State of Connecticut
Department of Social Services

Division of Health Services

Health Information Exchange
Medicaid Enterprise System
Implementation Advance Planning Document Update
for FFY 2024 and FFY 2025

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Version Record			
Version Number	**Date**	**Reviewer**	**Comments**
1.0	7/31/21	CMS	Initial IAPD for MES funding for Connecticut's Statewide Health Information Exchange. First MES IAPD following HITECH IAPDs.
1.1	9/17/21	CMS	Revised to include actual costs for Medicaid APIs, technology reseller, and subcontractor
1.2	9/28/21	CMS	Revised to expand cost allocation methodology discussion to include benefit to the Medicaid program.
1.3	11/24/21	CMS	Conditional approval sought at population-based cost allocation percentage while discussions continue about provider-based cost allocation.
1.4	12/30/21	CMS	Cost allocation methodology revised beginning with the second quarter of FFY22.
1.5	2/17/22	CMS	Cost allocation methodology revised to split the dual eligible population between Medicaid and Medicare for the population count and determination of the percentage of the Medicaid population enrolled in Medicaid.
2.0	6/17/22	CMS	Update for FFYs 23 and 24
3.0	6/__/23	CMS	Update for FFYs 24 and 25

Contents

Tables and Figures

Section 1: Executive Summary

With this Medicaid Enterprise System (MES) Implementation Advanced Planning Document Update (IAPD-U), the State of Connecticut Department of Social Services (Department or DSS) requests funding for Design, Development, and Implementation (DDI) and related services to continue building out Connecticut's new Statewide Health Information Exchange (HIE) known as Connie.

Connecticut statute requires the Office of Health Strategy (OHS) to initiate and oversee a statewide HIE. Incorporated as Health Information Alliance, Inc., a 501 (c)(3) organization, the statewide HIE is doing business as Connie. In October 2020, Connie contracted with the Chesapeake Regional Information System for our Patients (CRISP) for the initial technology stack to support HIE functionality. May 3, 2021 was the official date for Connie's commencement of operations.

DSS supported the creation of Connie under a Memorandum of Agreement (MOA) with OHS that provided Health Information Technology for Economic and Clinical Health (HITECH) funding for HIE activities completed through the end of Federal Fiscal Year (FFY) 21. For FFY 22 and forward, funding to support the HIE has been requested through an MES IAPD. The DSS-OHS MOA is updated annually to align with each IAPD-U submitted by DSS to the Centers for Medicare and Medicaid Services (CMS). This MES IAPD-U supports continued DDI for Connie under a phased implementation approach. Separately, DSS is submitting an Operational APD (OAPD) for functionality that is live. The Table below provides a roadmap listing the HIE Use Case Service (UCS) and Supporting Function (SF) and the FFY that the service went live or the FFY the service is targeted to go live.

Table 1. Connie Phased Implementation Roadmap

Implementation FFY	Use Case Service	Supporting Function
2021	Empanelment and Alerts	MPI
2022	Provider Portals, Provider Directory, eReferrals	Clinical data, PMP Access, Best Possible Medication History (BPMH), Image Exchange
2023	---	Advanced Health Care Directives (AHCD), Immunizations, Provider Mediated eConsent, Emergent Imaging, Dental Health Records, Connie Patient Access API
2024	Patient Portal	Connie Encounters Worklist, Referral Enhancement – Health Related Social Needs/Social Determinants of Health (HRSN/ SDOH) referrals[1] Provider Portal Enhancements • Problem List Filters • Allergy Lists

[1] Formerly referred to as SDOH (screening, referral, resource directory analytics)

Implementation FFY	Use Case Service	Supporting Function
		• BPMH – Pharmacy data • Electronic Test Order and Results (ETOR) Consent Enhancements – Continuity of Care Document (CCD) Sensitive Data Filters – Provider Mediated Affirmative (PrMA)
2025	Electronic Quality Measures (eCQM) (formerly known as Quality Measurement), Hospital Bed Capacity, Population Health Navigator	eReferral Enhancements – eConsult Provider Portal Enhancements • Dental Health Records • HRSN/SDOH Assessment • Medicaid Redetermination • Post-Acute Network Tool Provider Directory Enhancement • Provider Directory – Link to eReferral

As more fully described in Section 3 of this IAPD, Connecticut seeks funding to enhance HIE UCS along with SF and data sources. The following table lists the Connie UCS and SF supported by federal funding. Support for functionality in planning or DDI is being requested in this IAPD-U while funding for operational functionality (highlighted in gray) is being requested in a separate OAPD.

Table 2. HIE Use Case Services (UCS) and Supporting Functions (SF)

= Operations or Go Live in FFY24 | = DDI in FFY24 | = Planning in FFY25

Implementation FFY	ID	Name	Supports Use Case	FFY 24 Status	Certification Required
2021	**UCS 01**	**Empanelment and Alerts**	n/a	Operations	Certified
2022	**UCS 02**	**Provider Portals: Web-Based Portal (LogOnce Technology) and InContext App (Smart on FHIR Portal)**	n/a	Operations	Certified
2022	SF 01	Clinical Data	UCS 02	Operations	Not Required (NR)
2022	SF 02	PMP access	UCS 02	Operations	NR
2022	SF 03	Best Possible Medication History (BPMH)	UCS 02	Operations	NR
2022	SF 08.1	Image Exchange	UCS 02	Operations	NR
2022	**UCS 03**	**eReferral**	n/a	Operations	NR
2022	**UCS 04**	**Provider Directory**	n/a	Operations	NR
2023	SF 04	Advance Health Care Directives	UCS 02	Operations	NR
2023	SF 05	Immunizations	UCS 02	Operations	NR
2023	SF 06	eConsent (Provider Mediated Affirmative Consent)	UCS 02	Operations	NR
2023	SF 08.2	Stroke Network/Emergent Imaging	UCS 02	Operations	NR
2023	SF 09	Dental Health Records	UCS 02	Operations	NR
2023	SF 10	Connie Patient Access API	UCS 02	Operations	NR
2024	**UCS 11**	**Patient Portal**	n/a	DDI	Required
2024	SF 12	HRSN/SDOH referral [formerly known as SDOH (screening, referral, resource directory analytics)]	UCS 03	DDI	NR
2024	SF 13	Connie Encounters Worklist	UCS 01	DDI	NR
2024	SF 17	Problem List Filters	UCS 01	DDI	NR
2024	SF 18	Allergy List	UCS 01	DDI	NR

Implementation FFY	ID	Name	Supports Use Case	FFY 24 Status	Certification Required
2024	SF 19	BPMH-Pharmacy Data	UCS 03	DDI	NR
2024	SF 20	CCD Sensitive Data Filters (PrMA Enhancement)	UCS 06	DDI	NR
2024	SF 30	Electronic Test Orders and Results (ETOR)	UCS 02	DDI	NR
2025	**UCS 06**	**eCQM (formerly known as Quality Measurement)**	n/a	Planning	Required
2025	**UCS 08**	**Hospital Bed Capacity**	n/a	Planning	TBD
2025	**UCS 09**	**Population Health Navigator**	n/a	Planning	NR
2025	SF 11	eConsult	UCS 03	Planning	NR
2025	SF 14	SDOH Assessment	UCS 01	Planning	NR
2025	SF 15	Post-Acute Network Tool	UCS 01	Planning	NR
2025	SF 16	Medicaid Redetermination	UCS 01	Planning	NR
2025	SF 21	Radiology User Access Single Sign On (SSO)	UCS 01	Planning	NR
2025	SF 22	Provider Directory – link to eReferral	UCS 01	Planning	NR
2025	SF 23	Dental Health Records – Enhancements	UCS 01	Planning	NR
2026	SF 07	eConsent (Patient Mediated Affirmative Consent)	UCS 07	Planning	NR
NA	**UCS 05**	**Electronic Case Reporting** – Use Case Dropped			
NA	**UCS 07**	**Durable Medical Equipment Order Tracking** – Use Case Dropped			

The HIE technology provided by CRISP is an integrated technology stack. OHS, Connie, and CRISP have estimated the incremental costs associated with each of the listed UCS and SF. Connie has provided a budget estimate that includes personnel and administrative needs as well as contracted services from CRISP and other consulting vendors. OHS and DSS have also estimated the associated personnel and contracting needs to meet the statutory and Medicaid agency requirements associated with the proposals presented in this IAPD-U.

This IAPD-U presents Connecticut's HIE MES funding request for DDI for FFY 24 and FFY 25. The funding details are summarized in the table below.

This HIE MES IAPD-U is for the period from October 1, 2023 through September 30, 2025.

The total Federal share requested in this APD for FFYs 24 and 25 is $8,266,221 and the State share is $1,596,087. There is also a total of $7,558,835 not allocated to Medicaid for which the State is responsible.

Table 3. Summary of FFY 24 and FFY 25 Funding Request

DDI	Total Costs	Costs Allocated to Medicaid	90% Federal Share	10% State Share	50% Federal Share	50% State Share	Total Federal Share	State Share Total	Costs Not Allocated to Medicaid
FFY 24	$ 9,350,432	$ 5,281,909	$ 4,039,136	$ 448,793	$ 396,990	$ 396,990	$ 4,436,126	$ 845,783	$ 4,068,523
FFY 25	$ 8,070,711	$ 4,580,399	$ 3,464,764	$ 384,974	$ 365,331	$ 365,331	$ 3,830,095	$ 750,304	$ 3,490,312
Total	**$ 17,421,143**	**$ 9,862,308**	**$ 7,503,900**	**$ 833,767**	**$ 762,321**	**$ 762,321**	**$ 8,266,221**	**$ 1,596,087**	**$ 7,558,835**

To ensure that Medicaid pays only its appropriate share, DSS is cost allocating HIE activities. On February 23, 2022, DSS received approval of a 40% cost allocation percentage for HIE activities effective January 1, 2022. (See CMS Approval Letter attached as Appendix C.) DSS is requesting the same cost allocation methodology with an updated cost allocation percentage of 43% in this IAPD-U. For more details, see Section 8.

Section 2: Activities Completed Since the Last Approved HIE MES APD

On March 22, 2022, Connecticut received certification for the empanelment and alerts functionality. The Connie Portal, Provider Directory, and eReferral use case services which went live in FFY 22 have been certified in other states using the CRISP shared services technology stack and, as such, do not require certification in Connecticut. Funding for these operational functionalities is being requested separately in an OAPD. So far in FFY 23, the following activities have been completed:

- Emergent Imaging has been tested and is ready for onboarding with four receiving hospitals and one sending hospital then metrics collection can begin.
- Provider Mediated Affirmative Consent has been tested and implementation is being rolled out.
- Connie Patient Access API, Dental Health Records, Advanced Health Care Directives and Immunizations are actively being worked on with target implementations by the end of FFY 23.

