decreased by 23.3% and follow-up after 30 days dropped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

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



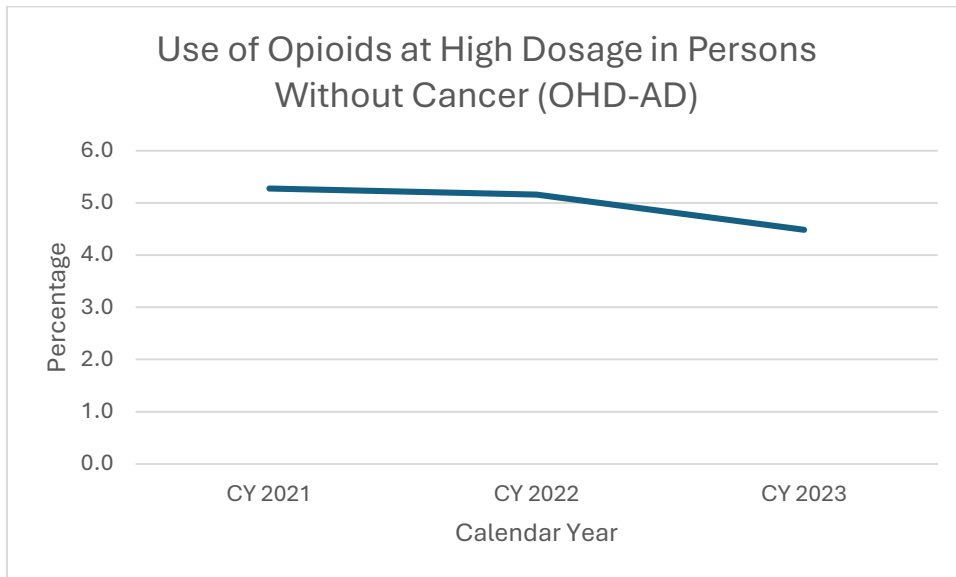
In contrast, the percentage of ED visits for beneficiaries age 18 years and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness, increased following the implementation of the Demonstration by 12.0% for seven days and 10.6% for follow-up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

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



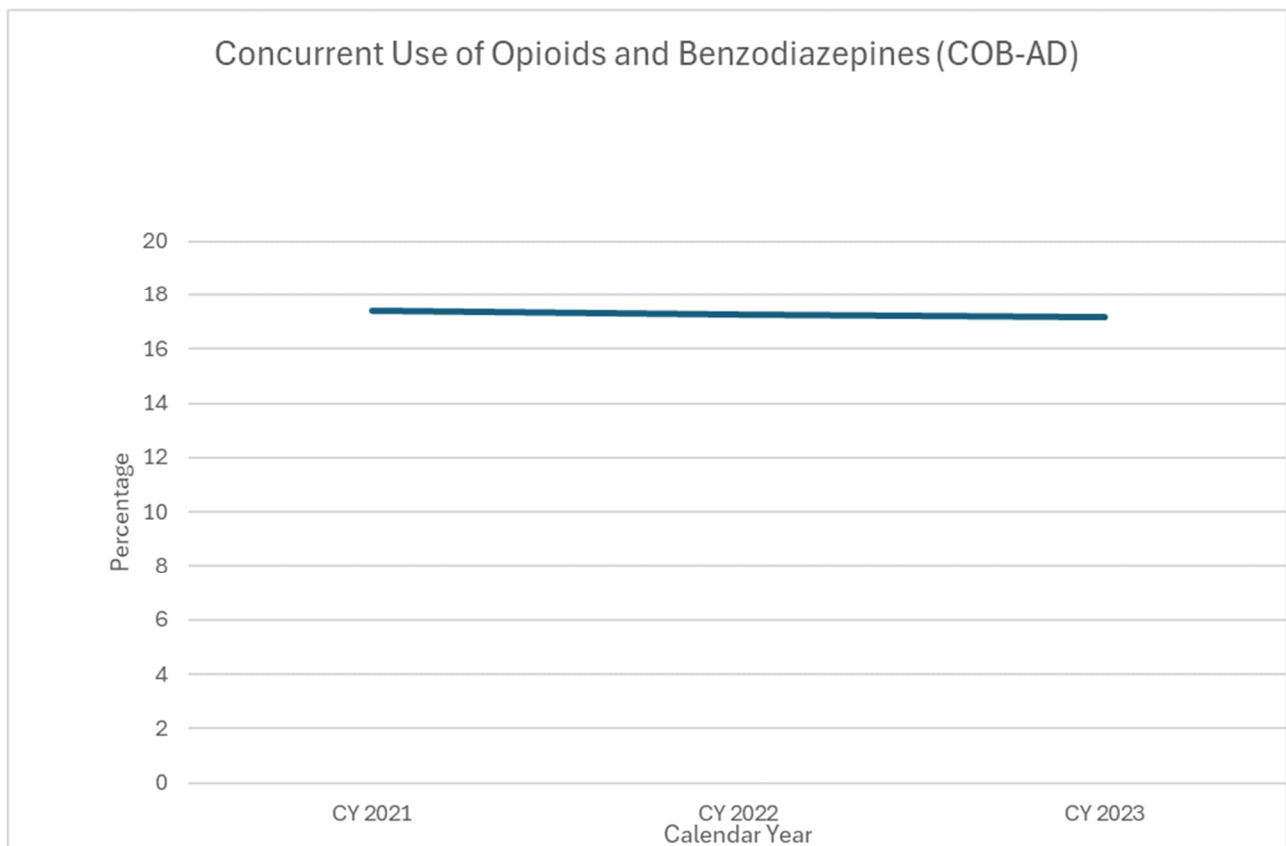
Two specific metrics show improvement with the implementation of the Demonstration. In these two metrics, decreased utilization were positive outcomes. The Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) improved from a rate of 5.16 to 4.49 by decreasing 13.0% in year two of the Demonstration.

Figure D.18. Use of OHD-AD



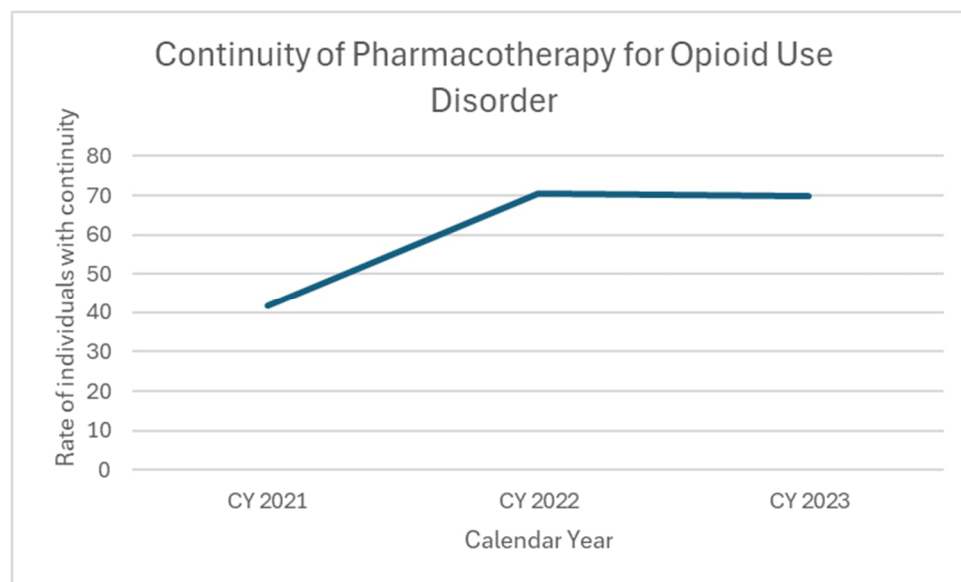
Similarly, the Concurrent Use of Opioids and Benzodiazepines (COB-AD) improved by decreasing from a rate of 17.25 to 17.15 or a decrease of 0.6% in year two of the Demonstration.

Figure D.19. Concurrent Use of COB-AD



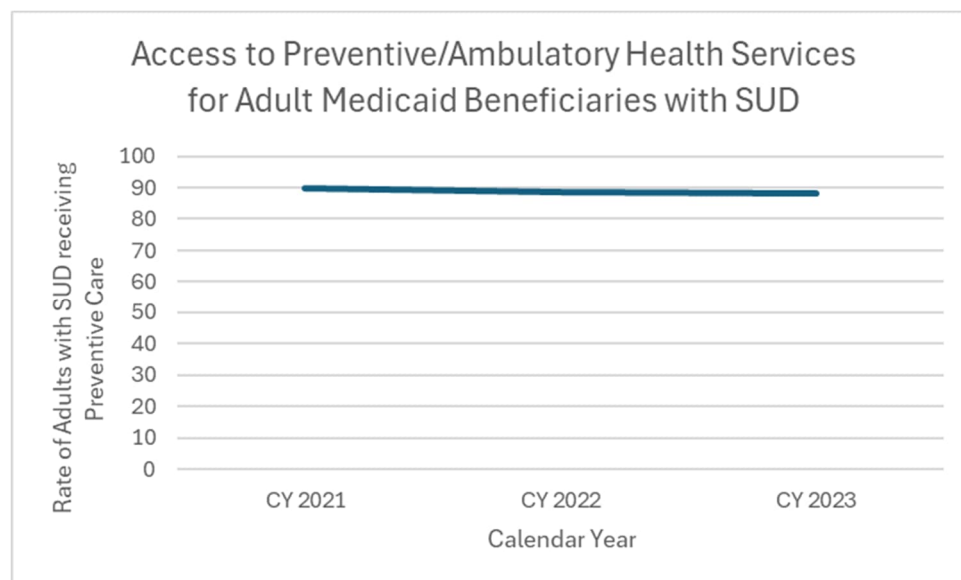
Connecticut almost doubled the rate of individuals with continuity of pharmacotherapy for Opioid Use Disorder (OUD) (increasing from a rate of 41.8 to 70.5) in year one of the Demonstration. However, the second year of the Demonstration decreased slightly (-0.9%) but still rounded to a rate of 70.

