Connecticut Medical Assistance Program Provider Bulletin 2021-XX
Policy Transmittal 2021-XX December 2021
_____DRAFT_____ Effective Date: TBD, 2021
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TO: State Operated and Private Psychiatric Hospitals and Free-Standing Substance Use Disorder (SUD) Residential Treatment Facilities

RE: Implementation of Medicaid Reimbursement for SUD Treatment at Psychiatric Hospitals and Free-Standing Residential Treatment Facilities

DRAFT DRAFT

Effective for dates of service on or after January 1, 2022 or later based on the date of formal approval from the Centers for Medicare and Medicaid Services (CMS), the Department of Social Services (DSS) will reimburse substance use disorder (SUD) residential treatment at psychiatric hospitals and free-standing SUD residential treatment facilities for all Medicaid eligible members, inclusive of HUSKY A, C, and D, as well as members eligible for the Children's Health Insurance Plan (CHIP), also known as HUSKY B. This policy is applicable to adolescents who are at least 13 years of age and adults of any age.

Initial Provider Eligibility and Provisional Certification

All existing and licensed SUD residential treatment providers that receive state funding from the Departments of Mental Health and Addiction Services (DMHAS), Children and Families (DCF), Social Services, Correction (DOC) or the Judicial Branch's Court Support Services Division (CSSD) will be eligible to enroll in the Connecticut Medical Assistance Program (CMAP) under a provisional certification. Providers may receive provisional certification for up to 24 months. To qualify for the provisional certification, providers must meet initial criteria and meet milestones regarding staffing and compliance with the American Society of Addiction Medicine (ASAM) most recent edition. Any provider that does not maintain provisional certification or achieve full certification from DMHAS or DCF, or their designated agent, within 24 months of the implementation date, will be disenrolled from CMAP.

Ongoing Enrollment and Full Certification

During the provisional certification period, DMHAS and DCF, or their designated agent, will conduct an assessment and monitor all providers to ensure that all providers are making progress to meet the criteria for the latest version of ASAM. A monitoring tool will be shared with providers so they can self-assess throughout the provisional certification period. All providers will be required to maintain provisional certification and achieve full certification in order to maintain enrollment in CMAP. After two years, all certified providers must maintain full compliance with all ASAM requirements and state standards.

Provider Monitoring

DMHAS and DCF, through their designated agent, will be responsible for monitoring providers during the provisional certification period and throughout the entire duration of the waiver. Providers that achieve full certification will be required to participate in ongoing monitoring.

Provider Training

The state agencies referenced above are committed to initial and ongoing training for providers. Provider training topics will be conducted by various entities, including the state agencies, depending on the topic of the training. Provider training will include, but not be limited to, the following topics:

- Medicaid enrollment
- Provisional certification process
- Authorization procedures
- Billing procedures
- ASAM 3rd edition
- Motivational interviewing

Existing Authorizations

There are several scenarios whereby a provider may have an existing authorization from a state agency (DCF, DOC, CSSD), Beacon Health Options or Advanced Behavioral Health (ABH) to provide services to a Medicaid member. All existing authorizations will be honored for at least thirty (30) days post implementation date once the provider is enrolled in Medicaid. All authorizations from ABH will be transitioned to Beacon Health Options, the Medicaid Administrative Services Organization (ASO). Authorizations provided by DCF, DOC or CSSD will be granted a 30-day authorization. Beacon will begin concurrent reviews 30 days post implementation for these cases. Assuming a January 1, 2022 implementation date, Beacon Health Options will not begin the concurrent review process for Medicaid members authorized by a state agency through January 31, 2022 until February 1, 2022.

