A-1: Population Description. Connecticut takes pride in the quality and effectiveness of its behavioral health system. It is consistently ranked by Mental Health America and other bodies as one of the top-performing systems in the country. Despite our relative successes, access to comprehensive outpatient behavioral health services remains a struggle for Connecticut residents with mental health and substance use disorders, and it is necessary that improvements be made. Connecticut has considered various models for redesigning outpatient behavioral health services, and we are excited by this opportunity to bring the Certified Community Behavioral Health Clinic (CCBHC) model to Connecticut. In Connecticut, the Medicaid program is locally branded as the HUSKY Health Program, and throughout this application, HUSKY Health will be used when referring to Connecticut Medicaid.

Population Demographics		
Group	**CT Total Population**	**HUSKY Health Membership**
Total Population	3,600,000	1,154,450
Youth (vs. adult)	20.2%	34.2%
Female Sex	51.0%	53.1%
Unknown	N/A	44.3%
White	78.4%	34.8%
Black	12.9%	17.1%
Asian	5.2%	3.2%
Native American/Alaskan Native	.003%	0.6%
Hispanic	18.2%	19.8%
Disability	25.7%	7.6%*
LGBTQ	4%	Unknown
* Disability is more narrowly defined for HUSKY C eligibility and is tied to an income limit.		

The demographics of the Connecticut total and HUSKY Health populations are summarized in the table to the left. The total population of Connecticut is 3.6 million, and 20.2% are youth aged 0-17, 51.0% are female, 78.4% are White, 12.9% are Black, 5.2% are Asian, and .003% are American Indian/Alaskan Native. Also, 18.2% identify as Hispanic or Latino. Roughly 25% of the state population has a disability, and this population has a rate of depression over three times the rate of those without a disability (43% vs.14%). There are two federally recognized Native American Tribal Communities in Connecticut and three other smaller tribal communities that are recognized by state statute but not federally. Youth, females, and those who identify as Black, Asian, or Hispanic are over-represented in the HUSKY Health population, and those who are White are under-represented. The six largest religious groups in Connecticut are Catholic, Protestant, Judaism, Mormon, Jehovah's Witnesses, and Islam. There are, however, many smaller minority religious groups in the state. Roughly 4% of individuals identify as Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ) which is below the 4.5% average for the country. Connecticut has three counties where the preponderance of communities is classified as rural based on population density. The current HUSKY Health population in the state of Connecticut is 1,154,450. Of the HUSKY Health membership, 34.2% are youth under 18, and 53.1% are female. Those who chose not to identify their race were classified as unknown and represent 44.3%, while 34.8% are White, 17.1% are Black, and 3.2% are Asian, and 19.8% identify as Hispanic or Latino. Disability rates for the HUSKY Health population are based on HUSKY C eligibility. HUSKY C is also known as Medicaid for the Aged/Blind/Disabled and Medicaid for Employees with disabilities. Since this definition is more narrowly defined, only 7.6% of the HUSKY Health population are considered disabled.

Category	Group	Mental Health	Substance Use Disorder
Sex	Female	32.86%	6.51%
	Male	27.27%	10.64%
Race	Asian	16.00%	1.93%
	Black	26.57%	8.17%
	Multiracial	31.54%	6.26%
	Native American/Alaskan Native	34.01%	9.68%
	Pacific Islander	24.71%	6.38%
	Unknown	24.82%	6.97%
	White	39.31%	10.96%
Ethnicity	Hispanic	30.24%	7.26%
	Non-Hispanic	30.25%	8.75%
Geography	Urban/Suburban	29.92%	8.39%
	Rural	35.42%	9.33%
SDoH	None	29.28%	8.03%
	One or More	73.23%	27.09%
Primary Language	English	31.88%	9.41%
	Spanish	22.08%	3.39%
	Other	15.53%	1.24%

For HUSKY Health members, the Connecticut Behavioral Health Partnership (CT BHP) has developed an interactive population profile dashboard that includes all HUSKY Health members and is filterable by demographics, geography, preferred language, spending, utilization, housing status, social drivers of health (SDoH), prescription use, telehealth, and diagnosis (including chronic behavioral health and medical disorders). This profile provides a detailed description of this project's primary population of interest.

The table above is drawn from the current HUSKY Health population profile dashboard. It provides the percentage of individuals within population sub-groups that have had at least one HUSKY Health encounter with any mental health (MH), or substance use disorder (SUD) diagnosis on the claim. Rates of MH diagnoses are higher for women than men, although the reverse is true for SUD diagnoses. Individuals identifying as White, Native American, Multiracial, or Black have higher rates of MH diagnoses, and as Asian have the lowest. The pattern is similar for SUD diagnoses, where those identifying as White, Native American, and Black have the highest rates, and as Asian have the lowest. Rates for Hispanic and non-Hispanic populations for MH diagnoses are comparable, but there is a slightly higher rate for the non-Hispanic population for diagnoses of SUD. The geographic data clearly shows higher rates of diagnoses in rural settings for both MH and SUD, but this is partly due to a higher prevalence of the White population in rural areas and Whites generally being more likely to receive MH and BH services than other populations. This data clearly demonstrates the dramatic impact of having one or more social drivers of health (SDoH) on rates of MH and SUD diagnoses, with rates of MH disorders 2.5 times higher and rates of SUD diagnoses 3.4 times higher when there is at least one SDoH indicator. Finally, the preferred language of HUSKY Health members shows significantly higher MH and SUD diagnosis rates for English speakers vs. Spanish and others. This may be mainly due to stigma, mistrust, or access issues leading to lower rates of BH service use by Spanish speakers.

A-2. Need. The 2024 Mental Health America report ranked Connecticut second of all states on an aggregate of 15 measures that assess BH prevalence, substance use, access to care, insurance coverage, etc. Despite this relatively positive overall finding in comparison to other states, prevalence rates in Connecticut are close to national averages in most cases, and access varies by racial and cultural group, geography, sex, and other group characteristics. Prevalence rates based on the 2021-2022 SAMHSA BH Barometer are presented in the table to the left. In nearly all cases, Connecticut rates are within the margin of error of the national average. The longer-term trend in the rise of depression, anxiety, and trauma-related disorders in children was accelerated by the pandemic in 2020, and Connecticut has been impacted significantly. In 2021, the Connecticut opioid death rate peaked at 1,413 and placed the state within the top 13 states with the highest opioid mortality rate. In addition, opioid-involved fatality rates have been increasing at a greater rate for young people who identify as Black. Although the death rate has decreased slightly, the crisis continues, complicated by the impact of the addition of fentanyl, xylazine, and other psychoactive substances to opioids, marijuana, and other drugs sold in the local illicit drug trade.

