July 5th, 2018

***Note:** This template is being finalized for review and approval by OMB. It is structured for easy and consistent use by states and will facilitate cross state assessment and the identification of trends, challenges and best practices to support learning collaboration and policy / operations enhancements as may be needed. Until such time, its use is optional, although it conveys the nature and extent of monitoring information that CMS is seeking on SUD demonstrations, and the state's comments on its structure and ease of use are helpful in finalizing it. The SUD STCs require the state's compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 waiver reporting and analytics functions, the state is required to work with CMS to:*

a. *Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;*
b. *Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and*
c. *Submit deliverables to the appropriate system as directed by CMS.*

When this template is OMB approved, then the state will be required to use it.

1. Title Page for the State's SUD Demonstration or SUD Components of Broader Demonstration

The state should complete this Transmittal Title Page at the beginning of a demonstration and submit as the title page of all SUD Monitoring Reports. The content of this transmittal table should stay consistent over time.

State	*Kentucky*
Demonstration Name	*SUD Demonstration, Kentucky Helping to Engage and Achieve Long Term Health (KY HEALTH)*
Approval Date	*January 12, 2018.*
Approval Period	*January 12, 2018 – September 30, 2023*
SUD (or if broader demonstration, then SUD Related) Demonstration Goals and Objectives	*Effective upon CMS' approval of the SUD Implementation Protocol, as described in STC 93, the demonstration benefit package for all Medicaid beneficiaries as authorized by this demonstration will include OUD/SUD residential treatment, crisis stabilization and withdrawal management services provided in IMDs, which are not otherwise matchable expenditures under section 1903 of the Act. Medicaid beneficiaries residing in IMDs under the terms of this demonstration will have coverage of all benefits that would otherwise be covered if the beneficiary were not residing in an IMD. Effective upon CMS' approval of this demonstration, methadone treatment services will be a covered service under the state plan for Medicaid beneficiaries.* *The coverage of OUD/SUD residential treatment, crisis stabilization, withdrawal management and methadone treatment services will expand Kentucky's current SUD benefit package available to all Medicaid beneficiaries. Note: room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.* *A waiver of the NEMT assurance is granted for methadone treatment services to allow the state not to provide NEMT for methadone services to all Medicaid beneficiaries, except that NEMT for methadone services will be provided for children under age 21 who are subject to EPSDT, former foster care youth, and for pregnant women. (A waiver of the NEMT assurance for all other Medicaid covered services is granted for beneficiaries eligible through the new adult group, as defined in 42 CFR 435.119, except for beneficiaries in that group who are under age 21 and subject to EPSDT, pregnant, medically frail, survivors of domestic violence, or former foster care youth.)*

2. Executive Summary As previously reported, Kentucky HEALTH was stopped, per Federal Court Ruling on 3/27/19. The Commonwealth, in conjunction with the Dept. for HHS, filed an appeal with the Federal Circuit of Appeals. Briefs were submitted to the Appellate Court and oral arguments are planned for October 11, 2019. Anticipated court decision is expected by late fall 2019.

Due to the late timing of the 3/27/2019 court ruling, the Commonwealth provided Provider Site Support to seven (7) health care, dental and vision providers the first week of April. This allowed the teams to see if any policy or technology issues were occurring and offered the ability to respond/resolve around the state as necessary. No major issues were reported.

Outreach to beneficiaries, community partners, and other key stakeholders continued for this reporting period. We facilitated strategy sessions to brainstorm key messaging needs. Program status language was added to the Kentucky HEALTH website. We made the decision to keep our forum platform active, and facilitated a Community Forum on 6/6/19 in London, KY. Community forums are open to all stakeholders, including beneficiaries. The Pulse Newsletter was distributed to ~6,000 Kentucky HEALTH stakeholders on 6/5/19.
A Change Agent Forum was facilitated for Department for Community Based Services (DCBS) caseworkers and leadership to maintain program engagement and understanding.

Beneficiaries continue to have the ability to create an account and accrue dollars on the Citizen Connect, a platform designed for the My Rewards component of Kentucky HEALTH. During the reporting period, the MRA team reviewed the course catalog, and developed an outreach plan based on account balances. The My Rewards Courses are not required, but our outreach is an effort to increase account creation and develop familiarity with system navigation.

Within the technology requirements of the Kentucky HEALTH program, the Kentucky HEALTH code "rollback" was deployed on 4/1/19.

Reporting on the Substance Use Disorder (SUD) component, in April, we submitted State Plan Amendment (SPA) to CMS for 90-day review and comment period. The final Administrative Regulations were submitted in June 2019 eRegs batch.
The state initiated vendor joint application design (JAD) sessions with system teams with system changes for deployed on 6/20/19 so providers could perform maintenance in Partner Portal.
Further, we facilitated forums with the Narcotic Treatment Providers (NTPs) and MCOs to review the SUD program, policy and system changes, and expectations from the respective groups. We also hosted an MCO IT Forum focused on system changes and MCO system impacts on 5/23/19.
Target annual goals for SUD were shared with CMS during this reporting period.
Lastly, UPenn developed the Kentucky HEALTH Evaluation Plan and it was submitted to CMS on 5/19/19

3. Narrative Information on Implementation, by Reporting Topic

Prompts	Demonstration year (DY) and quarter first reported	Related metric (if any)	Summary
1.2 Assessment of Need and Qualification for SUD Services			
1.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.	*EXAMPLE DY 1, Qtr. 2*	*EXAMPLE 8: Medicaid beneficiaries with SUD diagnosis treated in an IMD*	*The number of beneficiaries with a SUD diagnoses treated in an IMD in the last quarter decreased by 5% due to the closure of one IMD in the state.*
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
1.2.2 Implementation Update			
Compared to the demonstration design details outlined in the STCs and implementation plan, have there been any changes or does the state expect to make any changes to: A) the target population(s) of the demonstration? B) the clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration?	*EXAMPLE DY 1, Q2*	*EXAMPLE N/A*	There are no planned changes to the target population or clinical criteria.
Are there any other anticipated program changes that may impact metrics related to assessment	*DY 1, Q2*	*EXAMPLE 6 and 7: Medicaid*	*no*

of need and qualification for SUD services? If so, please describe these changes.		*beneficiaries with SUD diagnosis (monthly)*	
☐ The state has no implementation update to report for this reporting topic.			
2.2 Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)			
2.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			*N/A*
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
2.2.2 Implementation Update			
Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to: a. Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g. outpatient services, intensive outpatient services, medication assisted treatment, services in intensive residential and			

inpatient settings, medically supervised withdrawal management)? b. SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication assisted treatment services provided to individuals in IMDs?			
Are there any other anticipated program changes that may impact metrics related to access to critical levels of care for OUD and other SUDs? If so, please describe these changes.			
[Add rows as needed]			
☒ The state has no implementation updates to report for this reporting topic.			
3.2 Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)			
3.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. Changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state is reporting metrics related to Milestone 2, but has no metrics trends to report for this reporting topic.			