New Authorizations

For any new admissions of Medicaid eligible members on or after January 1, 2022 or later based on the date of CMS approval, providers will need to seek authorization from Beacon Health Options and document that admission to the ASAM Level of Care (LOC) is supported using a multidimensional psychosocial assessment as outlined in the latest ASAM criteria. Treatment plans consistent with the requirements of the latest edition of ASAM based on the multidimensional assessment must be developed and documented for all Medicaid members. This is applicable to all Medicaid eligible members regardless of the referring state agency. For example, if CSSD facilitates and refers a member to a residential facility and that individual is eligible for Medicaid, the provider must seek authorization from Beacon Health Options.

External Toxicology Laboratory Testing and Billing Guidelines

Toxicology testing for substance use disorder purposes is an important treatment component for residential treatment programs. Testing serves as a part of the clinical review of residents in a residential setting. External toxicology laboratory tests are not included in the Department's rate for residential treatment services. All external toxicology laboratory tests ordered shall be medically necessary for each member. No more than four external toxicology laboratory tests may be ordered under a single standing order. No more than one external toxicology test may be ordered per week. Each external toxicology laboratory test in excess of one per week requires a specific order from a qualified physician, physician assistant or APRN that is documented in the medical record of the member and explains why such additional external toxicology laboratory test or tests is medically necessary. In each member's medical record, the provider shall include clinical documentation demonstrating the need for any external laboratory testing ordered or referred by the provider. The provider shall also include documentation in each member's medical record that appropriate medical personnel employed by the provider have reviewed and interpreted external laboratory tests and explain in the medical records how such interpretation of the tests has affected the member's plan of care.

Supplemental Nutrition Assistance Program (SNAP) Requirements

Providers who elect to request the use of the member's SNAP benefits must be authorized by the USDA Food and Nutrition Service (FNS) as a retailer. Providers must designate an employee as an authorized representative. The provider must provide the Department a list of currently participating residents, monthly, that includes a statement signed by a

responsible agency official attesting to the validity of the list. The Department is required to conduct periodic random on-site visits to assure the accuracy of the list. The provider may not receive more than one half of the benefit allotment prior to the 16th of the month. The provider must have the means to return the benefits to the individual's EBT account through a refund, transfer or other means.

When an individual leaves the treatment center, the center must perform the following:

- Notify the State agency. If possible, the center must provide the household with a change report form to report to the State agency the household's new address and other circumstances after leaving the center and must advise the household to return the form to the appropriate office of the State agency within 10 days. After the household leaves the treatment center, the center can no longer act as the household's authorized representative for certification purposes or for obtaining or using benefits.

- Provide the household with its EBT card if it was in the possession of the treatment center. The treatment center must return to the State agency any EBT card not provided to departing residents by the end of each month.

- If no benefits have been spent on behalf of the individual household, the center must return the full value of any benefits already debited from the household's current monthly allotment back into the household's EBT account at the time the household leaves the center.

- If the benefits have already been debited from the EBT account and any portion spent on behalf of the household, the following procedures must be followed.
    - If the individual leaves prior to the 16th day of the month, the center must ensure that the household has one-half of its monthly benefit allotment remaining in its EBT account unless the State agency issues semi-monthly allotments and the second half has not been posted yet.

    - If the individual leaves on or after the 16th day of the month, the State agency, at its option, may require the center to give the household a portion of its allotment. If the center is authorized as a retailer, the State agency may require the center to provide a refund for that amount back to the household's EBT account at the time that the household leaves the center. Under an EBT system where the center has an aggregate EBT card, the State agency may, but is not required to, transfer a portion of the household's monthly allotment from a center's EBT account back to the household's EBT account. In either case, the household, not the center, must be allowed to have sole access to any benefits remaining in the household's EBT account at the time the household leaves the center.

- If the individual has already left the treatment center, and as a result, the treatment center is unable to return the benefits, the treatment center must advise the State agency, and the State agency must effect the return instead. These procedures are applicable at any time during the month.

Billing Codes

Effective January 1, 2022, the following codes must be used for Medicaid eligible members. Each code is a per diem rate and may be billed when a member is at the facility for the entire day and overnight. Billing on the day of discharge is not permitted.