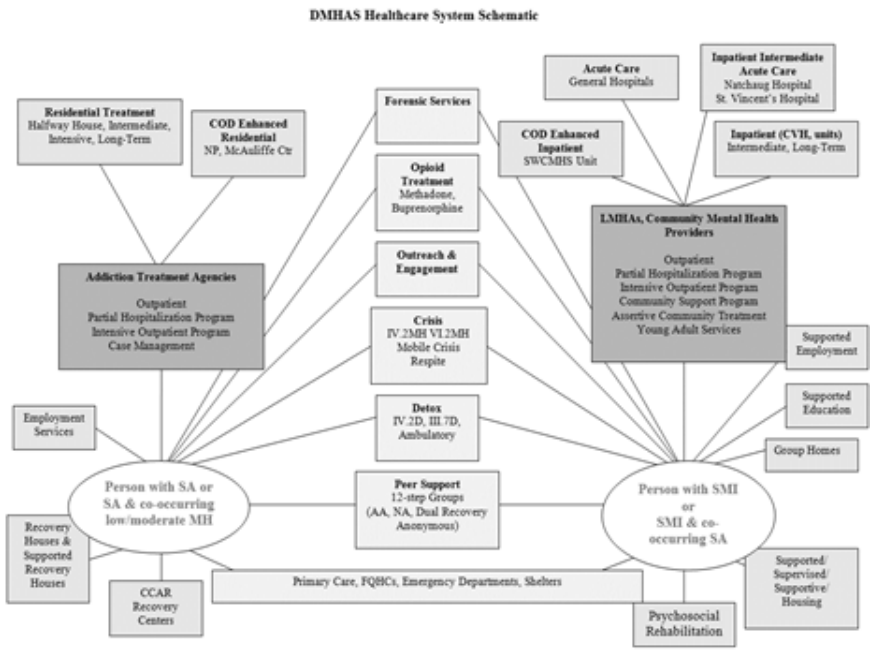
For HUSKY Health members, the population profile dashboard (described above) provides insight into the nature and needs of the population. This tool helps the state to better identify, track, and serve specialty populations with the highest needs, with the capacity to drill down to specific populations. For example, individuals experiencing a first episode of psychosis (FEP) benefit significantly from early intervention with services and supports that address educational, social, and occupational needs in addition to clinical services. Our data demonstrates that this small (< 300 identified per year) population has tremendous needs, as indicated by higher rates of homelessness (5 times higher), HUSKY Health spending (6.4 times higher), emergency department (ED) visits (3.3 times higher), and SUD diagnoses (7.7 times higher) than the general population. Geographic filtering reveals that almost 70% of this population resides in New Haven and Hartford Counties. Similarly, those individuals that have an SDoH identifier have three times the average rate of HUSKY Health expenditures, eight times the rate of homelessness, and three times the rate of ED visits. Specialty populations that would benefit from enhanced services include children 12-17, young adults 18-24 and 25-34, those with SUD (mainly alcohol and opioid use disorders), FEP, Serious Mental Illness (SMI), eating disorders, Department of Children and Families (DCF) involved, unhoused, those exposed to trauma, with comorbid BH and chronic medical disorders, veterans, as well as those with more severe and long-standing depression and anxiety. Also, increased outreach is indicated for nearly all races, but particularly persons of color who are much less likely to access services. Connecticut will use this data and stakeholder feedback to select priority populations for the Demonstration (if funded).

Disorder/Behavior	Youth 12-17	Adults 18 or Older
Any Mental Illness	9.0%	21.0%
Major Depression	19.8%	8.6%
Serious Mental Illness	NA	5.4%
Suicidal Thoughts/Behaviors	11.0%	4.2%
Suicide Attempts	3.4%	0.6%
Alcohol Use in the Past Month	8.2%	61.1%
Illicit Drug Use in the Past Month	9.0%	17.1%
Any SUD Diagnosis	7.7%	18.4%
Alcohol Use Disorder	3.6%	12.8%
Opioid Use Disorder	1.0%	1.8%

A-3. BH System. Public behavioral health services in Connecticut are funded, organized, and provided, in part, through the Connecticut Behavioral Health Partnership (CT BHP), a collaboration of three state agencies: the Department of Social Services (DSS), the Department of Mental Health and Addiction

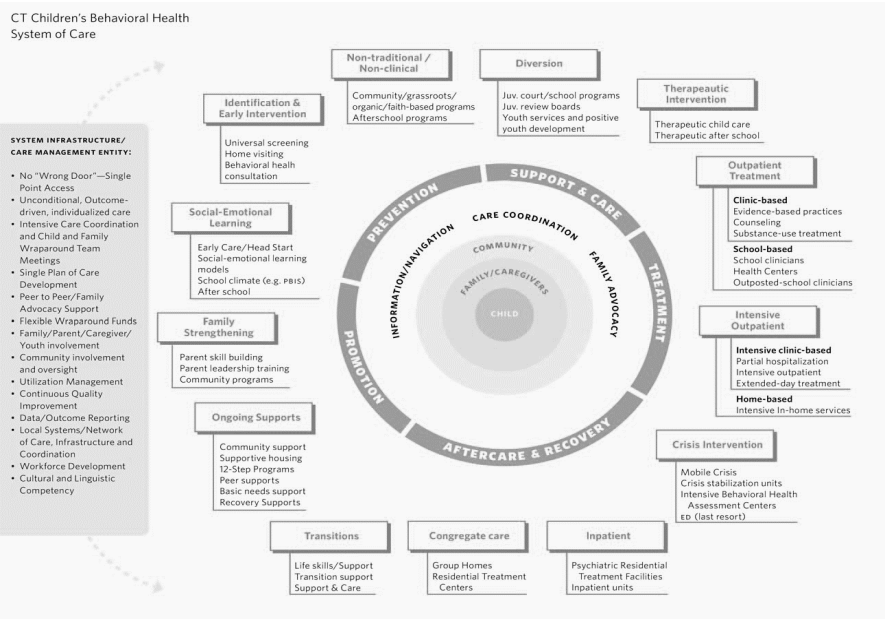
Services (DMHAS), and the Department of Children and Families (DCF). The partnership contracts with Carelon Behavioral Health Connecticut (Carelon BH CT) as the Administrative Services Organization (ASO) for HUSKY Health behavioral health services. DSS is the state's Medicaid agency and the lead applicant for this proposal. DSS utilizes a managed fee-for-service model to pay for Medicaid-covered services and uses a single vendor to pay all claims associated with Medicaid services. All medical and behavioral health claims and eligibility data are aggregated in a single repository available to the ASOs for performance improvement and care management. Each key partner in the system is described below, and schematics of the service system operated by DCF and DMHAS are also provided.

DSS is the single state agency for the administration of HUSKY Health and the Children's Health Insurance Program and delivers and funds a wide range of programs and services as Connecticut's multi-faceted health and human services agency. DSS serves about 1 million residents of all ages in all 169 Connecticut cities and towns. We support the basic needs of children, families, older and other adults, including persons with disabilities. Services are delivered through 12 service centers, central administration, and online and phone access options. With service partners, DSS provides federal/state food and economic aid, health care coverage, independent living and home care, social work, child support, home-heating assistance, and protective services for older adults. Other vital service areas include supporting the health of nearly 1,000,000 residents through HUSKY Health (Medicaid & Children's Health Insurance Program), including medical, dental, behavioral health, prescription medications, long-term services, and supports; and, helping nearly 370,000 residents afford food and supports Connecticut's economy with the federally funded Supplemental Nutritional Assistance Program (SNAP). DSS has 1,700 dedicated staff led by Commissioner Andrea Barton Reeves.