Section 3: Statement of Needs and Objectives

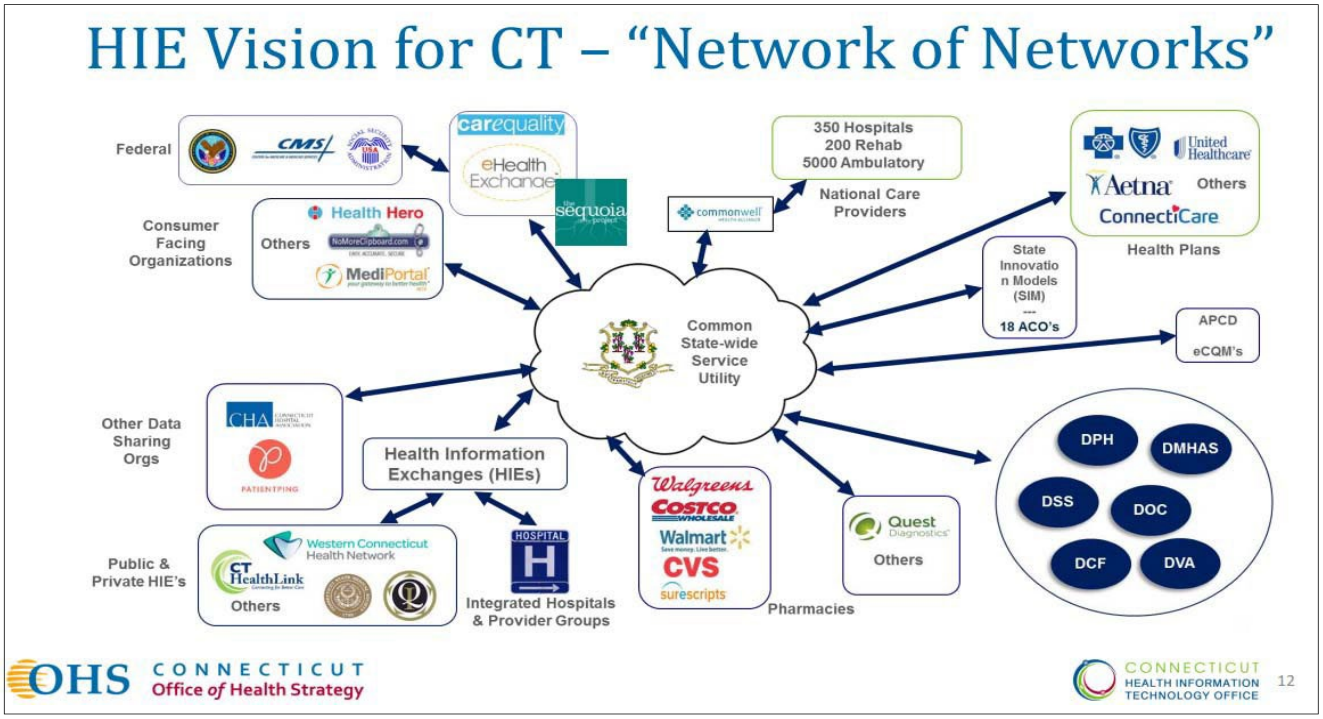
Project Background

Connecticut General Statute Section 17b-59f and 17b-59g assigned authority to the executive director of the Office of Health Strategy (OHS), in consultation with the State Health Information Technology Advisory Council (HIT Advisory Council), to oversee the development and implementation of the statewide HIE and coordinate the state's health information technology and health information exchange efforts to ensure consistent and collaborative cross-agency planning and implementation. These statutes also establish the HIT Advisory Council with responsibility to advise the executive director of OHS and the Health Information Technology Officer (HITO) in developing priorities and policy recommendations for advancing the State's health information technology and HIE efforts and goals. Connecticut's HIT strategy enables the executive director of OHS to coordinate with Medicaid and other state and private partners to strengthen the State and Federal efforts to accelerate the adoption of health information technology, promote health information exchange, and encourage utilization of certified Electronic Health Records (EHR). These efforts include activities that enhance provider directories, quality measure reporting, care coordination among healthcare providers, and improve patient matching and attribution.

Connecticut is pursuing a network-of-networks model for statewide HIE. This model will support connectivity between existing HIE organizations offering data sharing services to providers and hospitals and will also support those providers and hospitals leveraging EHR functionality to connect and share health data through national interoperability initiatives. This model was deliberated and affirmed by the legislatively created statewide HIT Advisory Council. The HIE services are being developed to support identified use cases and ensure healthcare organizations in Connecticut have the ability to exchange data in a secure, standard, and flexible environment, whether they are connecting through a community or private HIE service provider, using national standards for point-to-point exchange, or participating in a national interoperability initiative. Figure 1 depicts the HIE vision of Connecticut, where the statewide HIE:

- Provides a mechanism for providers and other caregivers to connect directly to the Statewide HIE Entity;
- Leverages existing data sharing initiatives;
- Establishes the ability to participate with national interoperability initiatives;
- Implements a common statewide service utility to support secure connectivity across the provider and caregiver community and the implementation of current and future use cases; and
- Provides mechanisms for the participation of community organizations, behavioral health providers, long-term and post-acute care providers, and others who may not have the technology or resources to participate in the same manner as those with certified electronic health record (EHR) systems.

Figure 1. Network of Networks



The statewide HIE, Connecticut's state designated entity for HIE, was incorporated as Health Information Alliance, Inc., a 501 (c)(3) nonprofit, and is doing business as Connie. After a Request for Quotes process in 2020, Connie contracted with the Chesapeake Regional Information System for our Patients (CRISP) for the initial technology stack to support HIE functionality.

State statute requires healthcare organizations to connect or begin the process to connect to the statewide HIE with an expectation that hospitals and clinical laboratories begin the process to connect within one year of the HIE becoming operational and all other licensed health care providers and organizations begin the process to connect within two years. May 3, 2021 is the official date for Connie's commencement of operations for purposes of provider compliance with regulatory timeframes for connections. One hundred percent of hospitals have met the mandate. Connie is in negotiations with several labs licensed in CT to create the connection to Connie. Nearly eighty percent of all other licensed health care providers and organizations in the state of CT have met the year 2 requirement. For a dynamic, up-to-date list of organizations actively sharing data with Connie, and what data is being shared, please go to https://conniect.org/for-organizations/

An initial HIE UCS for empanelment and alerts is in operations and received CMS certification on March 22, 2002. DSS worked with CMS to request certification for the Connie provider portals, provider directory, and eReferral functionalities. CMS made a decision that since these Use Cases have been previously certified in Maryland, for CRISP, they did not have to go through certification in Connecticut. DSS is separately submitting an OAPD for these live UCS.

Funding in this IAPD-U is being requested for planning and DDI related to the new UCS and enhancements discussed below.

The following section describes Needs and Objectives (N&O) addressed through this funding request.

N&O 1 Planning

FFY 24	FFY 25
eCQM (formerly known as Quality Measurement) (UCS 06)	To be decided
Hospital Bed Capacity (UCS 08) (NEW) Population Health Navigator (UCS 09) (NEW)	
Patient Portal Enhancement • eConsent - Patient Mediated Affirmative Consent (SF 07) (revised)	
eReferral Enhancement • eConsult (SF11)	
Portal Enhancements • SDOH Assessment (SF 14) • Post Acute Network Tool (SF 15) (NEW) • Medicaid Redetermination (SF 16) (NEW) • Radiology User Access SSO (SF 21) (NEW) • Dental Health Records Enhancements (SF 23) (NEW)	
Provider Directory Enhancement • Provider Directory - Link to eReferral (SF 22) (NEW)	

Outcomes and metrics for use cases in planning will be proposed in the next IAPD-U when the use cases move into DDI. The descriptions below include high level descriptions of the anticipated benefits for the Medicaid program.

FFY 24 Use Cases in Planning

eCQM (UCS 06) (formerly known as Quality Measurement)

Quality measures are typically calculated from claims data, and clinical data is used to validate the measure. Clinical data and patient-generated information (e.g. outcomes) can significantly enhance the measurement of healthcare quality across provider and payer populations. Clinical information available through an HIE can be used to enhance claims data to better identify performance and gaps in care.

A statewide electronic system for clinical quality measurement will enable providers and encourage payers to more effectively participate in value-based payment models. Measures that monitor care delivery and health outcomes must securely aggregate data from multiple data sources and organizations at multiple levels to best reflect the individual's entire experience of the healthcare system, risk factors and exposures, and impacts to individual health. Such a system and its reporting output can be configured to support Medicaid and its providers, and other payers and providers, with the ultimate benefit of higher quality and safety for patients.

Durable Medical Equipment (UCS 07)

This use case is no longer under consideration for DDI.

Hospital Bed Capacity (UCS 08) (NEW)

A real time display of hospital bed capacity across the State of Connecticut could be useful across a broad range of use cases. Most immediately, emergency medical services (EMS) providers could utilize a dashboard showing available bed space, as well as current bed utilization and whether that hospital is currently busier than normal, not quite as busy as they normally are or if they are about average compared to a normal day. This will not only save time for EMS providers making patient transport in the moment but could lessen the wait time for patients to receive care upon arrival at an Emergency Department.

Population Health Navigator (UCS 09) (NEW)

Quality measures are important tools to assist organizations in assuring the health of their populations. For providers to meet quality measures, however, they need actionable information about patient gaps in care. For example, they need to know if their patient needs a colorectal cancer screening, or they have already received a clear screening out of network within the last five years. They need to know if the patient is current on vaccines and boosters, if the patient has been re-admitted to the hospital after being discharged, or if the patient has experienced an avoidable hospitalization. Flagging specific situations where the provider can intervene to provide preventative care is critical for improved patient outcomes. Connie will investigate the feasibility to create a Population Health Navigator tool, available at the point-of-service for providers, and/or as a dashboard across a provider's patient panel, to identify actionable gaps in care.

Patient Portal Enhancement

eConsent – Patient Mediated Affirmative Consent (SF 07) (revised[2])

Patient Mediated eConsent functionality will reflect the patient perspective associated with SF 06 (Provider Mediated Affirmative Consent) which moved to Operations in Q3 of 2023. This functionality will support the interactive participation of patients and their authorized representatives to manage their consent choices for data that could be shared through the HIE. The consent tool is configurable and enables patients to register consent to allow their substance use disorder (SUD) data to be shared through the HIE with members of their care team.

- Electronic signatures for patient consent
- Follows HIE general designation of the program or person permitted to disclose SUD data and able to view data
- Flexible expiration dates for consent registration
- Consent tool features including:
  - Provider and payer specific forms with multiple consent options

[2] Was previously considered a use case service but is now considered a supporting function.

- Consent history tracking anyone accessing SUD data.

eReferral Enhancement

eConsult (SF 11)

eConsults are asynchronous, consultative, provider-to-provider communications within a shared electronic health record (EHR) or through an HIE. They are an important part of the solution for transferring medical advice between medical specialists and primary care providers in an efficient and effective manner.

Provider Portal Enhancements

SDOH Assessment (SF 14)

Many national standards including National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS), CMS and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are adding requirements related to both completing SDOH assessments for patients at the point of care and providing information or resources to clients indicating needs. Connie will ingest and display SDOH screening data in the Connie Clinical Information application in order to capture identified social needs. For providers using a standardized screening tool, Connie will be able to ingest the data from your EMR, assign z-codes and display those codes in the social needs section of the portal. For providers utilizing a non-standardized assessment tool, Connie will work with CRISP Shared Services (CSS) to develop a standard operation procedure (SOP) to have the assessments mapped and pulled into the data feed, so they are able to display social needs for patients.

Post-Acute Network Tool (SF 15) (NEW)

When patients are transferred to Long Term Post-Acute Care (LTPAC) facilities following an acute hospital stay to continue their recovery or rehabilitation, the coordination of care and effective transition are critical to positive health outcomes. Smooth transitions of care are highly dependent upon having the right information about each patient available in a timely manner. LTPAC patients are more likely to have chronic conditions and co-morbidities that require them to frequently transition between multiple care providers. Medicare beneficiaries with multiple chronic conditions may see up to 16 physicians per year. When multiple physicians are treating an individual following a hospital discharge, 78 percent of the time information about the individual's care is missing. HIE can benefit these patients by improving communication among providers and assuring that individuals and their care teams have the right information available at the point of care to provide the best patient care.

Implementation of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires that assessment data in all LTPAC settings – Home Health Agencies (HHAs), Inpatient Rehabilitation Facilities (IRFs), Long Term Health Care (LTCH) and Skilled Nursing Facilities (SNFs) – be standardized and interoperable. Connie will work with participating skilled nursing and other post-acute care settings to identify the

appropriate data elements required to support electronic sharing of Long Term Care/Post Acute Care (LTC/PAC) bed availability, services provided, clinical notes, assessments, and coordinate care plans.

Medicaid Redetermination (SF 16) (NEW)

As part of the Consolidated Appropriations Act of 2022, Congress has set March 31, 2023 as a firm end date for continuous Medicaid coverage. After that time, Connecticut will need to conduct eligibility redeterminations for approximately a million beneficiaries before the public health emergency ends. Unfortunately, clinical information cannot be shared with DSS to support eligibility. Nevertheless, using Medicaid member rosters, Connie will be able to flag patients who are coming up on redetermination in the next 90 days for their provider. Providers could then encourage their patients to update DSS on their contact information to ensure that they do not lose eligibility because DSS was unable to contact them.