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



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

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



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

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

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

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

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

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

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

Table D.3. Average Length of Stay in IMDs

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

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

Table D.4. SUD Provider Availability

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

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

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

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

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

Table D.6. Hospital Readmissions Among Beneficiaries with SUD

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

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

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

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

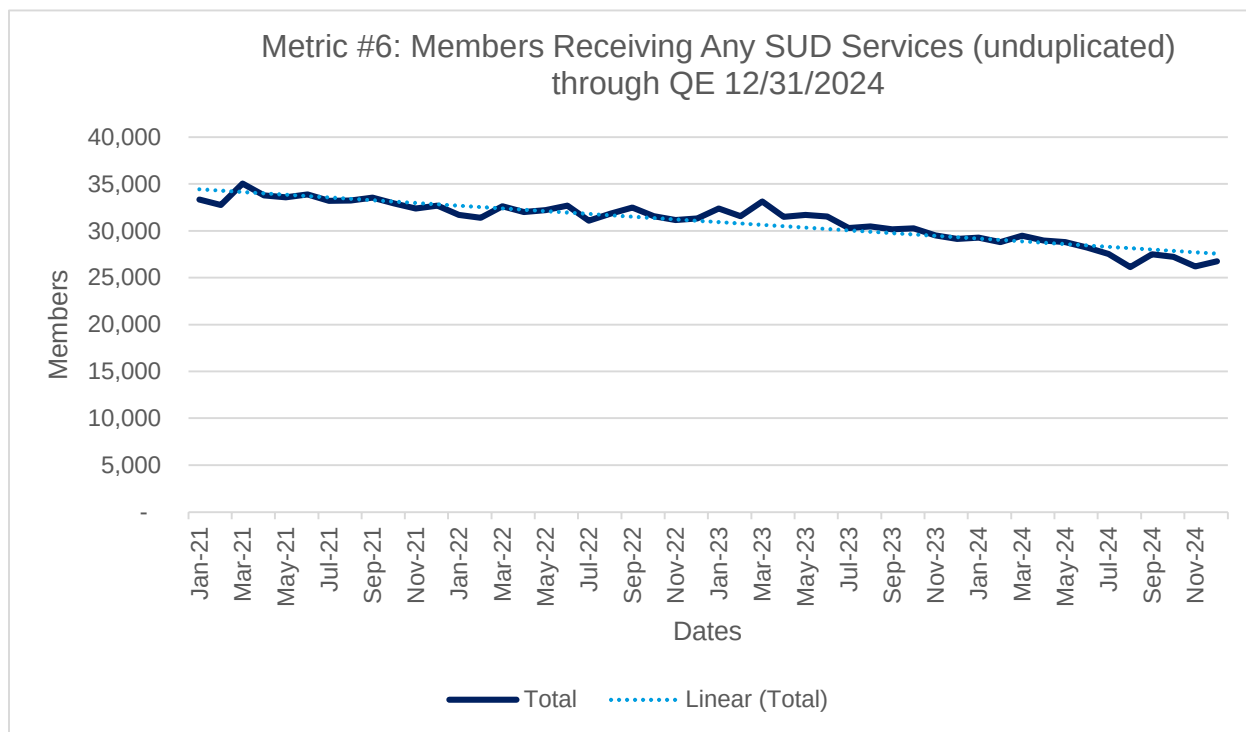


Figure D.23. Metric #6: Pregnant Members Receiving any SUD Services

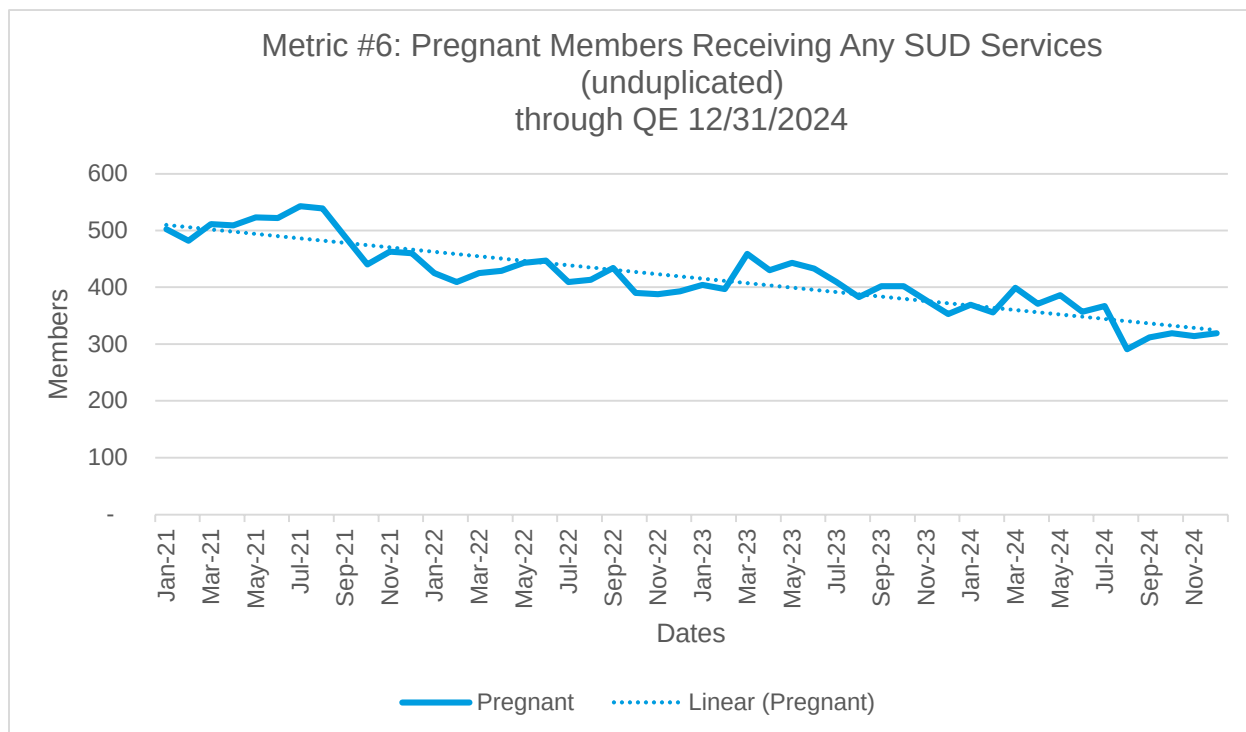


Figure D.24. Metric #6: Dual Eligible Members Receiving any SUD Services

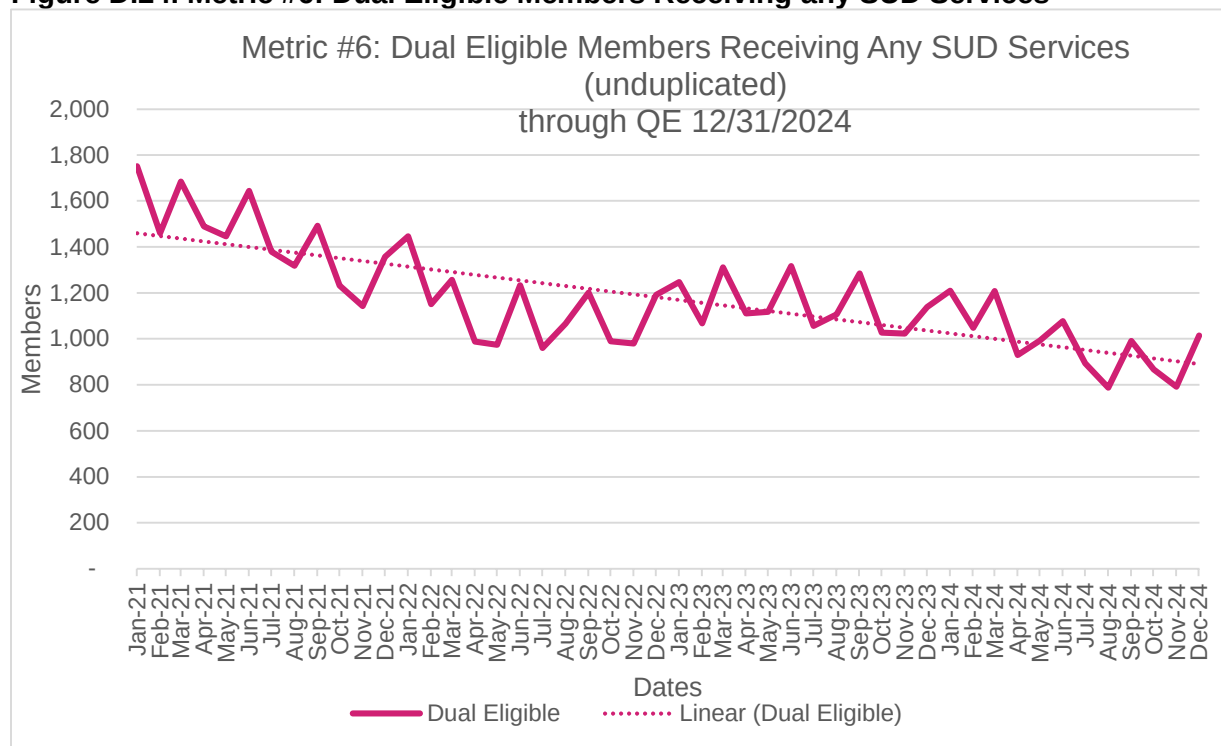


Figure D.25. Metric #6: Non-Adult Members by Age Receiving any SUD Service

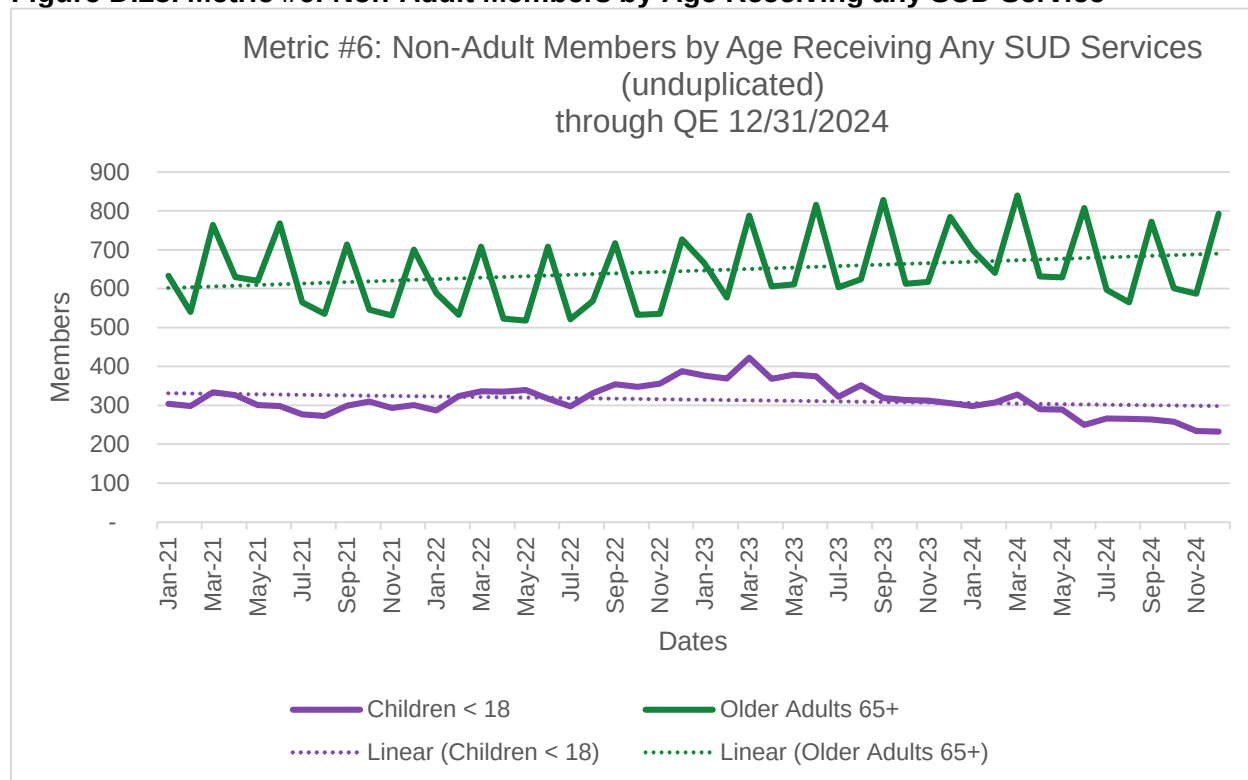


Figure D.26. Metric #6: Members with OUD Diagnosis Receiving any SUD Services

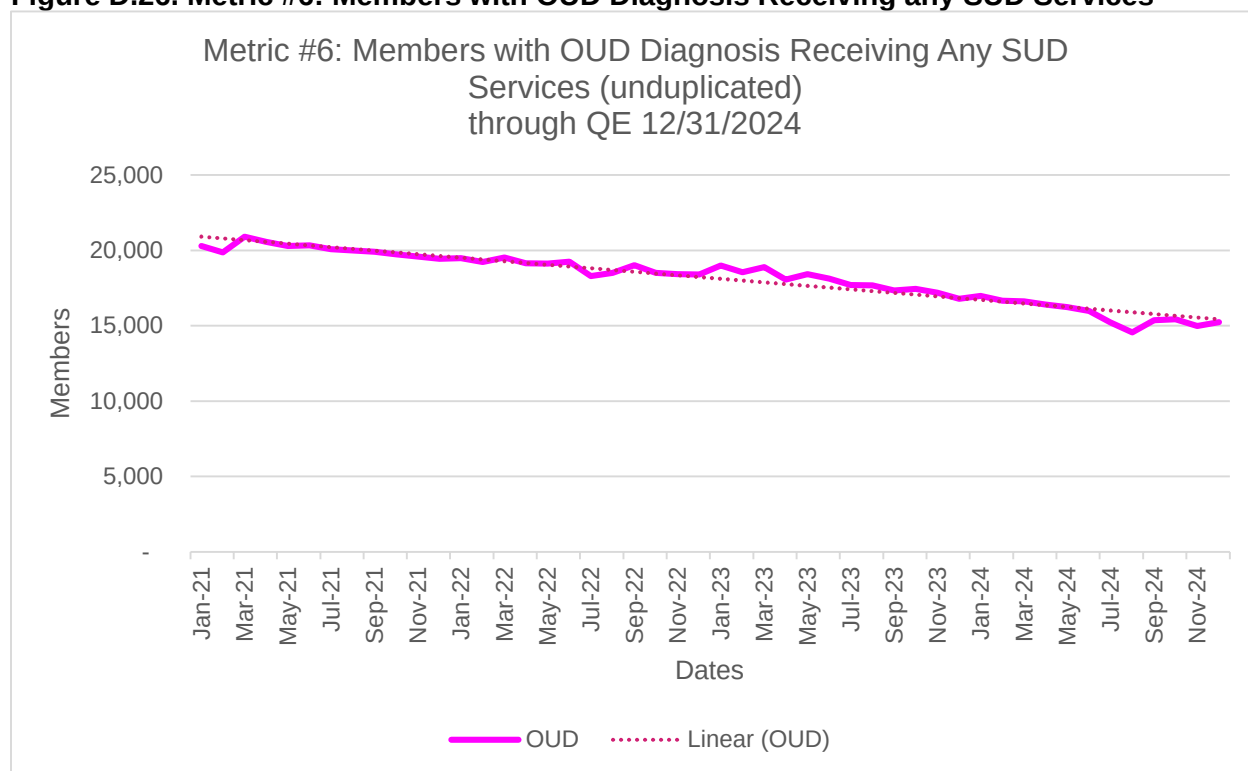
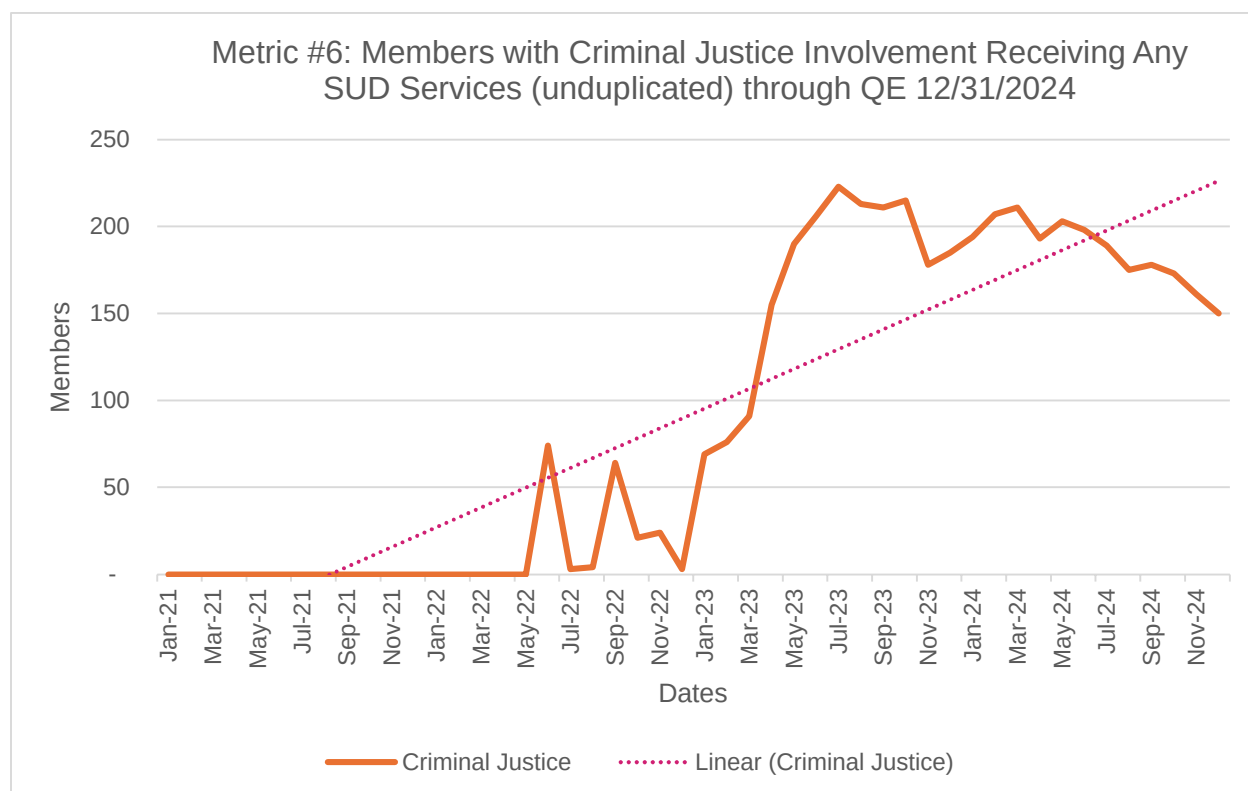
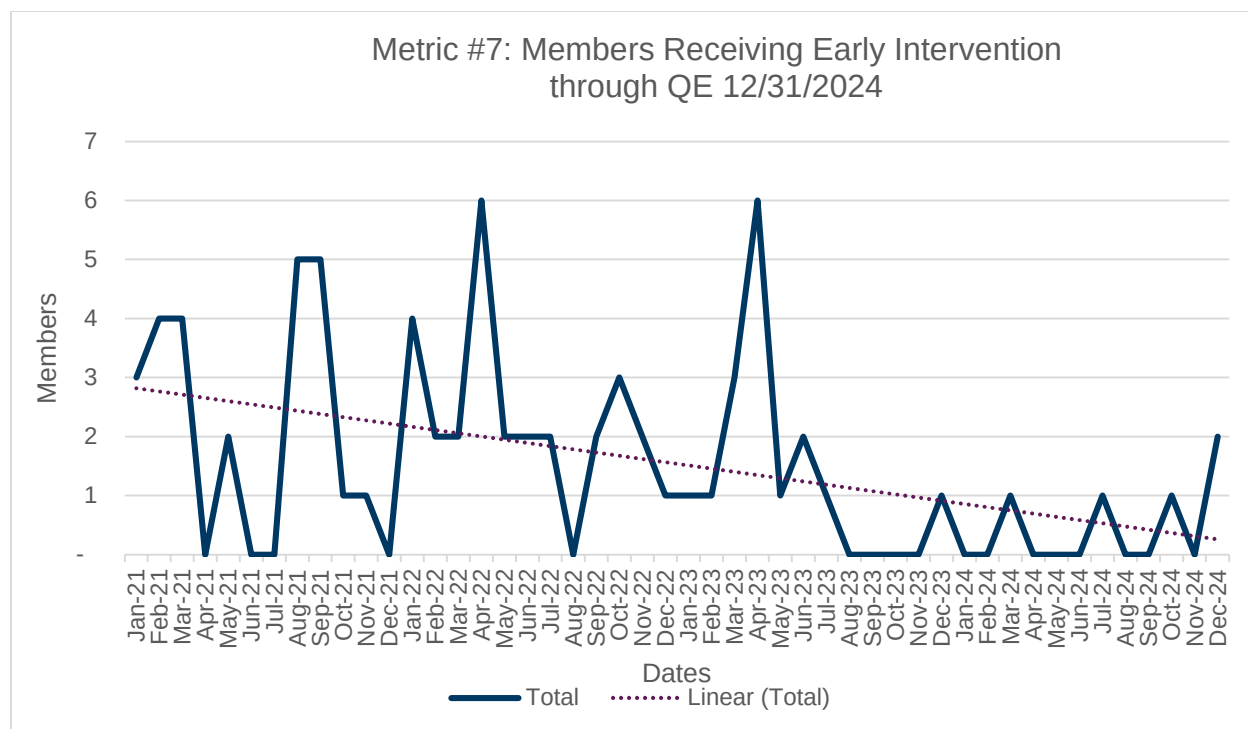


Figure D.27. Metric #6: Members with Criminal Justice Involvement Receiving any SUD Services



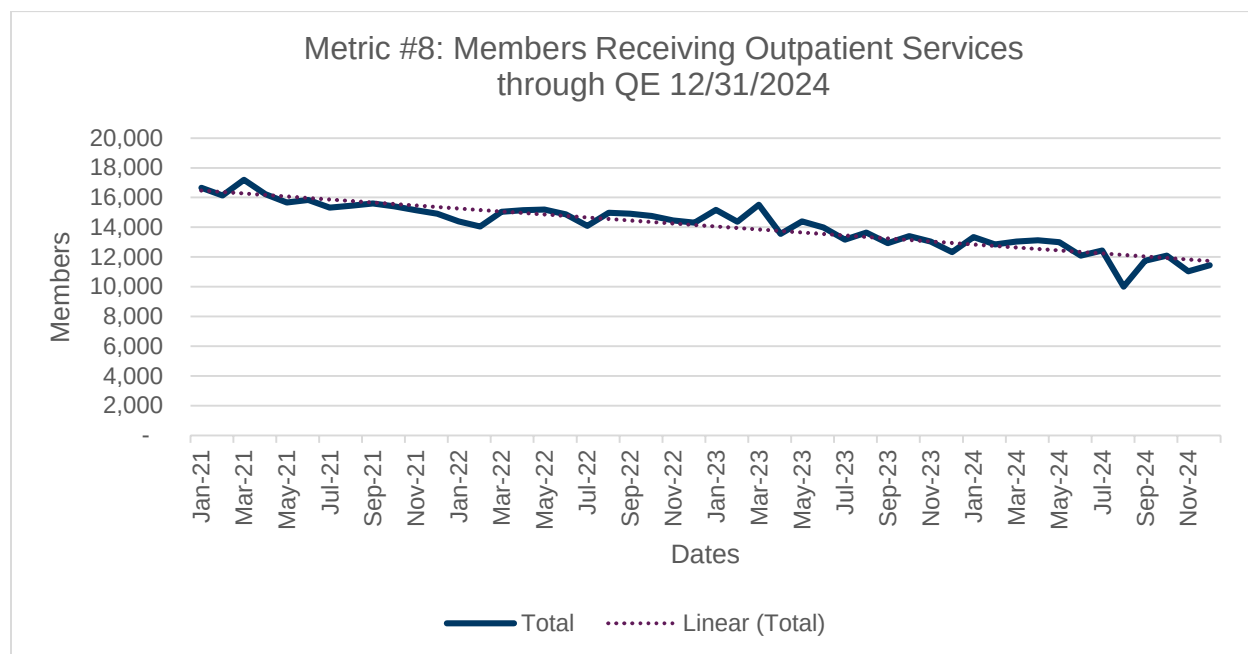
The graph below shows utilization of Medicaid members receiving Early Intervention.

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



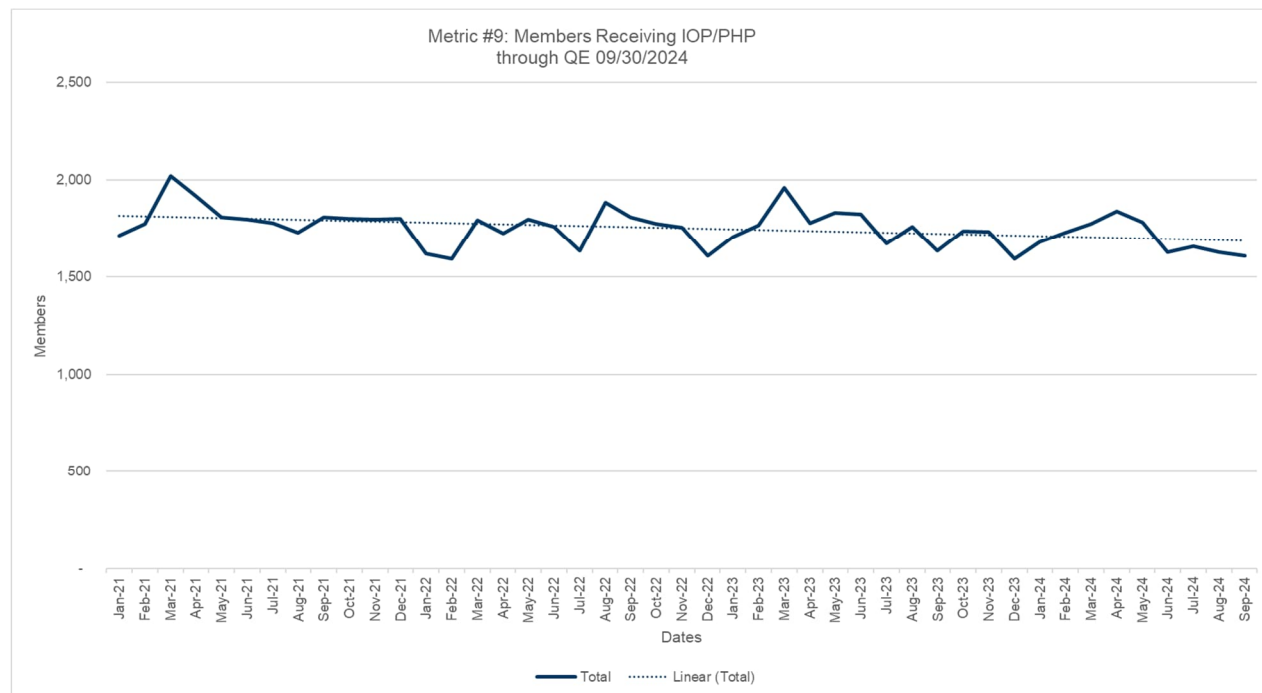
The graph below shows utilization of outpatient services prior to the Demonstration and after the Demonstration beginning on April 14, 2022.

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



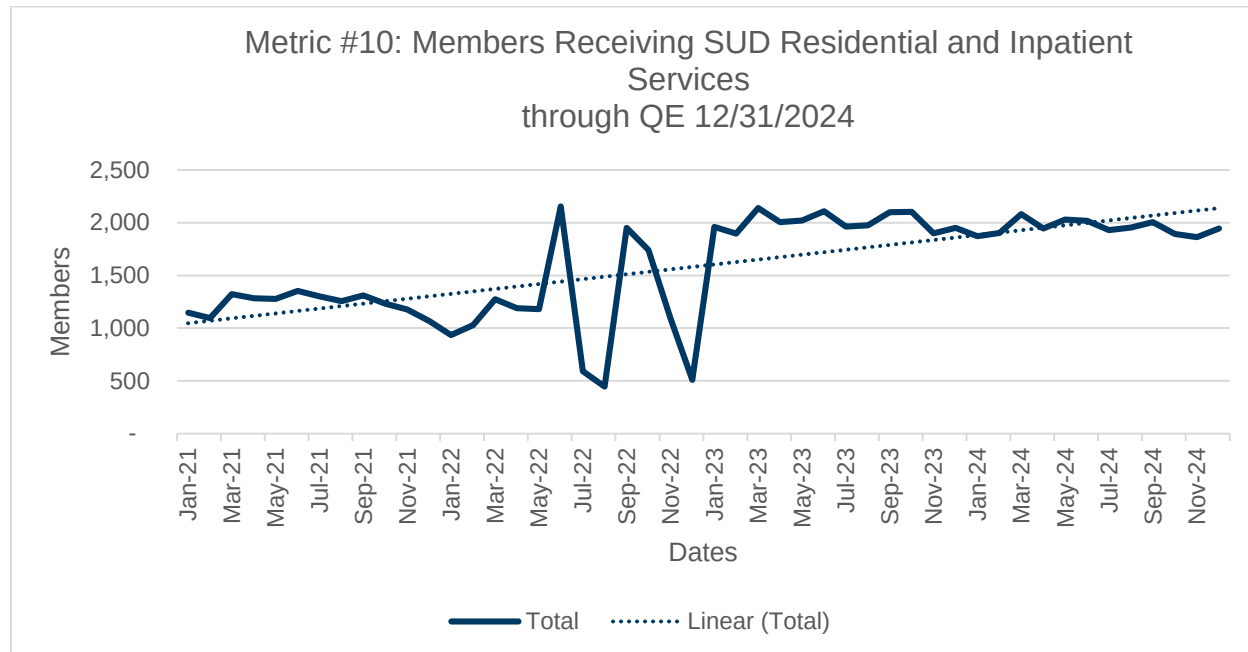
The table below shows Medicaid members receiving Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP) services prior to and after the inception of the Demonstration on April 14, 2022.