DMHAS serves as both the state's State Mental Health Authority (SMHA) and Single State Agency for Addiction Services (SSA). DMHAS is an independent state agency with the statutory responsibility to promote and administer an integrated system of comprehensive behavioral health preventive, treatment, and rehabilitative services. The DMHAS mission is to "promote the overall health and wellness of persons with behavioral health needs through an integrated network of holistic, comprehensive, effective, and efficient services and supports that foster dignity, respect, and self-sufficiency in those we serve." The Department's primary purpose is to assist persons experiencing mental health and substance use disorders to

recover and sustain their health through the delivery of high-quality services that are person-centered, promote hope, attend to trauma, improve overall health, and are anchored to a recovery-oriented system of care that is culturally competent and rooted in evidence-based practices (EBPs). DMHAS is responsible for providing a wide range of treatment services to adults, including inpatient hospitalization, outpatient clinical services, 24-hour emergency care, day treatment, psychosocial and vocational rehabilitation, restoration to competency, and forensic services (including alternative incarceration programs), outreach services for persons with serious mental illness who are unhoused, and comprehensive, community-based mental health treatment and support services. DMHAS manages six state-operated and seven non-profit Local Mental Health Authorities, 150+ non-profit BH agencies, and a variety of regional services to also serve persons with substance use disorders.



DCF is responsible for the legislative mandates of prevention, child protective services, children's behavioral health, and education. With an annual operating budget of approximately $800 million, the Department provides contracted as well as direct services through a central office, 14 area offices, and two facilities. The mission statement of DCF is "Partnering with communities and empowering families to raise resilient children who thrive." DCF submitted the Connecticut Children's Behavioral Health Plan in fulfillment of Public Act 13-178 requirements. The public act was one part of the Connecticut General Assembly's response to the tragedy in Newtown, CT, in December 2012, in which 20 grammar school children and six adult school staff were murdered by a young adult who had unmet mental health needs. The Plan provides Connecticut with a unique and timely opportunity to align policy and systems to support youth and families and to promote healthy development for all our children. Public Act 13-178 directed Connecticut DCF to include in the implementation plan the following strategies to prevent or reduce the long-term negative impact of mental, emotional, and behavioral health issues on children: prevention, developmentally appropriate services, comprehensive care through a continuum of services, engaging communities, families, and youth in service planning and delivery, sensitivity to diversity, results-based accountability, data-informed quality assurance, integration of school and community-based services, enhancing early intervention, consumer input, and public information/accountability.

A-4. Capacity of the Medicaid State Plan. The CT BHP was created to improve the quality, access, outcomes, and efficiency of a wide range of HUSKY Health-funded and other state-funded behavioral health services offered by both state-run and private, non-profit providers.

Also, other service innovations in primary care and medical care provision have helped to provide HUSKY Health with the experience and expertise to ensure compliance with the nine CCBHC service requirements.

DCF licenses outpatient psychiatric clinics for children in Connecticut, and their adult counterparts for MH and SUD clinics are licensed by the Connecticut Department of Public Health (DPH). Both DCF and DPH have stringent staffing and staff qualification requirements that often exceed those required under the CCBHC. Between licensing, clinic accreditation, CCBHC accreditation, and Connecticut's certification process, we are confident we can ensure compliance with staffing standards, including responsiveness to assessed community needs, linguistic and cultural competence, and appropriate training. Regarding availability and access to services, some of the required access requirements are already being met by HUSKY Health's Enhanced Care Clinics or the large number of clinics that have moved to a treatment-on-demand intake process and the CT BHP will ensure that all access and availability requirements are met. CCBHC providers will not deny care to those seeking service based on their ability to pay or residing outside the provider's service area. Those community clinics that are already contracted to provide Mobile Crisis Services (MCS) to adults or youth will already have the capacity to provide 24-hour crisis services within at least one of the two statewide crisis systems (Connecticut has separate adult and youth statewide systems that are both accessible via 211 which is also the state hub for 988). CT has also recently implemented four BH urgent crisis centers in the state. Those who do not currently participate in the existing MCS system or only participate in one or the other (child or adult) will be required to contract with an existing MCS provider via a Designated Collaborating Organization (DCO). The screening, assessment, and diagnosis requirements align with existing licensure and state agency contracting requirements (DCF and DMHAS), and a crosswalk will be completed to resolve any potential regulatory conflicts early in the planning process. Standardized screening and assessment tools required by funding agencies are described in Attachment 2. All services of the CCBHCs will be provided within a person-centered and family-centered care philosophy, as has been required for many years by both DCF and DMHAS. While outpatient MH and SUD services are at the foundation of care delivery in the clinics, the capacity to treat across the lifespan is a special focus for Connecticut, given concerns about the capacity of historically adult providers to deliver children's services and vice versa. Initial selection criteria will be designed with this concern in mind. The state will provide support to enhance expertise and capacities to organizations that have not historically been age-span providers (in addition to utilizing DCOs to provide portions of care, where appropriate). Similar challenges exist regarding the delivery of both SUD and MH services. The state will work to ensure that all clinics effectively provide age-span general and specialty services as required under the program. The implementation of EBPs for both SUD and MH services will be promoted through the activities described in section D-8. Integrated care for adults in Connecticut is provided through the Behavioral Health Home Program (14 programs covering all eight Connecticut counties) and for children through the Integrated Care for Kids (InCK) Program and Person-Centered Medical Homes (PCMH and PCMH+). Some Federally Qualified Health Centers (FQHCs) also provide integrated care, but many existing BH clinics do not. Drawing upon the expertise provided through these programs, Connecticut is well-positioned to support primary care screening and monitoring within the CCBHC model to ensure compliance. Targeted case management (TCM) services are already reimbursed and provided under HUSKY Health. We expect eligible clinics to be well-versed in providing this service, but

additional support and technical assistance will be developed if necessary. Psychiatric rehabilitation services are essential, especially considering the findings reported in section A-2 concerning the impact of SDoH on mental health, functioning, and well-being. While psychiatric rehabilitation services are provided through grant-funded programs and some clinic settings (particularly hospital-based), they are not widely available in BH clinics across the state. Connecticut will promote compliance through monitoring, providing training, and technical assistance in psychiatric rehabilitation. As referenced in sections B-1 and C-3 of this application narrative, Connecticut currently provides and funds (through grants and contracts) peer supports, peer counseling, and family caregiver supports. Reimbursement of peer services under HUSKY Health is limited to the 1115 Substance Use Disorder (SUD) demonstration. Based on the state's experience with peer services that are grant funded and those reimbursed under the SUD demonstration, we have ample experience to draw on in expanding peer services to CCBHCs. Finally, the provision of Intensive Community Based Care for Veterans and Members of the Armed Forces will be supported and implemented through an existing partnership between DMHAS and the Veterans Administration and in conjunction with the DMHAS Military Support Program (MSP), the DMHAS Veterans Recovery Center (VRC), and existing community support/education programs such as the NAMI Homefront program for family, friends, and significant others of military members and veterans. In addition to these required services, Connecticut also plans to include and fund care coordination services as a required service under the demonstration. This will build upon the state's experience and success with care coordination for children with serious emotional disorders (SED) (Wraparound), the PCMH+ program (which provides comprehensive care coordination in primary care), and individuals with autism spectrum disorders.