Radiology User Access SSO (SF 21) (NEW)

It is common practice for Radiologists and Radiology practices to utilize radiology specific EMR systems or radiology specific user interfaces through EMR systems utilized by their health system. In order to streamline access to patient data through Connie, including radiology images, Radiologists need to be able to connect to Connie through a single-sign-on button. This will be similar functionality to the InContext application through current EMR systems.

Dental Health Records Enhancements (SF 23) (NEW)

Dental health information is an essential part of overall patient information and can inform other healthcare diagnosis and treatment. According to a literature review conducted by UCONN Health, electronic dental records (EDRs) are generally not as interoperable as EHRs. These systems are often more fragmented, and data is limited due to how dentists use their systems. Meaning dental data is often entered in procedure codes rather than diagnosis codes. In addition, there is usually little detail beyond procedure codes in dental systems because they are primarily used for billing. Therefore, dental data that may be of interest to medical providers may not exist in a structured format or at all in an EDR.

Nevertheless, the American Dental Association Standards Committee on Dental Informatic developed a core data set for communication among dental and other health information systems in 2019. The standards include a number of diagnostic codes that when utilized within the EDR, will be of mutual benefit among dental and medical providers. ADA is working to socialize these standards among their membership to encourage adoption. Connie will set up a work group to review the standards and determine how the information is most effectively displayed within existing Connie services.

Provider Directory Enhancement

Provider Directory – Link to eReferral (SF 22) (NEW)

A health provider directory supports management of healthcare provider information, both individual and organizational, in a directory structure. Provider directories are critical tools for executing value-based payment. This is because the information contained in them is essential for properly attributing patients to providers for measuring value. Attribution depends on accurately knowing which patients are associated with which providers or provider organizations. The directory of providers links patient cost and quality information to a specific provider or group of providers. Value-based payment models require provider directories as a means of attributing quality/value to providers.

Successful participation in value-based payment arrangements requires supportive activities that depend on provider directories. This includes care coordination and referral management, which cannot be optimally performed without accurate and interoperable electronic provider directories.

To begin to leverage the Provider Directory as a provider relationship management tool for more direct and meaningful use, Connie will begin scoping the process to connect the Provider Directory to Connie's eReferral system.

Value Proposition: access to a routinely updated provider directory will increase care coordination and decrease total cost of care.

FFY 25 Use Cases in Planning

Topics for use case planning in FFY25 are to be determined.

N&O 2 Use Case Service Enhancements in DDI

FFY 24	FFY 25
eReferral Enhancement – HRSN/SDOH referrals [formerly known as SDOH (screening, referral, resource)] (SF12) (NEW)	eReferral Enhancement – eConsult (SF 11)
Portal Enhancements • Connie Encounters Worklist (SF 13) (NEW) • Problem list Filters (SF 17) (NEW) • Allergy Lists (SF 18) (NEW) • BPMH – Pharmacy Data (SF 19) (NEW) • CCD Sensitive Data Filters (SF 20) (NEW) • Electronic Test Orders and Results (SF 30) (NEW)	Portal Enhancements • SDOH Assessment (SF 14) • Post Acute Network Tool (SF 15) • Medicaid Redetermination (SF 16) • Dental Health Records Enhancements (SF 23)
	Provider Directory Enhancement • Provider Directory – Link to eReferral (SF 22)

Because these enhancements will build on existing technology that is or will be certified, no new outcomes and metrics are proposed.

FFY 24 UCS Enhancements in DDI

eReferral Enhancement

HRSN/SDOH Referrals [formerly known as SDOH (screening, referral, resource)] (SF 12) (NEW)

The state requests funding to plan for the implementation and operation of a service to integrate HRSN data and to support HRSN-related referrals, to be supported by Connie. Social Determinants are now widely accepted as having significant influence on an individual's overall health and on the probability of a desired health outcome when treatment is needed. HRSN data is fragmented across numerous social service agencies and non-profit organizations and is not normalized or in common formats. Capturing this data and making it available in conjunction with other clinical health data will result in more informed treatment and care coordination. Care coordination may involve the subsequent referral of a patient to an appropriate social service provider.

HRSN referrals is an enhancement to eReferrals which are among primary care and home-based service organizations. The HRSN enhance will broaden the referrals to community-based organizations, as well as integrate referrals facilitated through other systems within the HIE. Referrals in the HRSN environment are more complex due to disparate systems used by social service agencies and community-based organizations, which are typically not connected to an HIE. Closing the loop on such referrals is a further complex need.

Provider Portal/InContext Enhancements

Connie Encounters Worklist (SF 13) (NEW)

Connie is adding an Encounters Worklist feature to the Connie Portal, enabling providers to review a list of their patients encounters at emergency rooms, inpatient or outpatient settings. The proposed enhanced function enables providers a population view of their patient encounters across the healthcare system. Worklist features will include:

- Customizable, user specific list filtering with the ability to save filters for easy reuse
- Downloading alert data in spreadsheet format
- Managing notifications by status by marking patients 'complete' or 'in progress'
- View patients' readmission count

Problem List Filters (SF 17) (NEW)

A Problem List derived from Consolidated Clinical Document Architecture (CCDA) will be deployed that launches within the InContext/Clinical Information application. It consists of a new popup tab or table that displays the extracted problems from the CCDA. The display will include active problems and excludes resolved problems identified in the CCDA. Also,

display functionality will include the ability to sort and filter on the date and problem. The problem list enhancements will allow different provider types to filter the list to focus on problems most relevant to their patient treatment, and enable the filter to persist across patients.

Allergy Lists (SF 18) (NEW)

Allergies are of serious concern to health professionals, whether in the context of hospital care of a healthcare provider's visit. Serious errors, sometimes grave, can occur if an allergy is not identified in advance of a surgical procedure or even simple, in-office treatment for an infection. Although allergy lists are routinely taken in certain settings, this information is not always readily available and updated across a patient's full care team.

Connie proposes to implement an approach similar to the development of the Problem List. An allergy list will be derived from CCDAs, made available to the patient's care team through the InContext/Clinical Information application. It will consist of a new tab or table that displays the extracted allergies from the CCDA. The allergy list will benefit from the Problem List filter enhancements.

BPMH – Pharmacy data (SF 19) (NEW)

The Best Possible Medication History use case is currently supporting the Medication Management feature within the InContext/Clinical Information Application. Medications have been parsed from CCDs. Identical medications identified across multiple CCDs are de-duplicated, and the same medications with slight changes are grouped for providers to easily review a patient's medication list. The value of the first iteration of a BPMH is however, limited. CCDs indicate either what has been prescribed and/or what a patient has indicated they are taking. Who prescribed the medication is not clear and if the medication prescribed is being taken, is unclear for the current data source. Through this enhancement, Connie will incorporate pharmacy data into the current Medication Management display to show medications filter, and, if possible, medications dispensed, as well as who prescribed the medication. Connie is currently in the process of onboarding pharmacies, which will supply the data necessary to support the design, development and implementation (DDI) required for this use case.

CCD Sensitive Data Filters (SF 20) (NEW)

Provider Mediated Affirmative Consent (PrMA eConsent) enables SUD providers to share data protected by 42 Code of Federal Regulations (CFR) Part 2 through the HIE. PrMA eConsent improves care coordination between SUD providers and other healthcare providers, strengthen continuity of care for patients throughout SUD treatment levels, and ease SUD workflow burden when obtaining consent and disclosing information. Currently, enabling 42 CRF Part 2 data to be separately housed within Connie's Sensitive Data repository requires the participating organization to be able to send Connie this sensitive data independently in a CCD format. One critical limitation is the ability of providers who may provide both SUD treatment services and other healthcare services to filter their data so that sensitive data can be sent independently of non-sensitive data. When a provider

is unable to filter their data, one or two approaches is taken: either no data is sent to Connie, or all data is sent but treated as sensitive, meaning that even if the patient's encounter at the facility is unrelated to their SUD treatment, the clinical information would not be shared unless they have also affirmed consent that their SUD data can also be shared. Consequently, only if a patient enrolled in the 42 CFR part 2 program is willing to share their SUD treatment information, will Connie be able to share their non-sensitive treatment information as well, e.g. radiology images, dental care, allergies. This limitation significantly impacts the 17 Federally Qualified Health Centers (FQHC) onboarding with Connie.

The PrMA enhancement will enable Connie to screen incoming CCDs from organizations that have indicated that they have 42 CFR Part 2 programs among other health care services. During the proposed enhancement, Connie will identify CCDs that contain codes that have been deemed sensitive. When a CCD contains data that meets the sensitive data criteria, the CCD will be diverted to the sensitive data repository, to await PrMA consent before being made available to the patient's treating providers.

Electronic Test Order and Results (SF 30) (NEW[3])

The State of Connecticut Department of Public Health (DPH) is replacing its current laboratory information management system (LIMS). As part of this system, DPH will implement a Laboratory Web Portal (LWP) to facilitate electronic test order and results (ETOR) exchange and synchronize test orders between the LWP and DPH's LIMS. Connie will be used to transport the orders and results between healthcare providers and the LIMS system. Connie serves as the message router between providers and the Connecticut Public Health Laboratory (CT-PHL) for lab orders and results. Connie will interface with the CT-PHL's LIMS service, which will manage the synchronization of test orders and results.

Connie will send clinical laboratory test results as standardized structured data so they can be incorporated into an EHR and enable an integration from the Connie Portal to CT-PHL to display the user order interface, requiring only one set of credentials for the two portals. Due to interpretations of state public health data rules, Connie will only temporarily store messages (less than 72 hours) to support technical operations (replays, troubleshooting, etc.). Connie will capture volume-based metrics including labs submitted by facility over time.

FFY 25 UCS Enhancements in DDI

eReferral Enhancement. See discussion in N&O 1, above.

eConsult (SF 11)

[3] Was part of the electronic case reporting use case but is being implemented as a supporting function.

Portal Enhancements. See discussion in N&O 1, above.

SDOH Assessment (SF 14)

Post Acute Network Tool (SF 15)

Medicaid Redetermination (SF 16)

Dental Health Records Enhancement (SF 23)

Provider Directory Enhancement. See discussion in N&O 1, above.

Provider Directory – Link to eReferral (SF 22)

N&O 3 Planning Use Case Services Moving to DDI

FFY 24	FFY 25
Patient Portal (UCS 11) (NEW)	eCQM[4] (UCS 06)
	Hospital Bed Capacity (UCS 08)
	Population Health Navigator (UCS 09)

FFY 24 UCS Moving from Panning to DDI

Patient Portal (UCS 11) (NEW)

A patient portal is a secure online website that gives patients, convenient, 24-hour access to personal health information from anywhere with an internet connection. Just making a portal available to patients will not ensure that they will use it. A portal should be engaging, user-friendly, and support patient-centered outcomes. It should also enable a patient to understand the information available about their provider, their health, support a patient's need to have a single source of information about their health and healthcare, assist a patient in identifying information discrepancies and directing a patient to where they can address inaccuracies and manage the information they have consented to sharing including the permitted purposes.

Connie's Patient Access Principles Policy articulates that Connie will provide patients timely and direct access to their electronic health information within Connie to (a) align with federal and state information blocking and interoperability rules, and (b) to strive to attain the Patient Access goals of the State-wide Health Information Exchange as describe in Connecticut State Statute **Sec. 17b-59d:**

(1) Allow real-time, secure access to patient health information and complete medical records across all health care provider settings;
(2) Provide patients with secure electronic access to their health information;
(3) Allow voluntary participation by patients to access their health information at no cost; and

[4] Formerly known as Quality Measurement

(4) Promote the highest level of interoperability.