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



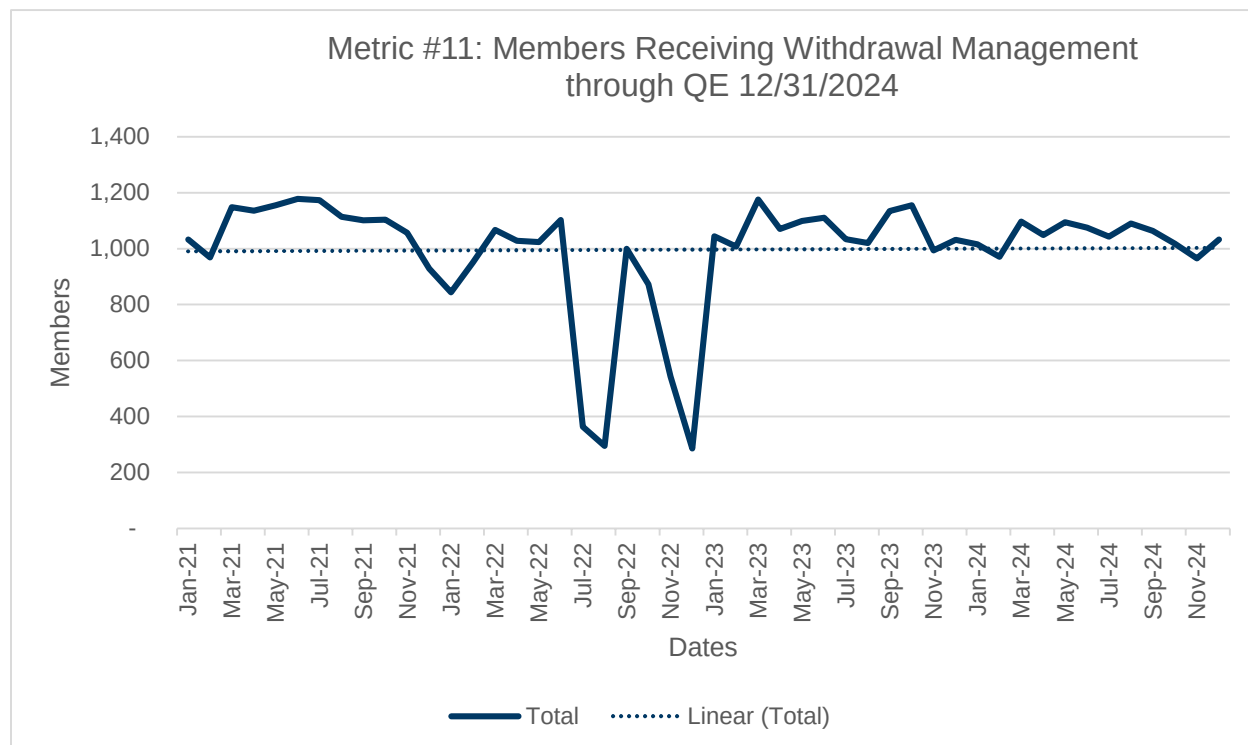
The figure below shows members receiving residential and inpatient care prior to and after the implementation of the Demonstration on April 14, 2022. The three months with very little utilization in 2022 represent months when providers were unable to process claims within three months of the date of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

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



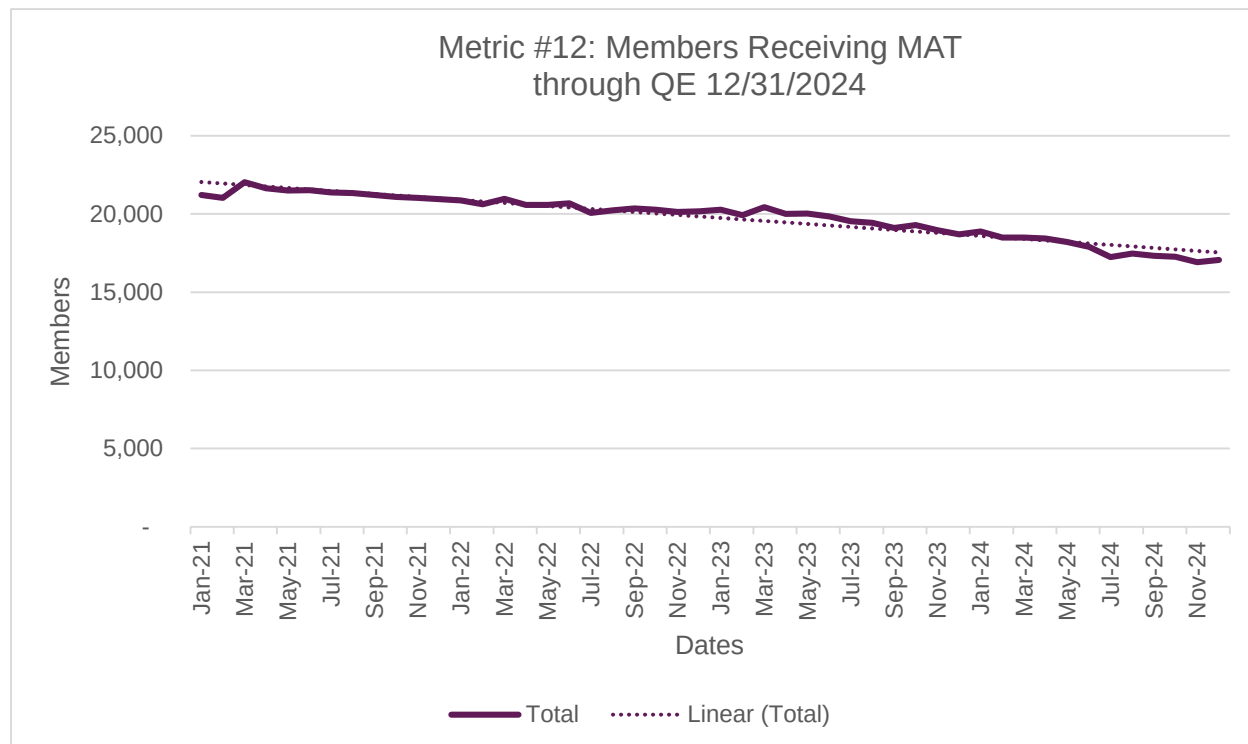
The next graph demonstrates the number of members receiving withdrawal management prior to and after the Demonstration implementation on April 14, 2022. The three months with little utilization also reflect months when providers held claims for longer than three months after the date of service prior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

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



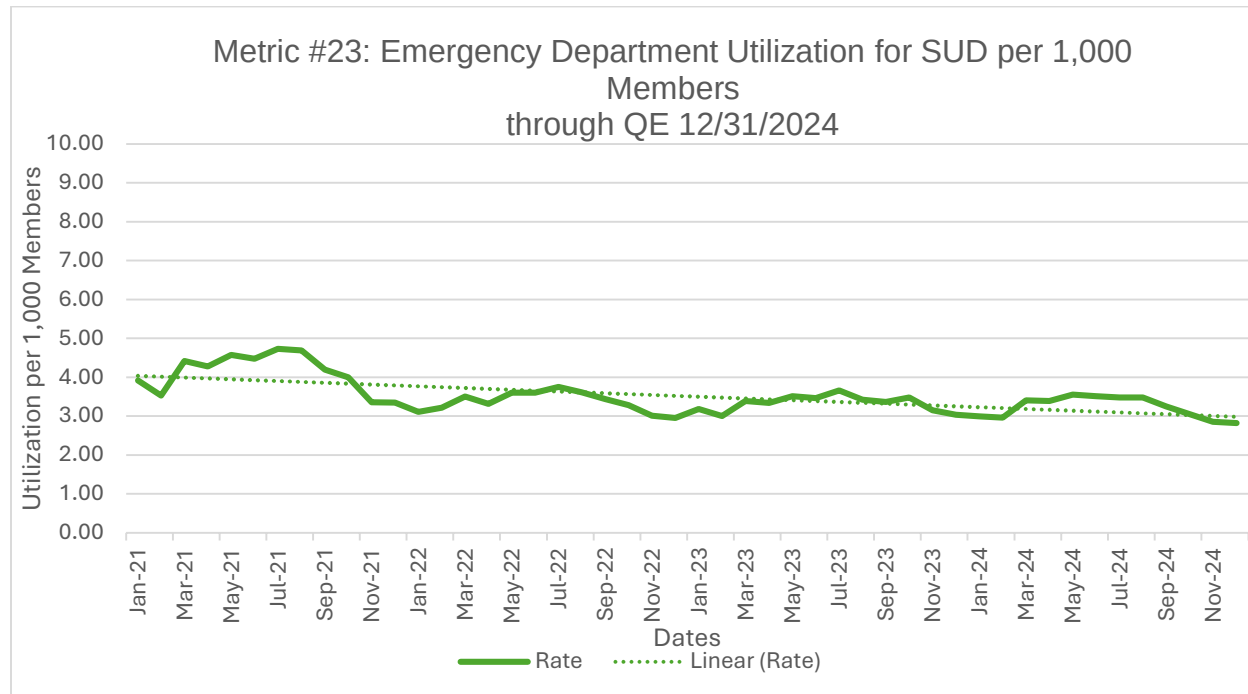
In the figure below, Connecticut reports the number of members receiving Medication- Assisted Treatment (MAT) prior to and after the Demonstration implementation on April 14, 2022. As noted in the annual metrics above, the number of providers who are providing MAT is increasing. However, as seen in these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

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



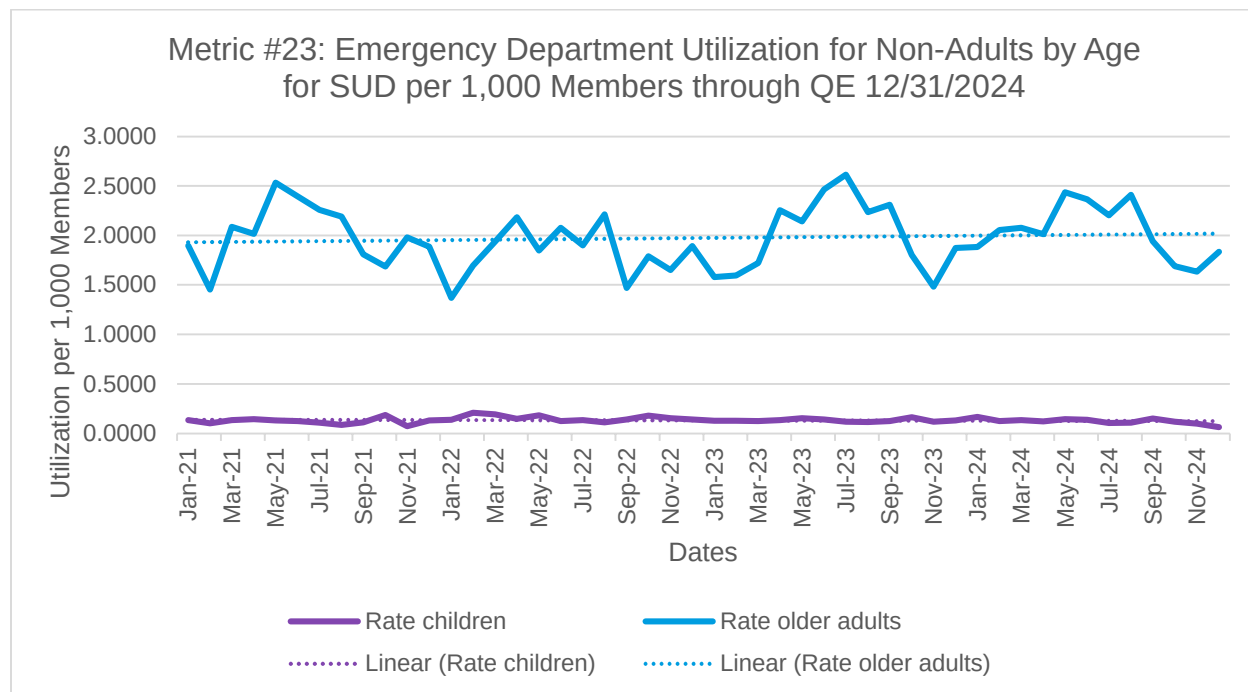
In the figure below, Connecticut demonstrates that the ED for SUD per 1,000 members after the Demonstration has declined overall.

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



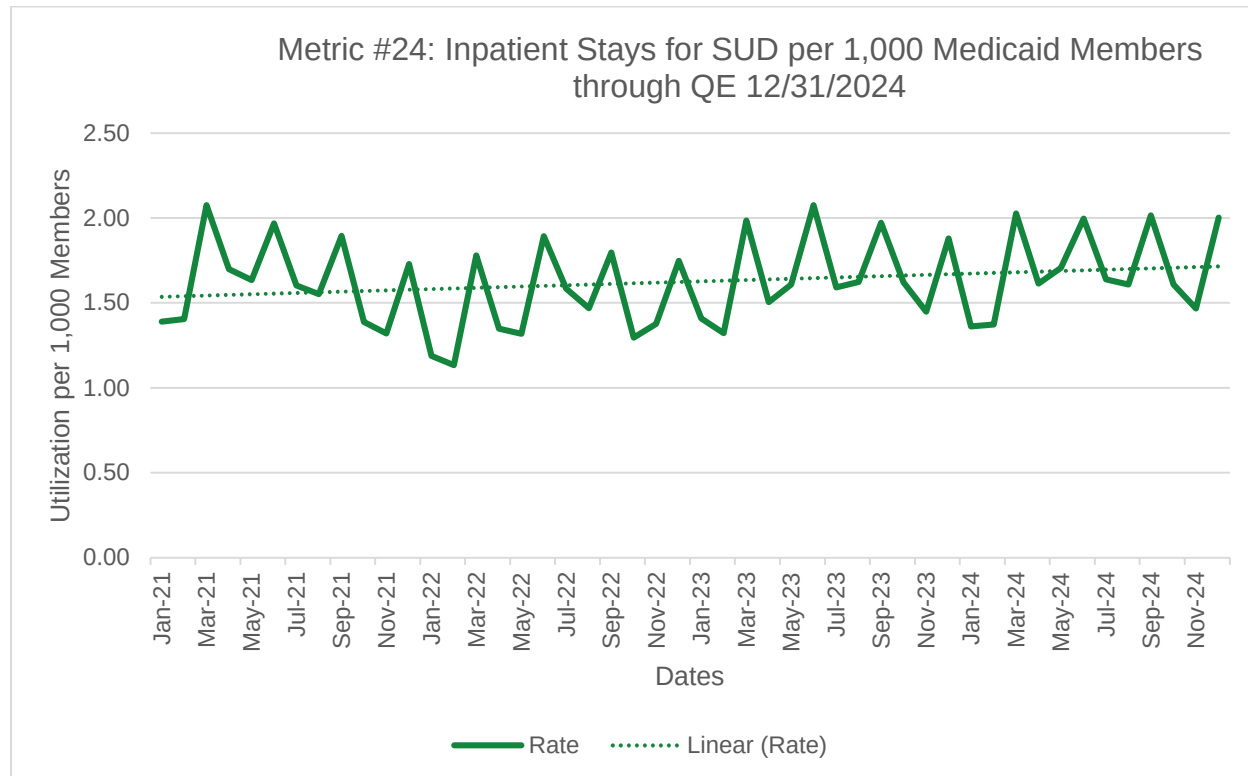
However, the number of older adults receiving ED visits for SUD has risen slightly with the beginning of the Demonstration. The number of youth has remained relatively constant.

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



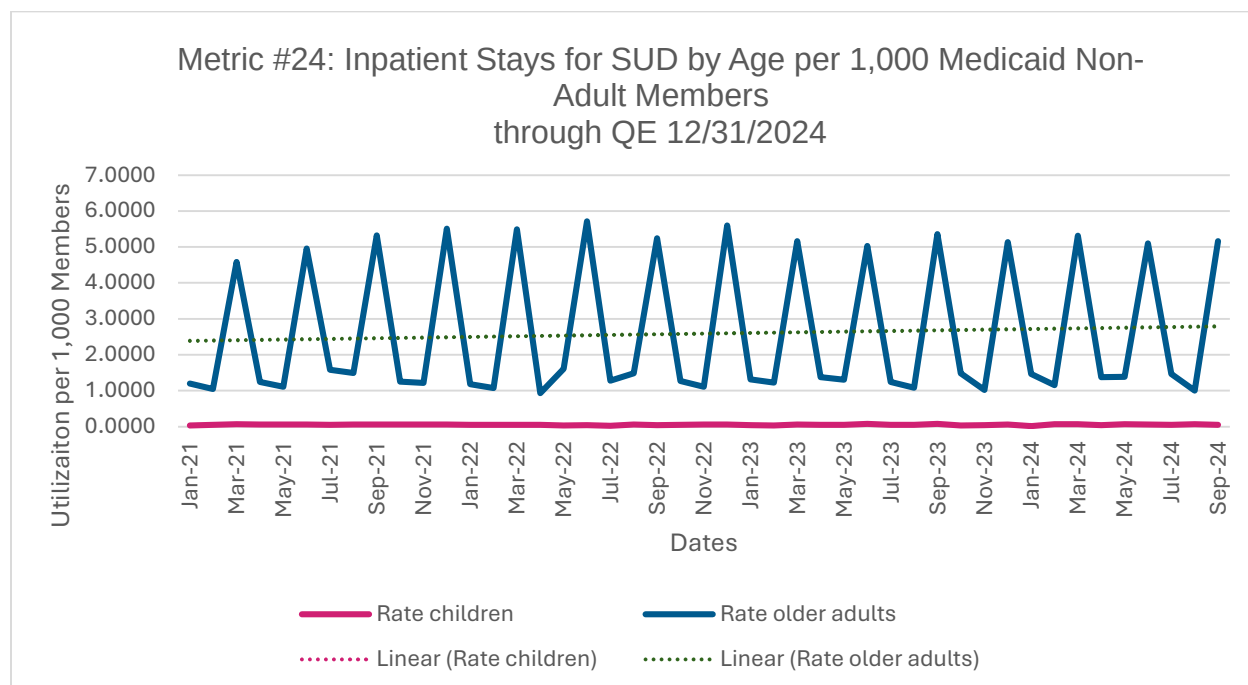
The SUD inpatient hospitalization rate shows overall increases since the beginning of the Demonstration.