☐ The state is not reporting any metrics related to this reporting topic.			
3.2.2 Implementation Update			
Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to: a. Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria? b. Implementation of a utilization management approach to ensure: i. Beneficiaries have access to SUD services at the appropriate level of care? ii. Interventions are appropriate for the diagnosis and level of care? iii. Use of independent process for reviewing placement in residential treatment settings?			
Are there any other anticipated program changes that may impact metrics related to the use of evidence-based, SUD-specific patient placement criteria (if the			

state is reporting such metrics)? If so, please describe these changes.			
☒ The state has no implementation updates to report for this reporting topic.			
4.2 Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)			
4.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. Changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☐ The state is reporting metrics related to Milestone 3, but has no metrics trends to report for this reporting topic.			
☒ The state is not reporting any metrics related to this reporting topic.			
4.2.2 Implementation Update			
Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to: a. Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards? b. State review process for residential treatment providers' compliance with qualifications standards?			

c. Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site?			
Are there any other anticipated program changes that may impact metrics related to the use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities (if the state is reporting such metrics)? If so, please describe these changes.			
[Add rows as needed]			
☒ The state has no implementation updates to report for this reporting topic.			
5.2 Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)			
5.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
5.2.2 Implementation Update			

Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care?			
Are there any other anticipated program changes that may impact metrics related to provider capacity at critical levels of care, including for medication assisted treatment (MAT) for OUD? If so, please describe these changes.			
[Add rows as needed]			
☒ The state has no implementation updates to report for this reporting topic.			
6.2 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)			
6.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
6.2.2 Implementation Update			

Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to: a. Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD? b. Expansion of coverage for and access to naloxone?			
Are there any other anticipated program changes that may impact metrics related to the implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD? If so, please describe these changes.			
[Add rows as needed]			
☒ The state has no implementation updates to report for this reporting topic.			
7.2 Improved Care Coordination and Transitions between Levels of Care (Milestone 6)			
7.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			

☒ The state has no metrics trends to report for this reporting topic.			
7.2.2 Implementation Update			
Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports?			*KY DMS submitted an Implementation Plan change on 5/21/19 to CMS with updated IT changes and date changes. CMS approved 8/21/19.*
Are there any other anticipated program changes that may impact metrics related to care coordination and transitions between levels of care? If so, please describe these changes.			*Not at this time.*
[Add rows as needed]			
☐ The state has no implementation updates to report for this reporting topic.			
8.2 SUD Health Information Technology (Health IT)			
8.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. Changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
11.2.2 Implementation Update			

Compared to the demonstration design and operational details outlined in STCs and implementation plan, have there been any changes or does the state expect to make any changes to: a. How health IT is being used to slow down the rate of growth of individuals identified with SUD? b. How health IT is being used to treat effectively individuals identified with SUD? c. How health IT is being used to effectively monitor "recovery" supports and services for individuals identified with SUD? d. Other aspects of the state's plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels? e. Other aspects of the state's health IT implementation milestones? f. The timeline for achieving health IT implementation milestones?			

g. Planned activities to increase use and functionality of the state's prescription drug monitoring program?			
Are there any other anticipated program changes that may impact metrics related to SUD Health IT (if the state is reporting such metrics)? If so, please describe these changes.			
[Add rows as needed]			
☒ The state has no implementation updates to report for this reporting topic.			
9.2 Other SUD-Related Metrics			
9.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
9.2.2 Implementation Update			
Are there any anticipated program changes that may impact the other SUD-related metrics? If so, please describe these changes.			
[Add rows as needed]			
☒ The state has no implementation updates to report for this reporting topic.			
10.2 Budget Neutrality			

10.2.1 Current status and analysis			
Discuss the current status of budget neutrality and provide an analysis of the budget neutrality to date. If the SUD component is part of a comprehensive demonstration, the state should provide an analysis of the SUD-related budget neutrality and an analysis of budget neutrality as a whole.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
10.2.2 Implementation Update			
Are there any anticipated program changes that may impact budget neutrality? If so, please describe these changes.			
[Add rows as needed]			
☒ The state has no implementation updates to report for this reporting topic.			
11.1 SUD-Related Demonstration Operations and Policy			
11.1.1 Considerations			
Highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any			

other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.			
[Add rows as needed]			
☒ The state has no related considerations to report for this reporting topic.			
11.1.2 Implementation Update			
Compared to the demonstration design and operational details outlined in STCs and the implementation plan, have there been any changes or does the state expect to make any changes to: a. How the delivery system operates under the demonstration (e.g. through the managed care system or fee for service)? b. Delivery models affecting demonstration participants (e.g. Accountable Care Organizations, Patient Centered Medical Homes)? c. Partners involved in service delivery?			

Has the state experienced any significant challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers)? Has the state noted any performance issues with contracted entities?			Update provided in the DY2Q1 report
What other initiatives is the state working on related to SUD or OUD? How do these initiatives relate to the SUD demonstration? How are they similar to or different from the SUD demonstration?			
[Add rows as needed]			
☐ The state has no implementation updates to report for this reporting topic.			
12.1 SUD Demonstration Evaluation Update			
12.1.1 Narrative Information			
Provide updates on SUD evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. See report template instructions for more details.	DY2, Q2	N/A	The state and independent evaluator (University of Pennsylvania) have been in consultation as they prepare the second draft of the evaluation plan and respond to CMS feedback on the first draft of the plan. They have been collecting additional information, as requested by CMS, for the second draft.
Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected	DY2, Q2	SUD Evaluation Plan Draft #2	The state and the University of Pennsylvania expect to submit the second draft of the SUD evaluation plan by the CMS due date (8/24/2019).

timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.		due 8/24/2019	
List anticipated evaluation-related deliverables related to this demonstration and their due dates.	DY2, Q2	SUD Evaluation Plan Draft #2 due 8/24/2019	The state received feedback from CMS on the first draft of the SUD evaluation plan on June 24, 2019, and plans to submit the second draft of the evaluation plan by the due date on 8/24/2019.
[Add rows as needed]			
☐ The state has no SUD demonstration evaluation update to report for this reporting topic.			
13.1 Other Demonstration Reporting			
13.1.1 General Reporting Requirements			
Have there been any changes in the state's implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol?			
Does the state foresee the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes?			
Compared to the details outlined in the STCs and the monitoring protocol, has the state formally requested any changes or does the state expect to formally request any changes to:			

a. The schedule for completing and submitting monitoring reports? b. The content or completeness of submitted reports? Future reports?			
Has the state identified any real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation?			
[Add rows as needed]			
☒ The state has no updates on general reporting requirements to report for this reporting topic.			
13.1.2 Post Award Public Forum			
If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual report.			
[Add rows as needed]			
☐ There was not a post-award public forum held during this reporting period and this is not an annual report, so the state has no post award public forum update to report for this reporting topic.			
14.1 Notable State Achievements and/or Innovations			
14.1 Narrative Information			

Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.			Update provided in the DY2Q1 report
Summary of the authorization of extension of coverage to former foster care youth who were the responsibility of another state			The state already had a Former Foster Child (FFC) TOA, but we did not distinguish between in or out of state. A question exists in the eligibility application (IEES) to capture this distinction. Kentucky currently has 15 members who are FFC from another state.
Summary of authorization to alignment of a beneficiary's annual redetermination with their employer sponsored insurance (ESI) open enrollment period, including any children enrolled in Medicaid or CHIP and covered by a parent or caretaker's ESI			Currently, all Medicaid beneficiaries are given a redetermination date. There is no consideration in place for open enrollment periods outside of Medicaid. The KI-HIPP component of Kentucky HEALTH will require beneficiaries who have been enrolled in Kentucky HEALTH for 12 months AND employed for 12 months, to enroll in their employer sponsored insurance (ESI) if it is deemed cost effective. Our intent is to leave determination dates as is for the beneficiary through their first year in the KI-HIPP program, then align redetermination date with the open enrollment period of their ESI. We will then monitor to determine if this is beneficial for the members.