SECTION B: Proposed Implementation Approach

B-1. Capacity, Access, and Availability. The capacity, access, and availability of services will be expanded through 1) disparity analysis/mitigation, 2) support of community engagement, 3) support of board governance strategies, 4) cultural and linguistic competence supports, 5) leveraging SDOH data and mitigation strategies to improve outcomes and remove obstacles to participating in care, 6) EBP training and implementation support, 7) workforce development, and 8) advanced data analysis to support early intervention and targeted outreach. This response will focus on items 1-5 above, and items 6-8 will be covered in the response to question B-8. Connecticut began ramping up its focus on improving equity and reducing disparity in BH access in 2014 when a series of health equity studies and projects were initiated. Reporting, monitoring, and working to mitigate disparities is now integrated into the CT BHP Provider Analysis and Reporting (PAR) program that provides data and performance improvement consultation across nine key levels of care. Enhanced community engagement and outreach with at-risk or underserved populations is an effective intervention to improve access and continuity of care. For example, the CT BHP ASO developed an algorithm to predict who was least likely to engage in timely follow-up following hospitalization. Noting that the population identifying as Black was far less likely to follow up timely, the intervention strategy included provider education, data tracking, and planned outreach periodically after hospital discharge to address barriers to service continuation experienced by many individuals in the Black community. Connecticut plans to provide CCBHCs with real-time notifications of key BH encounters (ED visits, hospitalizations, etc.) to assist providers in conducting outreach at critical moments in the care journey. The CT BHP has been tracking the demographics of board membership and clinical staffing at ECCs to

increase the proportion of leaders and practitioners that better represent the characteristics of those served. Connecticut has also been leading a statewide effort to engage providers in a workplace improvement project based on the Culturally and Linguistically Appropriate Services (CLAS) standards. Embracing CLAS provides a more accepting and responsive environment for service recipients, and participation in this initiative will be required of all CCBHCs. In recent years, HUSKY Health has enhanced its collection of SDoH data to understand, better address, and coordinate challenges associated with SDoH. Several approaches have been employed, including the incorporation of data-based imputation strategies for community-level analysis, incentives and requirements for utilizing SDoH coding on claims, and direct collection of SDoH data components (housing status, shelter use, standardized assessments such as PRAPARE, preferred language, and eligibility classifications indicative of disability status). SDoH data is integrated with BH and medical claims, as well as authorization, eligibility, and pharmacy data sets. The ASO's AVP of Health Equity & Special Projects is developing strategies to educate and support HUSKY Health recipients, providers, and other stakeholders regarding SDoH, health disparities, and the role of culture, race, gender, gender identity, sexual orientation, and other SDoH in health and wellbeing.

B-2. CCBHC Selection. Connecticut has been thoughtful regarding the potential impact of the CCBHC program in achieving program goals, maximizing outcomes and access to priority populations, and supporting the existing network of community BH service providers. The state has not yet certified clinics as CCBHCs. Connecticut has a draft State Request for Funding Application (RFA) for CCBHC program participation that will be updated based on stakeholder feedback during the planning year. The RFA will be used to identify and select three CCBHC programs to participate in the initial phases of the demonstration program if awarded. Based on the program's success, ongoing community needs assessment, stakeholder feedback, budgetary, and other considerations, a subsequent RFA may be conducted during the demonstration to select up to one additional clinic. Beyond initial eligibility requirements related to licensure, accreditation, and utilization of an electronic health record (EHR), Connecticut's approach aims to balance goals related to maximizing geographic coverage (criteria based on service to urban, suburban, and rural communities), numbers to be served, lifespan coverage (including the adequacy of care provided to children and families), capacity to provide crisis services that augment and coordinate with the states existing crisis system, clinic size (small, medium, and large clinics based on numbers served), agreement to, or current participation in the state's Health Information Exchange (HIE), experience serving specialty populations (e.g., veterans, clinical specialty areas, underserved racial or culturally defined population groups), and capacity to provide all of the services and fulfill all requirements of the CCBHC program. The state will also utilize components of SAMHSA's CCBHC Criteria Compliance Checklist [CMS-10398 (#45)] in the selection process. To prepare clinics for certification, the state will coordinate training, technical assistance, and other resources available from SAMHSA, the National Council, CMS, and the Social Work Innovations Institute at the University of Connecticut (UCONN, a SAMHSA CCBHC TA Partner Organization). Seven organizations in Connecticut have received a SAMHSA Clinic Implementation grant, and it is expected that one or more will be expected to apply to the program, bringing lessons learned in their efforts to implement CCBHCs. Support related to billing, data collection, and submission, use of quality data in service improvement, and other areas will be provided by DSS, DCF, DMHAS, and ASO staff as needed.

B-3. Urban & Rural Communities: Connecticut is committed to serving individuals in the state's rural, suburban, and urban areas. Like many states, the availability of clinic services is highly correlated with population density, with fewer sites in rural areas. Geographically, Connecticut is a small state (4,842 square miles, 3rd smallest in the country) with eight counties, and two that contain the preponderance of rural communities as defined by population density (lowest population by square mile - Litchfield and Windham counties). Litchfield (northwest) and Windham (northeast) counties also have the two lowest HUSKY Health BH provider density ratios of counties in the state. Administrative data shows that 6% of HUSKY Health members (roughly 61,000 individuals) reside in rural communities, and the rates of any mental health or substance use disorder are 15% and 14% higher for those living in rural vs. urban/suburban settings. While a recent ASO geo-access study demonstrated that 99.9% of HUSKY Health members had access to outpatient BH provider sites within the standard distances set by CMS, the distance threshold is higher in rural communities. There is also less available public transportation, creating more significant challenges in accessing care. In general, the number and size of clinics track with population density, resulting in clinics clustering in rural and urban settings. Despite this general pattern, certain urban areas with many at-risk groups also require more accessible services. For these reasons, the inclusion of clinics serving urban, suburban, and rural communities will be considered in the selection criteria and driven by stakeholder input and data regarding both population and BH service provider densities.

B-4. Adding Clinics. The state is considering but not committed to adding up to one additional CCBHC (beyond the three to be certified during the planning grant) during the demonstration. Analysis of the program's success in meeting established goals and objectives, fiscal impacts, budget issues, community needs, and other considerations will determine whether to add another CCBHC. There are two methods under consideration when selecting an additional clinic. One method would be to use the RFA process for the clinic selection during the planning phase and include one clinic as an “alternate” that would be eligible to seek certification if the decision is made to add another clinic during the demonstration. This option would promote fairness, given the same criteria for all potential CCBHCs, and the same reviewers would be utilized in selecting the first and second waves of CCBHCs. This option is also the most efficient since only one RFA process would be required. The second option would be to release a second RFA during the demonstration program for the one additional clinic.

B-5. Move from Planning to Implementation. The grant year will be guided by a detailed work plan that will be broken down into four phases. A phased approach will help to smooth the transition from planning to implementation activities. Further details regarding sub-objectives and activities will be detailed in the final plan, but a high-level snapshot is provided in the table below.

