ADMINISTRATIVE REGULATIONS

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

Notice of Intent to Implement Behavioral Health Recovery Program Policies

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In accordance with the authority granted in Section 17a-485i of the Connecticut General Statutes (C.G.S.), notice is hereby given that, **effective November 14, 2011** the Commissioner of Mental Health and Addiction Services intends to implement policies pertaining to the Behavioral Health Recovery Program (BHRP) as follows:

Department of Mental Health and Addiction Services
Behavioral Health Recovery Program

Section 1: Definitions

As used in sections 1 to 16, inclusive, of the Department of Mental Health and Addiction Services behavioral health recovery program policies:

(1) "Appeal" means a formal request for review of a clinical or basic recovery supports provider's service authorization or payment decision;

(2) "Authorization" means the approval of a request for clinical or basic recovery supports;

(3) "Authorized representative" means a person designated by the eligible recipient or a person authorized by law to act on behalf of an eligible recipient for the purpose of filing an appeal, or grievance;

(4) "Available resources" means other community or financial resources that cover services offered under the behavioral health recovery program;

(5) "Basic recovery supports" means transitional supportive services provided as an adjunct to clinical treatment services to assist eligible recipients to achieve and maintain recovery;

(6) “Basic recovery supports provider” means an entity that has been contracted or otherwise recognized by DMHAS to provide basic recovery supports under the behavioral health recovery program;

(7) “Behavioral health recovery program ” means a program administered by DMHAS that provides clinical and basic recovery supports for individuals who are subsidized under Medicaid as low income adults pursuant to Sections 1902(a)(10)(A)(i)(VIII) and 1902(k)(2) of the Social Security Act;

(8) “Behavioral health treatment services” means services designed for the treatment of psychiatric disorders or substance use or dependence disorder(s) or both;

(9) “Case management” means an assessment followed by recovery planning and discharge planning intended to link individuals to clinical recovery supports or basic recovery supports;

(10) “Cash assistance” means financial assistance provided by the state or federal government to individuals who are considered disabled or unemployable;

(11) “Clinical recovery supports” means services under the behavioral health recovery program that are provided in a licensed residential substance abuse treatment facility or in an institute for mental disease;

(12) “Clinical recovery supports provider” means an entity that has been contracted to provide clinical recovery supports under the behavioral health recovery program;

(13) “CFR” means Code of Federal Regulations;

(14) “Credentialing” means a process by which entities attest to or verify qualifications to provide clinical or basic recovery supports to eligible recipients in order to be eligible to receive reimbursement from DMHAS;

(15) “Commissioner” means the commissioner of the Department of Mental Health and Addiction Services;

(16) “Co-occurring substance use disorder” means a concurrent psychiatric disability and substance use disorder;

(17) “DMHAS” means the Department of Mental Health and Addiction Services or its designated agent;

(18) “DSS” means the Department of Social Services;

(19) “Designated agent” means an organization under contract with DMHAS to provide utilization management, claims processing, or other administrative support services necessary for the operation of the behavioral health recovery program;

(20) “Direct payment” means payment issued by DMHAS or its designated agent directly to entities for clinical or basic recovery supports provided to eligible recipients;

(21) “Discharge plan” means the written summary of an individual’s behavioral health services needs, developed in order to arrange for appropriate care after discharge or upon transfer from one level of care to another;

(22) “Eligible recipient” means an individual who receives clinical recovery supports or basic recovery supports through the behavioral health recovery program under CT Medicaid as a low income adult pursuant to Connecticut General Statute § 17a-485i as enacted by Public Act 10-60;

(23) “Independent housing” means short-term assistance provided to secure affordable and safe housing via a lease agreement with a landlord;

(24) “Institute for mental disease (IMD)” means a hospital, nursing facility or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases including medical attention, nursing care and related services;

(25) “Intensive residential treatment” means a residential substance use disorder treatment service delivered in a facility that meets and maintains all licensing requirements of federal and state statutes or regulations applicable to intensive residential treatment;

(26) “Intermediate or long-term residential treatment” means a residential substance use disorder treatment service delivered in a facility that meets and maintains all licensing requirements of federal and state statutes or regulations applicable to intermediate or long-term treatment or care and rehabilitation;

(27) “Job readiness” means activities including, but not limited to, recent job searches, vocational/educational classes, and vocational/educational groups;

(28) “Licensed behavioral health professional” means a person licensed by the State of Connecticut such as licensed professional counselors (LPCs), licensed alcohol and drug counselors (LADCs), and licensed marriage and family therapists (LMFTs).

(29) “Livery transportation” means taxi transportation provided to and from behavioral health recovery program clinical recovery supports services and supported recovery and shelter housing services;

(30) “Medicaid low income adult” means a member of a subgroup of the CT Medicaid covered population formerly known as recipients of the state administered general assistance program;

(31) "Payor of last resort" means a state agency that will only make payments for clinical or basic recovery supports services to the extent that no other source of payment is available;

(32) "Quality management" means the process of reviewing, measuring, and working to continually improve the quality of clinical and basic recovery supports;

(33) "Recovery" means a process of restoring or developing a positive and meaningful sense of identity apart from one's condition and then rebuilding one's life despite, or within the limitations imposed by that condition;

(34) "Recovery plan" means a written, individualized plan, based on the eligible recipient's needs, strengths and preferences, and developed with the involvement of the recipient or his or her authorized representative;

(35) "Shelter housing" means a facility the primary purpose of which is to provide temporary or transitional shelter for the homeless in general or for specific populations of the homeless;

(36) "Substance use disorder services" means services delivered for the care and treatment of individuals with substance use disorders that include medical, psychiatric and biopsychosocial assessments; individual, group and family counseling; peer counseling; vocational counseling and education groups;

(37) "Supported recovery housing" means a clean, safe, drug and alcohol-free transitional living environment under the behavioral health recovery program with on-site case management services available at least eight (8) hours per day five (5) days per week;

(38) "Supported recovery housing provider" means an entity under contract with DMHAS to provide supported recovery housing for the behavioral health recovery program.

Section 2: Covered Services

(a) Clinical recovery supports: The following clinical recovery supports shall be covered within the behavioral health recovery program:

(1) Acute psychiatric hospitalization: A medically necessary, inpatient behavioral health treatment service delivered in an institute for mental disease that meets and maintains all applicable licensing requirements of federal and state statutes or regulations pertaining to treatment of a psychiatric disability or co-occurring disorder, where an individual's admission is the result of a serious or dangerous condition that requires rapid stabilization of psychiatric symptoms. Acute

psychiatric hospitalization is used when 24-hour medical and nursing supervision are required to deliver intensive evaluation, medication titration, symptom stabilization and intensive, brief treatment. Acute psychiatric hospitalization may be delivered to individuals committed under a physician's emergency certificate (PEC), pursuant to section 17a-502 of the Connecticut General Statutes, and may occur on a locked psychiatric unit;

(2) Intensive residential treatment: A medically necessary, residential substance use disorder service delivered in a facility that meets and maintains all applicable licensing requirements of federal and state statutes or regulations pertaining to intensive residential treatment services. Services shall be delivered in a 24-hour setting to treat individuals with a substance use disorder or a co-occurring disorder who require intensive residential treatment. Intensive residential treatment services are delivered within a fifteen (15) to thirty (30) day period and include a minimum of thirty (30) hours of substance use disorder services per week;

(3) Intermediate or long-term residential treatment: A medically necessary, residential substance use disorder service delivered in a facility that meets and maintains all applicable licensing requirements of federal and state statutes or regulations pertaining to intermediate or long-term treatment or care and rehabilitation. Intermediate or long-term residential treatment services shall be delivered in a 24-hour setting to treat individuals with a substance use disorder or a co-occurring disorder who require intermediate/long term residential treatment. Services shall be delivered in a structured recovery environment and shall comply with the following applicable requirements:

(A) If the facility is licensed for and delivers intermediate or long-term residential treatment, a minimum of twenty (20) hours per week of substance use disorder services shall be delivered to each individual;

(B) If the facility is licensed for care and rehabilitation and delivers long-term care, a minimum of twenty (20) hours of substance use disorder services shall be delivered to each individual per week; and

(C) If the facility is licensed for intermediate or long-term residential treatment and delivers transitional or halfway-house services, a minimum of four (4) hours per week of substance use disorder services shall be delivered to each individual;

(4) Medically managed detoxification: A medically necessary, inpatient substance use disorder service delivered in an institute for mental disease that meets and maintains all applicable licensing requirements of federal and state statutes or regulations pertaining to the treatment of substance use disorders, where the individual’s admission is the result of a serious or dangerous condition that requires rapid treatment for a substance use disorder. Medically managed inpatient detoxification is used when on-site, 24-hour medical and nursing

supervision are required to deliver intensive evaluation, medication titration, symptom stabilization and intensive, brief treatment. Medically managed inpatient detoxification shall deliver evaluation for substance use disorders and withdrawal management. For individuals who have co- occurring disorders, psychiatric assessment and management shall be available. Medically managed inpatient detoxification may be delivered to patients committed under a physician's emergency certificate (PEC), pursuant to section 17a-684 of the Connecticut General Statutes;

(5) Observation bed-substance use: A medically necessary, substance use disorder service delivered in a private freestanding residential detoxification facility that meets and maintains all applicable licensing requirements of federal and state statutes or regulations pertaining to supervised stabilization, clinical monitoring and, when necessary, laboratory testing to facilitate the formulation of an appropriate diagnosis and suitable treatment program for an individual who is in urgent need of care and treatment for a substance use disorder. Observation beds may be used for no more than twenty-three (23) hours before discharge or transfer to another level of care is required.