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



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

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



Integrated System for the Treatment of SUDs Performance Target

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

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

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

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

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

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

Provider Certification and Monitoring¹⁴

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

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

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

Residential Phase 1 Monitoring

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

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

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

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

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

Residential Phase 2 Monitoring

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

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

Residential Phase 3 Monitoring

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

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

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

Residential Phase 4 Monitoring

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

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

Table D.7. ABH Demonstration Year 1 Certification Monitoring

CT 1115 SUD Demonstration Provider Certification Totals								
April 2022-March 2023								
ASAM Level of Care	Number of Providers Provisionally Certified		Number of Providers Certified Level 1		Number of Conditional Certifications		Total Number of Active Programs 3/31/2023	
Ambulatory Outpatient	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent
1-WM	33	7	0	0	0	0	33	7
2-WM	10	7	0	0	0	0	10	7
2.1	94	26	0	0	0	0	94	26
2.5	25	8	0	0	0	0	25	8
Total	162	48	0	0	0	0	162	48
Residential Programs	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent
3.1	7	0	0	0	0	0	7	0
3.3	2	0	0	0	0	0	2	0
3.5	11	1	0	0	0	0	11	1
3.5 PPW	5	0	0	0	0	0	5	0
3.7 R	7	0	0	0	0	0	7	0
3.7- Co-Occurring Enhanced	3	0	0	0	0	0	3	0
3.7 Withdrawal Management	7	0	0	0	0	0	7	0
Total	42	1	0	0	0	0	42	1
Total Active Programs As of 3/31/2023 Combined							204	49
*Full certification for residential and ambulatory programs did not go into effect until June of 2024. Each program participated in 4 phases of certification monitoring during the two year provisional certification period.								

CT 1115 SUD Demonstration Provider Certification Totals								
April 2022-March 2023								
ASAM Level of Care	Number of Providers Provisionally Certified		Number of Providers Certified Level 1		Number of Conditional Certifications		Total Number of Active Programs 3/31/2023	
Ambulatory Outpatient	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent
1-WM	33	7	0	0	0	0	33	7
2-WM	10	7	0	0	0	0	10	7
2.1	93	26	0	0	0	0	93	26
2.5	26	8	0	0	0	0	26	8
Total	162	48	0	0	0	0	162	48
Residential Programs	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent
3.1	7	0	0	0	0	0	7	0
3.3	2	0	0	0	0	0	2	0
3.5	11	1	0	0	0	0	11	1
3.5 PPW	5	0	0	0	0	0	5	0
3.7 R	7	0	0	0	0	0	7	0
3.7- Co-Occurring Enhanced	3	0	0	0	0	0	3	0
3.7 Withdrawal Management	7	0	0	0	0	0	7	0
Total	42	1	0	0	0	0	42	1
Total Active Programs As of 3/31/2023 Combined							204	49
*Full certification for residential and ambulatory programs did not go into effect until June of 2024. Each program participated in 4 phases of certification monitoring during the two year provisional certification period.								

Table D.8. ABH Demonstration Year 2 Certification Monitoring

CT 1115 SUD Demonstration Provider Certification Totals								
April 2023-March 2024								
ASAM Level of Care	Number of Providers Provisionally Certified		Number of Providers Certified Level 1		Number of Conditional Certifications		Total Number of Active Programs 3/31/2024	
Ambulatory Outpatient	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent
1-WM	0	1	0	0	0	0	33	8
2-WM	0	0	0	0	0	0	10	7
2.1	17	1	0	0	0	0	109	27
2.5	2	1	0	0	0	0	29	9
Total	19	3	0	0	0	0	181	51
Residential Programs	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent
3.1	0	0	0	0	0	0	7	0
3.3	0	0	0	0	0	0	2	0
3.5	0	0	0	0	0	0	11	0
3.5 PPW	0	0	0	0	0	0	5	0
3.7 R	0	0	0	0	0	0	7	0
3.7- Co-Occurring Enhanced	0	0	0	0	0	0	3	0
3.7 Withdrawal Management	0	0	0	0	0	0	7	0
Total	0	0	0	0	0	0	42	0
Total Active Programs As of 3/31/2024 Combined							223	51
*Full certification for residential and ambulatory programs did not go into effect until June of 2024. Each program participated in 4 phases of certification monitoring during the two year provisional certification period.								

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

Table D.9. Overall Demonstration 3 Monitoring Site Visits

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

Total Adol and Adult Monitoring Visits
240

Table D.10. ABH Demonstration Year 3 Certification Monitoring

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

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

Residential Services Certification

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

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

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

Residential Phase 5 Monitoring

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

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

Table D.11. On-site Review areas

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

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

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

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

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

All providers by LOC	% Met Standards — Self-Report 2022	Phase 4 Site Visit Results — 2024		
		CORE Standards	ADMIN Standards	SUPPORT Standards
Organization Wide	83%			
ASAM 3.1	77%	96%	95%	87%
ASAM 3.3	72%	97%	96%	94%
ASAM 3.5	77%	95%	95%	90%
ASAM 3.5 Adol	82%	-	-	-
ASAM 3.5 PPW	79%	98%	97%	91%
ASAM 3.7	85%	92%	92%	92%
ASAM 3.7RE	77%	96%	96%	96%
ASAM 3.7WM	94%	97%	96%	88%

		Phase 4 Site Visit Results — 2024		
All providers by LOC	% Met Standards — Self-Report 2022	CORE Standards	ADMIN Standards	SUPPORT Standards
ASAM 4.0WM	95%			

Ambulatory Services Certification

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

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

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

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

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

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

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

- **Level I Certification (Three Years):** Seventy ambulatory adult programs and two adolescent programs achieved Level I Certification, effective November 16, 2024 – November 15, 2027.
- **Level II Certification (Six Months):** Eighteen adult programs and zero adolescent programs were certified at Level II, effective November 16, 2024 – May 15, 2024. They

will be surveyed again to measure their progress in meeting the Level I Certification requirements towards the end of the six-month period.

- **Conditional Certification (One Year):** Eleven adult programs and six adolescent programs were conditionally certified, effective November 16, 2024 - November 15, 2025.
- **Provisional Certification Expiration/Non-Operational:** Fifty adult and twenty-eight adolescent programs received a letter that their Provisional Certification ended effective November 15, 2024.

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

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

Outpatient Hospitals

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

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

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

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

Behavioral Health Federally Qualified Health Centers (FQHCs)

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

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

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

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

Grievance and Appeal Reporting

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

Table D.16. Reported SUD Grievances

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

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

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

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

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

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

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

Table D.15. Reported SUD Appeals

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

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

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

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

SUD Provider Appeals

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

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

Provider Level 1 Appeals by Level of Care and Outcome DY3

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

Appendix E: Budget Neutrality Language and Worksheets

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

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

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

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

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

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

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

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

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

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

E.4. Extension Request for SDOH

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

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

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

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

Appendix F

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

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

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

Reentry Initiative

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

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

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

Objectives and Goals

Reentry Initiative

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

Program Description

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

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

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

Goals/Objectives

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

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

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

Current and New Beneficiaries Impacted by the Re-Entry Initiative

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

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

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

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

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

Possible Medicaid programs include, but are not limited to:

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

Medicaid and CHIP Requirements

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

Cost Sharing

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

Delivery System

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

Eligibility

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

Benefit Coverage

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

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

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

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

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

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

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

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

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

Allowable SDOH services for the JI population include:

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

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

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

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

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

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

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

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

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

Table F.1.

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

Estimated Impact of the Demonstration

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

Table F.2. Estimated Projections of Annual Enrollment

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

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

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

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

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

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

Demonstration Hypotheses and Evaluation

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

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

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

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

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

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

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

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

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

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

Data Source: Claims/encounter data.

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

Waiver and Expenditure Authorities

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

Table F.4. Waivers Requested

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

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

Table F.5. Expenditure Authority Requested:

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

Appendix G

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

Post Award Forums

The State held four sets of annual post-award forums for the Demonstration 1115 including dates in October 2022, October 2023, and September 2024 and September 2025.

First Annual Post Award Forum

Summary

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

Details

The post-award forum was held on October 21, 2022. Spanish translation was made available during the forum. The forum was attended by 69 individuals. The presentation given at the forum has been posted to the State's dedicated website for the Demonstration. Also posted are the public comments received during the forum, as well as the State's response, where applicable. Feedback on the process was positive, with providers noting inclusivity and strong collaboration while maintaining a focus on person-centered and recovery-oriented care. Treatment providers noted continued challenges with workforce given staffing shortages in multiple disciplines. Relatedly, a request was made to not duplicate existing training offered by agencies so as to not further strain staffing resources. Clarification was provided by the State regarding the inclusion of LADCs. Advocacy was made to continue monitoring length of stay for members to ensure that there is no inadvertent impact. Providers are interested in continued support around the authorization process and expressed interest in opportunities to use a *flex bed* approach whereby members can remain in care within one program as they transition between LOCs. Housing needs were identified as a continued challenge for discharge planning when a member is ready to transition back to the community. Encouragement was offered by a participant to combine efforts of this Demonstration with other Diversity, Equity, and Inclusion (DEI) efforts to increase diversity among licensed staff and leadership. Lastly, concern was expressed that two years for implementation may not be long enough to adequately implement ASAM third edition and the State's standards.

Attendees self-report statistics:

- An individual eligible for Medicaid — one attendee.

- Five attendees were interested parties.
- 32 attendees were Medicaid enrolled providers.
- 16 attendees were State agency staff.

Attendee rating of the current Connecticut SUD treatment system:

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

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

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

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

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

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

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

Feedback

1. Process

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

2. Workforce

- a. We underestimated how difficult it has been to hire licensed clinical staff, especially for residential staff. We are concerned with the geographical difficulties. It is hard to hire staff in both outpatient and residential settings. The lack of licensed staff will impact the ability to meet the standards, and could impact future audits. The lack of staff has increased pressure on program managers. We ask that State partners be aware of this.
- b. It has been extremely difficult to hire licensed clinical staff, especially for residential and outpatient settings. There is a concern about how this will impact the ability to meet the standards and future audits. This also places additional burden on the managers of the programs. There are currently vacancies for counselor positions and drug courts that require licensed staff.
- c. Providers have tried numerous recruitment strategies (e.g., signing bonuses, benefit package revisions, and partnerships with universities). The struggle with hiring issues are compounding other issues. Vacant counselor positions place pressure on pre-licensure individuals as well as managers and directors.
- d. Workforce recruitment remains a significant challenge because providers are facing incredible competition. It is challenging to meet guidelines and compliance with the workforce issues.

3. Length of Stay

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

4. Training

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

5. Authorization

- a. Please continue to revisit the authorization process to see if once implementation has passed that processes could be streamlined to further reduce those burdens.
- b. Residential authorizations have been a challenge, but are improving. Concurrent authorizations are the most challenging. Having the same expectations as commercial insurers may be more difficult in Medicaid and make access more difficult.

6. Flex beds

- a. We recommend allowing providers to flex the LOC that a bed can be certified for. Flexing the beds would allow members to remain in care where they are.
- b. Allowing for flex beds as the length of stay tightens up will keep an individual in treatment for longer periods.

7. Housing

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

8. DEI

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

9. Implementation Timelines and Flexibility

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

10. LADCs

- a. Will LADCs be covered?

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

Second Annual Post Award Forum

Summary

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

Details

The State held its second annual public forum on October 11, 2023. The forum was attended by 59 individuals of which 11 were SUD providers; 11 were contractors; two were members of the public; 24 were other State agency staff, eight were DSS staff, and one was unknown. The forum presentation was posted to the State's dedicated website for the Demonstration along with public comments received and the State's response, where applicable. Comments and responses are noted below and include topics on the progress of the Demonstration including access, program processes and requirements, provider certification, quality of chart audits, provider rates, workforce challenges; concerns around streamlining the rate structure; provider certification timelines; and concern around a reduction in available beds. Actual comments and responses:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Response: Thank you for the comment.

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

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

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

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

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

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

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

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

13. Rates: Regarding the rates, we are concerned that there does not appear to be a plan for their sustainability over time. While we were pleased that the State attempted to acknowledge the rapid inflation of costs that was happening as the rates were being

developed, the data upon which those rates were built is already several years old. Our economy is changing rapidly, and the market pressures related to the healthcare workforce have been significant over the last several years. The assumptions made in the rates regarding the salaries of staff are already woefully insufficient. While wage inflation has been significant, it is far from the only cost increase faced by providers. Without a plan or commitment to continue to adjust rates to account for inflation, this waiver could soon be inadequate to fund the service system it supports.

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

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

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

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

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

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

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

Third Annual Post Award Forum

Summary

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

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

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

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

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

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

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

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

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

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

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

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

6. We are providing ASAM 3.7 WM, Intensive Outpatient Program (IOP)/Partial Hospitalization Program (PHP), and are applying for methadone. We are very happy that ASAM has been implemented. The use of a standard assessment and treatment planning has improved SUD care in Connecticut. It has improved consistency, and it facilitates communication with Carelon. We also like that there is now an expectation of a multidisciplinary team.
7. We provide ASAM 3.7. Similar to RNP and Rushford, we are dealing with high levels of medical acuity at ASAM 3.7. We have a client who had severe sleep apnea and could not stay away in group. We were able to get him into a sleep study and address those needs.
Response: Thank you for your comment. We will take this back.
8. Further comments: Agreed! We are being asked to treat conditions that are out of our scope.
9. And will the slides be sent out after the meeting?

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

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

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

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

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

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

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

3. Providers have financial vulnerability to comply with all regulations.
4. Licensed Practical Nurses are not permitted to do nursing assessments? LADCs cannot give psychiatric diagnoses. Can the 1115 waiver override these issues?

Response: The 1115 waiver cannot override the Nurse/LADC practice act in the State. The State advocates will need to advocate for change at the legislature. Everyone should partner

together to advocate for needed reforms. Please send DMHAS a copy of a blank nursing assessment.

5. 100% of staff we hire are interns. To be able to hire interns, we need to be able to pay the interns for their internships.
6. Agencies need more staff to hire. Associate licensed staff can now go into independently licensed offices. This decimated the workforce. Independent practitioners can also do telehealth. We need more workforce development.

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

7. The 1115 reviews conflict with the Medicaid policy for outpatient care cited by DSS staff.
8. Providers have submitted recommendations about the 25% intern ratio. This waiver rule is a hindrance to the SUD operations. It is very hard to track and maintain.

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

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

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

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

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

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

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

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

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

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

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

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

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

16. Interns, Associates, and Medical Assistant (MA) licensed staff have very different training and permissions. While an associate license is pending, associates are allowed to provide clinical care with active oversight, but MA licensed staff are not.
17. IOP runs for three hours. Having a requirement like 1/3 would make more sense for the intern policy. Associate licenses are necessary for access. We are in the Southeast corner of the State. Clinics and private practices are now having a hard time finding individuals with associate licenses. In between MA level practitioners are working towards their licenses. The issue isn't the Associate licensed practitioners, it is the individuals with MA level.
18. ABH is auditing for this under the 1115 for IOP and PHP. Under the 1115 Demonstration, the MA level practitioner can't do anything.
19. We have lost experienced CADCs and had to hire interns. It is frustrating. We keep having this conversation and we need a fix.
 - General DSS response regarding Medicaid behavioral health outpatient service regulations (e.g., ASAM 1):
 - Originally group/solo practices could not hire associate or MA level practitioners. They can only bill the work that the practitioner does itself. However, the rules changed and now a group/solo practice can have an Associate level practitioner practicing if the licensed practitioner co-signs all notes and has a running log of a weekly meeting where all cases are discussed.
 - Behavioral health clinic settings can bill Connecticut Medicaid for MA level and Associate practitioners. The rate of supervision is outlined in the Medicaid regulations for unlicensed or associate licensed staff to do the work. There must be a meeting one time a week for supervision. The clinic is the billing entity with supervision from the Medicaid Director who is responsible for all care in the clinic.
20. Medicaid program does not have certification requirements for ASAM 1, only for higher more intensive level of care.
 - Certification is not required for providers only providing level of care Level 1 – Outpatient Services.
 - SUD intensive ambulatory and residential providers (i.e., all levels of care other than Level 1 – Outpatient Services) serving adults must be certified by the Connecticut DMHAS or its designee.
 - SUD intensive ambulatory and residential providers (i.e., all levels of care other than Level 1– Outpatient Services) serving children must be certified by DCF or its designee.

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

Fourth Annual Post Award Forum

Public Notice of Fourth Annual Post Award Forum

Notice of the fourth Annual Post Award forum was posted on the Secretary of State Public Meeting Calendar on July 30, 2025, at 1:28 pm EDT and the notice was posted on the DSS website on July 31, 2025, prior to 5:00 pm EDT at: <https://portal.ct.gov/dss/-/media/departments-and-agencies/dss/health-and-home-care/substance-use-disorder-demonstration-project/notice-of-2025-public-forum-and-agenda.pdf?rev=f5f27689f22642bea8c126b6dc9085c7&hash=1837E717C5C463BBFEC08E76793168AA>

Summary

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

There were three questions asked during the forum.

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

Responses:

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

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

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

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

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

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

Public Notice for the Extension Request

1. Connecticut provided an open comment period for public comments from December 9, 2025 – January 18, 2026.
2. The 30-day public comment period began on December 9, 2025, to January 17, 2026. Written comments at any of the public hearings or submitted by email were accepted until 5:00 pm EST. As of close of the comment period, the comments were included in Attachment 5, that pertain to the 1115 Demonstration submission.
3. Connecticut published a Public Notice in the Connecticut Law Journal on December 09, 2025 and again December 16, 2025. The notice can be found at Attachment 1. The notice included a summary description of the Demonstration, the location and times of the public hearings, information on different ways to provide comments, and an active link to the full public notice document on the State's website.
4. The State also published on its website the full public notice¹⁶ with information about public input process and planned hearings, the draft Demonstration renewal application, and a link to the Demonstration page on the CMS Website on December 16, 2025 with notice that comments would be accepted until January 18, 2026. Below is the link to access the public notice posting, Demonstration Extension application draft, and the full public notice.

Connecticut's Draft 1115 Demonstration Extension and public hearing information are posted to the DSS website at this link:

<https://portal.ct.gov/dss/-/media/departments-and-agencies/dss/health-and-home-care/substance-use-disorder-demonstration-project/ct-section1115-demonstration-extension-application.pdf?rev=cc2bf3fcd8004d74a57b8628604e042f&hash=03433EBE4A5C253EA262EB8726D4A897>

5. Connecticut certifies that it used an electronic mailing list to notify the public. Connecticut used the electronic mailing list that is used for the Medical Assistance Program Oversight Council (MAPOC) to email the Abbreviated Public Notice, Full Public Notice, and Extension Application. The brief public notice was also used by all State agencies to notify stakeholders via their listservs. The Abbreviated Public Notice and a copy of the list serve email can be found at Attachment 3.
6. The State conducted two public hearings on the 1115 Demonstration Extension application including one in-person hearing with remote access. The first public hearings wwas held on December 22, 2025, from 10:00 A.M.-12:00 P.M. via web conference, teleconference, and/or in person at 55 Farmington Avenue, First Floor, Room 1011, Hartford, CT 06105. and one during the **MAPOC** via web conference and teleconference on January 9, 2026, from 1:00 P.M.-3:30 P.M. Public Hearing Slides can be found in Attachment 4. Additional information regarding the public hearings is included below. Members of the public will be invited to make comments in person via the telephone or the virtual platform, Zoom as follows:.