☐ The state has no notable achievements or innovations to report for this reporting topic.

Commonwealth of Kentucky
Section 1115 Substance Use Disorder (SUD) Demonstration
Implementation Plan

Date: 08-22-19Amended

Overview

The Commonwealth of Kentucky is facing a substance use crisis of epic proportions. [1] In 2016, the commonwealth lost 1,404 Kentuckians due fatal drug overdoses. Over the past 5 years Kentucky has seen a 38% increase in overdose deaths. Historically among the Substance Use Disorder (SUD) population the number of patients who have one of the common co-morbidities associated with SUD are much greater than patients without an SUD. For example, the state has seen a rapid increase (nearly 115%) in cases of Neonatal Abstinence Syndrome (NAS).[2] Of those cases, Medicaid accounted for over 80%. In 2016 the Center for Disease Control (CDC) identified 220 counties in the United States that are most susceptible for Human Immunodeficiency Virus (HIV) outbreak, of the 220 counties 54 reside in the Commonwealth of Kentucky.

Kentucky has created multiple initiatives to combat the SUD crisis and increase awareness. Below are a number of programs that have either been implemented or are under development:

- In 2012, Kentucky passed sweeping legislation that has become a national model. This statute required; the use of Prescription Drug Monitoring Program (PDMP) for all prescribers of controlled substances, regulated pain clinics by requiring them to be physician or hospital owned, and fostered increased cooperation among the PDMP, Kentucky licensure boards and law enforcement.
- In 2015, Kentucky passed several harm reduction measures including; Syringe Exchange, Naloxone Distribution and the Good Samaritan Law.
- In 2015, the Kentucky Board of Medical Licensure (KBML) promulgated a regulation containing buprenorphine prescribing guidelines to help improve the effectiveness of medication assisted treatment with buprenorphine.

[1] Slide 5 SUD DMS Provider Forums 2017 (using 2011-2016 data)
[2] Produced by the Kentucky Injury Prevention and Research Center, May 2016. Kentucky Inpatient Hospitalization Claims Files, Frankfort, KY, [2000-2015]; Cabinet for Health and Family Services, Office of Health Policy. Data for 2010-2015 are provisional; therefore these results are subject to change.

- In 2017 House Bill 333 – Introduced as the professional standard of a 3-day prescribing limit on Schedule II controlled substances for acute pain.
- Kentucky Opioid Response Effort (KORE) Initiatives:
  - ER Bridge Clinics – Established Bridge Clinics in three (3) major Hospital Systems, where individuals admitted to the Emergency Room as a result of drug overdose will have the option to begin treatment at a "Bridge Clinic", which will then be able to provide Medication Assisted Treatment (MAT). Peer Support Specialists will also meet with individuals in the ED to provide support around accessing treatment and recovery services. Following discharge, Peer Support Specialists as well as other treatment staff (e.g., case managers, certified providers, and licensed evaluator) will contact individuals as part of an assertive, ongoing engagement effort. Individuals accepting services will have rapid access to treatment, including MAT, by being transferred to a Bridge clinic located nearby.
  - Sponsoring opioid stewardship aimed at prescriber education and reducing the dependence on opioids for pain management.
  - Expand prevention programs Sources of Strength in middle, high and post-secondary institutions.
- Department for Behavioral Health Developmental and Intellectual Disabilities (DBHDID) Grant > Behavioral Health & Primary Care Integration.
- State Wide Screening referral service for substance abuse treatment Helpline.
- In 2018 Kentucky will implement –a Web based treatment locator designed for referrals from Primary Care Physicians, Emergency Room and Health Departments.
- Addition of Methadone coverage for SUD treatment via state plan.

Section I – Milestone Completion

Milestones

1. Access to Critical Levels of Care for OUD and Other SUDs

To improve access to Opioid Use Disorder (OUD) and SUD treatment services for Medicaid beneficiaries, it is important to offer a range of services at varying levels of intensity across a continuum of care since the type of treatment or level of care needed may be more or less effective depending on the individual beneficiary.

- Outpatient Services;
- Intensive Outpatient Services;
- Medication assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state);
- Intensive levels of care in residential and inpatient settings; and
- Medically supervised withdrawal management

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Coverage of outpatient services	Department for Medicaid Services (DMS) currently provides a comprehensive array of behavioral health services including; Screening, Assessment, Crisis Intervention, Partial Hospitalization, Individual, Group and Family therapies, Peer Support, Targeted Case	Will add treatment plan development for alcohol and/or substance abuse to the array of services allowed in State Plan. Will continue providing coverage of outpatient services through the State Plan.	• Amend State Plan to include service planning for SUD treatment. • Update regulations to reflect added service. DMS Division of Policy and Operations will oversee completion of tasks.

	Management, and residential service for SUD. DMS also provides medication assisted treatment with buprenorphine, and vivitrol. These services will continue under Kentucky's State Plan. Click Here for State Plan Amendment		• DMS Senior Behavioral Health Policy Advisor will oversee completion of tasks. • Estimated completion September 12, 2019.
Coverage of intensive outpatient services	Intensive Outpatient Program (IOP) is currently a covered service through Kentucky's State Plan and is an alternative to or transition from inpatient hospitalization or partial hospitalization for mental health or substance use disorders. IOP must be provided at least three (3) hours per day and at least three (3) days per week. This service will continue under Kentucky's State Plan. Partial Hospitalization is a short-term (average of four (4) to six (6) weeks), less than 24 hour, intensive treatment program for individuals experiencing significant impairment to daily functioning due to substance	Currently Partial Hospitalization may be provided in a hospital or Community Mental Health Center (CMHC). Propose to add Behavioral Health Services Organization (BHSO) as an allowable setting to perform partial hospitalization services. Will continue to cover IOP throughout the demonstration under State Plan.	• Amend regulations adding partial hospitalization to the service array for a BHSO. • DMS Senior Behavioral Health Policy Advisor will oversee completion of tasks. • September 12, 2019 completion time from approval of implementation plan.

	use disorders, mental health disorders or co-occurring mental health and substance use disorders. This service is designed for individuals who cannot effectively be served in community-based therapies or IOP. Click Here for State Plan Amendment		
Coverage of medication assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state)	DMS currently covers MAT for Buprenorphine and Vivitrol.	DMS will expand MAT to cover Methadone for the treatment of Substance Use Disorders.	• DMS will amend the State Plan to include coverage of Methadone for MAT. • Amend behavioral health services organization regulation to include narcotic treatment program. • DMS Senior Behavioral Health Policy Advisor will oversee completion of tasks. • Estimated Time Frame: September 12, 2019.
Coverage of intensive levels of care in residential and inpatient settings	DMS currently provides coverage of residential services for Substance Use Disorders (SUD) in the State Plan. Services must be provided under the medical direction of a physician and provide continuous nursing	Kentucky will perform its own certification program developing forms for on-site visits with a four-person team from Department for Medicaid Services Behavioral Health Policy Team. DMS will certify providers to the	State Plan Amendment and Regulation changes to reflect certification levels • DMS Senior Behavioral Health Policy Advisor will oversee completion of tasks.