(b) Basic recovery supports: The following basic recovery supports shall be covered within the behavioral health recovery program:

(1) Independent housing: Assistance provided to secure and maintain affordable and safe housing via a lease agreement with a landlord;

(2) Livery Transportation: Taxi transportation provided to and from behavioral health recovery program clinical recovery supports services and supported recovery housing services;

(3) Shelter housing: A clean, safe, drug and alcohol-free non-permanent, shelter-based living environment;

(4) Supported recovery housing: A clean, safe, drug and alcohol-free transitional living environment with on-site case management services available at least 8 hours per day 5 days per week;

(5) Basic needs: Goods which are provided to eligible recipients through the issuance of a gift card;

(6) Other: Any other support deemed appropriate by DMHAS, or its designated agent that is intended to and has a high likelihood of enhancing the eligible recipient’s recovery.

Section 3: Eligibility for Services

(a) Clinical recovery supports: In order to be eligible for clinical recovery supports under the behavioral health recovery program, an individual shall:

(1) Be determined eligible by DSS for under the Medicaid program for low-income adults in accordance with Connecticut General Statute Section 17b-261n, as amended by Public Act 11-44.

(2) Be determined by DMHAS staff or the designated agent to need covered clinical recovery supports. Such determination shall be based upon an evaluation of necessity that includes, but is not limited to:

(A) evaluation of problems identified by the individual;

(B) evaluation of the individual's history of behavioral health treatment services; and

(C) meeting the criteria for a diagnosis of one or more psychiatric disabilities, substance use disorders or both as specified in the following range of DSM-IV diagnostic codes: 291.1 to 292.9, inclusive; or 295.0 to 315.9, inclusive, except for diagnosis 307.89, Pain Disorder.

(b) Basic recovery supports: In order to be eligible for basic recovery supports under the behavioral health recovery program, an individual shall:

(1) Be determined eligible by DSS under the Medicaid program for low-income adults in accordance with Connecticut General Statute Section 17b-261n as amended by Public Act 11-44; and

(2) Be determined by a treatment or supported recovery house provider to:

(A) be actively engaged in behavioral health treatment services;

(B) be employable and not receiving cash assistance; and

(C) be in need of basic recovery supports and have no available resources to meet such need(s).

Section 4: Limitations, Exclusions and Non-Payment of Services

(a) Clinical recovery supports:

(1) Limitations: The following limitations for clinical recovery supports shall apply:

(A) Group therapy sessions shall be limited to a maximum of twelve (12) individuals per group session, excluding the supervising clinician(s); and

(B) Education groups shall be limited to a maximum of twenty-four (24) individuals per group session, excluding the supervising professional(s).

(2) Exclusions and non-payment: The following exclusions and non-payment for clinical recovery supports shall apply:

(A) Any clinical recovery supports delivered to an eligible recipient with a primary diagnosis which is outside the range of DSM-IV diagnostic codes of 291.1 to 292.9, inclusive; 295 to 307.88, inclusive or 307.90 to 315.9, inclusive;

(B) Services that DMHAS determines to be experimental in nature;

(C) Services that the designated agent determines are not medically necessary;

(D) Services which the designated agent determines to be similar or identical that are delivered to the same eligible recipient;

(E) Activities that DMHAS determines are primarily for vocational or educational guidance that relate solely to a specific employment opportunity, job skill, work setting or development of an academic skill;

(F) Therapies, treatments or procedures that relate to transsexual or gender-change medical or surgical procedures;

(G) Activities, treatment or items delivered to an eligible recipient for which the contracted provider does not usually charge others;

(H) The day of discharge or transfer, unless the eligible recipient is discharged or transferred on the same day as he or she is admitted;

(I) A leave of absence or pass from an inpatient or residential facility that occurs without staff permission or against staff advice;

(J) A leave of absence or pass from an inpatient or residential facility with staff permission, if the absence is longer than 24 hours, unless authorized in advance by the designated agent;

(K) Electroconvulsive therapy, unless delivered by a licensed psychiatrist and pre-authorized by the designated agent;

(L) Hypnosis, unless delivered by a licensed psychiatrist or psychologist and pre-authorized by the designated agent;

(M) Psychological or intelligence testing, unless delivered by a licensed psychologist and pre-authorized by the designated agent;

(N) Neuropsychological testing, unless delivered by a licensed psychologist and preauthorized by the designated agent;

(O) Clinical recovery supports delivered by a staff member who is not a licensed behavioral health professional or who is not a Connecticut certified alcohol and drug counselor, unless the following conditions are met:

(i) The staff member is employed by or under contract with a licensed facility whose medical director or clinical supervisor has determined that the staff member is qualified to deliver behavioral health treatment services to eligible recipients;

(ii) For acute psychiatric hospitalization, the staff member is actively pursuing behavioral health licensure and is under the direct supervision of licensed behavioral health professional with at least two (2) years of experience in the delivery of behavioral health treatment services; and

(iii) The supervising clinician has signed the eligible recipient's recovery plan;

(P) Clinical recovery supports delivered by staff of a licensed facility at a location other than that which is specified on the facility's license.

(b) Basic recovery supports:

(1) Limitations: The following limitations for basic recovery supports shall apply:

(A) Basic recovery supports shall be limited to goods and services intended to assist the eligible recipient to progress toward recovery goals; and

(B) Basic recovery supports will only be authorized when no other available resources are identified;

(2) Exclusions and non-payment: The following exclusions and non-payment for basic recovery supports shall apply:

(A) Service locations that do not comply with all applicable laws, regulations, and ordinances regarding zoning, building, fire, health and safety;

(B) Independent housing:

(i) When the eligible recipient is not named in the lease as either the lessee or an authorized occupant;

(ii) Located outside of the State of Connecticut;

(iii) At a licensed behavioral health treatment services facility;

(iv) At a contracted supported recovery or shelter housing location; and

(v) Where the eligible recipient must follow written or stated rules are not part of the rental agreement or are not permissible by law;

(C) Supported recovery or shelter housing:

(i) Not currently certified and contracted by DMHAS (see Sections 10 and 11 Credentialing and Contracting);

(ii) Not authorized by DMHAS or its designated agent;

(iii) The day of discharge or transfer, unless the eligible recipient is discharged or transferred on the same day as he or she is admitted;

(iv) A leave of absence that occurs without staff permission;

(v) A leave of absence or pass if the absence is longer than 24 hours, unless authorized in advance by DMHAS, or its designated agent; and

(vi) Services that can not be substantiated by appropriate documentation;

(D) Livery transportation:

(i) Not currently contracted by DMHAS; and

(ii) To locations other than the clinical and basic recovery supports providers contracted by the Behavioral Health Recovery Program;

(E) Basic needs goods other than clothing and personal items for the intended eligible recipient.

Section 5: Prior Authorizations

(a) Clinical recovery supports.

(1) The prior authorization review for clinical recovery supports shall determine whether covered clinical recovery supports are medically necessary and confirm the appropriate level of care. Clinical recovery supports providers shall obtain prior authorization from the designated agent by contacting the designated agent by telephone before admitting a potentially eligible recipient or eligible recipient to covered clinical recovery supports services.