Phase	Primary Focus	Primary Objectives
1	Initiation and Needs Assessment	• governance and leadership • needs assessment • engage stakeholders • finalize consulting agreements
2	Strategic Planning, Infrastructure, and Clinic Selection	• strategic and operational planning • policy and regulatory framework • capacity building and ta • clinic selection • begin consultation activities
3	Implementation Planning	• finalize service areas and participation requirements • support selected providers in achieving certification • clinic certification with data collection and site reviews • modify data systems and evaluation metrics as needed • finalize statewide policies and procedures • finalize contracts/agreements
4	Early Implementation and Continuous Monitoring	• scale up implementation • install continuous monitoring and improvement infrastructure • sustainability planning • initial clinic certification is completed

The first priorities are engaging stakeholders, establishing a steering committee, and conducting a statewide needs assessment. Developing a plan for the year with stakeholder input comes next, along with selecting clinics through an RFA and utilizing consultation and feedback to develop and deliver TA. Halfway through the year, the shift begins towards planning for clinic implementation and work on key infrastructure necessary for clinics to meet all CCBHC requirements. During the final quarter, clinics begin implementing key components, recruiting staff, and using continuous quality improvement to track readiness utilizing a readiness assessment tool available on the SAMHSA website. Clinic certification will be completed prior to the end of the planning year.

B-6. PPS Rate Setting Methodology: The Department of Social Services (DSS), the State Medicaid Agency, in partnership with DCF and DMHAS, will contract with an actuary firm to develop and certify a PPS-2 cost-based, per-clinic monthly rate. Connecticut considered both prospective payment system (PPS) payment models and is more inclined to pursue a monthly rate instead of an encounter rate to pay for value instead of volume. The Department will develop the PPS-2 rate and all the associated tasks for developing the rate, including certification of the rate in compliance with 42 CFR 438.6(c). The state will establish a monthly base rate per clinic and use rate adjustment-based factors such as acuity (child and adult) and region/geography. In addition to a monthly base rate and rate adjustment factors, the Department will develop an outlier payment to reimburse clinics for services that exceed the established threshold. Finally, as part of the PPS-2 payment methodology, the Department will establish performance payments for those clinics that meet established thresholds on the quality measures.

To develop a PPS-2 for clinics, the Department will issue a cost report that clinics must complete to meet the certification requirements. The Department is prepared to use the CMS CCBHC cost report. The Department currently requires cost reporting for clinics such as Federally Qualified Health Centers (FQHCs) and Chemical Maintenance Facilities, and therefore, some clinics are familiar with the cost report process. The Department will also use the Medicare Economic Index (MEI) to rebase the PPS-2 in the second year of the demonstration. Connecticut is not a managed care state; therefore, managed care considerations are not applicable. The Department will develop a monthly base rate that will be based on a claim submitted to the Medicaid

Management Information System (MMIS). Claims must include a CPT code that is included as one of the core services outlined in the scope of services section. No payment will be made to the clinic if a claim is not submitted or if a claim is submitted without an applicable CPT code. HUSKY Health is fortunate to have a single repository of all Medicaid claims with the MMIS. Connecticut does not use managed care organizations and uses a single entity to adjudicate and pay claims. A single repository of all Medicaid claims is invaluable in the process of claims analysis. This will significantly benefit the process when analyzing claims history. The Department will develop the PPS-2 and all ancillary services with support from a contracted actuary firm. Ancillary services include but are not limited to stakeholder engagement and education (on-site), desk reviews of cost reports with the applicable review of claims data, development of specific clinic PPS-2 rate, outlier payment methodology, performance payment methodology, and final certification of PPS rates for certified clinics.

B-7. Establishing a PPS: The Department will establish an actuarially sound monthly rate by using the following process. All clinics that wish to become certified must submit a cost report to the state. All services the clinic provides, as outlined in the scope of services, will be priced using existing fee schedules. New services will be priced using existing fee schedules through government-approved sources such as Medicare and/or Tricare. Service utilization data will be analyzed to determine the frequency and type of service or services used by HUSKY Health members. A base rate for each clinic will be established based on frequency and expected service utilization. Rate adjustment factors will be calculated for those members with higher acuity and who need more intense services or longer duration of services. Cost updates will be collected in Year 1 of the demonstration to inform a rebasing methodology. Outlier payment methodology will be established for costs incurred by clinics that exceed an established threshold. Finally, performance payments will be based on a minimum utilization threshold, a minimum performance threshold on the quality measure set, and a minimum improvement threshold on the quality measure set. The clinic must meet or exceed established outcomes thresholds to qualify for the performance payment.

The CCBHC demonstration allows states to increase their federal match on Medicaid members who are not CHIP or part of the expansion population from the standard 50% federal match to 65% federal match. When Medicaid is net funded, as it is in Connecticut, the federal match is designed to cover the state's cost related to Medicaid services. The state's budget related to Medicaid services, or the state share, is based on the federal match. If the federal match increases, the state shares decreases in net funding. The Department will work to develop a fiscal impact analysis to estimate the potential net increase in costs or the net savings. The CCBHC model includes a cost-based reimbursement model and new services (care coordination, psychosocial rehab, evidence-based treatment, peer-based services, and off-site services, including mobile crisis) that will increase the cost of care. A base prospective payment system (PPS) rate will be a per member per month (PMPM) payment for every HUSKY Health member the CCBHC serves. In addition, there will be enhanced payment for complex members, outlier payments for those members who exceed the cost of the base rate based on utilization, and a Quality Bonus Payment based on member outcomes on established quality measures. It is likely that this model will result in a net increase in costs for the two-year demonstration period, even when factoring in the enhanced federal match.

B-8. Service Capacity Expansion: The discussion of strategies to improve service capacity and access to BH care in CCBHCs continues from question B-1 with the description of components

6-8 (EBP support, workforce, and outreach). Connecticut has a robust system of over 40 EBPs that HUSKY Health providers utilize, but the capacity and use of fidelity management are variable across models and providers. A priority list of models to potentially expand has been developed by the directors of EBP at each state agency, and they include Medications for Opioid and Alcohol Use Disorders, Screening Brief Intervention and Referral to Treatment, Modular Approach to Therapy for Children, Assertive Community Reinforcement Approach, Person-Centered Recovery Planning, Evidence-Based In-Home Family Treatment Models, Treatment on Demand, Adult Trauma Models, and Integrated Dual Disorder Treatment. Connecticut has proposed grant funding for consultation on EBP training and implementation support within this project. Expanding access to EBPs would improve access to care and outcomes. Connecticut has conducted several major BH workforce studies in the past year, including a DCF-funded Child Health and Development Institute (CHDI) workforce strategic plan for youth and family services and a State Health Horizons project that offers tuition assistance for students considering careers in social work and nursing. Under the planning grant, the state plans to engage leadership from these initiatives as consultants to further develop workforce support (one of the most direct ways to enhance access, availability, and capacity). In particular, the state plans to engage the CHDI of Connecticut, which currently contracts with DCF for the management of EBPs in the adult and child systems and is a principal player in the workforce development projects mentioned above. In addition, the CT BHP, in conjunction with the ASO, also uses data in the form of quality metrics, utilization data, demographics, and geo-access and mapping analyses to drill down to the person level and identify individuals that may require outreach, assistance, and support to connect to care. Providing this kind of person-centered and data-driven outreach will improve access to those populations and individuals who have been most negatively impacted by barriers to access.