To begin to meet these expectations, in FY 2024 Connie will develop an initial iteration of the Patient Portal. Using a secure username and password, with patient ID validation, patients will be able to view their health information available within Connie. Connie will work towards a complete display of patient clinical data that could include patient demographics, care team, encounters, lab results, medications, noted problems, immunizations, health related social needs recorded, and referrals to CT healthcare consumers through the Connie Patient Portal. Future enhancements will include interactive features, including but not limited to Patient consent management.

Value Proposition:

- Empowering patients in the healthcare decision making, supporting value-based healthcare systems
- Medicaid members will have more timely access to more detailed clinical information in support of goals of the CMS Interoperability and Patient Access final rule (CMS-9115-F)

Proposed Patient Portal Outcome:

CT Medicaid attests Medicaid providers and Medicaid beneficiaries use of the HIE patient portal technical investments will improve health outcomes by allowing them to be more active participants in their health care.

Proposed Patient Portal Metrics:

• # of unique patients accessing the portal

• # of unique Medicaid members accessing the portal

Rationale for Proposed Patient Portal Outcome and Metrics:

The Patient Portal gives patients 24/7 electronic access to their health information, allowing them to be active participants in their health care which has been shown through studies to: reduce anxiety, positively impact consultations, better doctor-patient relationship, increase awareness and adherence to medication, and improve patient outcomes (e.g., improving blood pressure and glycemic control in a range of study populations). In addition, patient access to their health information was found to improve self-reported levels of engagement or activation related to self-management, enhanced knowledge, and improve recovery scores, and organizational efficiencies in a tertiary level mental health care facility.

FFY 25 USC Moving from Planning to DDI

Three use cases will move from planning in FFY 24 to DDI in FFY 25:

1. eCQM (formerly known as Quality Measurement) (UCS 06)

2. Hospital Bed Capacity (UCS 08)
3. Population Health Navigator (UCS 09)

A description of these use cases and potential Medicaid outcomes are discussed above in N&O 1. Metrics for outcomes based certification will be proposed in the next IAPD-U.

Section 4: Statement of Alternative Considerations

This IAPD-U supports planning and development aligned with the Medicaid Enterprise System to add use case services to the Connecticut HIE as well as to enhance existing use case services. The use case activities proposed in this funding request utilize the services of Connie, the state designated entity for health information exchange in Connecticut. Through participation on the HITAC and on Connie's Operational Advisory Committee, DSS has an opportunity to influence the priority of Connie's use case development. Cost allocated Medicaid funding provides additional incentive with associated assurance that needed use cases will be developed and aligned with MES needs. Utilizing Connie in this way, where DSS and Medicaid invest in a portion of the cost based on cost allocation, is a cost-effective approach to meeting the needs of the agency. OHS with HITAC advice determined that a federated model for HIE was best for the state, and that there should be a separate entity to operate the HIE. This work was mandated in Connecticut General Statute 17b-59a (3) (d) which directs OHS to oversee the development and implementation of the State-wide Health Information Exchange in compliance with 17b-59d. Connie is now the designated statewide HIE utilizing CRISP as an integration partner, which was selected through a competitive request for quotes process, as the core technical infrastructure. With the investment made in the HIE, the state considers developing these use cases with and through Connie as being the best path forward. The alternative would be to invest the full amount to develop these services and restrict them to the Medicaid agency.

Section 5: HIE State Personnel and Contractor Resources

DSS dedicates State personnel to oversee and manage CMS funded HIE activities through the Medical Operation's Health Information Technology Unit. DSS created an HIE Funding Oversight Committee to provide DSS governance over Medicaid funds provided to OHS for the statewide HIE and to ensure that Medicaid needs are met.

OHS also dedicates State personnel for HIE planning and oversight responsibilities identified in the Connecticut General Statutes. Personnel and contract resources will be used by OHS to:

- Chair the HIE Board of Directors and administratively oversee the HIE:
- Chair and support the HITAC (and its subcommittees) as an advisory body;
- Develop initial high-level functional needs for HIE use cases that are not fully defined;
- Develop policies for statewide race, ethnicity, and language data collection for state agencies and for providers participating in the HIE as required by P.A. 21-35
- Follow up the 5-year Statewide Health IT Plan currently being developed to begin planning and develop recommendations;
- Continued coordination of statewide HIT efforts as required by the general statutes
- Prepare and submit an Annual Health IT report to the legislature;
- Set standards as defined in the general statutes regarding HIE, including in the areas of
    - Security
    - Privacy
    - Data content
    - Structures and format
    - Vocabulary
    - Transmission protocols

DSS HIE Resource Request

DSS HIE Staffing Resource Requirements

DSS HIE State Personnel Resources are described in more detail in the Table, below.

Table 4. DSS HIE State Personnel Resources for FFY 24 and FFY 25
Total DSS State Personnel Costs - Cost Allocation is not required for this Medicaid-specific work

DSS Staff Title	FFY 2024			FFY 2025			Description of Responsibilities
	% of Time	Project Hours	Cost with Benefits	% of Time	Project Hours	Cost with Benefits	
Medical Operations Manager	50%	1,040	$132,397	50%	1,040	$140,062	Responsible for the overall administration and operations of the Medicaid Systems, which includes the MMIS and Medicaid PI Program/ MAPIR systems.
Health Program Supervisor	100%	2,080	$241,612	100%	2,080	$255,593	Leads the DSS HIT unit and the overall administration of the Medicaid PI Payment Program and Interoperability Rule's Patient Access Projects. Reports directly to the Medical Operations Manager and supervises the Health Program Associate.
HIE Business Lead Manager	100%	2,080	$187,022	100%	2,080	$191,698	DSS subject matter expert. Provides expertise in Connecticut's current Medicaid business environment and evaluates that HIE funding deliverables meet Medicaid business requirements. Also participates in HIE collaboration and provides input into Medicaid business process needs.
HIE Supervising Accountant	50%	1,040	$ 91,698	50%	1,040	$ 97,314	Position reports to DSS Agency Chief Financial Officer and is responsible for assisting in oversight on financial, fiscal, and budget items related to HIE funding milestones.
HIE Grants and Contracts Specialist	25%	520	$ 44,943	25%	520	$ 47,690	Position reports to DSS Agency Chief Financial Officer and is responsible for assisting in oversight of HIE contracts.
Grand Total			**$697,672**			**$732,357**	

DSS HIE Contractor Resource Requirements

The Department will also continue to partner with vendors to support:

1. EPMO. DSS will continue EPMO Portfolio Management activities under the Direction of the DSS Commissioner to support DSS staff with project management and subject matter expertise for the implementation, oversight, and funding of HIT/HIE activities in support of the CT DSS Medicaid Program.

2. HIE Technical Lead. This consultant will continue to work with the CT DSS Medicaid Program to define, select, and implement solutions to meet the needs of the business in support of Medicaid.

Table 5. DSS Contractor Resources for FFY 24 and FFY 25
Total DSS Contractor Costs - Cost Allocation is not required for this Medicaid-specific work

	FFY 2024	FFY 2025	Responsibilities
1. EPMO HIT/HIE Portfolio Management			
HealthTech Solutions	$1,000,000	$ 700,000	The contract is for a team of consultants to provide project management and subject matter expertise to DSS for the implementation, management, oversight, and funding of HIT/HIE activities in support of the Connecticut Medicaid Program. SME support will include HIT/HIE planning, technical expertise, creation/editing of Advance Planning Documents, and coordination with the EPMO and other Medicaid projects.
2. HIE Technical Lead			
Slalom Consulting Services	$ 500,000	$ 500,000	One FTE consultant to work with DSS Medicaid Program to define, select and implement solutions to meet the needs of the business in support of Medicaid. Also works with statewide entity to roll out HIT solutions for Medicaid recipients and other constituents. Provides expertise in Connecticut's current Medicaid technical environment, vendors and processes. Evaluates funding milestones against technical and use case requirements and specifications. Assists in identifying the appropriate transition teams and workgroups for HIE collaboration and provides input to transition task requirements as identified DSS assets are transitioned to the statewide HIE.
Total Contractor Resources	**$1,500,000**	**$ 1,200,000**	

Table 6. DSS HIE State Budget for FFY 24 and FFY 25
Total DSS Costs -Cost Allocation is not required for this Medicaid-specific work

	FFY 2024	FFY 2025
State Cost Category		**Total**
State Personnel	$ 697,672	$ 732,357
System Hardware	$ -	$ -
System Software	$ -	$ -
Travel/Conferences	$ 15,000	$ 15,000
Supplies	$ -	$ -
Contractors	$ 1,500,000	$ 1,200,000
Grand Total:	**$ 2,212,672**	**$ 1,947,357**

OHS HIE Resource Request

OHS HIE Staffing Resource Requirements

Table 7. OHS HIE State Personnel Resources for FFY 24 and FFY 25
Total OHS Staffing Costs Before Cost Allocation

Connecticut Office of Health Strategy Staff Title	FFY 2024			FFY 2025			Description of Responsibilities
	% of Time	Project Hours	Prorated Cost with Benefits	% of Time	Project Hours	Prorated Cost with Benefits	
N&O 1: State Staff							
Health Information Technology Officer (HITO)	95%	1,976	$ 328,826	86%	1,778	$ 304,822	Health Information Technology Officer- responsible for the overall success of the State's HIE strategy. Resides as Chair of the Health Information Alliance Board. Continues Administrative oversight on all HIE related projects.
HIE Program Manager	95%	1,976	$ 175,612	86%	1,778	$ 162,792	Responsible for the HIE portfolio. Responsible for the HIE service solution - vendor analysis, procurement, implementation & roll-out. Reports to the HITO.
HIT Planning Manager 1*	40%	832	$ 73,942	36%	749	$ 68,544	Responsible for implementing systems to improve health equity and address social determinants of health. Responsible for the strategic planning, stakeholder engagement, statewide councils, inter-agency planning and data governance. Reports to the HITO.
HIT Planning Manager 2*	25%	520	$ 46,214	23%	468	$ 42,840	Responsible for HIE sustainability and utilization and public health data exchange, for interagency data sharing with state-operated data systems, and making Connie infrastructure a shared public utility service. Measures and assesses how providers utilize HIE at the point of care to improve care quality, care coordination, and drive better health outcomes for individual patients and communities. Reports to the HITO.
HIT Project Manager*	40%	832	$ 97,879	36%	749	$ 90,734	Responsible for HHS interagency data sharing & coordination and establishing electronic data standards. Supports behavioral health (BH) providers with adoption to EHR and HIE, enabling improved coordination between BH providers, and integration between primary care and BH care. Supports the HITO in the planning, developing, and implementation of a financial incentive program for BH providers with TA and training. Reports to the HITO.
Consumer Information Representative	90%	1,872	$ 152,335	68%	1,404	$ 117,679	Responsible for all scheduling, filing, office administration and duties to support the HIT Unit. Reports to the HITO.
OHS Administrative Assistant	50%	1,040	$ 80,481	38%	780	$ 62,172	Develops all HIT PMO marketing materials, outside communications (emails, newsletters, signage/banners) and coordinates stakeholder engagement, outreach efforts.
Communication Manager	30%	624	$ 60,064	23%	468	$ 46,399	Supports the fiscal and contractual administration of the HIT and HIE portfolio and will oversee the audit functions. Reports to Fiscal Administrative Supervisor.
Fiscal Administrator Supervisor*	10%	208	$ 24,020	8%	156	$ 18,556	Supports the fiscal and contractual administration of the HIT and HIE portfolio and will oversee the audit functions.
Fiscal Administrative Officer	90%	1,872	$ 157,447	68%	1,404	$ 121,628	Supports the fiscal and contractual administration of the HIT and HIE portfolio and will oversee the audit functions.
Grants and Contracts Specialist*	10%	208	$ 22,653	8%	156	$ 17,499	Administrator of all OHS contracts. Contract communication liaison with OPM and Attorney General. Assigned to research, prepare, communicate and ensure execution of all HIE related contract compliance activities and justifications. Reports to Fiscal Administrative Supervisor.
Supervising Attorney*	10%	208	$ 32,714	8%	156	$ 25,271	Lead counsel for OHS. Supervises, modifies and approves staff attorney's work product.
Staff Attorney*	20%	416	$ 40,174	15%	312	$ 31,034	OHS attorney who oversees the HIT and HIE legal portfolio including HIE contracts, legal communications and HIE regulations. Reports to the Supervisory Attorney.
Total:			**$1,292,361**			**$1,109,971**	

** denotes new positions for FFY 24 & FFY 25*

OHS HIE Contractor Resource Requirements

OHS will continue to partner with CedarBridge Group LLC to support planning and workstream support associated with projects and activities identified in this IAPD-U. OHS also proposes adding a HIT Consultant role.