(2) The clinical recovery supports provider shall provide the designated agent with the following information for the purpose of prior authorization review of covered clinical recovery supports requested for a potentially eligible recipient or eligible recipient:

(A) Identifying information;

(B) DSM-IV provisional or admitting diagnosis or diagnoses;

(C) Level of care requested;

(D) Clinical presentation of the potentially eligible recipient or eligible recipient and justification for the requested clinical recovery supports, including such factors as mental status, natural supports and strengths;

(E) Recovery plan objectives;

(F) Current symptoms of a psychiatric disability, a substance use disorder or both;

(G) Clinical risk assessment and relapse potential;

(H) Medication(s) used;

(I) Substance(s) used;

(J) Whether the potentially eligible recipient or eligible recipient is voluntarily agreeing to treatment;

(K) Legal status of the potentially eligible recipient or eligible recipient, if known;

(L) The potentially eligible recipient or eligible recipient's preference for a covered clinical recovery supports provider;

(M) Treatment location;

(N) Provisional discharge or aftercare plan or both;

(O) Projected date of discharge;

(P) Name of the potentially eligible recipient or eligible recipient's primary care physician, if any; and

(Q) All other information that the designated agent may require.

(3) The designated agent may require a DMHAS designated mobile crisis team or another organization identified by DMHAS to collect information necessary for prior authorization of psychiatric hospitalization, following a face-to-face evaluation of the potentially eligible recipient or eligible recipient.

(4) The decision regarding prior authorization shall be rendered by the designated agent not later than three (3) hours after the receipt of all information that the designated agent determines is necessary and sufficient to render a decision.

(5) Upon completion of the review, the designated agent shall:

(A) Authorize the requested covered clinical recovery supports for a specific number of days;

(B) Authorize a different covered clinical recovery supports than requested; or

(C) Deny authorization, when the information received by the designated agent does not demonstrate that the requested covered clinical recovery supports is medically necessary.

(6) Prior authorization of covered clinical recovery supports is not a guarantee that DMHAS will pay a clinical recovery supports provider's claim for payment.

(b) Basic recovery supports

(1) The behavioral health treatment services provider or supported recovery housing provider shall apply for prior authorization of basic recovery supports on behalf of an eligible recipient through submission of the web-based application to DMHAS, or its designated agent, after ensuring that all fields have been completed accurately.

(2) At a minimum, the application shall include:

(A) The eligible recipient's identifying information;

(B) The type of basic recovery supports being requested;

(C) Behavioral health treatment services information, including the eligible recipient's admission date, type of treatment, provider and provider identifying information; and

(D) A valid release of information, provided by DMHAS, or its designated agent signed by the eligible recipient consenting to the release of confidential information related to the basic recovery supports application.

(3) DMHAS, or its designated agent, may request additional information relevant to the type of basic recovery supports being requested and will request such information when necessary.

(4) The provider shall ensure that an application for basic recovery supports is submitted to DMHAS, or its designated agent, not later than thirty (30) business days after the provider has conducted an assessment to determine the eligible recipient's need for the supports.

(5) Upon receipt of a properly completed application for basic recovery supports, DMHAS or its designated agent may authorize such request, provided the following determinations have been made:

(A) The information required by the eligibility section of these policies has been verified by DMHAS or its designated agent;

(B) The requested basic recovery supports is a covered service as described in Section 2 (b) of these policies;

(C) DMHAS, or its designated agent, has determined that there are no other available resources for which supports are being requested;

(D) The eligible recipient has not exceeded the maximum basic recovery supports program allowance within the last twelve months; and

(E) Funding is available to provide the requested basic recovery supports.

(6) DMHAS, or its designated agent, shall notify the applying provider regarding the disposition of the request for authorization for basic recovery supports not later than five (5) business days after a complete application is received.

(7) At a minimum, the authorization notification shall contain the following:

(A) Name, address and phone number of the entity and contact person making the authorization decision;

(B) Date of the authorization determination;

(C) Amount and type of basic recovery supports requested;

(D) Amount and type of basic recovery supports authorized;

(E) Date, location, and time during which basic recovery supports will be available; and

(F) Rationale for any basic recovery supports that were not authorized.

(8) Authorization of requests for basic recovery supports may extend for a period not to exceed thirty (30) days. After the first approved thirty (30) day period, requests for continued authorizations may be made in accordance with Section 6 of these policies.

(9) Prior authorization of covered basic recovery supports is not a guarantee that DMHAS will pay a basic recovery supports provider's claim for payment.

Section 6: Continued Authorizations

(a) Clinical recovery supports

(1) The continued authorization review shall determine whether previously authorized covered clinical recovery supports continue to be medically necessary. If a provider of a previously authorized clinical recovery supports, except for observation beds, determines that additional care may be needed beyond that which has been previously authorized, the provider shall contact the designated agent by telephone not less than four (4) hours prior to the expiration of the existing authorization for acute psychiatric hospitalization and medically managed detoxification and not more than forty-eight (48) hours prior to the expiration of the existing authorization for other clinical recovery supports in order to obtain a continued authorization.

(2) The provider of clinical recovery supports shall furnish all information that may be requested by the designated agent for the purpose of determining continued authorization of clinical recovery supports requested for a potentially eligible recipient or eligible recipient, including, but not limited to, the following:

(A) Identifying information;

(B) DSM-IV current diagnosis or diagnoses;

(C) Level of care requested;

(D) Clinical presentation of the potentially eligible recipient or eligible recipient and justification for the requested clinical recovery supports, including such factors as mental status, and strengths;

(E) Recovery plan objectives;

(F) Current symptoms of mental illness or substance use disorders or both;

(G) Clinical risk assessment and relapse potential;

(H) Medication(s) used;

(I) Substance(s) used;

(J) Whether the potentially eligible recipient or eligible recipient is voluntarily agreeing to treatment;

(K) Legal status of the potentially eligible recipient or eligible recipient, if known;

(L) Potentially eligible recipient or eligible recipient's preference for a clinical recovery supports and provider;

(M) Treatment location;

(N) Provisional discharge or aftercare plan or both;

(O) Projected date of discharge;

(P) Name of the potentially eligible recipient or eligible recipient's primary care physician, if any; and

(Q) All other information that the designated agent may require.

(3) The decision regarding continued authorization shall be rendered by the designated agent not later than three (3) hours after the receipt of all information that the designated agent determines is necessary and sufficient to render a decision.

(4) Upon completion of the review, the designated agent shall:

(A) Authorize the requested clinical recovery supports for a specific number of days over a specified time period;

(B) Authorize a different clinical recovery supports than requested; or

(C) Deny authorization when the information received by the designated agent does not demonstrate that the requested clinical recovery supports is medically necessary.

(5) Continued authorization of a clinical recovery supports is not a guarantee that DMHAS will pay a clinical recovery supports provider's claim for payment.

(b) Basic recovery supports

(1) The behavioral health treatment services provider or supported recovery housing provider may apply for continued authorization of basic recovery supports on behalf of an eligible recipient through submission of the web-based application to DMHAS, or its designated agent, after ensuring that all fields have been completed accurately.

(2) At a minimum, the application shall include:

(A) The eligible recipient's identifying information;

(B) The type of basic recovery supports being requested;

(C) Behavioral health treatment services information, including the eligible recipient's admission date, type of treatment, provider, and provider identifying information;

(D) A valid release of information, provided by DMHAS, or its designated agent signed by the eligible recipient consenting to the release of confidential information related to the basic recovery supports application;

(E) Evidence of specific steps taken by the eligible recipient toward independent functioning and job readiness; and

(F) Any other information requested by DMHAS, or its designated agent, needed to determine ongoing qualification.

(3) DMHAS, or its designated agent, shall notify the provider regarding the disposition of the request for authorization for basic recovery supports not later than five (5) business days after a complete application is received. Individuals who no longer meet the eligibility requirements as specified in section 3 (b) shall not be re-authorized for basic recovery supports.

(4) At a minimum, the continued authorization notification shall contain the following:

(A) Name, address and phone number of the entity and contact person making the authorization decision;

(B) Date of the authorization determination;

(C) Amount and type of basic recovery supports requested;

(D) Amount and type of basic recovery supports authorized;

(E) Date, location, and time during which basic recovery supports will be available; and

(F) Rationale for any basic recovery supports that were not authorized.

(5) Continued authorization of a covered basic recovery support is not a guarantee that DMHAS will pay a basic recovery supports provider's claim for payment.

Section 7: Recovery and Discharge Planning

(a) A recovery plan shall be developed by providers of clinical recovery supports and supported recovery housing for each eligible recipient.

(b) The recovery plan shall**:**

(1) Be developed with participation from the eligible recipient or, if the eligible recipient does not participate in its development, shall contain a written explanation as to why the eligible recipient did not participate;

(2) Reflect the following:

(A) Eligible recipient's preferences, interests, strengths and areas of health;

(B) Specific outcomes that the eligible recipient desires related to the eligible recipient's preferences, interests, strengths and areas of health; and

(C) Activities, supports, housing, employment and other recovery supports that may assist with the achievement of the eligible recipient's desired outcomes;

(3) Be reviewed regularly and, if necessary, revised; and

(4) Contain signatures of the eligible recipient, counselor or case manager responsible for the recovery plan.