PublicHearingwithoptionalvirtualWebinarHostedbyDSS

December 22, 2025

Time: 10:00 A.M. – 12:00 P.M.

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

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

Web Conference/Teleconference:

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

Meeting ID: 867 8537 9034
Passcode: 988428

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

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

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

PublicHearingConvenedbytheConnecticutGeneralAssemblyMedical AssistanceProgramOversightCouncil

January 9, 2026

Time: 1:00 P.M. – 3:30 P.M.

Join Zoom Meeting

<https://zoom.us/j/97350054937?pwd=JCoO97AjaR2cbVSgXNEZjAx5lV2nt2.1>

Meeting ID: 973 5005 4937

Passcode: 919295

One tap mobile:

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

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

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

7. A **summary of public comments** and feedback from commenters received during the public comment period is provided in Attachment 5.
8. The 30-day tribal comment period began on February 2, 2026 and will go until March 4, 2026. **Tribal notice** can be found at Attachment 6. Written comments or submitted by email will be accepted until 5:00 pm EST. The comments will be included in Attachment 7, that pertain to the 1115 Demonstration submission. Connecticut has two federally recognized tribes, the Mashantucket Pequot Tribal Nation and the Mohegan Tribe. The State has solicited feedback from both tribes by sending emails to the tribal representatives with a copy of the public notice, plus a copy of the budget neutrality, and waiver application (as well as a link to the DSS website with the relevant documents). This process follows the State's approved tribal consultation State Plan Amendment. Comments will be included in the Attachment 7.
9. After review of the comments and concerns, there were no changes to the renewal.
10. An additional 30 day public notice through the Legislative Process occurred beginning on February 4, 2026. A public Legislative Hearing was held on February X, 2026.

Section IX. Demonstration Amendment Contact

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

Telephone Number: 860-424-5077

Email Address: william.halsey@ct.gov

DEPARTMENT OF SOCIAL SERVICES

**Abbreviated Notice of Proposed Medicaid and
Children's
Health Insurance Program**

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

Pursuant to section 17b-8 of the Connecticut General Statutes and 42 C.F.R. § 431.408, the Department of Social Services (DSS) provides notice that it intends to submit to the Centers for Medicare & Medicaid Services (CMS) a Substance Use Disorder (SUD) Demonstration Waiver Extension pursuant to Section 1115 of the Social Security Act for Connecticut's Medicaid Program and Children's Health Insurance Program (CHIP) (Demonstration). Connecticut is seeking federal approval to extend its Medicaid SUD Demonstration Waiver, effective on April 1, 2027 to March 31, 2032. The Extension requests no changes to the SUD portion of the demonstration, except for a minor technical correction to the HUSKY A Medicaid eligibility group, for budget neutrality, to account for increased costs associated with non-SUD services. All pending amendments, including the amendment to implement a "Re- entry Initiative" to better support individuals' reentry from incarceration to the community (including addressing social determinants of health (SDoH) for individuals reentering the community), are proposed to be incorporated into the amendment (or extended authorization if the amendment is approved prior to the renewal).

Connecticut's Draft 1115 Demonstration Extension and public hearing information are posted to the DSS website at this link:

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

Please check this website regularly for updates. Public comment and public hearing information are included at the bottom of this notice. The public comment period will be open for 30 days from December 9, 2025 to January 10, 2026.

Description of Demonstration Waiver

This Demonstration was originally approved on April 14, 2022, and was the result of a collaborative effort among various State agencies and other partners, including the three partner State agencies of the Connecticut Behavioral Health Partnership: DSS, Connecticut’s single State agency for Medicaid and CHIP; the Department of Children and Families (DCF), the lead State agency for children’s behavioral health; and the Department of Mental Health and Addiction Services (DMHAS), the single State agency for adult behavioral health. Connecticut’s Medical Assistance Program (CMAP) includes the state’s Medicaid program and CHIP.

The Demonstration was a comprehensive project to enhance the State’s SUD service system in accordance with federal guidance. The Demonstration enables federal financial participation (FFP) Medicaid and CHIP matching funds for individuals receiving SUD services residing in Institutions for Mental Diseases that would ordinarily not be covered under federal law.

The Demonstration implements CMS guidance for SUD 1115 demonstration waivers, set forth in CMS State Medicaid Director Letter (SMD) #17-003, “Strategies to Address the Opioid Epidemic”, posted on the CMS website at this link: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>. Additional information about SUD 1115 demonstrations, including a list of other states that have already established a SUD 1115 demonstration, is posted to the CMS website at this link:

<https://www.medicaid.gov/medicaid/section-1115-demonstrations/substance-use-disorder-section-1115-demonstration-opportunity>.

The Re-entry Initiative portion of the Demonstration is the result of a collaborative effort among various state agencies and other partners, including DSS, Connecticut's single State agency for Medicaid and CHIP; the Department of Correction (DOC), the single State agency for the administration of carceral facilities; the Judicial Branch, the Department of Developmental Disabilities (DDS), the Department of Children and Families (DCF), the Department of Housing (DOH), and the Department of Mental Health and Addiction Services (DMHAS), the lead State agency for adult behavioral health. On March 27, 2024, the State submitted an amendment application requesting authority for a reentry initiative and SDoH, and it is currently pending with CMS. The state is seeking the authorities detailed in the amendment application as a part of this extension. The Re-entry Initiative is intended to be effective on or after July 1, 2026, upon CMS approval, with a renewal under this Extension from April 1, 2027 through March 31, 2032.

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

The State also intends to help address unmet needs related to a lack of adequate housing support, consistent with CMS guidance on SDoH, available on the CMS website at

this link: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/health-related-social-needs>.

SUD Program Description, Including Affected CMAP Members

CMAP enrollment did not change as a result of this Demonstration. As detailed above, the Demonstration enables CMAP coverage for individuals with SUD, who are residing in Institutions for Mental Diseases for which coverage would otherwise be prohibited under federal law. The Demonstration ensured that enhancements in the SUD service system were implemented. In accordance with CMS guidance, the Demonstration ensures that a complete American Society of Addiction Medicine levels of care service array is available as part of an essential continuum of care for Medicaid-enrolled individuals with opioid use disorder and other SUDs.

Re-entry Initiative and SDoH Program Description

The Re-entry Initiative enables Medicaid coverage and FFP using Medicaid and CHIP matching funds for adults incarcerated in correctional centers (jails and courthouses) and correctional institutions (prisons), and for youth detained in juvenile and community residential centers throughout the State receiving a targeted benefit package that would ordinarily not be covered under federal law. This Re-entry Initiative ensures a continuum of care strategy that enables robust coordination, service provision, and community connections after release.

The SDoH program enables Medicaid coverage and FFP for the eligible reentry population using Medicaid and CHIP matching funds. Services to address SDoH include rent/temporary housing, utility costs, pre-tenancy and tenancy sustaining services, housing transition navigation services, one-time transition and moving costs, housing deposits, medically necessary equipment, and medically necessary home accessibility and remediation services. Connecticut also requests authority to claim FFP in SDoH infrastructure investments to support the development

and implementation of Justice Initiative SDoH services, not to exceed 15% of the total Justice Initiative SDoH spend.

Where the Demonstration is Posted

The Demonstration Extension and related materials, including the Demonstration Waiver Extension, Interim Evaluation, and Budget Neutrality Summary, are posted on the DSS website at this link: <https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project>. Paper or electronic copies of the extension application and related materials may be obtained by emailing a request to Public.Comment.DSS@ct.gov or by writing to DSS, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. The proposed Demonstration Extension and related materials may also be obtained upon request at any DSS field office or the Town of Vernon Social Services Department.

Where and When to Submit Written Comments

To send comments about the Demonstration Extension, please email: Public.Comment.DSS@ct.gov or write to: Department of Social Services, Medical Policy Unit - SUD, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. In any correspondence, please reference “SUD 1115 Demonstration Waiver Extension.” Also, please send any other questions about the Demonstration to this contact information, including requests for a copy of the Demonstration (and/or related materials).

Anyone may send DSS written comments about the Demonstration Extension. Written comments must be received by DSS at the above contact information no later than January 18, 2026 (which is more than 30 days after the date of the publication of this notice in the Connecticut Law Journal). Please note that comments received will also be posted to the same website referenced above.

Public Hearings

In addition to the opportunity for anyone to send DSS written comments noted above, there will also be one in-person hearing (with an optional virtual platform for people to attend remotely) and one electronically convened public hearing to afford anyone the opportunity to provide DSS with verbal comments. Members of the public will be invited to make comments in-person via the telephone or the virtual platform, Zoom, as follows:

Public Hearing with optional virtual Webinar Hosted by DSS

December 22, 2025

Time: 10:00 A.M. – 12:00 P.M.

In-person at: 55 Farmington Avenue, First Floor, Room 1011, Hartford, CT 06105.

Web Conference/Teleconference:

Topic: Substance Use Disorder Demonstration Waiver Extension

Public Hearing

Join Zoom Meeting

<https://us06web.zoom.us/j/86785379034?pwd=WKIMSuKbiUuDK2Dun4TXSnBB0B3r2z.1>

Meeting ID: 867 8537 9034

Passcode: 988428

One tap mobile

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

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

Join instructions

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

Public Hearing Convened by the Connecticut General Assembly

Medical Assistance Program Oversight Council**January 9, 2026****Time: 1:00 P.M. – 3:30 P.M.****Join Zoom Meeting**

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

Meeting ID: 973 5005 4937**Passcode: 919295****One tap mobile:****+19292056099,,97350054937#,,,,*919295# US (New York)****+13017158592,,97350054937#,,,,*919295# US (Washington
DC)****Join instructions**

https://zoom.us/meetings/97350054937/invitations?signature=sH8AktJXumdvo7QBKhrk2VkzH_OLQYL9ZZxfXxE1nU

NOTICE OF CONNECTICUT STATE AGENCIES

DEPARTMENT OF SOCIAL SERVICES

CORRECTED - Previously Published Abbreviated Notice of Proposed Medicaid and Children's Health Insurance Program

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

Pursuant to section 17b-8 of the Connecticut General Statutes and 42 C.F.R. § 431.408, the Department of Social Services (DSS) provides notice that it intends to submit to the Centers for Medicare & Medicaid Services (CMS) a Substance Use Disorder (SUD) Demonstration Waiver Extension pursuant to Section 1115 of the Social Security Act for Connecticut's Medicaid Program and Children's Health Insurance Program (CHIP) (Demonstration). Connecticut is seeking federal approval to extend its Medicaid SUD Demonstration Waiver, effective on April 1, 2027 to March 31, 2032. The Extension requests no changes to the SUD portion of the demonstration, except for a minor technical correction to the HUSKY A Medicaid eligibility group, for budget neutrality, to account for increased costs associated with non-SUD services. All pending amendments, including the amendment to implement a "Re- entry Initiative" to better support individuals' reentry from incarceration to the community (including addressing social determinants of health (SDoH) for individuals reentering the community), are proposed to be incorporated into the amendment (or extended authorization if the amendment is approved prior to the renewal).

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

Please check this website regularly for updates. **Public comment and public hearing information are included at the bottom of this notice.** The public comment period will be open for 30 days from December 17, 2025 to January 18, 2026.

Description of Demonstration Waiver

This Demonstration was originally approved on April 14, 2022, and was the result of a collaborative effort among various State agencies and other partners, including the three partner State agencies of the Connecticut Behavioral Health Partnership: DSS, Connecticut's single State agency for Medicaid and CHIP; the Department of Children and Families, the lead State agency for children's behavioral health; and the Department of Mental Health and Addiction Services, the single State agency for adult behavioral health. Connecticut's Medical Assistance Program (CMAP) includes the state's Medicaid program and CHIP.

The Demonstration was a comprehensive project to enhance the State's SUD service system in accordance with federal guidance. The Demonstration enables federal financial participation (FFP) Medicaid and CHIP matching funds for individuals receiving SUD services residing in Institutions for Mental Diseases that would ordinarily not be covered under federal law.

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The Re-entry Initiative portion of the Demonstration is the result of a collaborative effort among various state agencies and other partners, including DSS, Connecticut's single State agency for Medicaid and CHIP; the Department of Correction, the single State agency for the administration of carceral facilities; the Judicial Branch, the Department of Developmental Disabilities, the Department of Children and Families, the Department of Housing, and the

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

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

The State also intends to help address unmet needs related to a lack of adequate housing support, consistent with CMS guidance on SDoH, available on the CMS website at this link: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/health-related-social-needs>.

SUD Program Description, Including Affected CMAP Members

CMAP enrollment did not change as a result of this Demonstration. As detailed above, the Demonstration enables CMAP coverage for individuals with SUD, who are residing in Institutions for Mental Diseases for which coverage would otherwise be prohibited under federal law. The Demonstration ensured that enhancements in the SUD service system were implemented. In accordance with CMS guidance, the Demonstration ensures that a complete American Society of Addiction Medicine levels of care service array is available as part of an essential continuum of care for Medicaid-enrolled individuals with opioid use disorder and other SUDs.

Re-entry Initiative and SDoH Program Description

The Re-entry Initiative enables Medicaid coverage and FFP using Medicaid and CHIP matching funds for adults incarcerated in correctional centers (jails and courthouses) and correctional institutions (prisons), and for youth detained in juvenile and community residential centers throughout the State receiving a

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Where the Demonstration is Posted

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Anyone may send DSS written comments about the Demonstration Extension. Written comments must be received by DSS at the above contact information no later than January 18, 2026 (which is more than 30 days after the date of the publication of this notice in the Connecticut Law Journal). Please note that comments received will also be posted to the same website referenced above.

Public Hearings

In addition to the opportunity for anyone to send DSS written comments noted above, there will also be one in-person hearing (with an optional virtual platform for people to attend remotely) and one electronically convened public hearing to afford anyone the opportunity to provide DSS with verbal comments. Members of the public will be invited to make comments in-person via the telephone or the virtual platform, Zoom, as follows:

Public Hearing with optional virtual Webinar Hosted by DSS

December 22, 2025

Time: 10:00 A.M. – 12:00 P.M.

In-person at: 55 Farmington Avenue, First Floor, Room 1011, Hartford, CT 06105.

Web Conference/Teleconference:

Topic: Substance Use Disorder Demonstration Waiver Extension
Public Hearing

Join Zoom Meeting

<https://us06web.zoom.us/j/86785379034?pwd=WKIMSuKbiUuDK2Dun4TXSnBB0B3r2z.1>

Meeting ID: 867 8537 9034

Passcode: 988428

One tap mobile

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

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Join instructions

<https://us06web.zoom.us/meetings/86785379034/invitations?signature=9yOtksi4kL1dnL-QybU-89TMqQE1JfziiQgIIWNSIM8>

**Public Hearing Convened by the Connecticut General
Assembly Medical Assistance Program Oversight Council**

January 9, 2026

Time: 1:00 P.M. – 3:30 P.M.

Join Zoom Meeting

<https://zoom.us/j/97350054937?pwd=JCoO97AjaR2cbVSgXNEZjAx5lV2nt2.1>

Meeting ID: 973 5005 4937

Passcode: 919295

One tap mobile:

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

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

Join instructions

https://zoom.us/meetings/97350054937/invitations?signature=sah8AktJXumdv07QBKhrk2VkzH_OLQYL9ZZxfXxE1nU

State of Connecticut Department of Social Services
Notice of Proposed Medicaid and CHIP Substance Use Disorder Sec. 1115 Demonstration Waiver
Extension Page 1

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid and Children's Health Insurance Program

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

Connecticut is seeking federal approval to extend its Medicaid Substance Use Disorder (SUD) Demonstration Waiver, effective on April 1, 2027, to March 31, 2032. The Extension requests no changes to the SUD portion of the demonstration, except for a minor technical correction to the HUSKY A Medicaid eligibility group, for budget neutrality, to account for increased costs associated with non-SUD services. All pending amendments, including the amendment to implement a "Re- entry Initiative" to better support individuals' reentry from incarceration to the community (including addressing social determinants of health (SDoH) for individuals reentering the community) are proposed to be incorporated into the amendment (or extended authorization if the amendment is approved prior to the renewal).

Connecticut's Draft 1115 Demonstration Extension and public hearing information are posted to the Department of Social Services (DSS) website at this link:

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

Please check this website regularly for updates. **Public comment and public hearing information are included at the bottom of this notice.** The public comment period will be open for 30 days from December 9, 2025, to January 10, 2026.

Description of Demonstration Waiver

Pursuant to Section 17b-8 of the Connecticut General Statutes and 42 C.F.R. § 431.408, DSS provides notice that it intends to submit to CMS a SUD Demonstration Waiver Extension pursuant to Section 1115 of the Social Security Act for Connecticut's Medicaid Program and Children's Health Insurance Program (CHIP) (Demonstration). This Demonstration was originally approved on April 14, 2022, and was the result of a collaborative effort among various State agencies and other partners, including the three partner State agencies of the Connecticut Behavioral Health Partnership: DSS, Connecticut's single State agency for Medicaid and CHIP; the Department of Children and Families, the lead State agency for children's behavioral health; and the Department of Mental Health and Addiction Services, the single State agency for adult behavioral health. Connecticut's Medical Assistance Program (CMAP) includes the state's Medicaid program and CHIP.

The Demonstration was effective on April 14, 2022, upon CMS approval, and is a comprehensive project to enhance the state's SUD service system in accordance with federal guidance. The Demonstration enables federal financial participation (FFP) Medicaid and CHIP matching funds for individuals receiving SUD services residing in Institutions for Mental Diseases (IMDs) that would ordinarily not be covered under federal law.

The Demonstration implements CMS guidance for SUD 1115 demonstration waivers, set forth in CMS State Medicaid Director Letter (SMD) # 17-003, “Strategies to Address the Opioid Epidemic”, posted on the CMS website at this link: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>. Additional information about SUD 1115 demonstrations, including a list of other states that have already established a SUD 1115 demonstration, is posted to the CMS website at this link: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/substance-use-disorder-section-1115-demonstration-opportunity>.

The Re-entry Initiative portion of the Demonstration is the result of a collaborative effort among various State agencies and other partners, including DSS, Connecticut’s single State agency for Medicaid and CHIP; the Department of Corrections, the single State agency for the administration of carceral facilities; the Judicial Branch, the Department of Developmental Disabilities, the Department of Children and Families, the Department of Housing, and the Department of Mental Health and Addiction Services, the lead State agency for adult behavioral health. On March 27, 2024, the State submitted an amendment application requesting authority for a reentry initiative and SDoH, and it is currently pending with CMS. The state is seeking the authorities detailed in the amendment application as a part of this extension. The Re-entry Initiative is intended to be effective on or after July 1, 2026, upon CMS approval, with a renewal under this Extension from April 1, 2027, through March 31, 2032.

The Re-entry Initiative implements the CMS’ guidance for Re-entry 1115 demonstration waivers, set forth in CMS SMD #23-003, “Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated”, posted on the CMS website at this link: <https://www.medicaid.gov/sites/default/files/2023-04/smd23003.pdf>.