	services in which a registered nurse shall be on-site during traditional first shift hours, continuously available by phone after hours' and on-site as needed in follow-up to telephone consultation after hours. Residential coverage have two levels of treatment. Short term services should have twenty-four (24) hour staff and have a duration of less than thirty (30) days. Long term services should have twenty-four (24) hour staff as required by licensing regulations with lengths of stay thirty (30) to ninety (90) days. DMS will not pay for this service in a unit of more than 16 beds or multiple units operating as one unified facility with more than 16 aggregated beds except for services furnished pursuant to the state plan benefit "inpatient psychiatric services for individuals under twenty-one (21)" (section 1905(a)(16) of the Act; 42 CFR 440.160) or pursuant to an exclusion for individuals age 65 or older who reside in institutions that	appropriate ASAM level for residential services in the current edition of The ASAM criteria.	• On-Site certification forms completed by September 30, 2019. • On-Site provider certification completed by December 31, 2019.

	are Institution for Mental Disease (IMDs) (section 1905(a) of the Act; 42 CFR 440.140.). Require BHSO to be licensed as a non-medical and non-hospital based alcohol and other drug treatment program in accordance with state licensing regulations. Click Here for State Plan Amendment		
Coverage of medically supervised withdrawal management(WM)	DMS currently covers medical detox in a hospital setting.	DMS will incorporate all levels of withdrawal management (Level 1 –WM Ambulatory withdrawal management without extended on-site monitoring, Level 2-WM Ambulatory withdrawal management with extended on-site monitoring, Level 3-WM Residential/inpatient withdrawal management and Level 3.2-WM Clinically managed residential withdrawal management, Level 3.7-WM medically monitored inpatient withdrawal management and Level 4- WM Medically managed intensive inpatient	• Amend service definitions to include withdrawal management at appropriate levels of care within State Plan and KY regulations. • DMS Senior Behavioral Health Policy Advisor will oversee completion of tasks. • Completed by September 12, 2019.

		withdrawal management) within the continuum of care offered in Kentucky.	

Kentucky defines the following categories of providers that are able to provide State Plan Services Behavioral Health and Substance Use Disorder services:

- Individual Practitioner: An individual practitioner who is licensed by the respective board in the Commonwealth of Kentucky or who is supervised by a licensed practitioner to render health services and/or bill DMS. The practitioners include: Licensed Professional Art Therapist, Applied Behavior Analyst, Licensed Professional Clinical Counselor, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Psychological Practitioner, Licensed Psychologist, Physician, Advanced Registered Nurse Practitioner with Psychiatry Specialty and Physician Assistant.
- Provider Group: A group of more than one individually licensed practitioner who forms a business entity to render behavioral health services and bill DMS.
- Licensed Organization: A business entity that employs licensed and non-licensed health professionals and is licensed to render behavioral health services and bill DMS. This organization must also meet the following criteria:
    (1) Be enrolled as a Medicaid provider in the Commonwealth of Kentucky;
    (2) Demonstrate experience serving the population of individuals with behavioral health disorders relevant to the particular services provided;
    (3) Have the administrative capacity to provide quality of services in accordance with state and federal requirements;
    (4) Use a financial management system that provides documentation of services and costs; and
    (5) Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements.

The Licensed Organizations include: Behavioral Health Services Organization and Community Mental Health Centers.

All providers must operate within the scope of their license. Providing services to Medicaid recipients outside a provider's licensure is considered fraud.

2. Use of Evidence-based, SUD-specific Patient Placement Criteria

Implementation of evidence-based, SUD-specific patient placement criteria is identified as a critical milestone that states are to address as part of the demonstration. To meet this milestone, states must ensure that the following criteria are met:

- Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, e.g., the ASAM Criteria, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines; and
- Utilization management approaches are implemented to ensure that (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, and (c) there is an independent process for reviewing placement in residential treatment settings.

Currently DMS, through Managed Care Contracts require the use of ASAM Criteria for authorization regarding Level of Care (LOC) for SUD treatment. Managed Care Organizations (MCO) apply ASAM to both outpatient and residential services with no predetermined limits of care established for these services. Continued involvement in a level of care is based on individual need determined through medical necessity criteria. DMS will continue to require ASAM Criteria for authorization of treatment and recovery services for individuals with an SUD through the contractual requirement with the MCO's. Below is the language utilized in the MCO contracts to address utilization management.

> [3]The MCO's shall have in place mechanisms to check the consistency of application of review criteria. The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate. The Medical Director and Behavioral Health Director shall supervise the UM program and shall be accessible and available for consultation as needed. Criteria approved under a prior contract must be resubmitted to ensure it meets the requirements of this Contract. Decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a physician who has appropriate clinical expertise in treating the Member's condition or disease. The clinical reason for the denial, in whole or in part,

[3] Language from MCO SFY 18 Contracts

specific to the Member shall be cited. Physician consultants from appropriate medical, surgical and psychiatric specialties shall be accessible and available for consultation as needed. The Medical Necessity review process shall be completed within two (2) business days of receiving the request and shall include a provision for expedited reviews in urgent decisions. Post-service review requests shall be completed within fourteen (14) days or, if the Member or the Provider requests an extension or the Contractor justifies a need for additional information and how the extension is in the Member's interest, may extend up to an additional fourteen (14) days.

A. The MCO's shall submit its request to change any prior authorization requirement to Department for Medicaid Services (DMS) for review.

B. For the processing of requests for initial and continuing authorization of services, the Contractor shall require that its subcontractors have in place written policies and procedures and have in effect a mechanism to ensure consistent application of review criteria for authorization decisions.

C. In the event that a Member or Provider requests written confirmation of an approval, the Contractor shall provide written confirmation of its decision within three working days of providing notification of a decision if the initial decision was not in writing. The written confirmation shall be written in accordance with Member Rights and Responsibilities.

D. The Contractor shall have written policies and procedures that show how the Contractor will monitor to ensure clinically appropriate overall continuity of care.

E. The Contractor shall have written policies to ensure the coordination of services:

1. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays;
2. With the services the Member receives from any other MCO;
3. With the services the member receives in Fee for Service (FFS); and
4. With the services the Member receives from community and social support providers.

F. The MCO shall have written policies and procedures that explain how prior authorization data will be incorporated into the MCO's overall Quality Improvement Plan.

DMS providers perform an assessment and collect other relevant information that will assist in determining the most appropriate level of care. DMS does not require the provider to utilize one specific multi-dimensional tool. In regulation, DMS defines assessment to include gathering information and engaging in a process with the individual that enables the provider to:

- Establish the presence or absence of a mental health disorder, substance use disorder, or co-occurring disorders;
- Determine the individual's readiness for change;
- Identify the individual's strengths or problem areas that may affect the treatment and recovery processes; and
- Engage the individual in developing an appropriate treatment relationship;

- Establish or rule out the existence of a clinical disorder or service need;
- Include working with the individual to develop a treatment and service plan; and
- Does not include psychological or psychiatric evaluations or assessments.

As part of the new waiver benefit, Kentucky will require utilization of ASAM's six dimensions of multidimensional assessment to ensure consistency in the assessment and treatment planning process for treatment of substance use disorders. The dimensions will assist the provider to create a holistic, biopsychosocial assessment of the recipient that will assist the provider with development of the treatment planning for any person seeking SUD services. The dimensions include acute intoxication and/or withdrawal potential; biomedical conditions and complications; emotional, behavioral or cognitive conditions and complications; readiness to change; relapse, continued use, or continued problem potential and recovery/living environment.