(c) A discharge plan shall be developed by providers of clinical recovery supports for each eligible recipient.

(d) A discharge plan developed by providers of clinical recovery supports shall:

(1) Be developed with participation from the eligible recipient or, if the eligible recipient does not participate in its development, shall contain a written explanation as to why the eligible recipient did not participate; and

(2) Reflect the following:

(A) Discharge date;

(B) Identifying information;

(C) DSM-IV, or its replacement, discharge diagnosis;

(D) Progress made toward the accomplishment of recovery plan objectives;

(E) Clinical presentation at the time of discharge, including such items as his or her mental status and response to treatment;

(F) Clinical risk and relapse potential;

(G) Medication(s) used during the present treatment episode;

(H) Circumstances of discharge, including whether the eligible recipient left upon completion of treatment or under some other discharge status and the details of that status;

(I) Involvement in discharge planning;

(J) Details of the discharge or aftercare plan or both for the eligible recipient, including the level of care recommended by the discharging provider and details of arrangements made to secure that care;

(K) Living arrangement(s) and address upon discharge; and

(L) Arrangements for any medication(s) that may be needed by the eligible recipient following discharge.

(e) A discharge plan shall be developed by providers of supported recovery housing for each eligible recipient.

(f) A discharge plan developed by providers of supported recovery housing shall:

(1) Be developed with participation from the eligible recipient or, if the eligible recipient does not participate in its development, shall contain a written explanation as to why the eligible recipient did not participate; and

(2) Reflect the following:

(A) Discharge date;

(B) Identifying information;

(C) Progress made toward the accomplishment of recovery plan objectives;

(D) Status at the time of discharge, including relapse potential, engagement in behavioral health treatment services, and employment;

(E) Circumstances of discharge, including whether the eligible recipient left upon completion of supported recovery housing or under some other discharge status and the details of that status;

(F) Involvement in discharge planning;

(G) Details of the discharge for the eligible recipient, including any additional basic or clinical recovery supports being recommended by the supported recovery housing provider and details of arrangements made to secure such supports; and

(H) Living arrangement(s) and address upon discharge.

(g) The following contracted providers of clinical recovery supports are required to participate in a discharge plan review for all eligible recipients being discharged from the following clinical recovery supports:

(1) Acute psychiatric hospitalization at institute for mental disease;

(2) Intensive residential treatment;

(3) Intermediate or long-term residential treatment; and

(4) Medically managed inpatient detoxification at institute for mental disease.

(h) Except when the eligible recipient leaves the facility unexpectedly, the provider of clinical recovery supports shall contact the designated agent to request a discharge review not more than two (2) business days, and not less than four (4) hours, before the eligible

recipient's scheduled departure. Reviews of unexpected discharges shall be conducted not later than one (1) business day following the date of the eligible recipient's discharge. If an eligible recipient leaves a facility but is expected to return, the provider of clinical recovery supports may delay the discharge review until either the eligible recipient returns or a decision is made to discharge the eligible recipient. The clinical recovery support provider shall conform to generally accepted standards of professional practice regarding the duration of time such provider shall delay a discharge decision for an eligible recipient who left the program unexpectedly and has not returned.

Section 8: Quality Management

Providers of clinical recovery supports, shelter housing and supported recovery housing shall:

(a) Comply with all state and federal requirements pertaining to the communication, storage, dissemination, and retention of confidential information regarding potentially eligible recipients and eligible recipients including the Health Insurance Portability and Accountability Act (HIPAA); 45 CFR 164, 42 CFR 2; and 17a-688(c) and Chapter 899 of the Connecticut General Statutes; and other such laws and regulations as may apply. In addition, the provider shall assume responsibility for obtaining any release of information that may be necessary to meet contractual data transmittal and basic or clinical recovery supports coordination requirements.

(b) Report every critical incident to the DMHAS Office of the Commissioner in the form and manner specified by DMHAS.

(c) Submit to DMHAS or its designated agent timely and accurate information in the format specified by DMHAS or its designated agent. This information includes, but is not limited to, the following:

(1) Demographic data regarding the eligible recipients served;

(2) Descriptions of the basic or clinical recovery supports delivered;

(3) Descriptions of the clinical or basic recovery supports provider’s staff sufficient for DMHAS to assess the clinical or basic recovery supports provider’s cultural competency;

(4) Eligible recipient outcomes;

(5) Census counts;

(6) Eligible recipient service records or charts;

(7) Results of risk assessment screenings (when appropriate); and

(8) A critical incident review summary, including recommendations, in the format and manner specified by DMHAS.

Section 9: Provider Application

(a) Clinical recovery supports provider

(1) A provider of behavioral health treatment services that is interested in participating in the behavioral health recovery program as a clinical recovery supports provider shall submit an application when there is an open competitive procurement process available through DMHAS. The application shall be completed by the provider and shall include, at a minimum, the following information:

(A) Name, address, telephone number and contact person;

(B) Target population, including age groups and genders treated;

(C) Level(s) of care or other service types offered and capacity for each;

(D) Treatment/program specialties;

(E) Staff licenses, competencies and language(s) spoken;

(F) A copy of the facility license(s); and

(G) A copy of the facility malpractice insurance certificate.

(2) The interested provider shall complete the application and return it to DMHAS by the due date and time as requested in the competitive procurement process. If an application is not submitted within the required time frame, DMHAS shall not accept the application per the competitive procurement guidelines.

(b) Basic recovery supports provider

(1) A provider of shelter housing, supported recovery housing, or livery transportation services that is interested in participating in the behavioral health recovery program as a basic recovery supports provider shall submit an application when there is an open competitive procurement process available through DMHAS. The application shall be completed by the provider and shall include, at a minimum, the following information:

(A) Name, address, telephone number and contact person;

(B) Target population to be served, including age groups and genders;

(C) Service types offered and capacity for each;

(D) Staffing patterns, competencies, and languages spoken;

(E) A copy of the commercial liability insurance certificate; and

(F) Verification of adherence to local zoning laws (housing providers only).

(2) The interested provider shall complete the application and return it to DMHAS by the due date and time as requested in the competitive procurement process. If an application is not submitted within the required time frame, DMHAS shall not accept the application per the competitive procurement guidelines.

(c) The provider shall be required to submit to DMHAS, or the designated agent, additional information or clarification, if any discrepancies or questions are identified.

(d) DMHAS retains the right to deny an application based on a competitive procurement process, the information contained in the application, or the current needs of the behavioral health recovery program.

Section 10: Credentialing

(a) A provider seeking to deliver the following services in the behavioral health recovery program shall comply with the applicable credentialing requirements:

(1) Acute psychiatric hospitalization;
(2) Intensive residential treatment;
(3) Intermediate or long-term residential treatment;
(4) Livery transportation;
(5) Medically managed detoxification;
(6) Observation bed-substance use;
(7) Shelter recovery housing; or
(8) Supported recovery housing.

(b) The purpose of the credentialing process is for DMHAS to determine if a provider applying to participate in the behavioral health recovery program has the requisite qualifications. The provider shall be required to meet all credentialing criteria as specified in this section. If any of the credentialing criteria are not met, the provider shall be denied participation in the behavioral health recovery program.

(c) The credentialing process shall include the assessment and validation of qualifications of providers to determine whether the provider is qualified to deliver specific basic or clinical recovery supports and whether the provider meets the credentialing requirements

specified for those clinical or basic recovery supports in this section. If DMHAS determines that a provider has not met the required qualifications as specified in this section, DMHAS shall not contract with the provider.

(d) The designated agent shall collect and review documentation that includes, but is not limited to:

(1) Status of appropriate zoning, licensure, or accreditation;

(2) Experience in providing basic or clinical recovery supports to individuals;

(3) Evidence of adequate insurance; and

(4) Descriptions detailing programmatic and staffing information for each basic or clinical recovery supports proposed for credentialing.

(e) The provider shall be required to submit to the designated agent additional information or clarification, if any discrepancies or questions are identified.

(f) A provider of behavioral health treatment services that has been sanctioned by DSS for violations while participating in the Medicaid program shall not be credentialed as a clinical recovery supports provider for the behavioral health recovery program.

(g) The designated agent shall make a recommendation to DMHAS regarding whether the provider meets the credentialing qualifications necessary to offer the proposed recovery supports. DMHAS, in its sole discretion, shall decide whether to accept the recommendation of the designated agent.

(h) DMHAS shall notify the provider of the outcome of the credentialing process. If DMHAS determines that the provider meets the requisite credentialing qualifications as specified in this section, then DMHAS may initiate the contracting process as specified in Section 11 of these policies.