Consistent with CMS guidance on SDoH, which is posted to the CMS website at this link: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/health-related-social-needs>, the State also intends to help address unmet needs related to a lack of adequate housing support:

(A) The program description, goals, and objectives to be implemented or extended under the demonstration project, including a description of the current or new beneficiaries who will be impacted by the demonstration.

SUD Program Description, Including Affected CMAP Members

CMAP enrollment did not change as a result of this Demonstration. As detailed above, the Demonstration enables CMAP coverage for individuals with SUD, who are residing in IMDs for which coverage would otherwise be prohibited under federal law. The Demonstration ensured that enhancements in the SUD service system are implemented. In accordance with CMS guidance, the Demonstration ensures a complete American Society of Addiction Medicine

(ASAM) levels of care service array is available as part of an essential continuum of care for Medicaid-enrolled individuals with opioid use disorder (OUD) and other SUDs.

Re-entry Initiative and SDoH Program Description

The Re-entry Initiative enables Medicaid coverage and FFP using Medicaid and CHIP matching funds for adults incarcerated in correctional centers (jails and courthouses) and correctional institutions (prisons), and youth detained in juvenile and community residential centers throughout the State receiving a targeted benefit package that would ordinarily not be covered under federal law. This Re-entry Initiative ensures a continuum of care strategy that enables robust coordination, service provision, and community connections after release.

The Social Determinants of Health (SDoH) program enables Medicaid coverage and FFP for the eligible reentry population using Medicaid and CHIP matching funds. Services to address SDoH include rent/temporary housing, utility costs, pre-tenancy and tenancy sustaining services, housing transition navigation services, one-time transition and moving costs, housing deposits, medically necessary equipment, and medically necessary home accessibility and remediation services. Connecticut also requests authority to claim FFP in SDoH infrastructure investments to support the development and implementation of justice-involved SDoH services, not to exceed 15% of the total justice-involved SDoH spend.

SUD Goals/Objectives

The Demonstration includes the following goals, all of which are designed to improve services and quality of life for CMAP members with SUD:

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

There were 18,489 unique Medicaid individuals served under the Demonstration from Demonstration year 1 through the first quarter of Demonstration year 4. There were a non-material number of CHIP individuals who received services under the Demonstration.

Re-entry and SDoH Goals/Objectives

Consistent with the CMS goals as outlined in SMD #23-003, Connecticut's specific goals for the Re-entry and SDoH Initiatives are to:

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

SDoH conditions contribute to poor health for individuals transitioning from correctional centers (jails and courthouses), correctional institutions (prisons), and juvenile and community residential centers throughout the state, and addressing them is key to successful reentry.

Current and New Beneficiaries Impacted by the Re-entry and related SDoH Initiative

To receive services under the Re-entry Initiative, including related services to address SDoH, a beneficiary must meet the following qualifying criteria:

- Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a State correctional system, including all correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile and community residential centers; and
- Be enrolled in Medicaid or otherwise eligible for CHIP, if not for their incarceration status; and
- Identified as expected to be released in the next 90 days and identified for participation in the Demonstration; AND

- Have one of the following conditions:
 - Is an individual incarcerated in a juvenile and/or community residential center; or
 - Is an adult and meets one or more of the following diagnosis or population requirements:
 - Mental illness;
 - SUD;
 - Co-occurring mental illness/SUD;
 - Chronic condition or significant non-chronic clinical condition;
 - Intellectual disability;
 - Acquired brain injury, including traumatic brain injury;
 - Positive test or diagnosis of HIV/AIDS; or
 - Currently pregnant or within a 12-month postpartum period.

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

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

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

Possible Medicaid programs include, but are not limited to:

1. Temporary Assistance for Needy Families or related groups, including children, parents, caretaker relatives and pregnant women (HUSKY A)
2. CHIP (HUSKY B)
3. Aged, blind, or disabled Medicaid or related groups (HUSKY C)
4. Adult Expansion Medicaid (HUSKY D)

(B) To the extent applicable, the proposed health care delivery system and the eligibility requirements, benefit coverage, and cost-sharing (premiums, co-payments, and deductibles) required of individuals that will be impacted by the Demonstration, and how such provisions vary from the State's current program features.

SUD

The Demonstration did not change the underlying HUSKY health program; in particular, it did not change the current CMAP fee-for-service delivery system, eligibility requirements, covered services, or cost-sharing. Connecticut's Medicaid program currently does not include any cost sharing. Connecticut's CHIP includes specified cost sharing for certain services.

The Demonstration did not change covered benefits, except that Connecticut was able to claim FFP to the state for individuals with SUD residing in IMDs. DSS submitted a Medicaid State Plan Amendment (SPA) during the Demonstration period to cover residential and inpatient treatment, as well as all levels of withdrawal management (ASAM levels 1 WM, 2-WM, 3.1, 3.2-WM, 3.3, 3.5, 3.7, 3.7 WM, 4).

Re-Entry and SDoH

The Re-entry Initiative does not change the underlying Medicaid program or CHIP; in particular, it does not change the current Connecticut fee-for-service delivery system, eligibility requirements, covered services, or cost sharing. Cost-sharing requirements do not differ from those provided under the State Plan for either Medicaid or CHIP.

The pre-release services authorized under the Re-entry Initiative include the provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth. All facilities must implement service level one, which includes the minimum CMS benefits. The State may begin claiming FFP for services covered through the initiative, expected to begin on or after July 1, 2026.

Service level one includes the following:

- Reentry transitional case management services to assess and address physical and behavioral health needs and SDoH;
- Medication-assisted treatment, for all Food and Drug Administration-approved medications, including coverage for counseling;
- Covered outpatient, prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid and CHIP State Plans) provided to the individual immediately upon release from the correctional facility (*note: medications under this service are reimbursed under State Plan authority and not the Demonstration*);

- Medications and medication administration;
- Screening for common health conditions within the incarcerated population, such as blood pressure, diabetes, hepatitis C, and HIV/AIDS; and
- Diagnosis and treatment for hepatitis C.

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

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

Allowable SDoH services for the Justice involved population include:

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

Administrative FFP will be available for the following activities related to justice-involved infrastructure development:

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

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

1. Pre-release Medicaid and CHIP application and enrollment processes for individuals who are not enrolled in Medicaid or CHIP prior to incarceration and who do not otherwise become enrolled during incarceration;
2. The screening process to determine a beneficiary's qualification for pre-release services;
3. The provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth. If a facility is not equipped to provide or facilitate the full set of pre-release services, the facility must provide a timeline of when it will be equipped to do so, including concrete steps and their anticipated completion dates that will be necessary to ensure that qualifying beneficiaries are able to receive timely any needed pre-release services;
4. Coordination among partners with a role in furnishing health care, housing, and SDoH services to beneficiaries, including, but not limited to, State agencies and State-contracted providers, as well as administrative services organizations, other behavioral health agencies, and community-based providers, including federally qualified health centers;
5. Appropriate reentry planning, pre-release care management, and assistance with care transitions to the community, including connecting beneficiaries to physical and

behavioral health providers and the administrative services organizations; making referrals to care management and community support providers that take place throughout the 90-day pre-release period; and providing beneficiaries with covered outpatient, prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid and CHIP State Plans);

6. Operational approaches related to implementing certain Medicaid and CHIP requirements, including, but not limited to, applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the Re-entry Initiative;
7. A data exchange process to support the care coordination and transition activities;
8. Reporting of requested data from DSS to support program monitoring, evaluation, and oversight; and
9. A staffing and project management approach for supporting all aspects of the facility's participation in the Re-entry Initiative, including information on the qualifications of the providers that the correctional system will partner with for the provision of pre-release services.

(C) An estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures, including historic enrollment or budgetary data, if applicable. This includes a financial analysis of any changes to the demonstration requested by the State in its extension request.

SUD

The Demonstration did not change annual CMAP enrollment or CMAP eligibility requirements. The Demonstration did not change the annual aggregate Medicaid and CHIP expenditures because it complied with federal budget neutrality requirements for SUD 1115 demonstration waivers. Utilization of Medicaid State Plan-covered services for individuals who receive SUD treatment services in an IMD was authorized only when DSS or its designee determined the admission and continued stay in a residential setting was medically necessary, including consideration of consistency with ASAM placement criteria and all other applicable requirements. Changes in the Medicaid State Plan-covered services and reimbursement were submitted in a separate SPA, as noted above, and any fiscal impact of those changes was part of the SPA, not this Demonstration.

Federal law in section 1115 requires the Demonstration to be budget-neutral to the federal government. In SMD #18-009, "Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects", posted on the CMS website at this link: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf>, CMS set forth budget-neutrality guidance for Section 1115 demonstration waivers. CMS notes in

SMD #18-009 (p. 6) that it has approved Medicaid payments for services to individuals residing in an IMD primarily to receive treatment for SUD, which would otherwise be coverable by Medicaid but for the federal law exclusion on Medicaid coverage for services in an IMD, as hypothetical expenditures. CMS applies hypothetical expenditures to a budget-neutrality test in which with-waiver and without-waiver costs are treated as the same, meaning the State is not required to account for separate savings to offset costs that would already be federally coverable under Medicaid but for the IMD exclusion.

Federal budget neutrality for this Demonstration was determined using per-member per-month CMAP expenditures for SUD IMD services for the following Medicaid Eligibility Groups within CMAP: HUSKY A (children and caretaker adult coverage groups), HUSKY C (aged, blind, and disabled coverage groups), and HUSKY D (low-income, adult Medicaid expansion coverage groups). HUSKY B (CHIP) expenditures were determined to be non-material and not included in the budget-neutrality test. The renewal application included a financial analysis of budget neutrality. The extension application includes a requested change to Husky A PMPMs.

Re-entry and SDoH

Prior to the Demonstration, Medicaid did not reimburse for medical services for adults incarcerated in correctional centers (jails and courthouses) or correctional institutions (prisons), nor for youth detained in juvenile and community residential centers (except for services provided while such individuals are patients in a medical institution, as authorized under Section 1905 of the Social Security Act). Under the Demonstration, through the Demonstration period ending March 31, 2032, there are 277,348 member months (approximately 26,000 individuals annually) that will receive a targeted benefit package 90 days pre-release, costing approximately \$1,477.54 per member per month. Ninety percent (90%) of all adults are expected to be in the HUSKY D eligibility category. Ten percent (10%) of adults are expected to be in the HUSKY A or HUSKY C eligibility categories. Out of the 26,000 individuals, 750 individuals are youth expected to be split between HUSKY A and C eligibility categories, with very few youth anticipated to be in the HUSKY C eligibility categories. A non-material number of youth are expected to be in HUSKY B (CHIP).

For SDoH, the Demonstration is projected to serve around 20% of individuals exiting Department of Corrections and JB-CSSD facilities. Those individuals can receive one-time only services, such as community transition services, rent/temporary housing for up to six months, and other services, such as tenancy sustaining support, for longer periods following discharge from the facility if Medicaid eligibility is maintained and the need for the SDoH support continues. It is estimated that there will be approximately 160,545 member months receiving services under the Demonstration Extension. The Demonstration estimates that rental assistance per person averages \$5,000 per person, tenancy supports average \$10,000 per person, and community transition services are capped at \$2,000 per person.

	Current	Future
Justice-involved Enrollment Member Months	\$0	277,348
Justice-involved Services	\$0	\$471,005,568
Justice-involved Non-Services	\$0	\$232,215,917
Justice-involved SDoH Enrollment Member Months	\$0	160,545
Justice-involved SDoH Services Total	\$0	\$249,968,565
Justice-involved SDoH Infrastructure	\$0	\$44,112,100

(D) The hypothesis and evaluation parameters of the demonstration.

SUD

Through a contract with an independent contractor, the State conducted an independent evaluation to measure and monitor the outcomes of the Demonstration in accordance with CMS guidance, focusing on the key goals and milestones of the Demonstration. It evaluated whether the CMAP SUD treatment system was more effective through a provision of a complete coordinated continuum of care using ASAM placement criteria and standards, including SUD residential treatment services. The researchers assessed the impact of providing the full continuum of SUD treatment services, particularly residential treatment, on hospital ED utilization, inpatient hospital utilization, and readmission rates. The Interim Demonstration Evaluation is included with the renewal and is available on the State's website.

Re-entry and SDoH

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

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

By providing Medicaid coverage prior to an individual's release from incarceration, the State will be able to bridge relationships between community-based Medicaid providers and justice-involved populations prior to release, thereby improving the likelihood that individuals with a history of behavioral health conditions and/or chronic diseases will receive stable and continuous care. The following hypotheses

and goals will be tested during the approval period:

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

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

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

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

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

1. Address unmet SDoH;

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

Data Source: Claims/encounter data.

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

(E) The specific waiver and expenditure authorities.

The specific waiver and expenditure authorities necessary to implement this demonstration are those that allow for the State to receive Medicaid and CHIP FFP for otherwise covered services furnished to otherwise eligible individuals, who are receiving treatment and withdrawal management services for SUDs in an IMD, which, absent this waiver, are not coverable in accordance with federal law.

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

Waivers Requested:

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

**Freedom of Choice Section 1902(a)(23)(A) 42 CFR
431.51**

To enable the State to require qualifying beneficiaries to receive pre-release services, as authorized under this Demonstration, through only certain providers.

Expenditure Authority Requested:

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

Where the Demonstration is Posted

The Demonstration Extension and related materials, including the Demonstration Waiver Extension, Interim Evaluation, and Budget Neutrality Summary, are posted on the DSS website at this link: <https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project>. Paper or electronic copies of the extension application and related materials may be obtained by emailing a request to Public.Comment.DSS@ct.gov or by writing to DSS, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. The proposed Demonstration Extension and related materials may also be obtained upon request at any DSS field office or the Town of Vernon Social Services Department.

Where and When to Submit Written Comments

To send comments about the Demonstration Extension, please email:

Public.Comment.DSS@ct.gov or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. In any correspondence, please reference “SUD 1115 Demonstration Waiver Extension.” Please also send any other questions about the Demonstration to this contact information, including requests for a copy of the

Demonstration (and/or related materials).

Anyone may send DSS written comments about the Demonstration Extension. Written comments must be received by DSS at the above contact information no later than January 11, 2026 (which is more than 30 days after the date of the publication of this notice in the Connecticut Law Journal). Please note that comments received will also be posted to the same website referenced above.

Public Hearings

In addition to the opportunity for anyone to send DSS written comments noted above, there will also be one in-person hearing (with an optional virtual platform for people to attend remotely) and one electronically convened public hearing to afford anyone the opportunity to provide DSS with verbal comments. Members of the public will be invited to make comments in person via the telephone or the virtual platform, Zoom as follows:

Public Hearing Convened by the Connecticut General Assembly Medical Assistance Program Oversight Council

December X, 2025; Join Zoom Meeting: <https://zoom.us/j/NCdz09>

• +1 646 931 3860 US, Meeting ID: XXXX XXXX, Passcode: XXXXXX

Public Hearing with optional virtual Webinar Hosted by DSS

January X, 2026: X:00 AM–X:00 PM;

In-person at: 55 Farmington Avenue, 9th Floor, Hartford, CT 06105.

Join Zoom Meeting: <https://us06web.zoom.us/j/>

• +1 646 931 3860 US; Meeting ID: XXXX XXXX, Passcode: XXXXXX

State of Connecticut Department of Social Services
Notice of Proposed Medicaid and CHIP Substance Use Disorder Sec. 1115 Demonstration Waiver
Extension Page 1

**STATE OF CONNECTICUT DEPARTMENT
OF SOCIAL SERVICES**

**Abbreviated Notice of Proposed Medicaid and Children's
Health Insurance Program**

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

Pursuant to section 17b-8 of the Connecticut General Statutes and 42 C.F.R. § 431.408, the Department of Social Services (DSS) provides notice that it intends to submit to the Centers for Medicare & Medicaid Services (CMS) a Substance Use Disorder (SUD) Demonstration Waiver Extension pursuant to Section 1115 of the Social Security Act for Connecticut's Medicaid Program and Children's Health Insurance Program (CHIP) (Demonstration). Connecticut is seeking federal approval to extend its Medicaid SUD Demonstration Waiver, effective on April 1, 2027, to March 31, 2032. The Extension requests no changes to the SUD portion of the demonstration, except for a minor technical correction to the HUSKY A Medicaid eligibility group, for budget neutrality, to account for increased costs associated with non-SUD services. All pending amendments, including the amendment to implement a "Re- entry Initiative" to better support individuals' reentry from incarceration to the community (including addressing social determinants of health (SDoH) for individuals reentering the community), are proposed to be incorporated into the amendment (or extended authorization if the amendment is approved prior to the renewal).

Connecticut's Draft 1115 Demonstration Extension and public hearing information are posted to the DSS website at this link:

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

Please check this website regularly for updates. **Public comment and public hearing information are included at the bottom of this notice.** The public comment period will be open for 30 days from December 9, 2025, to January 10, 2026.

Description of Demonstration Waiver

This Demonstration was originally approved on April 14, 2022, and was the result of a collaborative effort among various State agencies and other partners, including the three partner State agencies of the Connecticut Behavioral Health Partnership: DSS, Connecticut's single State agency for Medicaid and CHIP; the Department of Children and Families, the lead State agency for children's behavioral health; and the Department of Mental Health and Addiction Services, the single State agency for adult behavioral health. Connecticut's Medical Assistance Program (CMAP) includes the state's Medicaid program and CHIP.

The Demonstration was a comprehensive project to enhance the State's SUD service system in accordance with federal guidance. The Demonstration enables federal financial participation (FFP) Medicaid and CHIP matching funds for individuals receiving SUD services residing in Institutions for Mental Diseases that would ordinarily not be covered under federal law.

The Demonstration implements CMS guidance for SUD 1115 demonstration waivers, set forth in CMS State Medicaid Director Letter (SMD) #17-003, “Strategies to Address the Opioid Epidemic”, posted on the CMS website at this link: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>. Additional information about SUD 1115 demonstrations, including a list of other states that have already established a SUD 1115 demonstration, is posted to the CMS website at this link:

<https://www.medicaid.gov/medicaid/section-1115-demonstrations/substance-use-disorder-section-1115-demonstration-opportunity>.

The Re-entry Initiative portion of the Demonstration is the result of a collaborative effort among various state agencies and other partners, including DSS, Connecticut’s single State agency for Medicaid and CHIP; the Department of Correction, the single State agency for the administration of carceral facilities; the Judicial Branch, the Department of Developmental Disabilities, the Department of Children and Families, the Department of Housing, and the Department of Mental Health and Addiction Services, the lead State agency for adult behavioral health. On March 27, 2024, the State submitted an amendment application requesting authority for a reentry initiative and SDoH, and it is currently pending with CMS. The state is seeking the authorities detailed in the amendment application as a part of this extension. The Re-entry Initiative is intended to be effective on or after July 1, 2026, upon CMS approval, with a renewal under this Extension from April 1, 2027, through March 31, 2032.

The Re-entry Initiative implements CMS’ guidance for Re-entry 1115 demonstration waivers, set forth in CMS SMD # 23-003, “Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated”, posted on the CMS website at this link: <https://www.medicaid.gov/sites/default/files/2023-04/smd23003.pdf>.

The State also intends to help address unmet needs related to a lack of adequate housing support, consistent with CMS guidance on SDoH, available on the CMS website at this link: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/health-related-social-needs>.