DMS will ensure that providers are utilizing the appropriate clinician to perform the assessment which include a credentialed counselor or clinician, a certified addiction registered nurse, a psychologist or a physician. DMS will require all SUD providers to incorporate these dimensions as part of their assessment by July 1, 2019. DMS will outline requirements within regulations and ensure all providers will be trained on ASAM criteria. The estimated timeline for completion of changes in regulations related to assessment criteria is July 1, 2019. DMS Division of Policy and Operations will oversee completion of task.

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

Through the new Section 1115 initiative, states will have an opportunity to receive federal financial participation (FFP) for a continuum of SUD services, including services provided to Medicaid enrollees residing in residential treatment facilities that qualify as institutions for mental diseases. To meet this milestone, states must ensure that the following criteria are met:

- Implementation of residential treatment provider qualifications (in licensure requirements, policy manuals, managed care contracts, or other guidance) that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding the types of services, hours of clinical care and credentials of staff for residential treatment settings;

- Implementation of a state process for reviewing residential treatment providers to assure compliance with these standards; and

- Implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off site.

Currently DMS only reimburses residential SUD treatment with providers who have less than sixteen (16) bed facilities or for recipients who are under the age of twenty-one (21) or over the age of sixty-four (64). CMHC's, BHSO's and hospitals are DMS provider types licensed through Office of Inspector General (OIG) and provide residential SUD services. These services are based on individual need and may include screening, assessment, service planning, peer support, individual, group and family outpatient therapy. DMS requires residential services be provided under the medical direction of a physician and provide continuous nursing services on site during traditional first shift hours Monday through Friday and continuously available for telephone consultation afterhours and onsite as needed.

The Commonwealth of Kentucky will conduct two (2) statewide surveys to assess the current landscape of behavioral health providers and determine what level of care residential providers are able to provide. We began with a survey sent out to all Medicaid enrolled substance use disorder providers to determine the current landscape of available services. The purpose of the second survey (self-attestation) was for the residential providers to self-attest to their level of ASAM residential care. The landscape survey was completed on October 15, 2018. This will align with the DMS led certification process. Based on the results of the second self-attestation (survey) Kentucky would allow for reimbursement of residential services up to 96 beds in an IMD pending certification by the State conducted certification process. Based on the result of the provider self-attestation, the temporary waiver of the IMD exclusion began on April 01, 2019. DMS is internally considering payment adjustment based on residential level of care.

In order for a SUD residential provider to be eligible for the Institution of Mental Disease (IMD) exclusion, Kentucky will require the provider to be certified to the ASAM residential levels of care which are; 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, 3.7 Medically Monitored Intensive Inpatient Services. Kentucky Revised Statutes (KRS) 216B.015 defines the Office of Inspector General, Division of Health Care responsible for inspecting, monitoring, licensing and certifying all health care facilities. This includes acute care hospitals, which DMS designate as Medically Managed Intensive Inpatient Services. Kentucky feels the licensure requirement is sufficient and does not require this level of care to be certified. The SUD residential providers that are ASAM certified will then be able to receive the IMD exclusion for up to 192 beds for short-term residential treatment. Short-term residential treatment is defined as a statewide average length of stay of thirty (30) days.

Kentucky will perform its own certification program of residential 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, and 3.7 Medically Monitored Intensive Inpatient Services. Kentucky is developing forms for on-site visits with a four-

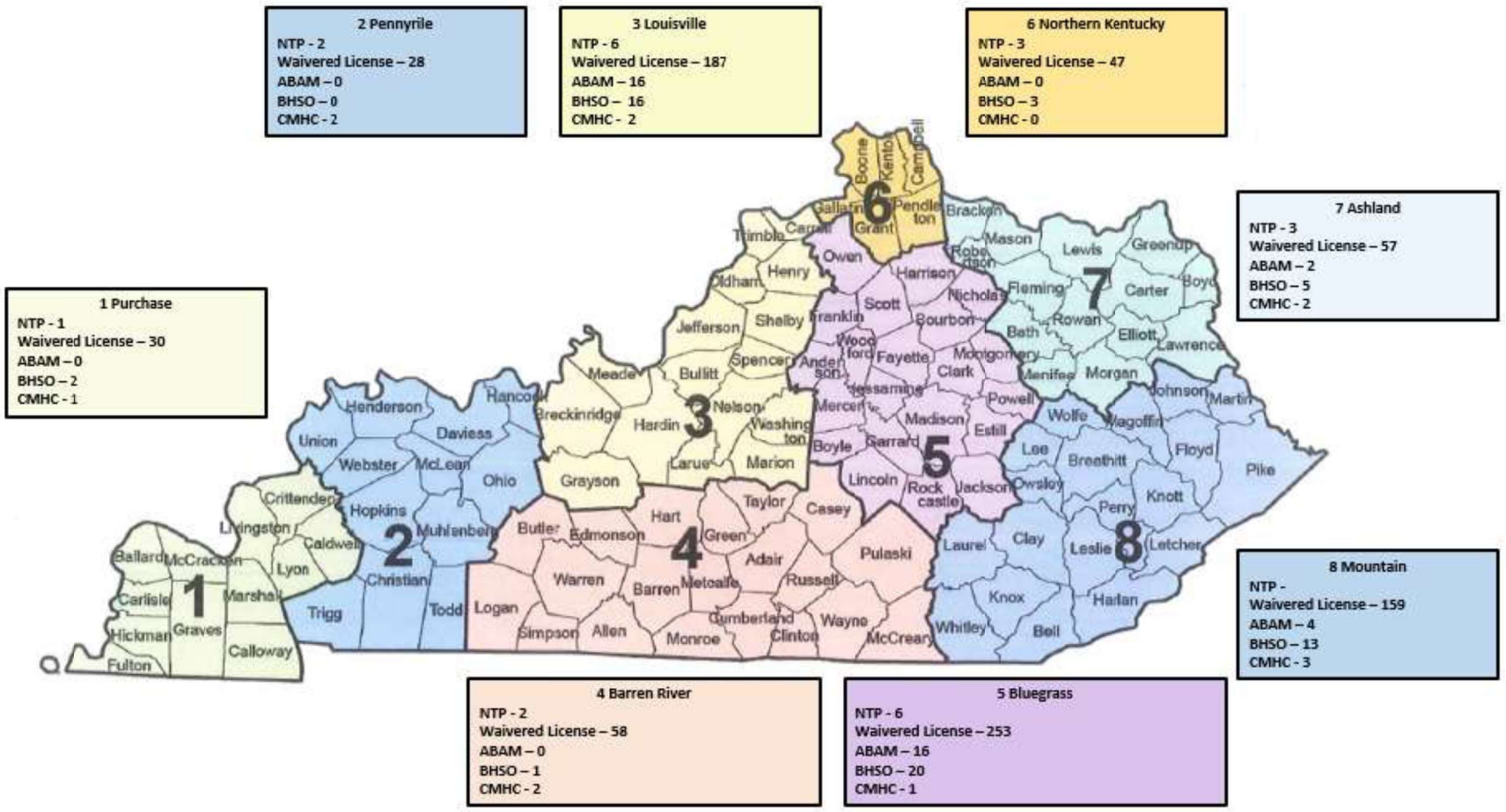
person team from Department for Medicaid Services Behavioral Health Policy team. Beginning October 15, 2018 this team will begin to conduct onsite visits of all Medicaid enrolled SUD residential providers to review settings, staff requirements, co-occurring capacity, and programming utilizing state created forms. Certification of all Medicaid enrolled residential SUD providers will be completed by January ~~15~~31, 2019. Moving forward DMS will continue to explore engaging with ASAM to participate in the pilot for level of care certification.