OHS HIE Contractor Resources for FFY 24 and FFY 25 are also detailed in a table below.

Table 8. OHS Contracts/Contractor Resources for FFY 24 and FFY 25
Total OHS Contractor Costs Before Cost Allocation

Connie Vendor Resources	FFY 2024	FFY 2025	Description of Responsibilities
Connie Resources*			
Core Infrastructure Costs	$ 935,747	$ 785,521	
Connie Operations Personnel	$ 1,621,349	$ 1,502,799	
Connie Administrative Personnel	$ 611,593	$ 432,624	
Connie Administrative Costs	$ 245,338	$ 438,039	
Connie Contracted Professional Services	$ 1,289,372	$715,000	
Use Case Services Subtotal	**$ 4,703,399**	**$ 3,873,983**	
Other OHS Contract Resources: Planning and Workstream Support			
CedarBridge Group LLC (or an alternative contractor selected through RFP)	$ 900,000	$ 900,000	The HIT Consultant provides portfolio management for the HIT projects, subject matter expertise, strategic facilitation for internal and external stakeholder meetings; and assists the development of proposals, funding requests and written materials.
Covendis (or alternative contractor)	$ 216,000	$ 216,000	The HIT Consultant provides portfolio management for the HIT projects, subject matter expertise, strategic facilitation for internal and external stakeholder meetings; and assists the development of proposals, funding requests and written materials.
Other OHS Contracting Subtotal	**$ 1,116,000**	**$ 1,116,000**	
OHS Contractor Total	**$ 5,819,399**	**$ 4,989,983**	

* The HIA Board has contracted with CRISP for interface and integration services, ongoing operating services and the development of new use cases.

Table 9. OHS HIE State Budget for FFY 24 and FFY 25
Total OHS Costs Before Cost Allocation

	FFY 2024	FFY 2025
State Cost Category		**Total**
State Personnel	$ 1,292,361	$ 1,109,971
Hardware/Software	$ 4,000	$ 3,600
Equipment/Supplies	$ 7,000	$ 6,300
Out of state travel and conference costs	$ 15,000	$ 13,500
Contractors	$ 5,819,399	$ 4,989,983
Grand Total:	**$ 7,137,760**	**$ 6,123,354**

Section 6: Proposed HIE Activity Schedule

The activities required to complete the proposed HIE objectives are provided in the Proposed HIE Activity Schedule included below.

Table 10 Proposed HIE Activity Schedule

Activity	Start Date *(Federal Fiscal Calendar)*	End Date *(Federal Fiscal Calendar)*
UCS 05 Electronic Case Reporting Use Case Dropped		
UCS 06 eCQM (formerly known as Quality Measurement) New Use Case Service in FFY24		
1.0 Planning and stakeholder engagement	Q3 23	Q4 23
2.0 Design Develop and Implement	TBD	TBD
3.0 Begin operations for certification	TBD	TBD
4.0 Complete certification process	TBD	TBD
5.0 Operational	TBD	n/a
UCS 07 Durable Medical Equipment Order Tracking Use Case Dropped		
UCS 08 Hospital Bed Capacity		
1.0 Planning and stakeholder engagement	Q1 24	Q4 24
2.0 Design Develop and Implement	Q1 25	Q4 25
3.0 Begin operations for certification	TBD	TBD
4.0 Complete certification process	TBD	TBD
5.0 Operational	TBD	n/a
UCS 09 Population Health Navigator		
1.0 Planning and stakeholder engagement	Q1 24	Q4 24
2.0 Design Develop and Implement	Q1 25	Q4 25
3.0 Begin operations for certification	TBD	TBD
4.0 Complete certification process	TBD	TBD
5.0 Operational	TBD	n/a
UCS 11 Patient Portal		
1.0 Planning and stakeholder engagement	Q2 23	Q4 23
2.0 Design Develop and Implement	Q1 24	Q4 24
3.0 Begin operations for certification	TBD	TBD
4.0 Complete certification process	TBD	TBD
5.0 Operational	TBD	n/a

Section 7: Proposed HIE Budget

Funding is requested for HIE activities beginning October 1, 2023 through September 30, 2025. CRISP and Connie have developed a total cost estimate for use case service enhancements and each new use case service presented in this IAPD-U which will be in either planning or DDI (Design, Develop, and Implement) at the beginning of FFY 24. (See Appendix B.1 for costs by use case.) Funding is requested for planning and DDI activities at 90% FFP and 50% at FFP for administrative activities, after cost allocation. (See Section 8 for details on the proposed cost allocation methodology.)

One use case service will be in DDI during FFY 24 and is expected to be live by October 1, 2024 (Patient Portal) and will require certification. In addition, seven use case service enhancements will be in DDI in FFY24 and are expected to be live by October 1, 2024 (HRSN/SDOH Referral Enhancement, Problem List Enhancement, Allergy List, BPMH-Pharmacy Data, CCD Sensitive Data Filters, Electronic Test Order and Results, and Connie Encounters Worklist). These enhancements support operational functionality for the Connie portals do not require separate certification.

Three new use case services and six use case service enhancements are being planned in FFY24 and will go into DDI in FFY25 (eCQMs, Hospital Bed Capacity, Population Health Navigator, Dental Health Record, SDOH Assessment, Post-Acute Network, Medicaid Redetermination, eConsult and Provider Directory – Link to eReferral). The need for certification will be determined during planning and any needed outcomes and metrics will be proposed in the next IAPD-U.

OHS staff resources and contractor support are primarily providing planning and strategic development in keeping with statutory requirements. The HITO position and the planning and workflow support vendor are both proposed at 90% FFP due to their direct role in planning and implementation activities. Administrative FFP at 50% is requested for other OHS staff, after cost allocation.

DSS costs are requested at 90/10 for DDI activities and are 100% attributable to Medicaid. OHS and HIE costs are requested at 90/10 for DDI activities and cost allocated at 40% attributable to Medicaid. Details on this cost allocation method are explained in Section 8: Cost Allocation Plan for HIE Implementation Activities of this IAPD.

Table 11. Proposed HIE Budget for FFY 24
Total Project Costs, Cost Allocation, and FFP

FFY 24	Total Project Costs	Cost Allocation		Federal and State Participation			Portion Not Allocated to Medicaid
		Medicaid Percentage	Costs Allocated to Medicaid	FFP	Federal Share	State Share	
DSS Costs							
Enhanced	$ 2,212,672	100%	$ 2,212,672	90%	$ 1,991,405	$ 221,267	$ -
Administrative	$ -	100%	$ -	50%	$ -	$ -	$ -
OHS Costs*							
Enhanced	$ 1,444,826	43%	$ 621,275	90%	$ 559,148	$ 62,128	$ 823,551.06
Administrative	$ 989,534	43%	$ 425,500	50%	$ 212,750	$ 212,750	$ 564,034.60
HIE Costs							
Enhanced	$ 3,846,468	43%	$ 1,653,981	90%	$ 1,488,583	$ 165,398	$ 2,192,486.89
Administrative	$ 856,931	43%	$ 368,480	50%	$ 184,240	$ 184,240	$ 488,450.75
Total Project Costs	$ 9,350,432		$ 5,281,909		$ 4,436,126	$ 845,783	$ 4,068,523.31

* Excluding HIE Costs which are shown separately

Table 12. Proposed HIE Budget for FFY 25
Total Project Costs, Cost Allocation, and FFP

FFY 25	Total Project Costs	Cost Allocation		Federal and State Participation			Portion Not Allocated to Medicaid
		Medicaid Percentage	Costs Allocated to Medicaid	FFP	Federal Share	State Share	
DSS Costs							
Enhanced	$ 1,947,357	100%	$ 1,947,357	90%	$ 1,752,621	$ 194,736	$ -
Administrative	$ -	100%	$ -	50%	$ -	$ -	$ -
OHS Costs*							
Enhanced	$ 1,420,822	43%	$ 610,954	90%	$ 549,858	$ 61,095	$ 809,868.60
Administrative	$ 828,549	43%	$ 356,276	50%	$ 178,138	$ 178,138	$ 472,272.76
HIE Costs							
Enhanced	$ 3,003,320	43%	$ 1,291,427	90%	$ 1,162,285	$ 129,143	$ 1,711,892.23
Administrative	$ 870,663	43%	$ 374,385	50%	$ 187,193	$ 187,193	$ 496,278.01
Total Project Costs	$ 8,070,711		$ 4,580,399		$ 3,830,095	$ 750,304	$ 3,490,311.59

* Excluding HIE Costs which are shown separately

The breakdown by quarters of the FFP follows in the Table, below.

Table 13. Federal Financial Participation by Quarter for FFY 24 and FFY 25

Quarter	To Be Reported on CMS-37
FFY 2024 Q1 (Oct20 – Dec20)	$1,109,033
FFY 2024 Q2 (Jan21 – Mar21)	$1,109,031
FFY 2024 Q3 (Apr21 – Jun21)	$1,109,031
FFY 2024 Q4 (July21 – Sep21)	$1,109,031
FFY 2023 Q1 (Oct20 – Dec20)	$957,524
FFY 2023 Q2 (Jan21 – Mar21)	$957,524
FFY 2023 Q3 (Apr21 – Jun21)	$957,524
FFY 2023 Q4 (July21 – Sep21)	$957,523

Section 8: Cost Allocation Plan for HIE Implementation Activities

Connecticut is in the process of standing up a new statewide HIE to offer providers access to a longitudinal view of patient records along with key functionality to support clinical decision-making and care coordination. While some functionality is live and is being funded through an Operational APD, several use cases are still in planning and development. The FFY 23 and FFY 24 CT HIE MES IAPD-U was approved on June 22, 2022 with the cost allocation methodology described below. Due to a lag in receiving Medicare data, new estimates of the Average Annual Medical Transactions Per Person are not yet available. DSS is therefore requesting the same cost allocation methodology as approved in the last IAPD with an updated cost allocation percentage based on the 2022 CT population and distribution of residents by insurance status.[5]

Cost Allocation Methodology Approved Effective 1-1-22

DSS proposed a cost allocation methodology based on the anticipated percentage of HIE transactions attributable to the Connecticut Medicaid population. CMS approved this methodology on February 23, 2022. (See CMS Approval Letter included as Appendix C.) Due to a lag in receiving updated Medicare data, Connecticut proposes to retain the original cost allocation methodology approved last year at 40% but with updated population numbers which bring the cost allocation percentage to 43% as described below.

As a newly forming HIE, transactional data is not yet available. As a proxy for HIE utilization by payer, DSS evaluated the per capita number of medical transactions (paid medical claims) in Connecticut by insurance coverage in a two part methodology:

- Part 1 estimates the intensity of utilization by payer group using 2019 APCD data.
- Part 2 predicts future HIE utilization by applying the weighted utilization determined in Part 1 to the updated 2022 population.

Part 1: Medical Utilization Intensity by Payer Group (no change from approved CAM)

APCD Data. Data for medical transaction volume for calendar year (CY) 2019 was provided by OHS from the State's All Payer Claims Database (APCD). APCD data is available for Medicaid, Medicare, and Commercial payers which includes state employee and retiree data. Data for the uninsured and ERISA plan participants are not available in the APCD.

The following analysis was based on APCD medical enrollment and medical claims data for CY 2019. Pharmacy data was excluded due to a lag in the availability of Medicare data.