SUD Program Description, Including Affected CMAP Members

CMAP enrollment did not change as a result of this Demonstration. As detailed above, the Demonstration enables CMAP coverage for individuals with SUD, who are residing in Institutions for Mental Diseases for which coverage would otherwise be prohibited under federal law. The Demonstration ensured that enhancements in the SUD service system were implemented. In accordance with CMS guidance, the Demonstration ensures that a complete American Society of Addiction Medicine levels of care service array is available as part of an

essential continuum of care for Medicaid-enrolled individuals with opioid use disorder and other SUDs.

Re-entry Initiative and SDoH Program Description

The Re-entry Initiative enables Medicaid coverage and FFP using Medicaid and CHIP matching funds for adults incarcerated in correctional centers (jails and courthouses) and correctional institutions (prisons), and for youth detained in juvenile and community residential centers throughout the State receiving a targeted benefit package that would ordinarily not be covered under federal law. This Re-entry Initiative ensures a continuum of care strategy that enables robust coordination, service provision, and community connections after release.

The SDoH program enables Medicaid coverage and FFP for the eligible reentry population using Medicaid and CHIP matching funds. Services to address SDoH include rent/temporary housing, utility costs, pre-tenancy and tenancy sustaining services, housing transition navigation services, one-time transition and moving costs, housing deposits, medically necessary equipment, and medically necessary home accessibility and remediation services. Connecticut also requests authority to claim FFP in SDoH infrastructure investments to support the development and implementation of Justice Initiative SDoH services, not to exceed 15% of the total Justice Initiative SDoH spend.

Where the Demonstration is Posted

The Demonstration Extension and related materials, including the Demonstration Waiver Extension, Interim Evaluation, and Budget Neutrality Summary, are posted on the DSS website at this link: <https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project>. Paper or electronic copies of the extension application and related materials may be obtained by emailing a request to Public.Comment.DSS@ct.gov or by writing to DSS, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. The proposed Demonstration Extension and related materials may also be obtained upon request at any DSS field office or the Town of Vernon Social Services Department.

Where and When to Submit Written Comments

To send comments about the Demonstration Extension, please email:

Public.Comment.DSS@ct.gov or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. In any correspondence, please reference “SUD 1115 Demonstration Waiver Extension.” Please also send any other questions about the Demonstration to this contact information, including requests for a copy of the Demonstration (and/or related materials).

Anyone may send DSS written comments about the Demonstration Extension. Written comments must be received by DSS at the above contact information no later than

January 11, 2026 (which is more than 30 days after the date of the publication of this notice in the Connecticut Law Journal). Please note that comments received will also be posted to the same website referenced above.

Public Hearings

In addition to the opportunity for anyone to send DSS written comments noted above, there will also be one in-person hearing (with an optional virtual platform for people to attend remotely) and one electronically convened public hearing to afford anyone the opportunity to provide DSS with verbal comments. Members of the public will be invited to make comments in-person via the telephone or the virtual platform, Zoom, as follows:

Public Hearing Convened by the Connecticut General Assembly Medical Assistance Program Oversight Council

December X, 2025: Join Zoom Meeting: <https://zoom.us/j/NCdz09>

• +1 646 931 3860 US, Meeting ID: XXXX XXXX, Passcode: XXXXXX

Public Hearing with optional virtual Webinar Hosted by DSS

January X, 2026: X:00 AM–X:00 PM;

In-person at: 55 Farmington Avenue, 9th Floor, Hartford, CT 06105.

Join Zoom Meeting: <https://us06web.zoom.us/j/>

• +1 646 931 3860 US; Meeting ID: XXXX XXXX, Passcode: XXXXXX

State of Connecticut Department of Social Services
Notice of Proposed Medicaid and CHIP Substance Use Disorder Sec. 1115 Demonstration Waiver
Extension Page 5

Join Instructions
https://portal.ct.gov/dss/health-and-home-care/substance-use-disorder-demonstration-project?language=en_US
https://portal.ct.gov/dss/health-and-home-care/substance-use-disorder-demonstration-project?language=en_US

Connecticut Substance Use Disorder 1115 Medicaid Waive Demonstration Extension Request



Marsocci, Jennifer <Jennifer.Marsocci@ct.gov>

To: ○ Madden, Lynn; ○ Freeman, Bob; ○ rcook@bhcare.org; ○ jfiorillo@bridgesmilford.org; ○ mkukulka@ccaoh.org;
○ Trine@coloradoars.com; ○ Thomas.Narducci@hhchealth.org; ○ mradhay@casaincct.org; **+289 others**
Cc: ○ Williams, Fatmata M.; ○ Mohammed, Alexis; ○ Massari, Hector; ○ Pallotto, Yvonne (NEMT); ○ LLOYD, KERI;
○ Halsey, William; ○ ROBLES, KRIS; ○ Haswell, Robert; ○ Michael; ○ SPRINGER, STEPHNEY; **+7 others**

Reply Reply All Forward ...

Tue 12/16/2025 12:07 PM

CT-SUD-1115-Renewal Abbreviated Public Notice.pdf .pdf File

CT-SUD-1115-Renewal Full Public Notice .pdf .pdf File

CT Section1115 Demonstration Extension Application.pdf .pdf File

On Behalf of the Department of Social Services:

Good Afternoon;

Attached please find the CT Section1115 Demonstration Extension Application, CT-SUD-1115-Renewal Abbreviated Public Notice, and CT-SUD-1115-Renewal Full Public Notice. Pursuant to section 17b-8 of the Connecticut General Statutes and 42 C.F.R. § 431.408, the Department of Social Services (DSS) provides notice that it intends to submit to the Centers for Medicare & Medicaid Services (CMS) a Substance Use Disorder (SUD) Demonstration Waiver Extension pursuant to Section 1115 of the Social Security Act for Connecticut's Medicaid Program and Children's Health Insurance Program (CHIP) (Demonstration). Connecticut is seeking federal approval to extend its Medicaid SUD Demonstration Waiver, effective on April 1, 2027, to March 31, 2032. The Extension requests no changes to the SUD portion of the demonstration, except for a minor technical correction to the HUSKY A Medicaid eligibility group, for budget neutrality, to account for increased costs associated with non-SUD services. All pending amendments, including the amendment to implement a "Re-entry Initiative" to better support individuals' reentry from incarceration to the community (including addressing social determinants of health (SDoH) for individuals reentering the community), are proposed to be incorporated into the amendment (or extended authorization if the amendment is approved prior to the renewal).

The Department of Social Services (DSS), in collaboration with the Department of Children and Families (DCF), the Department of Mental Health and Addiction Services (DMHAS), the Department of Corrections (DOC) and the Judicial Branch - Court Support Services Division (JBCSSD) proposes a SUD demonstration waiver extension pursuant to section 1115 of the Social Security Act (Demonstration). Connecticut's Draft 1115 Demonstration Extension request and public hearing information are posted to the DSS website at this link:
https://portal.ct.gov/dss/health-and-home-care/substance-use-disorder-demonstration-project?language=en_US.

Thank you

Connecticut SUD Medicaid 1115 Waiver Demonstration Extension Request Public Hearing

December 22, 2025



Agenda

1. Welcome and Opening Remarks
2. Meeting Information and Requests
3. State Partners
4. Description of Demonstration Waiver
 1. Substance Use Disorder Program Description
 2. Reentry Initiative and Social Determinants of Health Program Description
5. Hypothesis and Evaluation Parameters of the Demonstration
6. Specific Waiver and Expenditure Authorities
7. Where the Demonstration is Posted
8. Where and When to Submit Written Comments
9. Public Comment
10. Adjourn



Meeting Information and Requests

- Please enter your name and agency/organization (if you are attending on behalf of an agency/organization) in the chat.
- Please make sure you are muted during the meeting.
- Please raise your hand if you would like to comment during the public comment period.



3

Public Forum Information

- As a requirement of the 1115 Substance Use Disorder (SUD) Demonstration Extension, Connecticut must hold two public hearings within the 30-day public notice window to provide an opportunity for program stakeholders to give input and feedback on the Medicaid SUD 1115 Waiver including its amendments.
- One of the two hearings must be in-person or hybrid to allow in-person comments. The meetings will be held December 22 (hybrid) and January 9 (online in conjunction with CT MAPOC meeting).
- Public comment received today will be recorded, documented in the meeting minutes and responses to public comment will be posted to the DSS “Connecticut SUD 1115 Waiver Demonstration” page on ct.gov, Connecticut's Official State website, and on the Secretary of State website on the Public Meeting Calendar.
- Members of the public can also provide written comment by January 17 to Alexis.Mohammed@ct.gov.



4

State Partners

Department of Social Services (DSS)

- William Halsey – Medicaid Director
- Fatmata Williams – Deputy Director, Medicaid
- Trishan Lakha – Principal Cost Analyst
- Jennifer Marsocci – Project Manager
- Alexis Mohammed – Licensed Clinical Social Worker
- Yvonne Pallotto – Social Services Medical Administration Manager

Department of Children and Families (DCF)

- Kris Robles – Behavioral Health Clinical Manager
- Keri Lloyd – Behavioral Health Program Manager

Department of Corrections (DOC)

- Micah Mann – Parole Supervisor

Department of Mental Health and Addiction Services (DMHAS)

- Robert Haswell – Section Chief, Managed Services
- Shea Mitlehner – Behavioral Health Program Manager
- Kristy Messier – Behavioral Health Program Manager

Judicial Branch, Court Support Services Division (JBCSSD)

- Michael Aiello – Program Manager II

Mercer Government Solutions

- Brenda Jackson
- Laurie Klanchar, RN, MSN
- Shawn Thiele Sacks, LCSW



Description of Demonstration Waiver including Goals and Objectives and Impacted Beneficiaries

Substance Use Disorder Program Description



Connecticut SUD 1115 Medicaid Waiver History and Background — Substance Use Disorder Program Description

- As part of the US Department of Health and Human Services effort to combat the ongoing opioid crisis, CMS created an opportunity under the authority of section 1115(a) of the Social Security Act for states to demonstrate and test flexibilities to improve the SUD service system for beneficiaries.
- The purpose of this waiver is to allow coverage of residential and inpatient SUD services under HUSKY Health that have previously been excluded due to longstanding federal policies.
- Connecticut received CMS approval of the waiver on April 14, 2022, with a Demonstration approval period through March 2027.



7

Waiver Goals — Substance Use Disorder Program Description

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



8

Program Eligibility — Substance Use Disorder Program Description

This Demonstration removed Medicaid payment barriers for SUD residential and inpatient treatment, ensuring critical access for all coverage groups:

- HUSKY A — Medicaid for children, teens, parents, relative caregivers and pregnant women;
- HUSKY B — Children’s Health Insurance Program for children and teens up to age 19;
- HUSKY C — Medicaid for adults 65 and older and adults with disabilities, including long-term services and supports and Medicaid for Employees with Disabilities;
- HUSKY D — Medicaid for low-income adults without dependent children.



9

Delivery System — Substance Use Disorder Program Description

This Demonstration does not change the underlying HUSKY health program; in particular, it did not change the current CMAP fee-for-service delivery system, eligibility requirements, covered services, or cost-sharing. Connecticut’s Medicaid program currently does not include any cost sharing. Connecticut’s CHIP includes specified cost sharing for certain services.

The Demonstration did not change covered benefits, except that Connecticut is able to claim Federal Financial Participation to the state for individuals with SUD residing in Institutions for Mental Diseases and proposes to claim for individuals in carceral facilities and for SDOH services. DSS submitted a Medicaid State Plan Amendment (SPA) during the Demonstration period to cover residential and inpatient treatment, as well as all levels of withdrawal management (ASAM levels 1 WM, 2-WM, 3.1, 3.2-WM, 3.3, 3.5, 3.7, 3.7 WM, 4).



10

1115 Substance Use Disorder Demonstration Waiver Evaluation

- The independent evaluator for Connecticut’s SUD 1115 waiver demonstration is Mercer.
 - Mercer calculates the CMS-required SUD demonstration metrics following CMS technical specifications.
 - The metrics run three-months after the dates of services using the first of the following month for the “as of” date to have consistency and ensure the metrics are calculated based on a stable percentage of submitted claims.
 - Creating the metrics in this manner allows CMS to conduct valid comparisons across all states regardless of the date.
 - The dates of service for October 1–31, 2023, are reported “as of” February 1, 2024; November 1–30, 2023 dates of service “as of” March 1, 2024; and December 1–31, 2023 dates of service “as of” April 1, 2024.
 - The data are sent to Mercer, validated, compiled, metrics are calculated, and then the reports are written and submitted to CMS in September 2025.



11

Interim Evaluation — Conclusions

- The State has completed most activities in its implementation plan.
- The primary challenge remains the recruitment of new providers and expansion of existing provider capacity into new ASAM Levels of Care (LOCs).
- There has been a significant increase in utilization rates for residential, inpatient, and withdrawal management services, as well as overall admissions and lengths of stays for SUD. This has driven increases in SUD spending costs.
- The Demonstration has yet to see expected outcomes for people receiving services in terms of reductions in emergency department (ED) utilization and hospitalizations.
- The State has seen a statistically significant reduction in overdose deaths since the start of the Demonstration.
- Several care coordination challenges emerged in this evaluation related to transitions across different LOCs can be complicated due to lack of capacity and the needed LOC especially at LOC 3.1.
- Connections to primary/ambulatory care and follow-up after ED visits or hospital stays have declined under the Demonstration, underscoring the importance of improving care coordination efforts. Please note that the Department of Social Services, through the Connecticut Behavioral Health Partnership, has recently engaged in a contract with the Behavioral Health Administrative Services Organization (ASO) to offer proactive and targeted case management inclusive of individuals living with and recovering from SUDs. The new program was implemented October 1, 2025.



12

Interim Evaluation — Recommendations

Recommendations for the State, carried over from the midpoint assessment include:

- Continue to work with providers to explore flex-bed options to facilitate increased capacity for level 3.1 and level 3.5 LOCs. Continue to publicize and implement the residential rate adjustments made July 1, 2025.
- 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. Continue to publicize and implement the new Screening, Brief Intervention, and Referral to Treatment (SBIRT) coding and payments made July 1, 2025. Consider providing education in primary care settings for the new SBIRT coding and reimbursement.
- 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 enhancing regular meetings with State agencies and providers to move beyond policy and procedure updates and instead focus on problem-solving discussions for metrics that are not meeting Demonstration targets.
- Enhance bi-directional, problem-focused communications with providers and ASOs around managing care transitions across LOCs when bed capacity is limited. The State should ensure that ASAM LOCs focus on individualized treatment planning and not cost-control mechanisms.
- Communicate more information to providers when provider on-site reviews find areas of concern around quality of care (e.g., insufficient daily treatment dosage received by individuals) and use those opportunities to improve individualized care.
- Consider the following options to improve retention and continuity in care:
 - A targeted case management 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.



13

Description of Demonstration Waiver including Goals and Objectives and Impacted Beneficiaries

Reentry Initiative and Social Determinants of Health Program Description



14

Justice-Involved Waiver

History and Background

There is a long-standing prohibition in Medicaid that precludes Medicaid reimbursement for services provided to incarcerated individuals. This is known as the “inmate exclusion.”

In January 2023, California received approval from the Centers for Medicare and Medicaid Services (CMS) to waive the inmate exclusion rule with agreed-upon rules and procedures.

Currently, 19 states have been approved. Nine other states have Demonstrations pending.

In 2018, Congress passed the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act), which required the U.S. Department of Health and Human Services to guide states on how to seek 1115 demonstration authority to waive the inmate exclusion to improve care transitions to the community for incarcerated individuals.

CMS advised states to align Justice-Involved (JI) waiver applications with what has already been authorized if states want an expedited review of their applications.



15

Demonstration Goals — Reentry Program

Consistent with CMS' goals as outlined in the April 17, 2023, State Medicaid Directors' letter, Connecticut's specific goals for the reentry demonstration are to:

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



16

Connecticut's Waiver Application — Reentry Program

- Connecticut requested this authority, via an amendment to the SUD 1115 Demonstration Waiver, to design and implement a “Reentry Demonstration” that provides:
 - Medicaid coverage for eligible individuals in the state correctional system, including all correctional centers (jails and courthouses), and correctional institutions (prisons), and juvenile and community residential centers.
 - Eligible individuals include those with behavioral health needs, including mental health disorders and SUD, certain other health conditions, and detained youth.
 - Coverage period of up to **90 days** immediately prior to release from the correctional system.
 - An initial targeted benefit package to include case management services, medication-assisted treatment for SUD, a 30-day supply of medications upon release, and certain other supportive services being implemented in subsequent phase-ins.



17

Services are Needed

- Approximately 12,000 adults are released from correctional facilities per year.
 - It is estimated that 85% of adults will meet the waiver’s medical need criteria.
- Approximately 650 adolescents are released from juvenile and community residential centers per year.
- In 2022, Department of Correction (DOC) data analysis on the inmate population found:
 - 95.5% of the incarcerated population had at least one or more of the following:
 - A history of mental health disorders,
 - An active mental health disorder requiring treatment,
 - A history of SUD, or
 - An active substance use problem requiring treatment.
 - 80.8% of the incarcerated population had either an active mental health disorder requiring treatment, or an active SUD requiring treatment; 24.5% of the population had both.



18

Program Eligibility — Reentry Description

Youth	Adults
• All detained youth (under age 21) who are Medicaid eligible — no demonstrated health care need is required • Former Foster Care up to age 26	• Medicaid eligible • Meet one of the following health care need criteria: – Mental Illness – SUD – Chronic Conditions/Significant Clinical Condition – Intellectual or Developmental Disability – Acquired Brain Injury, including Traumatic Brain Injury – HIV/AIDS – Pregnant/Postpartum



19

Proposed Reentry Demonstration Services

Service Level 1: Five core services that must be operational at the start of the waiver

1. Transitional case management (pre- and post-release).
2. Medication-assisted treatment (MAT) for SUD.
3. 30-day supply of medications upon release.
4. Screening for common health conditions, such as blood pressure, diabetes, hepatitis C, and HIV.
5. Treatment for hepatitis C.

Service Level 2: Additional services to be implemented in Juvenile Facilities and eight adult facilities

- Physical and behavioral health clinical consultation.
- Laboratory and radiology services.
- Services by community health workers, to the extent covered under the Medicaid State Plan, including those with lived experience.
- Family planning services, including contraceptives and other birth control.
- Other services such as medications and medication administration; rehabilitative or preventive services, including those provided by community health workers; DME; and Social Determinants of Health (SDoH) such as housing supports.



20

Consolidated Appropriations Act, 2023

- Section 5121
 - In the 30 days prior to release, or within one week or as soon as practicable after release, screenings, diagnostic services and immunizations in accordance with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements.
 - Targeted case management services for Medicaid in the 30 days prior to release and for at least 30 days following release for Medicaid. This includes referrals to appropriate care and services in the geographic region of the home or residence for the eligible juvenile, where feasible.
- Section 5122
 - Connecticut will lift the Medicaid and CHIP eligibility exclusions for children who are incarcerated and pending disposition of charges.
 - States must ensure that all providers comply with Medicaid and CHIP provider participation and enrollment requirements.



21

Social Determinants of Health

Connecticut is requesting to cover certain housing related services and supports for the Justice-Involved population upon reentry to the community:

- One-time transition and moving costs (e.g., security deposit, first month's rent, utility activation fees, movers, relocation expenses, pest eradication, pantry stocking, and the purchase of household goods and furniture);
- Housing deposits to secure housing, including application and inspection fees and fees to secure needed identification;
- Medically necessary air conditioners, heaters, humidifiers, air filtration devices, generators, and refrigeration units as needed for medical treatment and prevention;
- Medically necessary home accessibility modifications and remediation services such as ventilation system repairs/improvements and mold/pest remediation; and
- Short-term rental assistance for homeless individual.