B-9. Board Governance: Connecticut envisions a series of committees that will govern the CCBHC Program. The totality of committee membership will be at least 51% individuals with lived experience. A steering committee will oversee the entire project, focusing on achieving SAMHSA and state-specific goals, and will be authorized to make final decisions based on sub-committee input. Membership on the Steering Committee will likely consist of the Project Director, CT BHP contract managers, the ASO lead on the project, other state agencies of cognizance (CT DPH, Office of Early Childhood, Office of Health Strategies), and representatives of Consumers and Families, Connecticut's tribal nations, Veterans Affairs, CT BHP Oversight Committee, and Providers. Final decisions on Steering committee membership and the final slate of sub-committees and workgroups will be worked out as we approach the grant kickoff. Subcommittees will likely include some or all of the following: Consumer and Family, Providers, Data and QI, Policy and Regulatory, Finance and Sustainability, and workgroups focused on the following topics: workforce, provider TA and training, EBP selection/implementation, IT and Data Systems, etc. In addition to the input via committees and workgroups, prior projects (SUD SUPPORT Grant, Enhanced Care Clinic implementation, Equity and Disparity Analyses, etc.) have also utilized technologically aided live polling of participants at various community meetings, electronic surveys distributed via email, live and virtual community conversations, and focus groups. With further input from stakeholders, we will select the best method or methods to collect the input needed. To keep stakeholders informed of developments, the state will make presentations at community meetings and produce a quarterly newsletter to be posted on the CT BHP website and/or distributed by email.

B-10. Stakeholder Input: The HUSKY Health Program, and the behavioral health services system in particular, have sustained multiple pathways for obtaining input from consumers, family members, providers, consumer advocacy organizations, state agency staff, and other stakeholders that will be utilized for input into the CCBHC Demonstration. Existing structures for stakeholder input include the CT BHP Oversight Council and its subcommittees (Operations, Coordination of Care, Quality Access and Policy – Adult and Child, Diversity Equity and Inclusion), the CT BHP Consumer & Family Advisory Committee (CFAC), five Adult Regional Behavioral Health Action Organizations (RBHAOs), Child and Family Local Systems of Care (LSOCs) consisting of 26 local community collaboratives organized across six geographic regions, multiple family advocacy organizations including Connecticut Parent Advocacy Association, and FAVOR – a family-led organization focused on improving educational and health outcomes for children and families. Organizations that also advocate on behalf of individuals with behavioral health and other challenges include the Connecticut Office of the Child Advocate, the Connecticut Chapter of the National Alliance on Mental Illness (NAMI), and the Center for Children's Advocacy. As noted earlier, five Native American Tribal Nations are recognized in the State of Connecticut, and two are recognized federally. Connecticut will reach out to the recognized tribal communities regarding their interest in participating in various CCBHC committees and seek a representative from the local Veterans Administration behavioral health leadership to participate in the initiative.

SECTION C: Staff and Organizational Experience

C-1. CCBHC Program Development: For the past 20 years, Connecticut has been consistently improving the delivery and effectiveness of medical, primary care, and BH services provided under the HUSKY Health Program, including BH outpatient services. This work began with the development of Enhanced Care Clinics (ECCs), a program that provides enhanced reimbursement to clinics that meet standards for timely access to care. Since 2008, a series of reports, grants, state-funded programs, Medicaid Waivers, and state plan amendments have advanced these efforts. In 2021, the state participated in The Connecticut Medicaid Academy facilitated by the Center for Healthcare Strategies, which included planning to improve outpatient behavioral health services under Medicaid. The following have all contributed to Connecticut's capacity and readiness to implement CCBHCs; 1) the creation of the CT BHP partnership that integrates the work of three state agencies (DSS, DCF, and DMHAS), and the establishment of the CT BHP Oversight Council to obtain input from a diverse stakeholder group (providers, legislators, HUSKY Health members, state leaders, etc.), 2) the absence of Medicaid managed care which simplifies the implementation of a prospective payment system and eases the access to and integration of data, 3) a series of studies by the ASO to evaluate the functioning of the outpatient system, explore innovations in practice such as measurement-based care, and identify, track, and work to mitigate health disparities, 4) movement of clinics and home-based services under the rehabilitation option offering the ability to provide services in the community, in school settings, and wherever underserved populations are located, 5) an unprecedented expansion (over 40 models supported) of EBPs in community care spurred by DMHAS, DCF, and DSS, 6) presence of a model statewide crisis service system with joint HUSKY Health and grant funding serving children and adults, 7) an 1115 SUD Medicaid Demonstration that integrates many substance abuse grant funded substance use treatment levels of care under Medicaid to improve access and standards of care and present opportunities for improved treatment of co-occurring MH and SUD disorders, 8) implementation of an Inpatient Pediatric Value-Based Payment model and the Person Centered Medical Home to improve access to care

and gain experience with alternative payment models, and reimbursement under HUSKY Health for care coordination and navigation services, 9) the Connecticut Housing Engagement and Support Service (CHESS) a HUSKY Health covered housing engagement program providing disease management, pre-tenancy and tenancy supports, and state funded housing subsidies, 10) the implementation of youth and adult Urgent Crisis Centers under HUSKY Health, and 11) the promotion of peer supports within the ASO including support of training and credentialing of peer support services and their deployment in EDs, Opioid Treatment Centers, and other community sites, as well as many other program innovations. Thus, the state program is well-positioned to ensure that all selected clinics can meet all the CCBHC certification provisions.

C-2. Organizations Participating: A total of eight state staff members from the three CT BHP partner agencies (DSS, DMHAS, and DCF) will provide leadership, oversight, and support to the planning grant, which are described below. There are four additional organizations that will be collaborating with CT BHP state agency staff to implement various components of the planning grant: Carelon BH CT, Mercer Consulting, CHDI, and NCQA. Each contracted agency will be providing specific expertise that will enhance the planning and early implementation efforts. Carelon BH CT will be responsible for assisting state staff or carrying out many of the activities required under the grant, including but not limited to project management, planning, coordination of TA and training, community engagement, quality metric development, analysis, and reporting, project meeting management, governance-related activities, disparity analyses as well as helping to establish data infrastructure and manage data collection, integration, analysis, reporting, and submission. Carelon BH CT has been the only behavioral health ASO since the initiation of the CT BHP contract in 2006. Carelon BH CT has been formally designated a Recovery Friendly Workplace (RFW) by the Connecticut Governor, is a Top Workplace in Connecticut and has consistently achieved 95% or better on contractual performance targets over the last five years. Carelon BH CT's expertise has been described elsewhere in this application. Mercer Consulting will provide expertise and assistance with the actuarial analysis required for the PPS rate setting and will prepare and assist with developing and submitting cost reports. Mercer has demonstrated expertise and an extensive track record working in these areas of practice, and Connecticut has engaged its services for many Medicaid waivers and projects under the State Plan, including the recent SUD 1115 Waiver and the PCMH and PCMH+ programs. The Child Health and Development Institute (CHDI) is a private, non-profit, state-contracted agency that has been centrally involved in many behavioral health public sector program improvement projects in Connecticut and nationally dating back to the early 2000s. Their specialty areas include program improvement and continuous quality improvement, EBP implementation and fidelity management, and behavioral healthcare workforce development.