APCD data includes the number of "Unique Individuals" with medical coverage by payer (Column B) and the number of "Medical Member Months" (Column C) by payer. Because individuals may

[5] Updating the population with 2022 data while retaining the 2019 CAM approach was approved by CMS on a call held 6-5-23 per Dzung Hoang and Terry Lew.

change insurance status within a year, DSS annualized medical members by dividing the number of Medical Member Months by 12 for each payer. See “Adjusted Medical Members” in Column D the table below.

APCD data also provided the “Number of Medical Transactions (Paid Medical Claims)” by payer (Column E). Dividing Column E by Column D yields the “Average Annual Medical Transactions Per Person” (Column F) for the available payers.

Table 14: APCD Data – Medical Transactions (Paid Medical Claims) by Payer

A	B	C	D	E	F
Payer	**Unique Individuals**	**Medical Member Months**	**Adjusted Medical Members** (Member Months/12)	**Number of Medical Transactions** (Medical Claims Paid)	**Average Annual Medical Transactions Per Person** (Based on 12 Months of Coverage)
Medicaid [1]	896,612	9,342,999	778,583	28,691,308	37
Medicare [2]	714,510	8,220,235	685,020	22,154,399	32
Commercial [3]	1,001,610	10,436,371	869,698	11,550,791	13
ERISA [4]					
Uninsured [5]					

Source: Connecticut's All Payer Claims Database

[1] Medicaid data includes dual eligibles.

[2] Medicare data includes all Medicare medical plans.

[3] Commercial includes data for individuals covered by health insurance companies as well as state employees and retirees.

[4] Data for individuals covered by ERISA plans are not available.

[5] Data for uninsured individuals are not available.

The data show that Medicaid members have the highest medical claims per year with an average of 37, followed closely by Medicare with an average of 32, and at a distance by Commercially insured with an average of 13 claims per year. These differences in per capita medical claims by payer suggest that HIE transactions will likely vary by payer as well and should be reflected in fair share determinations related to HIE costs.

Part 2: HIE Utilization Intensity by Payer Group

HIE Transactions by Payer. Using medical claims as a proxy for future HIE transactions requires a couple more steps. To predict HIE transactions by payer, DSS must:

1. Estimate data for the uninsured
2. Account for the proportion of the Connecticut population represented by each payer

Population Estimates updated for 2022.The number of Connecticut residents in each group in CY 2022 was estimated as follows:

1. DSS supplied the number of Medicaid beneficiaries and dual eligibles for CY 2022.
2. OHS supplied the number of Medicare beneficiaries for CY 2022 from a CMS website.
3. OHS supplied the number of Commercial and ERISA beneficiaries for CY 2022 from the OHS APCD.
4. The uninsured population was estimated by subtracting Medicaid, Medicare, Commercial, and ERISA covered lives from the total CY 2022 Connecticut population.

Per Capita Medical Claims Estimates. As shown in Table 15 below, per capita medical claims for the two missing groups were estimated using the following assumptions:

1. The number of ERISA per capita medical transactions (paid medical claims) will equal the Commercial average
2. The number of uninsured per capita medical transactions will be about half that of the Commercially insured

Weighted Averages. Because population size varies among the payers, DSS used a weighted average of per capita medical claims to estimate the volume of medical transactions by payer type. DSS determined the percentage of the 2022 Connecticut population using the known numbers and estimates discussed above and data for the total Connecticut population from the Census Bureau. The percentage of the population (Column C) for each coverage group was multiplied by the respective Medical Transactions Per Capita (Column D) to yield a weighted value for medical transactions per capita by payer (Column E).

The Weighted Medical Transactions Per Capita for each payer (Column E) was converted to a percentage by comparing each weight to the sum for all payers to derive an estimate of the Percentage of HIE Transactions (Column F) that would be attributable to each payer group.

Example. Future Medicaid utilization of the HIE was determined as follows:

1. 2022 CT Medicaid Population Percentage
   Purpose: Determine the portion of CT residents enrolled in Medicaid
   Calculation:
   a. Numerator: Medicaid enrollees from the APCD minus half of the dual eligibles (Column B Medicaid line)
   b. Denominator: Total CT Population from the Census Bureau (Column B Total line)
   c. Quotient: Percentage of CT Population (Column C)
   d. Equation: (966,672 / 3,626,205) * 100 = 26.7%

2. Weighting Medical Transactions
   Purpose: Account for the number of people in each payer group and the different medical utilization rates of each group
   Calculation:
   a. Factor 1: Percentage of CT Medicaid Population (Column C) from the step above
   b. Factor 2: Medical Transactions Per Capita (Column D)
   c. Product: Weighted Medical Transactions Per Capita (Column E)

d. Equation: 26.7% * 37 = 9.86

3. Estimated Share of HIE Transactions
   Purpose: Convert weighted medical transactions per capita to a percentage for use as a cost allocation percentage
   Calculation:
   a. Numerator: Weighted Medical Transactions Per Capita (Column E Medicaid Line) from the step above
   b. Denominator: Sum of Weighted Medical Transactions Per Capita (Column E Sum line) from the step above
   c. Quotient: Estimated Percentage of HIE Transactions (Column F)
   d. Equation: (9.86 / 23.07) * 100 = 43%

Revised Medicaid Cost Allocation Percentage

The foregoing analysis predicts that Medicaid medical members will account for 43% of HIE transactions. Consequently, DSS is proposing a Medicaid cost allocation percentage of 43% for HIE activities in FFY 24 and FFY 25. (See Table 15 below for details on cost allocation calculations.)

Note on Sustainability

The transition from HITECH to MES funding is occurring as Connie, the state designated entity for HIE, is beginning operations. A financial sustainability plan is being developed for Connie. However, for the next few fiscal years state funds are available to OHS to cover the state match as well as costs not allocated to Medicaid. A portion of the state's insurance fund is allotted to the OHS budget item relating to Connie and covers the state match and other costs not allocated to Medicaid.

Table 15: Cost Allocation Calculations

Using the Weighted Average of Medical Transactions Per Capita to Predict Future HIE Volume by Payer (*estimated*)

A			B	C	D	E	F
Payer	**Population**	**Duals Adjustment[2]**	**Revised Population**	**Percentage of 2022 CT Population**	**Medical Transactions Per Capita [9]**	**Weighted Medical Transactions Per Capita [10]**	**Estimated Percentage of HIE Tranactions [11]**
Medicaid[1]	1,002,453	(35,781)	966,672	26.7%	37 [6]	9.86	43%
Medicare	723,649	35,781	759,430	20.9%	32 [6]	6.70	29%
Commercial[3]	903,718		903,718	24.9%	13 [6]	3.24	14%
ERISA	837,680		837,680	23.1%	*13* [7]	3.00	13%
Uninsured [4]	*158,705*		*158,705*	*4.4%*	*6* [8]	0.26	1%
Total CT Population [5]	3,626,205		3,626,205	100%		23.07	1

[1] DSS is the source for data on the Medicaid population anf number of dual eligibles.

[2] Distributing duals between Medicaid and Medicare by subtracting half of duals (71,563/2 = 35,781) from Medicaid beneficiaries and adding half to the count of Medicare beneficiaries.

[3] Commercial beneficiaries include individuals covered by health insurance companies as well as state employees and retirees.

[4] Uninsured estimate is the remainder of the CT 2022 population after accounting for Medicaid, Medicare, Commercial, and ERISA beneficiaries.

[5] Source: Census QuickFacts v2022

[6] Source: APCD data - see table above.

[7] Estimate based on assumption that ERISA beneficiary utilization will be closer commercially insured beneficiary utilization than Medicaid or Medicare beneficiary utilization.

[8] Estimate based on assumption that uninsured patient utilization will be approximately half of utilization by commercially insured beneficiaries.

[9] Medicaid Transactions (Paid Medicaid Claims) Per Capita, as described in teh table above, is the volume of medical transactions per capita by bayer category.

[10] Weighted Medical Transactions Per Capita is the relative size of each patient group (Percentage of the 2022 CT Population) multiplied by Medical Transactions Per Capita for each patient group.

[11] The Estimated Percentage of HIE Transactions for each patient group is estimated by dividing each group's Weighted Medical Transactions Per Capita by the total Weighted Medical Transactions Per Capita.

Section 9: Assurances, Security, Interface Requirements, and Disaster Recovery Procedures

The table below indicates the Department of Social Services willingness to comply with the Code of Federal Regulation (CFR) and the State Medicaid Manual (SMM) Citations.

Table 16. Assurances

Standard	Yes	No	Explanation for any "No" responses.
Procurement Standards (Competition / Sole Source)			
42 CFR Part 495.348	X		
SMM Section 11267	X		
45 CFR Part 95.615	X		
45 CFR Part 92.36	X		
Access to Records, Reporting, and Agency Attestations			
42 CFR Part 495.350	X		
42 CFR Part 495.352	X		
42 CFR Part 495.346	X		
42 CFR Part 433.112(b)(5) – (9)	X		
45 CFR Part 95.615	X		
SMM Section 11267	X		
Software & Ownership Rights, Federal Licenses, Information Safeguarding, HIPAA Compliance, and Progress Reports			
42 CFR Part 495.360	X		
45 CFR Part 95.617	X		
42 CFR Part 431.300	X		
42 CFR Part 433.112	X		
Security and interface requirements to be employed for all State HIT systems.			
45 CFR 164 Securities and Privacy	X		