22

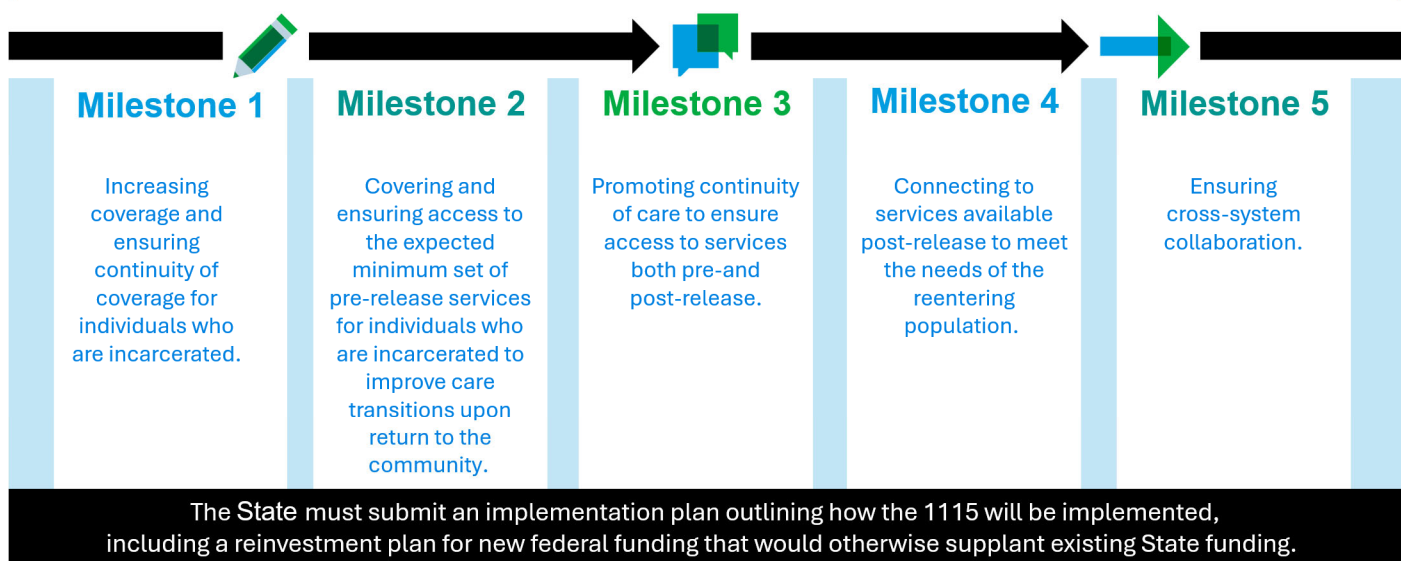
Demonstration Goals — Social Determinants of Health

- Social Determinants of Health (SDoH) conditions contribute to poor health for individuals transitioning from correctional centers (jails and courthouses), correctional institutions (prisons), and juvenile and community residential centers throughout the state, and addressing them is key to successful reentry.



23

CMS Reentry Milestones — Overview



24

DOC Facilities

Facilities with Service Level 1 & 2 plus CAA	Facilities which will initially have Service Level 1 plus CAA
- Garner - Manson YI* - Osborn CI - Robinson CI - Cybulski - York CI* *Priority facilities for CAA	- Bridgeport CC - Brooklyn CI - Cheshire CI - Corrigan CI - Hartford CC - New Haven CC - MacDougall-Walker RC



25

Juvenile Judicial Facility Types

Service Levels 1 & 2 plus CAA

Secure	Staff Secure	Residential
- Journey House (13) - Hamden (21) - Bridgeport Secure (17) - Hartford Secure (17) - Probation with Placement - Costs while in the Facility are Under Demonstration - Cost After Discharge (D/C) are Regular Medicaid - Annual number of discharges are in ()	- Two Unlocked Facilities: - REGIONS Waterbury (16) - REGIONS Hartford (13) - Probation with Placement - Costs while in the Facility are Under Demonstration - Cost After Discharge (D/C) are Regular Medicaid	- Three Facilities: - Connecticut Junior Republic CJR Litchfield Adolescent Male Intermediate Residential (AMIR) – (21) - Community Solutions, Inc Adolescent Female Intermediate Residential – girls (12) - CJR Litchfield Community Diversion and Respite Center (CDRC) – boys (41) - Traditional Probation - Staff Secure Facilities (up to 30 or 120 days or 4–6 months) - Costs while in the Facility are Under Demonstration - Cost After Discharge (D/C) are Regular Medicaid



26

Court Lock-up Facilities

Service Levels 1 & 3

17 court lockup facilities — Service Level 1 and 3

- 8 with Treatment Pathways Programs
- 17 with Jail Re-Interview Programs
- 17 with Mental Health Jail Diversion (Phased in DY7 April 1, 2028)

Service Level 1

- Reentry Transitional Case Management (RTCM) provided in the period up to 90 days immediately prior to the expected date of release.
- MAT for all types of SUD as clinically appropriate with accompanying counseling.
- 30 days of medications on hand.
- Medications and medication administration will be provided consistent with the State Plan.
- Screening, diagnosis, and treatment for hepatitis C consistent with Medicaid State Plan coverage for pharmacy, physician, laboratory, radiology, hospital.
- Screening for conditions (blood pressure, diabetes, hepatitis C, and HIV).

Service Level 3 (Mental Health Jail Diversion)

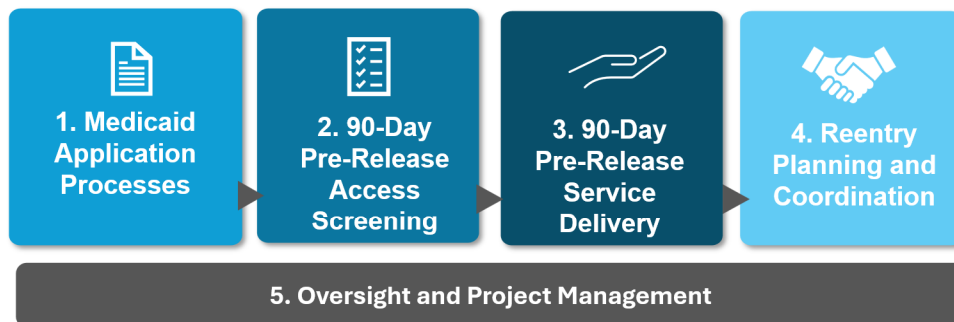
- Physical and behavioral health clinical consultation services.
- Rehabilitative or preventive services under the Medicaid State Plan.



27

Correctional Facility Readiness Assessment Approach

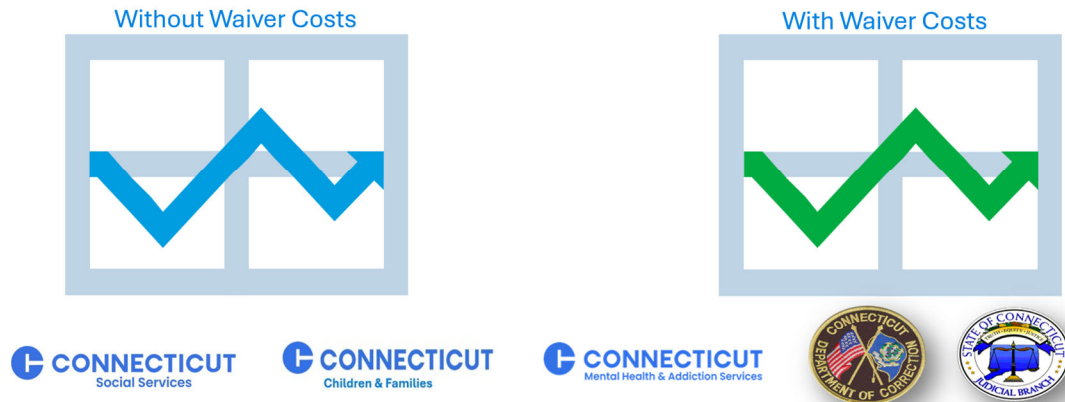
As a condition of the Demonstration, all prisons, courthouses, and juvenile facilities will be required to demonstrate readiness to participate in the justice-involved initiative prior to going live with pre-release services. The State's eligibility and behavioral health agencies will also be required to pass readiness. A readiness assessment process will focus on five key areas needed to operationalize 90-day pre-release services.



28

Federal Budget Neutrality

- CMS requires 1115 demonstration waivers to be budget neutral to the federal government.
- Federal Perspective: Hypothetical Costs on a Per Member Per Month (PMPM) Basis.
- Under SUD, Reentry, and SDoH 1115s, CMS allows states to treat service costs as if those costs were allowable under Medicaid (called Hypothetical Costs). The state is not liable for caseload growth.



29

Budget Neutrality and Reinvestment

- After three years, the Demonstration remains budget neutral which means that it is under the negotiated limit agreed to between the federal government and the State of Connecticut.
- Because of the type of Demonstration agreement, Connecticut does not accrue any federal savings under the Demonstration and must maintain levels of State spending on SUD prior to the Demonstration.
- As a condition of CMS approval of the Reentry Demonstration, Connecticut must commit to reinvesting all new federal dollars for services previously covered and paid for with state or local funds.



30

Illustrative Budget Neutrality Funding Calculation — Reentry Program

		Pre-Release — Total
Number of Member Months Served	(A)	51,000
Costs For Services	(B)	\$50,000,000*
Federal Portion	(B) * 86%	\$43,000,000**
State Portion	(B) * 14%	\$7,000,000

* Represents the amount reflected in the budget neutrality baseline amount (approximately \$50 million) for JI Services

** Represents the total amount of new federal funds for these pre-release services that will be reinvested into the system. 86% federal match percentage is calculated as:

- 90% Federal Match for 90% of the population (HUSKY D)
- 50% Federal Match for 10% of the population (non -HUSKY D)



31

Public Information on the Demonstration Waiver

Information on the waiver can be found here:

- [Substance Use Disorder Demonstration Project](https://portal.ct.gov/dss/health-and-home-care/substance-use-disorder-demonstration-project?language=en_US)

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

- [1115 Justice-Involved Demonstration Waiver](https://portal.ct.gov/dss/health-and-home-care/1115-justice-involved-demonstration-waiver?language=en_US)

https://portal.ct.gov/dss/health-and-home-care/1115-justice-involved-demonstration-waiver?language=en_US



32

Public Information on the Demonstration Waiver

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https://portal.ct.gov/dss/health-and-home-care/substance-use-disorder-demonstration-project?language=en_US
- [1115 Justice-Involved Demonstration Waiver](https://portal.ct.gov/dss/health-and-home-care/1115-justice-involved-demonstration-waiver?language=en_US)
https://portal.ct.gov/dss/health-and-home-care/1115-justice-involved-demonstration-waiver?language=en_US



32

Questions



33

Connecticut 1115 Public Hearing for the SUD Renewal

December 22, 2025

There were 11 individuals on the webinar and 5 individuals in person for the hybrid public hearing held on December 22, 2025. Five state agencies, one contractor, and one provider were represented in the attendees. After a 45-minute summary of the proposed renewal application, Connecticut remained in the hearing room and on the webinar link and received no comments.

Connecticut 1115 Renewal Public Hearing for SUD Renewal

January 9, 2026

There were seventy-five individuals on the webinar for the MAPOC public hearing held on January 9, 2026. Five Legislators, fourteen DSS staff, three other state agency representatives, one CMS representative, five DSS contractor staff, and multiple providers and advocates were represented in the attendees. After a 15-minute summary of the proposed renewal application received the following comments:

Question 1: Senator Lesser asked about the coverage of peer support under the Demonstration. Sabrina Trocchi, Wheeler Clinic, pointed out that there were no peer specialists in the outpatient levels of care. Research supports coverage of peer support in outpatient care. This is an area of concern and surrounding states cover this service.

Response: The Demonstration residential levels of care all include coverage of peer support and the Caelon contract includes peer support navigators for administrative assistance. Coverage of outpatient peer specialist services are on the DSS radar. DSS is considering coverage of peer specialists on a care management team.

Question 2: Senator Lesser asked about the status of the Reentry Initiative Amendment to the Demonstration.

Response: CMS has communicated that Connecticut should continue to answer questions regarding the Reentry Initiative and the Demonstration Amendment, which are subsumed into this demonstration renewal.

Question 3: Sheldon Toubman, Disability Rights of Connecticut, thanked DSS for its great work on the Demonstration and its commitment to continuing a fee-for-service delivery system (rather than Value-Based Purchasing) that pays providers fully for their work. In addition, he pointed out that historically there has been a concern of over institutionalization of individuals and that this Demonstration balances the need to treat SUD in larger facilities with that concern.

Response: Thank you for your support. DSS also would like to point out that there is a long-standing prohibition on Medicaid reimbursement for inmate care. DSS will be waiving a portion of that care (i.e., the last 90 days) to provide improved transition planning into the community.

Jackson, Brenda D

From: Mahoney, Ginny L. <Ginny.Mahoney@ct.gov>
Sent: Monday, February 2, 2026 12:25 PM
To: Vora, Setu K; Baumgart, Jared S; Mars, Heather A; Vital, Jennifer; Connie Hilbert; 'cjanus@moheganmail.com'; Teri McHale; 'Betty Ann MacDonald'; 'sjacobs@moheganmail.com'; sreels
Cc: Robinson-Rush, Dana; Holt, Catherine; Johnson, Colleen M; Mohammed, Alexis; Marsocci, Jennifer; Shields, Janice; Jackson, Brenda D; Henderson, Claudia; Halsey, William
Subject: RENOTICE: CT SUD 1115 Demonstration Waiver Extension - Tribal Notification
Attachments: CT-SUD-1115-Renewal Abbreviated Public Notice.pdf; CT-SUD-1115-Renewal Full Public Notice .pdf; CT Section1115 Demonstration Extension Application.pdf

CAUTION: This email originated outside the company. Do not click links or open attachments unless you are expecting them from the sender.

Dear Tribal Members,

Attached and below please find a reposting of the tribal notification with includes additional attachments and links which were missing from last week's tribal notification.

The Department of Social Services (DSS), in collaboration with the Department of Children and Families and the Department of Mental Health and Addiction Services, proposes a substance use disorder (SUD) demonstration waiver under Section 1115 of the Social Security Act (Demonstration). The Demonstration is a comprehensive project to enhance Connecticut's SUD services by ensuring a complete array of American Society of Addiction Medicine levels of care and enabling federal Medicaid and Children's Health Insurance Program (CHIP) matching funds for residential SUD services.

In addition to the SUD extension, DSS is requesting that the Centers for Medicare & Medicaid Services (CMS) include all pending amendments in the renewal (or extend those authorities if they are approved prior to the renewal). The pending amendment includes the Re-entry initiative that Connecticut would like to implement July 1, 2026. This Re-entry Initiative is the result of a collaborative effort among various State agencies and other partners, including DSS, Connecticut's single State agency for Medicaid and CHIP; the Department of Corrections, the single State agency for the administration of carceral facilities; the Judicial Branch, the Department of Developmental Disabilities, the Department of Children and Families, the Department of Housing, and the Department of Mental Health and Addiction Services, the lead State agency for adult behavioral health.

The Re-entry Initiative is intended to be effective upon CMS approval on or after July 1, 2026. The State requested to operate the Re-entry Initiative through the end of the current SUD Demonstration approval period, which is March 31, 2027. Once Demonstration authority and implementation documents are approved, the Re-entry Initiative will enable Medicaid coverage and federal financial participation using Medicaid and CHIP matching funds for adults incarcerated in correctional centers (jails and courthouses) and correctional institutions (prisons), and for youth detained in juvenile and community residential centers throughout the state receiving a targeted benefit package that would ordinarily not be covered under federal law. This Re-entry Initiative will ensure a continuum of care strategy that enables robust coordination, service provision, and community connections after release.

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

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

The Demonstration is described in more detail in the attached public notice (which was published, December 16, 2025, in the Connecticut Law Journal). **The tribal consultation period will last 30 days from now until March 4, 2026.**

Also attached are the draft waiver application and full public notice. These documents are also posted to the DSS website at this link: <https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project>.

Please let me know if you have any questions, and feel free to send any comments on the Demonstration prior to March 5, 2026. In addition, please also let me know if you would like to discuss the Demonstration with DSS. As described in the public notice, there is also a written public comment period and two public hearings in addition to this Tribal Consultation period. Thank you.

Please let me know if you have any questions or comments.

Thank you,



Ginny Mahoney

Health Prog. Supervisor, Medical Policy

[Connecticut Department of Social Services](https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project)

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From: Henderson, Claudia <Claudia.Henderson@ct.gov>

Sent: Friday, January 30, 2026 4:56 PM

To: Vora, Setu K <svora@mptn-nsn.gov>; Baumgart, Jared S <jbaumgart@mptn-nsn.gov>; Mars, Heather A <hamars@prxn.com>; Vital, Jennifer <jvital@mptn-nsn.gov>; Connie Hilbert <chilbert@moheganmail.com>; 'cjanus@moheganmail.com' <cjanus@moheganmail.com>; Teri McHale <tmchale@moheganmail.com>; 'Betty Ann MacDonald' <bmacdonald@moheganmail.com>

Cc: Mahoney, Ginny L. <Ginny.Mahoney@ct.gov>; Robinson-Rush, Dana <Dana.Robinson-Rush@ct.gov>; Holt, Catherine <Catherine.Holt@ct.gov>; Johnson, Colleen M <Colleen.Johnson@ct.gov>; Mohammed, Alexis <Alexis.Mohammed@ct.gov>; Marsocci, Jennifer <Jennifer.Marsocci@ct.gov>; Shields, Janice <Janice.Shields@ct.gov>

Subject: Tribal Notification of Renewal Request of Substance Use Disorder (SUD) Demonstration Waiver Extension Pursuant to Section 1115

Good afternoon,

The Department of Social Services (DSS) plans to submit the following renewal request of the [Substance Use Disorder \(SUD\) Waiver Extension Pursuant to Section 1115 of the Social Security Act](#) to the U.S. Centers for Medicare & Medicaid Services (CMS), which is summarized below:

Connecticut is seeking federal approval to extend its Medicaid Substance Use Disorder (SUD) Demonstration Waiver, effective on April 1, 2027, to March 31, 2032. The Extension requests no changes to the SUD portion of the demonstration, except for a minor technical correction to the HUSKY A Medicaid eligibility group, for budget neutrality, to account for increased costs associated with non-SUD services. All pending amendments, including the amendment to implement a “Re- entry Initiative” to better support individuals’ reentry from incarceration to the community (including addressing social determinants of health (SDoH) for individuals reentering the community) are proposed to be incorporated into the amendment (or extended authorization if the amendment is approved prior to the renewal).

As such, I am attaching the Connecticut Law Journal notice published on December 16, 2025, for which the 30-day public comment period has been completed for this waiver renewal request. Tribal comment period is open January 30 through March 31, 2026. Please submit comments to Alexis Mohammed at alexis.mohammed@ct.gov.

Please let me know if you have any questions or comments.

Thank you,



CLAUDIA V. HENDERSON

Staff Attorney

[Connecticut Department of Social Services](#)

Phone: 860-424-5841

claudia.henderson@ct.gov

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Attachment 7. Tribal Consultation Comments

Any comments received from tribes will be placed in this Attachment.