(i) A provider that is denied participation in the behavioral health recovery program may request reconsideration of such denial. Such request shall be submitted in writing to the DMHAS Commissioner not more than ten (10) calendar days following the date of receipt of the denial notice.

(j) Credentialing criteria that providers shall meet to qualify to deliver covered clinical and basic recovery supports under the behavioral health recovery program are as follows:

(1) Acute psychiatric hospitalization in an IMD shall be delivered in a facility that:

(A) Meets and maintains all applicable licensing requirements of federal and state statutes or regulations;

(B) Delivers acute psychiatric hospitalization on a psychiatric unit that is separate and distinct from a medical unit;

(C) Except as provided by state law, maintains professional liability insurance coverage of at least three million dollars ($3,000,000) per occurrence and ten million dollars ($10,000,000) in aggregate or, if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability;

(D) Is Joint Commission-accredited;

(E) Includes the following staff, licensed by the state of Connecticut and employed by or under contract with the facility in which acute psychiatric hospitalization operates:

(i) A medical director;
(ii) A board-certified or board-eligible psychiatrist;
(iii) A psychologist;
(iv) Social workers;
(v) A physician on site 24 hours per day, seven (7) days per week; and
(vi) Registered nurses on site 24 hours per day, seven (7) days per week.

(F) Maintains the ability to conduct an admission 24 hours per day, seven (7) days per week;

(G) Conducts a diagnostic evaluation, including screening for a co-occurring substance use disorder, a bio-psychosocial assessment and a risk assessment;

(H) Conducts a medical history and physical examination upon admission;

(I) Performs medication evaluation and monitoring;

(J) Conducts medical management and monitoring of coexisting medical problems, except that life support systems or a full array of medical services are not required;

(K) Performs appropriate observation and takes precautions for individuals who may be suicidal;

(L) Develops a recovery plan with each individual;

(M) Conducts individual and group therapy and, when indicated, family

therapy;

(N) Delivers rehabilitative social and recreational therapies, when indicated;

(O) Delivers laboratory services, when indicated; and

(P) Completes discharge planning that helps ensure the continuation of appropriate treatment.

(2) Intensive residential treatment shall be delivered in a facility that:

(A) Delivers substance use disorder services to individuals in a structured recovery environment that is supervised by staff 24/7 in order to address significant problems with behavior and functioning in major life areas due to a substance use disorder and to reintegrate such individuals into the community;

(B) Meets and maintains all applicable licensing and requirements of federal and state statutes or regulations;

(C) Except as provided by state law, maintains professional liability insurance coverage of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in aggregate or, if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability;

(D) Is Joint Commission or CARF-accredited or has a clinical supervisor with authority over all behavioral health treatment services;

(E) Employs or contracts with a clinical supervisor with authority over all behavioral health treatment services, who shall have a minimum of a master’s degree in a behavioral health treatment services field and at least three (3) years of full-time work experience in substance use disorders treatment and be licensed by the state of Connecticut or certified, as appropriate in his or her respective discipline;

(F) Maintains a sufficient number of staff to deliver the proposed intensive residential treatment in order to satisfy the needs of individuals;

(G) Delivers a minimum of thirty (30) hours per week of substance use disorder services. When performed by a staff member who is not a licensed behavioral health professional or a Connecticut certified alcohol and drug counselor the following conditions shall be met:

(i) The staff member is employed by or under contract with the facility;

(ii) The medical director or clinical supervisor has determined that the staff member is qualified to deliver substance use disorder services; and

(iii) The staff member is under the direct supervision of a licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health treatment services or a Connecticut certified clinical supervisor.

(H) Has the ability to deliver emergency psychiatric and emergency medical services or maintains written agreements enabling immediate access for individuals, when needed, to facilities that offer such care;

(I) Conducts an initial intake evaluation, including screening for a co-occurring psychiatric disability;

(J) Completes a bio-psychosocial assessment;

(K) Develops a recovery plan with each individual;

(L) Provides orientation and referral to a self-help program;

(M) Completes discharge planning that helps ensure the continuation of appropriate treatment;

(N) Provides adequate testing for or analysis of drugs of abuse as specified in applicable federal and state statutes and regulations; and

(O) Assists with vocational and pre-vocational planning.

(3) Intermediate or long-term residential treatment shall be delivered in a facility that:

(A) Delivers substance use disorder services to individuals in a structured recovery environment that is supervised by staff 24/7 in order to address significant problems with behavior and functioning in major life areas due to a substance use disorder and to reintegrate such individuals into the community;

(B) Meets and maintains all applicable licensing requirements of federal and state statutes or regulations;

(C) Except as provided by state law, maintains professional liability

insurance coverage of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in aggregate or, if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability;

(D) Is Joint Commission or CARF-accredited or has a clinical supervisor with authority over all behavioral health treatment services;

(E) Employs or contracts with a clinical supervisor with authority over all behavioral health treatment services, who shall have a minimum of a master's degree in a behavioral health treatment services field and at least three (3) years of full-time work experience in substance use disorder services and be licensed by the state of Connecticut or certified, as appropriate in his or her respective discipline;

(F) Maintains a sufficient number of staff to deliver the proposed intermediate or long-term residential treatment in order to satisfy the needs of individuals;

(G) Delivers a minimum of twenty (20) hours per week of substance use disorder services by facilities licensed for intermediate and long-term treatment and identified as delivering intermediate and long-term residential treatment; or a minimum of twenty (20) hours per week of substance use disorder services by facilities licensed for care and rehabilitation and identified as providing long-term care; or a minimum of four (4) hours per week of substance use disorder services by facilities licensed for intermediate and long-term treatment and identified as providing transitional or halfway house services. When performed by a staff member who is not a licensed behavioral health professional or a Connecticut certified alcohol and drug counselor the following conditions shall be met:

(i) The staff member is employed by or under contract with the facility;

(ii) The medical director or clinical supervisor has determined that the staff member is qualified to deliver substance use disorder services; and

(iii) The staff member is under the direct supervision of a licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health treatment services or a Connecticut certified clinical supervisor.

(H) Has the ability to deliver emergency psychiatric and emergency medical services or maintains written agreements enabling immediate access for individuals, when needed, to facilities that offer such care;

(I) Conducts an initial intake evaluation, including screening for a co-occurring psychiatric disability;

(J) Completes a bio-psychosocial assessment;

(K) Develops a recovery plan with each individual;

(L) Provides orientation and referral to a self-help program;

(M) Completes discharge planning that helps ensure the continuation of appropriate treatment;

(N) Provides adequate testing for or analysis of drugs of abuse as specified in applicable federal and state statutes and regulations; and

(O) Assists with vocational and pre-vocational planning.

(4) Livery transportation services shall:

(A) Meet and maintains all licenses and other federal, state, and local statutes or regulations;

(B) Maintain workers' compensation as required by the State of Connecticut;

(C) Maintain commercial liability insurance as required by the State of Connecticut;

(D) Employ or contract with a supervisor with authority over all services, who shall have a minimum of a at least one (1) year of full-time work experience with individuals with substance use disorders; or with co-occurring substance use and mental health disorders; and

(E) Maintain a sufficient number of staff to deliver the proposed livery transportation in order to satisfy meet the needs of individuals.

(5) Medically managed detoxification in an institute of mental disease shall be delivered in a facility that:

(A) Meets and maintains all applicable licensing requirements of federal and state statutes or regulations;

(B) Except as provided by state law, maintains professional liability insurance coverage of at least three million dollars ($3,000,000) per occurrence and ten million dollars ($10,000,000) in aggregate or, if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability;

(C) Is Joint Commission or CARF-accredited;

(D) Delivers emergency psychiatric services or maintain written agreements enabling immediate access for individuals, when needed, to facilities that offer such care;

(E) Completes an initial intake evaluation, including screening for a co-occurring psychiatric disability;

(F) Maintains the ability to conduct an admission 24 hours per day, seven (7) days per week;

(G) Performs a physical examination including a medical history upon admission, inclusive of laboratory testing;

(H) Performs a diagnostic evaluation and risk assessment;

(I) Conducts medical management and monitoring of substance withdrawal;

(J) Provides individual, group and, when indicated, family therapy;

(K) Completes a bio-psychosocial assessment;

(L) Develops a recovery plan with each individual;

(M) Performs appropriate observation and precautions for individuals who may be suicidal;

(N) Offers referrals to self-help programs;

(O) Provides medical management and monitoring of co-existing medical problems;

(P) Completes discharge planning that helps ensure the continuation of appropriate treatment; and

(Q) Includes the following staff, licensed by the state of Connecticut or certified as appropriate in their respective disciplines:

(i) A medical director;
(ii) A social worker or counselor experienced in the treatment of substance use disorders;
(iii) A physician on site 24 hours per day, seven (7) days per week;
(iv) A registered nurse on site 24 hours per day, seven (7) days per week; and
(v) A pharmacist.