Appendix A: System Diagrams

Figure 2. CRISP System Diagram

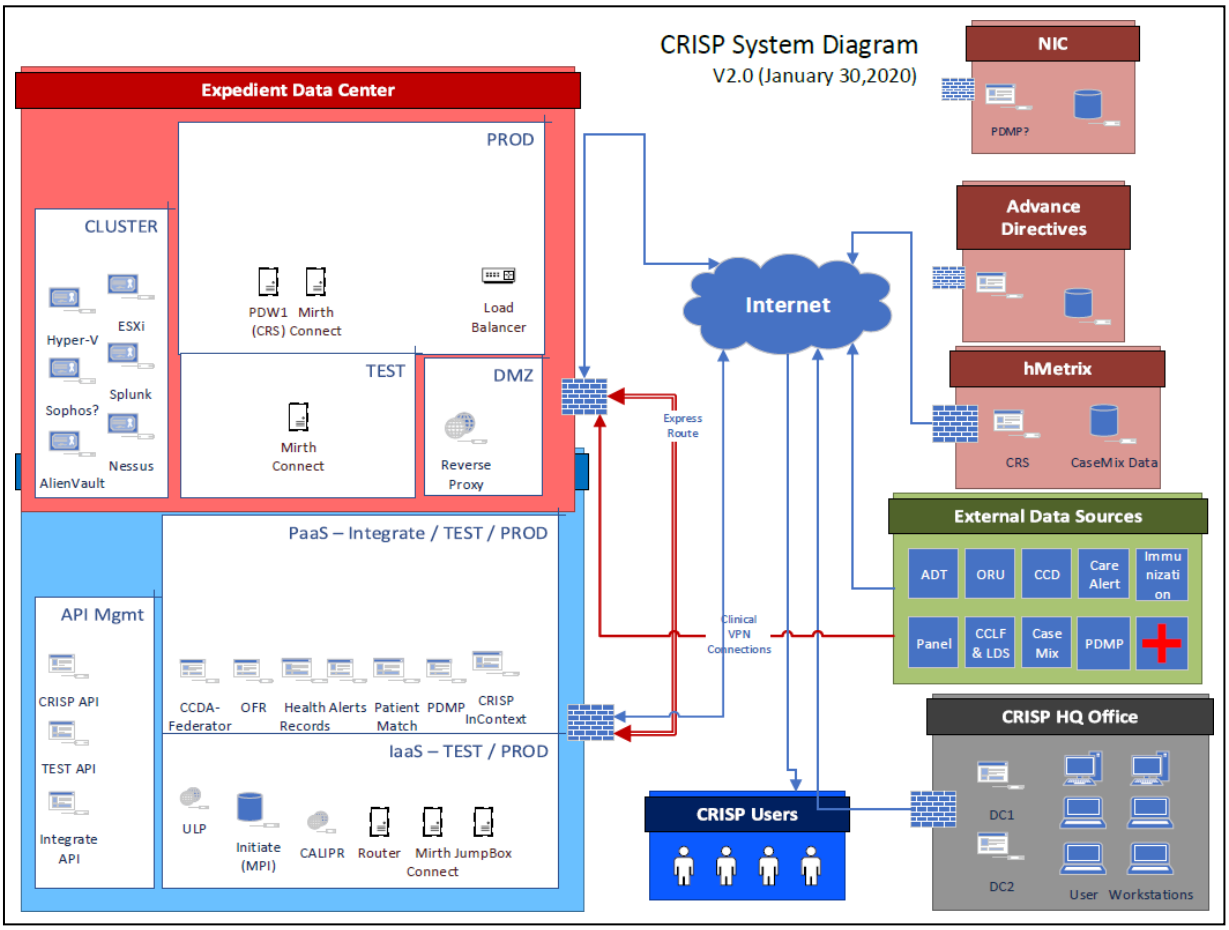


Figure 3. CRISP Shared Services System Diagram

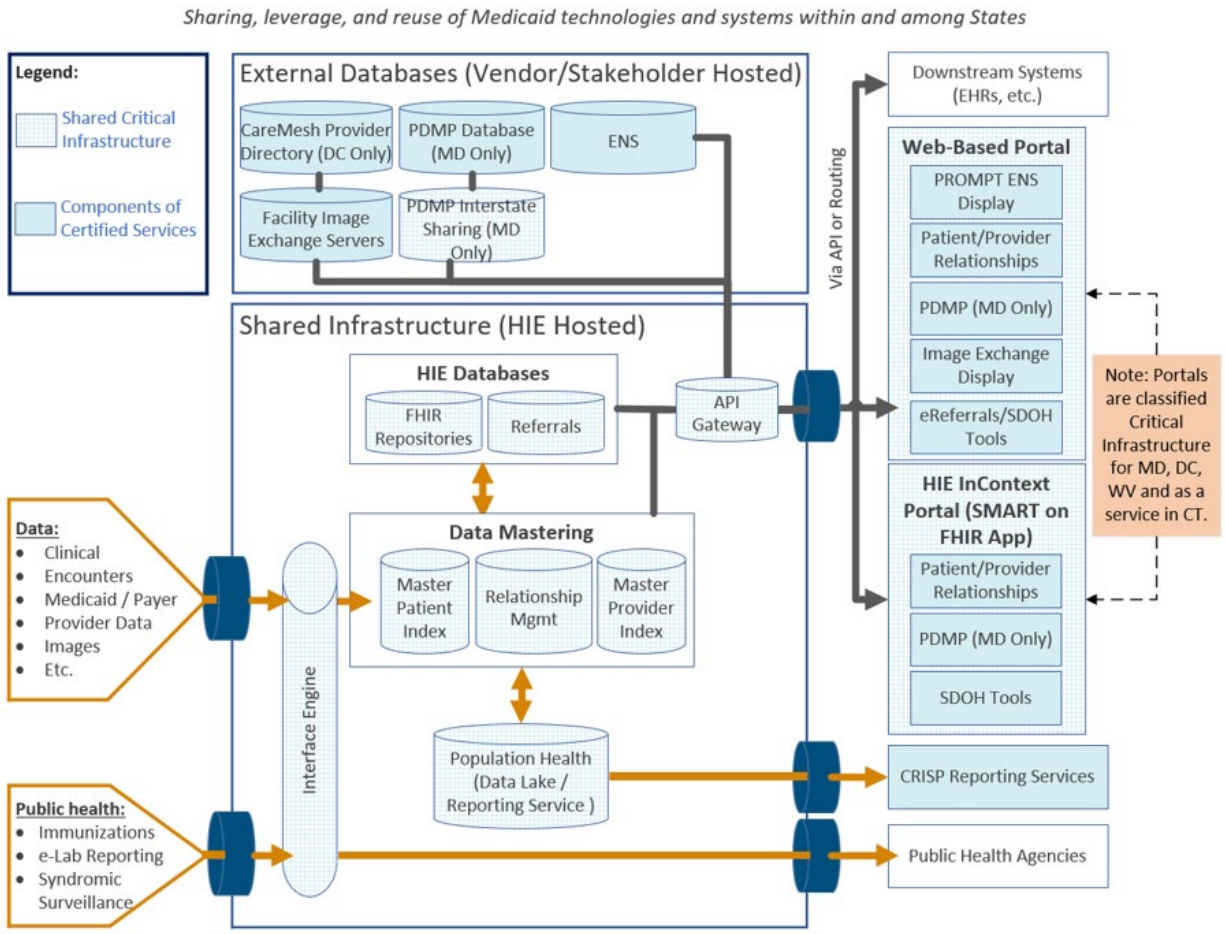


Figure 4. CRISP System Integration

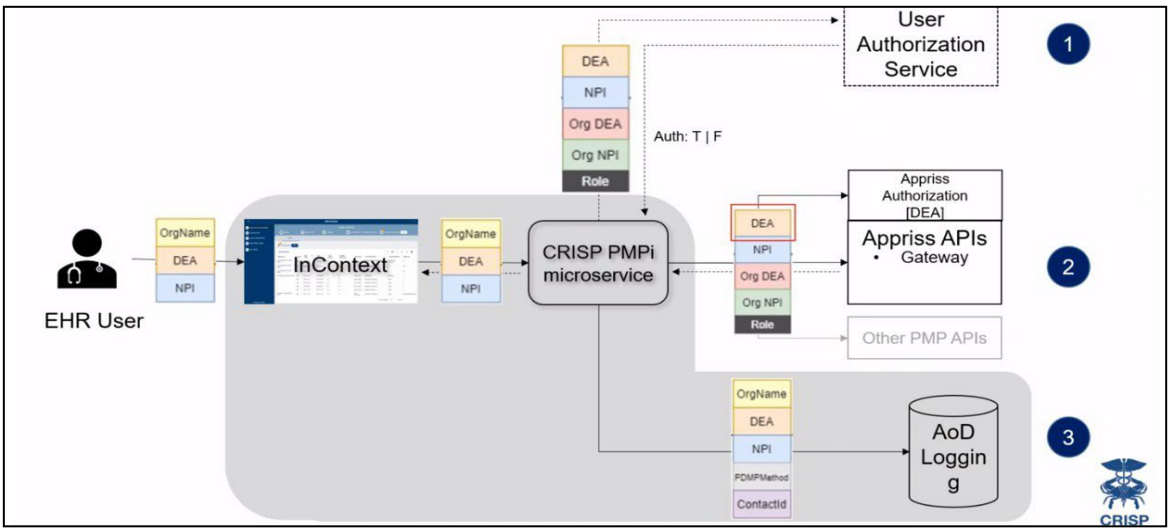
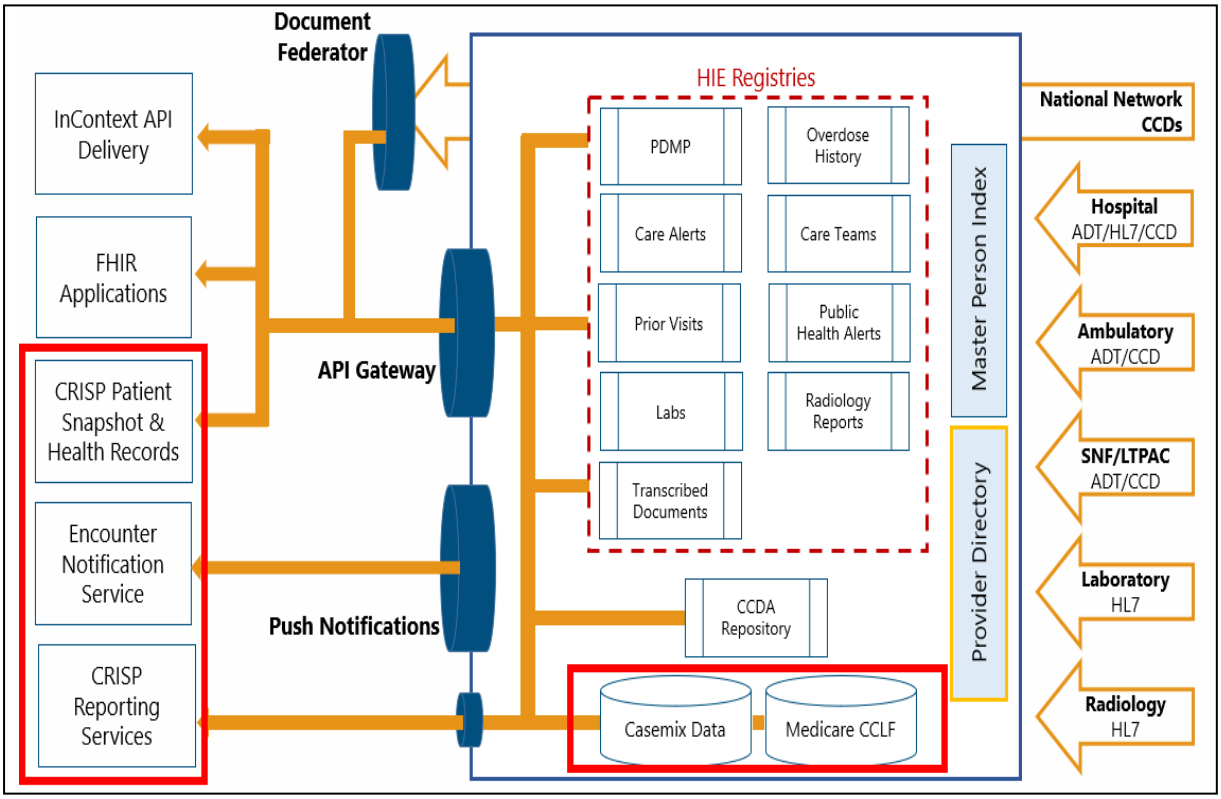


Figure 5. CRISP Data Flow


Document Federator
InContext API Delivery
FHIR Applications
CRISP Patient Snapshot & Health Records
Encounter Notification Service
CRISP Reporting Services
API Gateway
Push Notifications
HIE Registries
PDMP
Overdose History
Care Alerts
Care Teams
Prior Visits
Public Health Alerts
Labs
Radiology Reports
Transcribed Documents
CCDA Repository
Casemix Data
Medicare CCLF
Master Person Index
Provider Directory
National Network CCDs
Hospital ADT/HL7/CCD
Ambulatory ADT/CCD
SNF/LTPAC ADT/CCD
Laboratory HL7
Radiology HL7

Appendix B: Use Case Cost Breakout

Table 17. Use Case Cost Breakout for FFYs 24 and 25

IAPD Calculations	FFY 24	FFY 25
eReferral Service Enhancements		
Personnel - Eligible for Enhanced Funding	$ 618,165	$ -
Personnel - Not Eligible for Enhanced Funding	$ 238,697	$ -
Administrative Costs	$ 73,268	$ -
Core Infrastructure	$ 268,298	$ -
Contracted Professional Services (Planning and DDI)	$ 363,780	$ -
Total Service Enhancements	**$ 1,562,209**	$ -
Portal Services Enhancements		
Personnel - Eligible for Enhanced Funding	$ 721,192	$ -
Personnel - Not Eligible for Enhanced Funding	$ 278,480	$ -
Administrative Costs	$ 83,735	$ -
Core Infrastructure	$ 307,449	$ -
Contracted Professional Services (Planning and DDI)	$ 415,749	$ -
Total Critical Infrastructure Enhancements	**$ 1,806,605**	$ -
Connie Patient Portal		
Personnel - Eligible for Enhanced Funding	$ 75,938	$ -
Personnel - Not Eligible for Enhanced Funding	$ 14,850	$ -
Administrative Costs	$ 36,000	$ -
Core Infrastructure in DDI	$ 360,000	$ -
Contracted Professional Services	$ 50,000	$ -
Total Connie Portal Services	**$ 536,788**	**$ -**
FFY 25 DDI		
Personnel - Eligible for Enhanced Funding		$ 1,107,325
Personnel - Not Eligible for Enhanced Funding		$ 318,775
Administrative Costs		$ 322,766
Core Infrastructure in DDI		$ 785,521
Contracted Professional Services		$ 250,250
Total DDI		**$ 2,784,638**
Use Case Planning		
Personnel - Eligible for Enhanced Funding	$ 206,055	$ 395,473
Personnel - Not Eligible for Enhanced Funding	$ 79,566	$ 113,848
Administrative Costs	$ 52,335	$ 115,274
Contracted Professional Services (Planning and DDI)	$ 459,843	$464,750
Total Use Case Planning	**$ 797,798**	**$ 1,089,345**
Total Connie Budget by FFY	**$ 4,703,399**	**$ 3,873,983**

Appendix C: CMS 2-23-22 Approval Letter re: CAM

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-22-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

February 23, 2022

Commissioner Deidre Gifford
State of Connecticut
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105-3725

RE: CT-2021-12-29-MMIS-HIE-MES-IAPDU

Dear Ms. Gifford:

This letter is in response to Connecticut's submission dated December 29, 2021, requesting that the Centers for Medicare & Medicaid Services (CMS) review and approve the State's Implementation Advance Planning Document (IAPD) in support its Health information Exchange (HIE) program.