DMS currently offers all the service components of MAT within the State Plan. Methadone is currently payable for pain not for SUD treatment. DMS is adding the coverage of Methadone to our State Plan services for the treatment of SUD and will ensure residential providers are providing MAT on-site or facilitating access off site, by conducting a provider survey. The offsite facilitation of MAT for residential providers that do not provide medication as part of their treatment continuum will allow individuals who opt for medication as a part of their plan of care to receive the medication services outside of the residential provider. As part of the care coordination in a residential setting, the care coordinator will assist in the logistics of locating, scheduling and transporting an individual for their offsite medication services.

Kentucky has legislation to require the Cabinet of Health and Family Services (CHFS) to develop enhanced licensure and quality standards. These will be based on nationally recognized and evidence-based standards for substance use disorder treatment and recovery that include residential, outpatient and medication-assisted treatment (MAT) services. This legislation requires enhanced and streamline licensure requirements for SUD treatment providers as well as create statewide standards and outcome measures to ensure quality. DMS Division of Policy and Operations Senior Behavior Health Policy Advisor will oversee completion. Estimated for completion by September 12, 2019.

4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD

To meet this milestone, states must 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 must determine availability of treatment for Medicaid beneficiaries in each of these levels of care, as well as availability of MAT and medically supervised withdrawal management, throughout the state. This assessment should help to identify gaps in availability of services for beneficiaries in the critical levels of care.



DMS to develop and conduct a survey for Medicaid and Non-Medicaid providers to determine what services they provide related to SUD levels of care and potential for Medicaid enrollment. As part of the survey, Kentucky will be looking at medication assisted treatment (MAT) service capability. Through onsite visits we will verify MAT is offered on-site or facilitated offsite. Completion of provider survey will be within twelve (12) months of Implementation Plan approval. DMS Division of Policy and Operations is responsible for completion of task.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
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 (or at least in participating regions of the state) including those that offer MAT: Outpatient Services; Intensive Outpatient Services; Medication Assisted Treatment (medications as well as counseling and other services); Intensive Care in Residential and Inpatient Settings; Medically Supervised Withdrawal Management.		Kentucky Medicaid is conducting a statewide survey of treatment providers that currently offer outpatient, Intensive Outpatient services, MAT and Residential services. With pending changes to licensure requirements for SUD treatment and recovery providers, Kentucky Medicaid will create a Preferred prescriber program that incorporates DMS Pharmacy prescribing program. Participation in the preferred provider program will reduce the administrative burden on the provider. The following are the requirements for participation: • Providing treatment under the license of a buprenorphine waivered practitioner and co-located credentialed addiction treatment practitioners, • Can distribute buprenorphine products during induction • Provide prescriptions for buprenorphine products • Provide psychosocial treatment for opioid use disorder that include	• DMS removed prior authorization for al. MAT medications. Due to this change the need for preferred prescriber program has been eliminated. • DSM Senior Behavioral Health Policy Advisor and DMS Pharmacy Director will oversee completion of task. • Completion by September 12, 2019

		assessment of psychosocial needs, individual and/or group counseling, linkage and referral to community based services and support systems, care coordination of on-site and off-site treatment services, medical/prescription monitoring.	

5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

To meet this milestone, states must ensure that the following criteria are met:

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

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse	Prescribers are required to; obtain a report on beneficiaries from the prescription drug monitoring program (PDMP), obtain drug screens and encourage the patient's active participation in a behavioral modification program.	Revised buprenorphine criteria to increase response access and treatment. Streamlined administrative burden for quality care and qualified providers.	Develop program draft including revised clinical criteria and prior authorization forms -DMS Pharmacy Director is responsible for completion of this task -Expected on or before 11/1/18. 1/25/19 PA for bup over 24 mg and other bup

	DMS has implemented a 3 day supply limitation for controlled substances. (See statute link below) Click Here for KRS 218A.205	The Department for Medicaid Services (DMS) will align the Prior Authorization requirements (PA) for prescribing or dispensing buprenorphine –mono-product or buprenorphine combined with naloxone, with the professional standards from the KBML. (See regulation link below) Click Here for 201 KAR 9:270 Opioid Utilization Program that will include revised criteria to apply varying utilization controls to long acting opiates and short acting opiates; plus, the implementation of a Morphine Milligram Equivalent (MME) dosing limitations program, including treatment plan agreements and opiate PA requirements. A brief summary of the utilization controls being	products (injectable). PA for all controlled 2 substances Develop two (2) prior authorization forms. The first form aligning with KBML standards, the second form for the buprenorphine program. -DMS Pharmacy Director is responsible for completion of this task Complete - Following alignment of requirements there will be a 90 day provider notice and education period before changes can Go-Live. Expected on or before 11/1/18. Complete In-Progress -DMS Pharmacy Director is responsible for completion of this task -Approved by KY P&T Committee on 5/01/18; Go-Live 09/04/18 Complete

		reviewed include: limitations on Short Acting (SA) opioids for the treatment of acute pain, limitations on the treatment of chronic, non-cancer pain in non-hospice patients, other class limitations such as age limits, daily dose limits, limits on cough and cold opioid containing products, limits on codeine and tramadol products, and required review of overlapping claims for opioids and benzodiazepines. The MME dosing limitations involve a claim by claim analysis of current member utilization of both Long Acting (LA) and SA opioids. Once complete we will have a better understanding of how members may be utilizing multiple prescriptions to achieve higher cumulative MME and their per day dosing. A simplified conversion factor of 4 MME/unit for methadone will be used to resolve the IT systems limitations surrounding sliding scale as	

		recommended by CMS, until there is a new software release. Analysis will reveal the most common products contributing to the MME per day over 180 and over 300 both for FFS and the MCO populations. The program will allow exceptions for certain disease states such as cancer, sickle cell, and hospice. Additional considerations will apply for others like Long Term Care (LTC), acute surgical procedures, and Narcotic Treatment Program (NTP). We will establish MME thresholds for SA, LA, and combo use of opioids. And employ a step down methodology to reduce overall MME. Prior Authorizations will be revised to allow for new initial limits of opioids without PA up to a certain threshold MME (eg.. 90MME/day), while higher quantities require post limit PA, with an overall max MME threshold (eg.. 200MME/day). Post limit PA	

		approvals will be limited in duration for acute pain treatment (30 days) but one year for chronic pain care. This will include some required patient reassessment interval (eg.3 mo.) which exceptions for those actively battling cancer.	
Expanded coverage of, and access to, naloxone for overdose reversal	All Kentucky Health Plans currently cover naloxone Nasal Spray and syringes without a co-pay or prior authorization. Although a prescription is required, under a collaborative care agreement pharmacists throughout the Commonwealth are permitted to initiate protocol driven orders for naloxone products. As part Kentucky's Opioid Response Effort, Narcan kits (set of 2 doses) are distributed in the highest-risk regions of the Commonwealth through the Department for Public Health's mobile pharmacy as well as individual pharmacies who enter into an agreement with KPhA to dispense KORE-funded kits.	Increase access to Medication Assisted Treatment (MAT) providers to connect services between emergency room discharge for overdose or high risk to primary provider care and treatment. Resources and connectivity to those for beneficiaries in treatment or within a high risk populations will also be increased.	This effort to educate; beneficiaries, prescribers, dispensers, families and schools will be on-going.