(6) Observation bed-substance use shall be in a facility that:

(A) Meets and maintains all applicable licensing requirements of federal and state statutes or regulations;

(B) Except as provided by state law, maintains professional liability insurance coverage of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in aggregate or, if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability;

(C) Is Joint Commission or CARF-accredited or has a physician with experience in providing substance use disorders services, who is responsible for supervising all medical services;

(D) Delivers emergency psychiatric and emergency medical services or maintains written agreements enabling immediate access for individuals, when needed, to facilities that offer such care;

(E) Includes the following staff, licensed by the state of Connecticut or certified as appropriate in their respective disciplines and employed by or under contract with the facility:

(i) A registered nurse;
(ii) An alcohol and drug counselor; and
(iii) A clinical supervisor with authority over all services, who has a minimum of a master's degree in a behavioral health field and at least three (3) years of full-time work experience in substance use disorders services and is licensed by the state of Connecticut or certified, as appropriate in his or her respective discipline and employed by or under contract with the facility.

(F) Maintains that any behavioral health services performed by a staff member who is not a licensed behavioral health treatment services professional or a Connecticut certified alcohol and drug counselor shall meet the following conditions:

(i) The staff member is employed by or under contract with the facility;
(ii) The medical director or clinical supervisor has determined that the staff member is qualified to deliver substance use disorder services; and
(iii) The staff member is under the direct supervision of a licensed behavioral health treatment services professional with at least two (2) years of experience in the provision of substance use disorder services or a Connecticut certified clinical supervisor.

(G) Delivers to each individual up to twenty-three (23) hours of supervised stabilization, clinical monitoring and, when necessary, laboratory testing to facilitate the formulation of an appropriate diagnosis and suitable disposition for individuals in urgent need of care;

(H) Maintains the ability to conduct an admission 24 hours per day, seven (7) days per week;

(I) Conducts crisis intervention, as required;

(J) Completes an initial intake evaluation, including screening for a co-occurring psychiatric disability;

(K) Completes a diagnostic evaluation and risk assessment;

(L) Completes a physical examination and medical history conducted upon admission;

(M) Conducts medication evaluation and management;

(N) Includes laboratory services, when indicated; and

(O) Completes discharge planning that helps ensure the continuation of appropriate treatment.

(7) Shelter housing services shall be delivered in a facility that:

(A) Meets and maintains all zoning and other federal, state, and local statutes or regulations;

(B) Maintains workers' compensation as required by the State of Connecticut;

(C) Maintains commercial liability insurance as required by the State of Connecticut;

(D) Employs or contracts with a supervisor with authority over all services, who shall have a minimum of a at least one (1) year of full-time work experience with individuals with a substance use disorder; or with a co-occurring substance use and mental health disorder;

(E) Maintains a sufficient number of staff to deliver the proposed shelter housing in order to satisfy the needs of individuals;

(F) Provides services that are supervised by on-site staff at all times;

(G) Provides a detailed orientation to the program, including, but not limited to the review of the grievance procedure for persons requesting or receiving services, rights and responsibilities, and service descriptions and expectations;

(H) Provides orientation and referral to other recovery supports such as self-help programs, behavioral health treatment, medical, housing, employment, and transportation; and

(I) Maintains procedures for safe storage and self-administration of all resident medications.

(8) Supported recovery housing shall be delivered in a facility that:

(A) Meets and maintains all zoning and other applicable federal, state, and local statutes or regulations;

(B) Maintains workers' compensation as required by the State of Connecticut;

(C) Maintains commercial liability insurance as required by the State of Connecticut;

(D) Employs or contracts with a supervisor with authority over all services, who shall have a minimum of a at least one (1) year of full-time work experience with individuals with a substance use disorder, or with a co-occurring substance use and mental health disorders;

(E) Provides on-site staff eight (8) hours per day, five (5) days per week and with on-call staff available the remaining hours;

(F) Maintains a sufficient number of staff to deliver the proposed supported recovery housing in order to satisfy the needs of individuals;

(G) Completes an initial intake assessment, including screening for a co-

occurring disorder;

(H) Provides a detailed orientation to the program, including, but not limited to the review of the grievance procedure for persons requesting or receiving services, rights and responsibilities, and service descriptions and expectations;

(I) Develops a recovery plan with each individual;

(J) Delivers to each individual of a minimum of one (1) hour per week of case management services;

(K) Provides orientation and referral to other recovery support services such as self-help programs, behavioral health treatment services, medical, housing, employment, and transportation;

(L) Completes discharge planning that helps ensure the continuation of appropriate treatment services, employment, and housing;

(M) Performs directly or assists with access to drug and alcohol screening, randomly or as indicated; and

(N) Maintains procedures for safe storage and self-administration of all resident medications.

Section 11: Contracting

(a) DMHAS, in its sole discretion, may extend an offer to contract with a provider who has been credentialed to deliver a service under the behavioral health recovery program.

(b) A provider who has been credentialed shall not participate in the behavioral health recovery program unless the provider has executed a contract with DMHAS to deliver a service under the behavioral health recovery program. The contract shall specify the terms and conditions to which the clinical or basic recovery supports provider must adhere in order to participate in behavioral health recovery program.

(c) DMHAS shall not pay a provider who has not been credentialed and contracted to deliver services under the behavioral health recovery program in the absence of a fully executed contract with DMHAS.

(d) DMHAS may terminate a contract with a clinical or basic recovery supports provider after giving the clinical or basic recovery support provider a thirty (30) calendar days written notification or such notice as otherwise required by law and regulation. The commissioner, in his or her sole discretion, may terminate the contract for reasons that include, but are not limited to, the following:

(1) Loss, revocation, suspension, surrender or non-renewal of any credential required by Section 10 of these policies, such as the facility license or any other credential required as a condition of eligibility;

(2) The clinical or basic recovery supports provider has a diminished ability to provide clinical or basic recovery supports legally, including disciplinary action by a governmental agency or licensing board that impairs the contracted provider's ability to operate;

(3) Failure to comply with DMHAS credentialing and re-credentialing requirements criteria;

(4) Failure to notify DMHAS of any event that would affect or modify the information contained in the clinical or basic recovery supports provider's application for participation in the behavioral health recovery program;

(5) Disciplinary action by any other state, governmental agency or licensing board; or

(6) Termination of, or failure to maintain, adequate insurance coverage.

(7) Fraud, such as, the clinical or basic recovery supports provider:

(A) Presents a false claim for payment;

(B) Accepts payment for goods or services delivered that exceeds the amount due for the goods or clinical or basic recovery supports delivered to eligible recipients;

(C) Solicits to deliver or delivers clinical or basic recovery supports for any eligible recipient, knowing that such eligible recipient is not in need of such clinical or basic recovery supports;

(D) Accepts from any person or source other than the behavioral health recovery program any additional compensation in excess of the amount authorized; or

(E) Presents a claim for payment to DMHAS or its designated agent for clinical or basic recovery supports that were not delivered to an eligible recipient;

(8) Failure to comply with the terms and conditions established in the contract;

(9) Failure to comply with DMHAS quality management and utilization review, as specified in sections 5, 6 and 8 of these policies;

(10) Failure to deliver clinical or basic recovery supports to eligible recipients in an ethical manner;

(11) Neglect of or failure to perform clinical or basic recovery supports provider duties as specified in the contract with DMHAS;

(12) Failure to implement corrective action required by DMHAS as the result of an audit as specified in section 14 of these policies;

(13) Any other breach of the clinical or basic recovery supports provider's contract that is not corrected by the provider not later than thirty (30) calendar days after receipt of notice from DMHAS or its designated agent; or

(14) Failure to repay an overpayment made by DMHAS or its designated agent within the specified timeframe.

(e) DMHAS may terminate a clinical or basic recovery supports provider contract without prior notice, based upon any of the following circumstances:

(1) Funding for the contract is no longer available; or

(2) DMHAS determines that the clinical or basic recovery supports provider poses imminent potential harm to the health or welfare of eligible recipients. DMHAS shall provide written notification to the clinical or basic recovery support provider of the specific reasons for taking such action in writing within five (5) business days of contract termination.

(f) If the Commissioner seeks to terminate a clinical or basic recovery support provider's contract for any reason as specified this section, the clinical or basic recovery support provider shall receive written notification from DMHAS and an opportunity to respond in writing and/or in person as specified in section 15 of these policies.