Key staff that will lead CHDI efforts on this project include Jason Lang, Ph.D. (EBP), and Aleece Kelly, MPP (workforce).

Name	Org.	Position	Qualifications	Level of Effort	Grant Dollars
Fatmata Williams	DSS	Director of Medical Administration – Project Director CCBHC Planning	MPH, MSN, PMHNP-BC	.50	$0.00
Yvonne Prudente	DSS	Principal Cost Analysis	BS - Accounting	.10	$0.00
Nicole Godburn	DSS	Rate Setting Analyst		.05	$0.00
TBD	DSS	Advanced Social Worker	MSW	1.0	$0.00
Stephney Springer	DCF	Health Management Administrator-CT BHP	LCSW, Psy.D,	.25	$0.00
Francis Gregory	DCF	Administrator	Ph.D. - Psychology	.25	$0.00
Lois Berkowitz	DCF	Director of Special Projects	Psy.D.	.25	$0.00
Robert Haswell	DMHAS	Section Chief – Managed Services	LCSW	.25	$0.00
Mark Vanacore	DMHAS	Behavioral Health Clinical Manager	MA, LPC	.25	$.00

C-3. Staff Positions: If awarded, eight Connecticut State staff members will be key in implementing the planning grant. None of the state positions will be supported by grant dollars, and all will be funded with state dollars. All staff positions showing role, level of effort, and qualifications are included in the table above. In addition to the Connecticut state staff members, four organizations will be engaged to provide contracted services and consultation to support project activities. Designated staff from each of the partner agencies will provide leadership and oversight of the project with the assistance of other named and unnamed staff at their organizations. Project Director Fatmata Williams of DSS is the Director of Medical Administration for DSS and has extensive experience managing services and supervising staff members under the HUSKY Health program and has advanced degrees in public health and nursing, as well as a board- certified Psychiatric Nurse Practitioner. Stephney Springer of DCF is the co-director of the CT BHP with extensive clinical, supervisory, and management experience. Prior to her role overseeing the CT BHP, Dr. Springer managed multiple clinical behavioral services and programs funded by DCF and supervised clinical staff providing assessment and care to children involved in the child welfare system. Robert Haswell, LCSW, serves as the Section Chief for the Managed Services Division at DMHAS. He holds a BA in urban studies and an MSW, and he is currently pursuing his Ph.D. in social work. He has been at DMHAS since 2022, and prior to this, he provided clinical services and management of clinical programs at a major non-profit BH provider in Connecticut. Rob is a veteran, having served in the Army from 2006-2010. Both Fatmata Williams and Dr. Springer bring cultural understanding and advocacy for underserved populations to their work, and each brings over fifteen years of experience to their agency. Section Chief Haswell has worked extensively with underserved populations in direct care and administrative capacities and has developed a keen appreciation of their needs and challenges. He has one publication in a professional journal and one under review. Three additional staff will serve primary roles in the

initiative; Lois Berkowitz, Psy.D. (clinical psychology) of DCF, Francis Gregory, Ph.D. (clinical psychology) also of DCF, and Mark Vanacore, MS, LPC of DMHAS. Dr. Berkowitz, Director of Special Projects for DCF, has worked extensively in the field of behavioral healthcare management and has been at DCF since 2006. She has overseen the implementation of multiple projects and clinical programs serving a population with some of the greatest BH needs and challenges, including the development of the Enhanced Care Clinics. She has been on the DCF team managing the ASO contract since its inception. Prior to coming to DCF, Dr. Berkowitz worked for a major insurance company managing BH services and networks. Dr. Francis Gregory is the administrator of the Behavioral Health Community Services Division at DCF and has been in this role since 2022. He has also been on the Yale Child Study Center faculty since 2001 and is currently an Assistant Professor. Before his current role, Dr. Gregory served as superintendent of the state's only psychiatric hospital for children and as a Behavioral Health Clinical manager overseeing an array of DCF-funded clinical services. Mark Vanacore has been with DMHAS since 2014 as a Behavioral Health Clinical Manager within the Managed Services Division of the department. He assists the section chief in managing the ASO contract from the DMHAS perspective and draws on his experience in the private sector as a clinician, program supervisor, and program manager for adults with mental health and substance use disorders. Mark has presented at the American Public Health Association on SUD services and risk for re-arrest. Bio-sketches, qualifications, and position descriptions for the three CT BHP contract managers (Williams, Springer, & Haswell) are attached.

SECTION D: Data Collection and Performance Measurement (20 points –approximately four pages)

D-1. Data Collection. The state will collaborate closely with its administrative service organization (ASO), Carelon BH CT, to collect and report data required for quality measurement and federal reporting. Carelon BH CT is part of an NCQA-accredited healthcare management company. It already receives, processes, programs, and analyzes a complete claims set (Medical, Institutional, Behavioral Health, Dental, and Pharmacy) along with HUSKY Health eligibility data and select encounter data for HEDIS reporting and performance improvement purposes. Carelon BH CT receives the complete Medicaid Claims set and integrates this with SDoH indicators (e.g., housing status). Carelon BH CT currently produces 15 of the 25 required quality metrics under the program. Based on a preliminary review, the ASO has the necessary data to develop and compute five of the ten remaining measures. Challenges and proposed solutions for the five remaining metrics will be discussed under questions D-4 and D-5. During the planning and demonstration (if awarded) phases, the state and its ASO will ensure the successful collection of data from the CCBHC providers on a quarterly basis. We will collect data on the four required Infrastructure Development, Prevention, and Mental Health Promotion (IPP) indicators. In addition to these measures, we have decided to also collect data on three additional indicators at the organizational level, as these specific metrics will provide a deeper understanding of organizational changes resulting from the grant. These metrics assess whether the organization: a) entered into formal written inter- or intra-organizational agreements to improve mental-health-related practices and activities; b) demonstrated improved readiness to change their systems to implement mental-health-related practices; and g) implemented evidence-based mental-health-related practices/activities.

These metrics will be collected quarterly via Medallia or another secure survey tool available through the ASO. Carelon BH CT will aggregate the survey data and enter it into SPARS,

CMHS' data collection and reporting tool, and will also develop a Tableau© dashboard with interactive visualizations of quarterly data that can be used to track progress towards the established goals and inform services and care management. Carelon BH CT will analyze and report data to share at the CCBHC steering committee, provider meetings, and state partner meetings. Interactive data visualization allows for early detection of differences between providers or inter-organizational changes over time. These outcomes can spur further analyses focusing on the outcomes of the above-mentioned indicators in relationship to other organizational factors, such as the size of the organization, geographic location, and characteristics of the members served (e.g., diagnostic profiles and demographics). The data reviews and analyses will help us determine whether the goals, objectives, and intended outcomes are being achieved and whether adjustments are needed.