	KPhA is also helping to establish partnerships between community pharmacies and residential treatment programs to ensure individuals have free take-home Narcan upon discharge. A pharmacist comes to the treatment centers to provide the kits as well as training on their use. People Advocating Recovery (PAR) is distributing Narcan kits in community settings targeting eastern Kentucky, other underserved counties, and Oxford Houses. In addition to training on use, education is provided on signs and symptoms, stigma, and Good Samaritan law. In addition 1,000 Narcan kits are being distributed across four Emergency Departments (UK, UL, St. Elizabeth, and St. Claire) to individuals having experienced or at risk for opioid overdose.		

6. Improved Care Coordination and Transitions between Levels of Care

To meet this milestone, states must implement policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD, with community-based services and supports following stays in these facilities.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Additional policies to ensure coordination of care for co-occurring physical and mental health conditions	Kentucky currently offers targeted case management for individuals with a SUD and for individuals with SUD and a chronic/complex physical health issue. This level of case management is individuals with a moderate to severe SUD.	Kentucky Medicaid will implement care coordination services for all individuals within residential treatment to ensure services are coordinated for co-occurring conditions as well as link the recipient to appropriate community services by facilitating medical and behavioral health follow-ups and linking to appropriate level of substance use treatment within the continuum in order to provide ongoing support for recipients.	Amend State Plan to include care coordination within the SUD residential treatment definition outlining the duties of care coordination. Amend State Regulations to include care coordination duties to the SUD residential treatment definition. • DMS Senior Behavioral Health Policy Advisor will oversee completion of tasks. • Completed by September 12, 2019.

DMS is in the early stages of a learning opportunity with other states related to integration of primary and behavioral health care. This learning lab will assist Kentucky with development of a strategic plan to implement policy for integration of physical and behavioral health. Kentucky's vision is to improve outcomes and reduce cost for; adults with serious mental illness and/or substance use

disorder, criminal justice, children and youth with social-emotional disturbance, children in state custody who may have juvenile justice involvement.

Through the Learning Lab opportunity Kentucky intends to improve linkages among health, behavioral health and criminal justice data.

Section II – Implementation Administration

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

Name and Title: Ann Hollen, Senior Behavior Health Policy Advisor
Telephone Number: (502) 564-6890
Email Address: ann.hollen@ky.gov

Section III – Relevant Documents

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

Attachment A – Template for SUD Health Information Technology (IT) Plan

Section I.

As a component of Milestone 5, Implementation of Strategies to Increase Utilization and Improve Functionality of Prescription Drug Monitoring Programs (PDMP), in the SMD #17-003, states with approved Section 1115 SUD demonstrations are generally required to submit an SUD Health IT Plan as described in the STCs for these demonstrations within 90 days of demonstration approval.

The SUD Health IT Plan will be a section within the state's SUD Implementation Plan Protocol and, as such, the state may not claim FFP for services provided in IMDs until this Plan has been approved by CMS.

In completing this plan, the following resources are available to the state:

a. Health IT.Gov in "Section 4: Opioid Epidemic and Health IT."[4]
b. CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" and, specifically, the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.[5]

As the state develops its SUD Health IT Plan, it may also request technical assistance to conduct an assessment and develop its plan to ensure it has the specific health IT infrastructure with regards to the state's PDMP plan and, more generally, to meet the goals of the demonstration. Contacts for technical assistance can be found in the guidance documents.

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

[4] Available at https://www.healthit.gov/playbook/opioid-epidemic-and-health-it.
[5] Available at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html.

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

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

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

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

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

Table 1. State Health IT / PDMP Assessment & Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed	Measurements
5. Implementation of comprehensive treatment and prevention strategies to address Opioid Abuse and OUD, that is: --Enhance the state's health IT functionality to support its PDMP; and --Enhance and/or support clinicians in their usage of the state's PDMP.	*Provide an overview of current PDMP capabilities, health IT functionalities to support the PDMP, and supports to enhance clinicians' use of the state's health IT functionality to achieve the goals of the PDMP.*	*Provide an overview of plans for enhancing the state's PDMP, related enhancements to its health IT functionalities, and related enhancements to support clinicians' use of the health IT functionality to achieve the goals of the PDMP.*	*Specify a list of action items needed to be completed to meet the HIT/PDMP milestones identified in the first column. Include persons or entities responsible for completion of each action item. Include timeframe for*	

			completion of each action item	
Prescription Drug Monitoring Program (PDMP) Functionalities				
Enhanced interstate data sharing in order to better track patient specific prescription data	1.1 The Kentucky PDMP (KASPER) is housed in the Cabinet for Health and Family Services (CHFS) Office of Inspector General (OIG). KASPER is currently able to share data with 12 states including our six border states that have PDMPs. 1.2 Interstate data is available for prescriber and pharmacist PDMP users. KASPER users currently have no tools or analytics available to assist them with identifying other state PDMPs for which a data request may be appropriate for a specific patient (informed data sharing.)	1.1 CHFS plans to enhance KASPER to support more efficient onboarding of additional states. 1.2 CHFS is beginning to work with the Bureau of Justice Assistance and PDMP Training and Technical Assistance Center to investigate the use of data analytics to inform end users of high probability patient data matching states to select when performing an interstate request	1.1 Onboard additional interstate data sharing states. Responsibility: KASPER Integration Project Manager (OATS). Target completion: December 2022. 1.2 Develop data analytic functionality to allow prescriber/pharmacist users to make a more informed decision on other states from which to request data based on their practice location and patient demographic information. Responsibility: KASPER Project Manager. Target completion: July 2020.	1.1 New States will be added at a rate of approximately 1 per month beginning in On-going. Monthly meetings are held. Currently we are sharing data with 12 states. The plan is to be connected to the remaining states and D.C. by December 2022. 1.2 This "Informed Data Sharing" is to be completed by July 2022. The plan begins with KASPER data only, but will spread to the regional and national level after proper analysis and

				testing. Monthly meetings will be held.
Enhanced "ease of use" for prescribers and other state and federal stakeholders	KASPER provides real-time access to Schedule II through V controlled substance prescription data for authorized health care providers, state and federal law enforcement officers and prosecutors, the Kentucky Medicaid program and other stakeholders. It allows for delegates to request reports on behalf of prescribers and dispensers, and allows for institutional accounts to simplify access for providers in hospitals and long term care facilities. The available controlled substance information includes opioid morphine milligram equivalent (MME) information, basic Prescriber Report Card data, and the ability to review the prescriber controlled substance	1.1 The KASPER code was developed in 2005, and is in need of modernization. CHFS is planning development of a new KASPER system using a modular design. Included in the modular design will be integrating with Electronic Health Record (EHR) system's and the statewide Kentucky Health Information Exchange (KHIE).	1.1 Develop a new modular KASPER system designed to provide improved ease of use and operational efficiency. The new system modules will include 1.1.1 User management module, 1.1.2 PDMP System Application Module, 1.1.3 PDMP Sharing Module. Responsibility: KASPER Project Manager. Target completion: 12/2021	1.1.1 User management module, 4/2020. 1.1.2 PDMP System Application Module, 11/2020. 1.1.3 PDMP Sharing Module, 12/2021. Weekly Meetings will be held thru-out the entire project.