(g) The contract is effective through the date specified in the contract and, if not renewed, it is considered expired without prejudice to the clinical or basic recovery supports provider.

Section 12: Claims Administration

(a) Clinical or basic recovery supports providers shall only be paid for covered clinical or basic recovery supports when:

(1) Such supports are delivered to eligible recipients who have been determined to be eligible as specified in Section 3 of these policies; and

(2) The clinical or basic recovery supports provider received all applicable prior authorizations and continued authorizations as specified in these policies.

(b) The clinical or basic recovery support provider shall verify that DSS has determined the individual eligible under the Medicaid program for low-income adults in accordance with Connecticut General Statute Section 17b-261n, as amended by Public Act 11-44.

(c) Each claim for payment shall contain evidence that the clinical or basic recovery supports provider complied with all applicable prior authorization and continued authorization requirements as specified in these policies.

(d) The clinical recovery supports provider shall file claims for payment not later than 180 calendar days after the date on which the clinical recovery supports were delivered, unless there is a delay due to the need for coordination of benefits or DMHAS finds other good cause. If the clinical recovery supports provider is unable to file a timely claim for payment because DSS has not determined an individual's eligibility for medical services then the clinical recovery supports provider shall file a claim for payment not later than 365 calendar days after the date on which the clinical recovery supports were delivered.

(e) The basic recovery support provider shall file claims for payment not later than 60 calendar days after the date on which the basic recovery supports were delivered.

(f) Acceptance of a clinical or basic recovery supports provider's claim for payment shall not be a guarantee of payment.

(g) The designated agent shall accept any claims forms approved by DMHAS, including but not limited to, the CMS-1500 (formerly HCFA-1500) and the UB-92 forms.

(h) Clinical or basic recovery supports providers shall submit claims for payment that contain all information necessary to match the invoice with the covered clinical or basic recovery supports delivered and, if applicable, authorization data including, but not limited to, the following:

(1) Individual's name and address;

(2) Individual's EMS-ID number or Social Security number;

(3) Individual's DSM-IV diagnosis, if applicable;

(4) Date(s) of covered clinical or basic recovery supports;

(5) Type of covered clinical or basic recovery support delivered to the individual;

(6) Clinical or basic recovery support provider's name and address;

(7) Clinical or basic recovery support provider's I.D. number; and

(8) Clinical or basic recovery support authorization number.

(i) Payment of clinical or basic recovery supports providers' claims:

(1) All payments to clinical or basic recovery support providers will be processed and recorded by DMHAS or its designated agent. The appropriate funds available for the Behavioral Health Recovery Program will be used as the "payor of last resort";

(2) Clinical or basic recovery support providers' claims shall be paid in accordance with rates as specified by DMHAS;

(3) DMHAS may establish rates for the payment of covered clinical or basic recovery supports by using rate setting methods including, but not limited to, the following:

(A) A negotiated rate with a specific clinical or basic recovery supports provider for particular covered clinical or basic recovery supports or a particular level of care;

(B) An established per capita rate;

(C) Rates for eligible recipients in related diagnostic groups; and

(D) Bundled rates for a defined group of clinical or basic recovery supports.

(4) In order to participate in the behavioral health recovery program, the clinical or basic recovery supports provider shall agree to accept the rates set by DMHAS;

(5) The clinical or basic recovery supports provider shall be paid at the rate established by DMHAS for each covered clinical or basic recovery supports or at the billed rate, whichever is lower;

(6) The clinical or basic recovery supports provider shall not be paid for excluded or unauthorized clinical or basic recovery supports services; and

(7) The clinical or basic recovery supports provider shall not bill the eligible recipient for covered clinical or basic recovery supports.

(j) For independent housing only:

(1) DMHAS, or its designated agent, shall pay for goods and services delivered to eligible recipients by direct payment to the appropriate entity.

(2) DMHAS, or its designated agent, shall issue direct payments for approved services within thirty (30) business days of the authorization of such services.

(k) DMHAS reserves the right to review, update, or change rates at any time in order to meet the needs of the program or budget.

(l) DMHAS shall not make payments to a clinical or basic recovery supports provider for appointments missed by an eligible recipient. A clinical or basic recovery supports provider shall not bill an eligible recipient for missed appointments.

(m) When requested to do so by DMHAS, or its designated agent, the clinical or basic recovery supports provider shall submit cost reports, audited financial statements, or other documentation of costs for specified eligible recipients or services. Such documentation shall be in a form and format acceptable to DMHAS. The recovery supports provider shall submit requested data within thirty (30) days of receipt of the request from DMHAS, or its designated agent, unless DMHAS and the recovery supports provider mutually agree upon an alternative timetable for the provision of said cost information.

Section 13: Claims for Payment Grievances

(a) If a clinical or basic recovery supports provider's claim for payment is denied by the designated agent, the clinical or basic recovery supports provider may file a claim for payment grievance with the designated agent. Clinical or basic recovery supports providers may initiate a first-level claim for payment grievance to the designated agent not later than thirty (30) calendar days after the date of the denial decision. The first-level claim for payment grievance shall not include any right to a hearing from either DMHAS or its designated agent.

(b) DMHAS or its designated agent shall notify the recovery supports provider in writing of its first- level claim for payment grievance decision not later than thirty (30) calendar days following the date of receipt of all information as determined necessary by DMHAS to render a decision.

(c) A clinical or basic recovery supports provider may initiate a second-level claim for payment grievance. The second-level claim for payment grievance shall be submitted in writing directly to DMHAS not later than seven (7) calendar days following the date of the first-level claim for payment grievance denial decision. The second-level claim for payment grievance shall be submitted in writing and accompanied by all information as determined necessary by DMHAS to render a decision on the second-level claim for payment grievance.

(d) DMHAS shall neither accept, nor review, a second-level claim for payment grievance that does not conform with the submission requirements as specified in this section,

unless the designated agent has failed to respond to the clinical or basic recovery supports provider within the time frame as specified in this section.

(e) Any second-level claim for payment grievance decision issued by DMHAS shall be final and shall conclude the claim for payment grievance process. The second-level claim for payment grievance shall not include any right to a hearing from either DMHAS or its designated agent.

Section 14: Audit

(a) DMHAS or its designated agent may conduct audits of clinical and basic recovery supports provider's clinical, programmatic, fiscal or other records to verify the accuracy of claims for payment and compliance with state law, federal law and the recovery support providers contract. Audits shall be conducted when a clinical or basic recovery supports has been authorized, claims have been paid or when DMHAS deems it necessary to carry out its responsibilities under state or federal law.

(b) Audits may include, but are not limited to, review of the following:

(1) The clinical or basic recovery supports provider's claim(s) for payment;

(2) The covered clinical or basic recovery supports delivered by the clinical or basic recovery supports provider to an eligible recipient;

(3) The clinical or basic recovery supports provider's credentialing or re-credentialing information;

(4) The clinical or basic recovery supports provider's information supplied to DMHAS regarding a request for reconsideration of contract termination;

(5) The clinical or basic recovery supports provider's compliance with state and federal law and with the provider contract; and

(6) Whether the clinical or basic recovery supports provider has engaged in any fiscal irregularities.

(c) Clinical and basic recovery supports providers shall maintain records and permit DMHAS access to records as follows:

(1) All financial records related to delivery of covered clinical and basic recovery supports to eligible recipients for a period of not less than three (3) years after the date of expiration or termination of the behavioral health recovery program contract;

(2) Eligible recipient's medical, clinical recovery supports, basic recovery supports, or other records;

(3) Fiscal records and financial statements;

(4) Copies of all eligible recipients records in order to carry out its audit responsibilities; and

(5) A copy of any audit report prepared by an organization other than DMHAS.

(d) Audit methodology:

DMHAS shall select the clinical and basic recovery supports providers to audit, define the scope of the audit and establish the frequency of audits based on consideration of factors that may include, but are not limited to, any the following:

(1) Quality of clinical or recovery supports documentation;

(2) Volume of claims for payment submitted or paid;

(3) Type of claims for payment submitted or paid;

(4) Quality-of-care concerns;

(5) Service type;

(6) Geographic area; and

(7) Such other factors as deemed appropriate by DMHAS.