CT-2021-07-30-MMIS-IAPD-HIE (21-008M) was approved using an interim population-based cost allocation methodology on January 21, 2022. This IAPDU requests to change the interim methodology (26%), to a HIE-transactional allocation (40%). There are no changes to the scope or focus, however a higher cost allocation to Medicaid increased the budget amounts in Federal Fiscal Year (FFY) 2022 and FFY 2023.

Connecticut's APD requests authorization for $10,382,840 in Medicaid Management Information System (MMIS) funding, including the enhanced Federal financial participation (FFP) outlined in Appendix A. The requested funding will support the continued development of the State's HIE service offerings, enabling infrastructure, and overarching governance structures. Priority initiatives for the HIE include a provider portal, e-referral functionality, and a statewide provider directory. This APD includes a specific focus of providing data and technical services to improve care coordination and reduce the number of patients lost to follow-ups

CMS approves Connecticut's APD effective December 29, 2021, in accordance with Section 1903(a)(3) of the Social Security Act, 42 CFR 433, Subpart C, 45 CFR 95, Subpart F, and the State Medicaid Manual, Part 11. CMS is authorizing expenditures under this APD, in an amount not to exceed the approved Project Medicaid Detailed Budget Table (MDBT) in Appendix A. Authorization of federal funding for this project will expire on September 30, 2023. This approval letter supersedes any prior HIE APD for the Federal fiscal years (FFYs) approved within Appendix A.

Please note: CMS is approving this state Medicaid IT project and the associated funding; however, this APD approval does not constitute approval of any Medicaid program policies. Medicaid program policies must be reviewed and approved through the appropriate state plan amendment or waiver processes.

Page 2 – Ms. Gifford

Per regulations at 42 CFR 433.116, FFP is available at 75 percent of expenditures for operation of a Medicaid Enterprise System (MES) module or solution approved by CMS in accordance with CMS' MES certification requirements. The State can claim 75 percent FFP from the first day of the calendar quarter after the date the system met the conditions of initial approval, as established by CMS. This may include a retroactive adjustment of FFP if necessary to provide the 75 percent rate beginning on the first day of that calendar quarter. As outlined in the State Medicaid Manual (SMM), Section 11255, FFP for the operation of a non-certified MES is at 50 percent, pending system certification and CMS approval of retroactive operational funding.

If the State's project deviates from the CMS approved APD, FFP for project activities could be suspended and/or disallowed as provided for in federal regulations at 45 CFR 95.611(c)(3) and 95.612.

CMS' Consolidated MDBT in Appendix B includes approved funding for all MMIS Planning, Implementation, and Operational APDs for the listed FFYs.

This project is subject to all the requirements specified under Appendix C, which includes federal regulations and additional information about the State's responsibilities concerning activities described in the APD. The funding and scope of work approved in the APD are subject to these requirements. **Failure to comply with the federal requirements and State responsibilities in Appendix C is subject to FFP disallowance.**

The State must submit monthly status reports for the project. These reports should measure progress against the approved APD. Status reports must be submitted to the MES State Officer by the last day of each month, continuing through project completion.

Transformed Medicaid Statistical Information System (T-MSIS) Compliance
On August 10, 2018, CMS issued State Health Official (SHO) Letter 18-008, outlining T-MSIS data reporting requirements for state Medicaid and CHIP programs (https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO18008.pdf). As discussed in the CMCS Informational Bulletin (CIB) dated March 18, 2019 (https://www.medicaid.gov/federal-policy-guidance/downloads/cib031819.pdf) and subsequent T-MSIS guidance, Connecticut is required to maintain monthly production submissions of T-MSIS data files and continue to resolve T-MSIS data issues.

As of the October 2021 T-MSIS reporting period, Connecticut is compliant with T-MSIS requirements. Specifically, Connecticut has data quality issues in 1 T-MSIS Priority Items (TPIs), which meets the requirement to reduce data quality issues to no more than two TPI categories.

Timely, accurate, and complete T-MSIS data submission continues to be a CMS priority and is even more critical to national analyses of Medicaid and CHIP services, activities, and expenditures during the COVID-19 Public Health Emergency. To comply with T-MSIS Data Quality Assessment criteria, CMS requests that States continue to submit monthly T-MSIS data and continue, as much as possible, to work towards the recommended timelines for resolving TPIs. CMS will continue to measure and report on T-MSIS data quality issues, and provide ongoing technical assistance to states. Please review Appendix C (T-MSIS) of this APD response, which further details ongoing requirements for T-MSIS Data Quality compliance.

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The State must obtain CMS' prior approval for APDs, Requests for Proposals (RFPs), contracts, and contract amendments as specified in regulations at 45 CFR 95.611. Per 45 CFR 95.611(d), CMS has 60 days to review and respond to a state's APD submission. Failure to submit an Annual APD or APD Update in a timely manner may put the State at risk of having a gap in approved FFP. The State is reminded that funding for each FFY expires on September 30 of the corresponding FFY. An Annual APD or APD Update can be submitted at any time, however it must be approved by CMS before the funding expires to ensure there is no gap in approved FFP.

Formal submissions of future MMIS APDs, RFPs and contract actions should be sent to the CMS dedicated MMIS electronic mailbox: MedicaidMMIS@cms.hhs.gov with a cover letter addressed to Dzung Hoang, Director, Division of HITECH and MMIS.

If you have any questions, please contact your Medicaid Enterprise Systems (MES) State Officer, Alberta Pratt-Sensie, at 410-786-0251 or Alberta.Pratt-Sensie@cms.hhs.gov.

Sincerely,

Dzung Hoang, Director
Division of HITECH and MMIS

CC:
Edward Dolly, CMS/CMCS
Nicolas Aretakis, CMS/CMCS
Kia Banton, CMS/CMCS
Willie Tompkins, CMS/CMCS
Terrance Lew, CMS/CMCS
Debbie Simon, CMS/CMCS
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Rebecca Delabruere, CT
Michael Gilbert, CT
Deidre Gifford, CT
Kathleen Brennen, CT
Victoria Veltri, CT
Sumit Sajnani, CT
William Halsey, CT
Nicholas Venditto, CT

Appendix D: Standards and Conditions

Table 18. CT's MITA Standards and Conditions

Standard and Condition	Description of how CT Medicaid will meet these Standards and Conditions
1 - Modularity Standard	• Medicaid Provider Directory, Alerting, Direct Exchange, and the Business intelligence are being implemented as separate modules
2 - MITA Condition	• Connecticut strives to adhere to the Seven Conditions and Standards as outlined in MITA 3.0 There is ongoing emphasis on continuous movement toward maturity. • Wherever practicable MITA principles are deployed in terms of business, technical, and architectural standards.
3 - Industry Standards Condition	• Connecticut is aligning with industry standards with respect to development and testing of systems supporting Medicaid HIT initiatives. • Connecticut already uses Direct Secure Messaging, through a contractual agreement with the health information service provider. • Currently Connecticut's EHR Incentive program is engaged in: ○ Aligning to the MITA 3.0 principles by utilizing common industry standards whenever available. ○ Providing web-based access and integration. ○ Supporting MITA business process maturity to level 3 or 4.
4 - Leverage Condition	• As new systems are developed the State actively strives to assess components and solutions that have high applicability for reuse within the State and by other states. • Open-source, cloud-based, and commercial products will be utilized where practicable. • Customization will be avoided and minimized wherever possible. As an example, the MAPIR application is highly configurable. • Medicaid Provider Directory, Alerting, Direct Exchange and the Business intelligence leverage existing assets and Commercial Off The Shelf products.
5 - Business Results Condition	• The State seeks to improve abilities for the analysis and reporting of enterprise information in a timely and accurate manner to providers, recipients and the public. The application data within MAPIR can be placed in a state's data repository. As Meaningful Use continues to evolve, the State, in conjunction with the MAPIR collaborative, will determine the most appropriate use of the MAPIR system in capturing data that is useful for reporting purposes and measuring business results. • Medicaid Provider Directory, Alerting, Direct Exchange and the Business intelligence will benefit the Department's goal of better outcomes.

Standard and Condition	Description of how CT Medicaid will meet these Standards and Conditions
6 – Reporting Condition	• Connecticut strives to develop and maintain appropriate reports to contribute to program evaluation, continuous improvement in business operations, and transparency and accountability • Connecticut's Medicaid EHR Incentive Program maintains a reporting environment with a wide range of management reports available to program staff and for use in federal reporting. • Medicaid Provider Directory, Alerting, Direct Exchange and the Business intelligence solution will provide all necessary reports
7 - Interoperability Condition	• Connecticut's approach will ensure seamless interoperability between systems, both existing and those to be developed, including any statewide HIT/E efforts. Connecticut will ensure interoperability by continuing to adhere to standards-based protocols and architectures for all projects outlined in this IAPD.

Appendix E: Acronyms

Acronym	Description
ADT	Admissions, Discharges, Transfers
AIMS	APHL Informatics Messaging Services
APHL	Association of Public Health Laboratories
API	Application Programming Interface
ASO	Administrative Services Organization
CAM	Cost Allocation Methodology
CCD	Consolidated Clinical Document
CMS	Centers for Medicare and Medicaid Services
Connie	Connecticut's Health Information Exchange, assumed name of the HIE Entity, Health Information Alliance, Inc.
CPMRS	Connecticut Prescription Monitoring and Reporting System
CRISP	Chesapeake Regional Information System for our Patients, technology vendor for the CT statewide HIE
CT	Connecticut
DDI	Design, Development, Implementation
DME	Durable Medical Equipment
DSS	Department of Social Services
eCR	Electronic Case Reporting
EHR	Electronic Health Record
EPMO	Enterprise Project Management Office
FFY	Federal Fiscal Year
FHIR	Fast Healthcare Interoperability Resources
Health IT	Health Information Technology
HIA	Health Information Alliance, Inc., the statewide HIE Entity, which is using the assumed name "Connie"
HIE	Health Information Exchange
HIE Entity	Health Information Alliance, Inc., doing business as Connie
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HITAC or HIT Advisory Council	State Health Information Technology Advisory Council
HITECH	Health Information Technology for Economic and Clinical Health Act
HITO	Health Information Technology Officer
IAPD	Implementation Advance Planning Document
IAPD-U	Implementation Advance Planning Document Update
ICM	Intensive Care Management

Acronym	Description
IT	Information Technology
MAPIR	Medicaid Attestation Repository and Information System
MDM	Medical Document Management
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information System
MOA	Memorandum of Agreement
N&O	Needs and Objectives
OAPD	Operations Advance Planning Document
OHS	Office of Health Strategy
ORU	Observation Result
PA	Physician's Assistant
PMP	Prescription Monitoring Program
PrMA eConsent	Provider Mediated Affirmative eConsent
QDSOA	Qualified Data Sharing Organization Agreement
RAI	Request for Additional Information
SMA	State Medicaid Agency