Added Code	Description	Established Fee and Quantities
HOO10	Substance Use Disorder Treatment Services Residential ASAM 3.2 Withdrawal Management	Manually priced
H0011	Substance Use Disorder Treatment Services Residential ASAM 3.7 Withdrawal Management	* Manually priced
H2036	Substance Use Disorder Residential Treatment Services Residential ASAM 3.5	* Manually priced
H2036 HI	Substance Use Disorder Residential Treatment ASAM 3.3	* Manually priced
H2034	Substance Use Disorder Residential Treatment ASAM 3.1	* Manually priced
H0047	Substance Use Disorder Residential Room & Board	* Manually priced

Billing Guidelines

Providers may bill for the treatment services and room and board for every Medicaid member who was in treatment at the facility on the day that they occupied a bed until the next calendar day. For example, if a member was admitted at any time on January 2nd up until 11:59 p.m. on January 2nd, and that member occupied a bed on January 2nd and the morning of January 3rd, the provider may bill for January 2nd. Providers may not bill for services on the day of discharge. During the provisional certification period, providers may bill for services even though they may not meet the staffing requirements under the most recent edition of ASAM. Service duration requirements by level of care are in effect upon implementation of the program. For example, clinical or treatment hours may be billed during the provisional certification period even if they are not performed by the clinical staff required in the provider standards. This is only applicable during the provisional certification period.

Services must be provided in accordance with the latest edition of the American Society of Addiction Medicine (ASAM) guidelines. The amount, frequency, and duration of covered SUD services are provided in accordance with the member's individualized treatment plan and ASAM criteria. The applicable levels of care for the provision of SUD services and the service components covered within each setting are as follows, each of which aligns with the ASAM levels of care.

All residential are considered all-inclusive of SUD services and include the following activities: Assessment and individualized treatment plan development; Therapy; Health services and medication management; Peer support; Service coordination; Skill building and psycho-education. Psychotropic and other medication management (including prescribing, monitoring, administration and observation of self-administration, as applicable) are included to the extent medically necessary and as permitted under State Law. The cost of the medications are billed separately.

Each provider must obtain all licenses and certifications applicable to all age cohorts (children, adults, or both) that it serves and all levels of care that it providers. For services

provided outside the state in accordance with 42 C.F.R. § 431.52, the provider facility and each practitioner employed by or working under contract to the facility must have comparable credentials in the state in which the facility is located.

Provider Type/Specialty:

Provider Type/ Specialty.	Description
63/553	3.1 Clinically Managed Low-Intensity Residential Services
63/554	3.2 Clinically Managed Residential Withdrawal Management
63/555	3.3 Clinically Managed High-Intensity Residential
63/556	3.5 Clinically Managed High Intensity Residential
63/556	3.5 Pregnant and Parenting Women
63/557	3.7 Medically Monitored Intensive Inpatient Treatment
63/558	3.7 Medically Monitored Intensive Inpatient Treatment – Co-occurring Enhanced
63/559	3.7 Withdrawal Management-Clinically Monitored Inpatient Withdrawal Management

Other Medicaid Covered Services Available
Medicaid members who are in a psychiatric hospital or free-standing residential SUD treatment facility may access other Medicaid-covered services such as medical, dental, laboratory, and non-emergency medical transportation.

Accessing the Fee Schedule:
The updated fee schedule can be accessed and downloaded by accessing the Connecticut Medical Assistance Program (CMAP) Web site: www.ctdssmap.com. From this Web page, go to "Provider", then to "Provider Fee Schedule Download". Click on the "I accept" button and proceed to click on the appropriate fee schedule. To access the CSV file, press the control key while clicking the CSV link, then select "Open".

Posting Instructions:
Policy transmittals can be downloaded from the Web site at www.ctdssmap.com.

Distribution:
This policy transmittal is being distributed to providers of the CMAP by Gainwell Technologies.

Responsible Unit:

Date Issued: December 2021