	prescribing history to detect errors or fraud.			
Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange	There is currently limited connectivity between KASPER and the statewide health information exchange, KHIE.	Planned projects to integrate KASPER with KHIE include the following: 1.1 Prescriber and pharmacist users can request medical information based on a suspected drug overdose in an Emergency Department (ED). 1.2 Integration with KHIE, so prescriber and pharmacist KHIE users will be able to access KASPER patient data via KHIE without leaving the KHIE process workflow.	1.1 Drug toxicity screen results are being reported by the EDs to KHIE. The technical interface between KASPER and KHIE to obtain information regarding the presence of those results is under development. Responsibility: KASPER Project Manager. Target completion: 12/2018 1.2 Develop and implement technology to allow integrated data requests and responses between KASPER and KHIE. Responsibility: KASPER Project Manager. Target completion: 12/2020.	1.1 This interface is nearly complete. Will be ready by 12/2018. Weekly meetings are currently held. 1.2 This second phase of KASPER to KHIE integration will begin in 2019. Monthly meetings will be held. Should be completed by 12/2020.
Enhanced identification of long-term opioid use directly correlated to	1. KASPER currently identifies and flags patients who are	1.1 KASPER reports are going to be updated to include	1.1Modify KASPER reports to reflect overlapping controlled	1.1 This modification will take BA and

clinician prescribing patterns[6] (see also "Use of PDMP" #2 below)	receiving a current daily morphine milligram equivalent dose level of 100 or more. This includes a warning that these patients may be at a higher risk of drug overdose, and that increased clinical vigilance may be appropriate.	warning flags for overlapping opioid prescriptions and overlapping opioid and benzodiazepine prescriptions. 1.2 OIG will utilize an epidemiologist to study the correlation between initial opioid use and ongoing use and abuse.	substance prescriptions. Responsibility: KASPER Project Manager. Target completion: 12/2020. 1.2 Study correlations between initial opioid use and patient misuse and abuse patterns, as well as potentially problematic controlled substance prescribing practices. Responsibility: OIG Epidemiologist. Target completion: ongoing.	Development work. Weekly meetings will be held. 12/2020. 1.2 This is an ongoing study that the Epidemiologist will lead.
Current and Future PDMP Query Capabilities				
Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query)	1.1 KASPER currently utilizes advanced data analytics to match controlled substance prescription records to patients.	1.1 In March 2017 CHFS implemented a new KASPER Data Collection System. Via this system, CHFS is implementing new data	1.1 Continue KASPER data quality improvement efforts. This is needed to ensure and improve data quality. Responsibility: KASPER Project	1.1 This includes Business Analysts and Resource Management Analysts. This is an ongoing, daily happening.

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

		reporting edits that are helping to improve the quality of data collected. The improved data quality results in increased probability of accurate patient data matching. 1.2 CHFS is planning to implement an Enterprise Data Warehouse (EDW) that will house KASPER data.	Manager and Project Administrator. Target completion: ongoing. 1.2 Coordinate KASPER patient data matching processes and analytics to be consistent and support a Master Patient Indexing (MPI) within the EDW. Responsibility: KASPER Project Manager. Target completion: 6/2020.	1.2 This will be done in conjunction with the Data Analytics group within the Commonwealth. Weekly meetings will be held. Target completion of 6/2021.
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	The KASPER system is currently fully integrated with a major pharmacy chain, and CHFS has received requests from additional health systems to integrate with their EHR systems. The existing pharmacy integration allows the pharmacists to access	Integrate with additional EHR and pharmacy systems using solutions that present KASPER data directly in the physician workflow. Capitalize on the integration work done by EHR/Pharmacy system vendors in other states.	1.1 To support additional KASPER/EHR integration and KASPER/KHIE integration, OATS is conducting capacity planning reviews to ensure sufficient resources to support new integration projects.	1.1 This process may be included in the KASPER Modernization project. Weekly meetings will be held during this process.

	KASPER data in one simple step without leaving their pharmacy management system workflow.		CHFS is supporting federal efforts to develop an API/Web service for PDMP/EHR integration and may also develop an in-house API/Web service to support integration projects. Responsibility: KASPER Project Manager. Target completion: 9/2020.	
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	KASPER currently provides detailed prescription history and opioid MME data to health care provider users. Additional functionality is needed to improve the level of care.	1.1 Implement the ability for all KASPER users to obtain class A misdemeanor and felony drug conviction data for the patient. 1.2 Implement a patient dashboard capability to make it easier for healthcare provider KASPER users to identify overlapping prescriptions, early refills, multiple provider episodes, potential drug interactions and other	1.1 Implement a link to the Administrative Office of the Courts (AOC) CourtNet system to allow KASPER users to see drug conviction data for the previous five years. Responsibility: KASPER and AOC Project Managers. Target completion: 07/2018. 1.2 Evaluate existing patient dashboard tools and capabilities, and determine whether	1.1 This link is currently in the testing phase and will be completed by 7/2018. Weekly meetings are currently being held. 1.2 This evaluation will need to done prior to the modernization project.

		indicators that may indicate overdose risk, or controlled substance abuse or diversion.	they can be implemented into the current KASPER system or as part of the KASPER modernization project. Responsibility: OIG and OATS. Target completion: 12/2019	
Master Patient Index / Identity Management				
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	While KASPER and KHIE are not currently integrated, KHIE has a defined algorithm MPI that provides match, merge and search capability.	1.1 As noted above, a KASPER/KHIE integration project is in the planning stage. As part of this project KHIE will utilize the enterprise MPI solution for querying KASPER.	1.1 Procurement of a new KHIE vendor solution was just completed. The KASPER/KHIE integration project will be undertaken after implementation of the new KHIE system. Responsibility: KASPER and KHIE Project Managers. Target completion: 11/2019.	1.1 This MPI will be part of the KHIE system. This will require weekly meetings to properly identify the appropriate matching parameters.
Overall Objective for Enhancing PDMP Functionality & Interoperability				
Leverage the above functionalities / capabilities / supports (in concert with any other state health IT, TA or workflow effort) to	1.1 KASPER currently includes a Prescriber Report Card that provides aggregated controlled substance prescribing data and allows prescribers to	1.1 Phase 2 of the Prescriber Report Card will include patient level data allowing prescribers easier identification of at-risk	1.1 Implement phase 2: the enhanced KASPER Prescriber Report Card. Responsibility: KASPER Project Manager.	1.1 This drill down option is expected by early 4/2020. This phase 2 option will have monthly meetings between

implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids	compare their controlled substance prescribing with all Kentucky prescribers and with prescribers in their specialty area.	patients (drill down options) These Prescriber Report Cards are available to the Kentucky prescriber licensure boards to assist with reviewing for inappropriate or illegal controlled substance prescribing.	Target: completion date: 4/2020.	KASPER IT team and OIG.

The Commonwealth of Kentucky has assessed the current infrastructure/"ecosystem" that will be necessary to achieve the goals of the demonstration. The necessary changes have been identified and captured in the Kentucky HEALTH High Level Requirements (HLR) document which will be used to help determine cost and timeline as well as to monitor the overall status throughout development and implementation.

We have reviewed our last submission of the State Medicaid Health IT Plan (SMHP), Health Information Technology Plan to verify that SUD is aligned with the plan, it is. This has been addressed in the plan with integration to eKASPER and KHIE which also includes behavioral health data. It will become more tightly integrated and aligned as the Kentucky HEALTH demonstration project moves forward.

As applicable the Commonwealth of Kentucky will advance the standards referenced in the ISA and 45 CFR Subpart B, and the Manage Care Contractor (MCO) contracts will be updated to comply with the requirements.

Attachment A, Section II – Implementation Administration

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

Name and Title: David Vick/KASPER Program Manager

Telephone Number: 502.564.0105 x2479
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Attachment A, Section III – Relevant Documents

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