D-2. Supports re: CQI and Performance Assessment. The Quality Department of the CT BHP ASO employs over 30 staff members, including data analysts, programmers, quality improvement specialists, network managers, and health research scientists who utilize the Model for Improvement CQI model. This approach consists of two phases. Phase 1 focuses on setting goals, establishing measures, and choosing an intervention, and Phase 2 employs a Plan-Do-Study-Act process to test and refine the approach. This is augmented with a STEP model that incorporates implementation science methodologies to support fidelity to evidence-informed, evidence-based, and best practices. All of this is supported by multiple data ingestion, storage, management, analysis, and reporting tools, including an Informatica B2B Data Exchange or another secure data exchange solution, Enterprise Data Warehouse, SAS © for advanced analytics, Tableau© data visualization (or another interactive business intelligence dashboard), and access to multiple electronic survey tools. As noted above, the ASO receives a complete statewide claims feed from the state's Medicaid claims vendor. The ASO also participates in the State's Health Information Exchange (HIE, known as CONNIE), which allows providers to export their EHR data to the platform to be accessed by approved entities. Along with the ASO, the state will modify existing data collection, analysis, and reporting systems to meet the needs of SAMHSA, the state, providers, and evaluators. Other performance improvement components include education, training, and provider reporting. Using provider claims and other data, the ASO's PAR program (described in section B-1) guides providers in conducting CQI. A similar process will be utilized to support CCBHCs. With the assistance of SAMHSA, the National Council, and other consultations, we will organize and ensure the provision of TA and support to providers to establish or modify existing data systems and engage in performance improvement processes. External consultants (see budget narrative) and staff at both DMHAS, DCF, and DSS that currently manage extensive arrays of EBPs for children, families, and adults will also provide support and have input into model selection and implementation.

D-3. Plan for Performance Assessment. For the past several years, the CT BHP has been planning an initiative to improve the access, quality, outcomes, and efficiency of outpatient behavioral health services provided under Medicaid. Initial goals derived from that planning process have been updated since the decision was made to pursue the implementation of CCBHCs as the vehicle for improving clinic services. Goals include and align with the CCBHC program goals and include state specific goals regarding geographic coverage, providing opportunities for qualified smaller clinics to participate, ensuring that services for children and adolescents are given equal importance in program implementation, and requiring that CCBHCs provide and coordinate with the adult and youth crisis system services and provide clinic based

crisis services to augment services provided via the statewide networks. Other goals include but are not limited to improving the accessibility, quality, and comprehensiveness of services, increasing the use of data to guide and improve performance, providing integrated mental health and medical care, coordinating services across systems, improving financial sustainability through an alternative payment model, and promoting recovery and whole-person care.

The capacity of existing clinics to provide all nine required services, either directly or through a DCO, will likely present some challenges initially. While 1) crisis services, 2) screening, assessment, and diagnosis, 3) person-centered and family-centered treatment planning, 4) outpatient mental health and substance use services, and 5) targeted case management (TCM) are routinely provided and funded throughout the HUSKY Health service network, individual clinic provision of these core services across the age span is not uniform. To meet all service requirements, some clinics will need to develop additional expertise and staffing resources or partner with a DCO. The CT BHP and its ASO, in conjunction with the resources provided by SAMHSA and the National Council, are prepared to provide TA, training, and support where required and will draw on the existing PAR programs to engage providers in a community of practice in areas where specialized capacity and expertise (e.g., substance use disorder, or child services) are required. Some FQHCs, hospital-based clinics, and programs participating in the state's Behavioral Health Home project already provide primary care screening and monitoring. However, some programs will require support regarding staffing and programming, which we plan to provide through our workforce planning and the TA resources noted above. The same applies to psychiatric rehabilitation services, and support will also be provided for this service requirement when necessary. Peer and family/caregiver services are currently available in Connecticut via grant-funded programs throughout the service system but have not historically been reimbursed under HUSKY Health (with some exceptions). Connecticut will leverage the expertise of existing peer and family support networks to support clinics that will be newly offering this service.

The CT BHP and its ASO have a strong track record of using data to improve care, as described in the answers to D-1, D-2, and elsewhere in this application. We regularly track performance on the majority of quality measures required under this program, produce periodic estimates of final rates for timely review, and disaggregate performance by provider. We will also utilize a Tableau© dynamically filtered dashboard for tracking, reporting, and evaluating performance with the providers. Challenges include developing five metrics that are not currently programmed and accessing provider data that we do not currently access (time to service, provider EHRs, and satisfaction surveys).

Carelon BH CT has begun work to program the five measures and will be ready to report on them within the planning year. We plan to access the satisfaction surveys currently collected and reported by the child and adult service systems, and this will require developing data-sharing agreements and working out the technical details of the data exchanges. Although this is highly technical, complex work, the CT BHP has a strong track record of completing similar data integration tasks for multiple projects, including our support of a CMS Integrated Care for Kids (InCK) grant, the Five Hundred Familiar Faces data integration project under a Governor's task force initiative, the Connecticut Housing Engagement and Support Service (CHESS) program, and other projects.

D-4. Challenges with Evaluation Data Collection. Based on prior experience with similar projects, we anticipate the following challenges that may be associated with the data collection

required for the national evaluation. It can be labor-intensive and challenging to negotiate compliance and legal frameworks regarding nondisclosure, data-sharing agreements, and data use with third-party data sources. Also, third-party data source organizations may experience difficulties in complying with federal (HITRUST, HIPAA, SOC) and state data security measures to safeguard sensitive health data. Data source organizations, particularly those that lack a robust data infrastructure, may have difficulty adhering to mutually agreed-upon data dictionaries, data standards, and data layout specifications, which can impair data quality and the ability to integrate this data with other data sets. We have also experienced that third-party sources are variable in their ability to automate data exchanges and meet the set frequency of necessary data exports and imports to meet deliverable timelines. Finally, based on our most recent discussions with the managers of the state HIE, there may be initial challenges accessing sensitive patient treatment and clinical data protected by 42 CFR part 2. The state, in collaboration with Carelon BH CT, has negotiated previous challenges with collecting data for programs that support providing care for HUSKY Health members. With guidance from the state, the ASO will facilitate negotiations with third-party data source organizations regarding nondisclosure/ data use agreements, compliance with state and federal data security measures, and adherence to mutually agreed upon data specifications to support collection of all National Evaluation program data. To date, projects carried out to evaluate efforts to improve services under Medicaid have not required IRB approval given the ASOs existing contracts with the DSS and the CT BHP and the nature of the evaluation projects (e.g., not involving random assignment of members to different treatment arms) but this will be resolved prior to project commencement, and IRB approval will be pursued if necessary.

D-5. Capacity to Collect Data. As noted in D-3, Data required for some of the quality measures will require access to data that is not currently available. With regards to other evaluation data, Connecticut will be able to provide a full claim set for the CCBHC-certified clinics and other clinics not participating in the program that is compliant with CMS-64 reporting, financial cost reports that are submitted as a requirement under this initiative, client satisfaction surveys via state-collected data (DMHAS and DCF), and outcomes data via the DMHAS and DCF data systems. New data collection processes will need to be developed for other data sources, such as certain client-level encounter data, chart-based registry data, EHR data, some portions of quality data, clinic characteristics, and certification data. Options for obtaining this data and the ability to report it include accessing DCF and DMHAS data sources for encounter and outcome data, utilizing state and ASO staff to collect required registry data, negotiating with the state's HIE to obtain file downloads or using SAMHSA-provided or custom Excel templates for EHR data, the use of electronic survey tools for clinic characteristics and program implementation data, and integration of clinic specific NCQA CCBHC accreditation data. Options for collecting IPP data and quality metrics are described above in responses to questions D-1 through D-3.