(e) Audit Resolution:

(1) When the audit is completed, DMHAS shall send the clinical or basic recovery supports provider a copy of the draft audit report. The clinical or basic recovery supports provider shall be given the opportunity to meet with a DMHAS representative in an exit conference to discuss the findings noted in the draft audit report;

(2) During the exit conference, the clinical or basic recovery supports provider may submit additional documentation to DMHAS as a result of the findings noted in the draft audit report or the clinical or basic recovery supports provider may request to submit such documentation subsequent to the exit conference. The clinical or basic recovery supports provider shall submit all such documentation to DMHAS not later than thirty (30) calendar days after the exit conference. DMHAS shall not consider documentation that is not submitted on time; and

(3) DMHAS shall send the clinical or basic recovery supports provider a copy of the final audit report with DMHAS's recommendations and a statement of the proposed audit adjustments, if any.

(f) Corrective Action:

(1) Not later than ten (10) business days after receipt of the DMHAS final audit report, the clinical or basic recovery supports provider shall submit to DMHAS a corrective action plan to address adverse audit findings, if any, included in the DMHAS final audit report. The corrective action plan shall contain the following elements:

(A) The name, address and telephone number of the clinical or basic recovery supports provider's staff person responsible for ensuring that corrective action is implemented;

(B) A detailed description of the corrective action planned; and

(C) The anticipated completion date of the corrective action.

(2) If the DMHAS final audit report includes information that indicates a threat to the health or welfare of an eligible recipient, the clinical or basic recovery supports provider shall initiate corrective action not more than 24 hours following such notification; and

(3) If the clinical or basic recovery supports provider does not agree with the audit findings or believes corrective action is not required, then the corrective action plan may include a statement to that effect and specific reasons in support of such opinion.

(g) Recovery of overpayment:

If audit adjustments require recovery of excess payments made to the clinical or basic recovery supports provider DMHAS may adjust any payment currently due the clinical or basic recovery supports provider by DMHAS or its designated agent.

(1) If DMHAS seeks to recover any payments to a clinical or basic recovery support provider under contract with DMHAS, the clinical or basic recovery support provider shall receive a thirty (30) calendar days written notification from DMHAS and an opportunity to respond in writing and/or in person as specified in section 15 of these policies; and

(2) If audit adjustments require recovery of excess payments made to a clinical or basic recovery supports provider who is not currently under contract with DMHAS, recovery shall be sought in an action brought by the State of Connecticut against the clinical or basic recovery supports provider.

(h) Sanctions for non-compliance with DMHAS standards:

(1) A clinical or basic recovery supports provider who, as a result of an audit, is found to be out of compliance with the provisions of these policies, may be subject to

sanctions as determined by the commissioner, including but not limited to, the following:

(A) Reduction in the number of referrals made to the clinical or basic recovery support provider for one or more recovery supports;

(B) Reduction in the capacity for which DMHAS contracts with the clinical or basic recovery supports provider for one or more clinical or basic recovery supports;

(C)Suspension of referrals made to the clinical or basic recovery supports provider for one or more clinical or basic recovery supports;

(D) Termination of the clinical or basic recovery supports provider's credentials for one or more clinical or basic recovery supports;

(E)Termination of the clinical or basic recovery supports provider's contract; and

(F) Such other sanctions as the commissioner deems appropriate.

(2) If DMHAS seeks to subject a clinical or basic recovery supports provider to sanctions following an audit, the clinical or basic recovery support provider shall receive a thirty (30) calendar days written notification from DMHAS and an opportunity to respond in writing and/or in person as specified in section 15 of these policies

(i) DMHAS, or its designated agent, shall document all information regarding alleged or suspected fraud. Behavioral Health Recovery Program staff will work with DMHAS' internal audit division and law enforcement authorities as appropriate according to state and federal guidelines governing confidentiality.

(j) Any clinical or basic recovery supports provider determined to have committed fraud by DMHAS' internal audit division is subject to automatic or administrative termination of Behavioral Health Recovery Program credentialing and contract, and will no longer be a credentialed and contracted clinical or basic recovery supports provider for the Behavioral Health Recovery Program as noted in Section 11 of these policies.

Section 15: Notice and an Opportunity to Respond for Clinical and Basic Recovery Support Providers

(a) Clinical and basic recovery supports providers shall receive written notification as specified in these policies and have an opportunity to respond in writing and/or in person in the following circumstances:

(1) The clinical or basic recovery supports provider is subject to recovery of payments following an audit conducted by DMHAS or its designated agent as specified in these policies;

(2) The clinical or basic recovery supports provider is subject to sanctions following an audit conducted by DMHAS or its designated agent as specified in these policies; or

(3) The commissioner has determined that the clinical or basic recovery supports provider's participation in the behavioral health recovery program should be terminated for any of the reasons specified in these policies.

(b) The clinical or basic recovery supports provider shall request an opportunity to respond to the DMHAS determinations specified in (1) to (3) of subsection (a) of this section by submitting a written request to the commissioner, not more than thirty (30) days after the mailing of the DMHAS's written notification to the clinical or basic recovery supports provider. The request shall be mailed to: Commissioner, Department of Mental Health and Addiction Services, 410 Capitol Avenue, 4th Floor, P.O. Box 341431, Hartford, CT 06134.

(c) A meeting shall be scheduled as soon as possible following the receipt of a written request from clinical or basic recovery supports provider. The meeting shall be with the commissioner's designee. At the meeting, the clinical or basic recovery supports providers shall have the opportunity to respond orally and/or in writing to the DMHAS's determinations specified in (1) to (3) of subsection (a) of this section. The opportunity to respond shall not include any right to a hearing.

(d) Upon the conclusion of the meeting and/or review of the provider's written responses, the commissioner's designee shall prepare a recommendation regarding the DMHAS intent to: (1) recover an audit adjustment; (2) impose sanctions on the clinical or basic recovery supports provider; or (3) terminate the clinical or basic recovery supports provider's contract.

(e) The clinical or basic recovery supports provider shall be notified in writing of the DMHAS decision regarding: (1) recovery an audit adjustment; (2) imposition of sanctions on the recovery support provider; or (3) termination of the recovery support provider's contract.

Section 16: Appeals and Fair Hearings

There are two (2) levels of appeals that an individual may file with DMHAS or its designated agent:

(a) First-level appeal.

(1) A first-level appeal may be filed by the individual or his or her authorized representative. The first-level appeal shall be filed with the designated agent not later than seven (7) calendar days after the decision by the designated agent to deny, reduce or terminate covered behavioral health treatment services, unless good cause is shown for late filing as determined by the designated agent. A first-level appeal is not a "contested case" pursuant to section 4-166(2) of the Connecticut General Statutes.

(2) A first-level appeal shall be filed in writing with all supporting information or records. All records relating to a first-level appeal shall be kept confidential, unless disclosure is otherwise required by law or authorized in writing by the individual.

(3) DMHAS or its designated agent shall send written notice of the first-level appeal decision by the designated agent to the individual or his or her authorized representative and to the clinical or basic recovery supports provider not later than seven (7) calendar days after the designated agent has determined it has received all information necessary to render a decision.

(4) If the designated agent fails to issue a decision within seven (7) calendar days, the individual or his or her authorized representative may treat it as a denial and request further review under the second-level appeal.

(b) Second-level appeal.

(1) The individual or his or her authorized representative may file a second-level appeal of a first-level appeal decision that denies, reduces or terminates covered behavioral health treatment services. The second-level appeal shall be filed with DMHAS not later than seven (7) calendar days after the first-level appeal decision, unless good cause is shown for a late filing, as determined by DMHAS. A second-level appeal is not a "contested case" within the meaning of section 4-166(2) of the Connecticut General Statutes.

(2) The second-level appeal shall be filed in writing with all supporting records. All records relating to the second-level appeal shall be kept confidential, unless disclosure is otherwise required by law or authorized in writing by the individual.

(3) The individual or his or her authorized representative and the clinical or basic recovery supports provider shall be sent written notice of the second-level appeal decision of DMHAS not later than seven (7) calendar days after DMHAS has determined it has received all information necessary to render a decision.

(4) DMHAS shall neither accept nor review a written second-level appeal if a first-level appeal submitted to the designated agent is still being reviewed within the time period permitted by this section.

(c) Fair hearing. Any individual who requested a covered clinical or basic recovery supports from the designated agent and had the covered clinical or basic recovery supports denied or, if delivered, reduced or terminated without the individual's consent and who has received an unfavorable second-level appeal from DMHAS, may request a fair hearing. The process for such a hearing shall be the same as specified in sections 17a-451 (t)-1 to 17a-451 (t)-15, inclusive, of the Regulations of Connecticut State Agencies.

Statement of Purpose: To adopt policies pertaining to the Behavioral Health Recovery Program.

A copy of the complete text of this policy is available at no cost, upon request, from the Department of Mental Health and Addiction Services, Attention: Managed Care Unit, 410 Capitol Avenue, 4th Floor, P.O. Box 341431, MS 14MCP, Hartford, CT 06134.