RESIDENTIAL FLEX BEDS - FREQUENTLY ASKED QUESTIONS (FAQs)

Below is a compilation of questions received throughout the planning of the 1115 Demonstration Waiver along with responses that we hope assist you as we transition into implementation. Please note, the State has made efforts to ensure that the provider standards does not conflict with any Department of Public Health (DPH) licensing regulations (see §19a-495-570 of the Regulations of Connecticut State Agencies). In some instances, the provider standards exceed what is required within the licensing regulations. If now, or in the future, the licensing regulations exceed the standards, providers should ensure compliance with the higher expectation. New questions and responses not present in previous versions of this document appear in red font.

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1. **If a program is presented with two potential admissions - one whose clinical presentation requires treatment for the program's target population (e.g. ASAM level of care, Spanish-speaking, gender-specific or other special needs population) and one whose clinical presentation does not meet the program's target population but could be admitted given the program's participation in the flex bed option – is the program allowed to give priority to the member whose clinical needs match the program's target population?**

   A. Providers may develop their own processes for screening members who they believe meet the criteria for admission for the Medicaid levels of care for which they are enrolled. This screening should be rooted in the ASAM 3rd Edition placement criteria to minimize incidents of members not meeting medical necessity for the requested level of care at the time the initial authorization is requested. Providers may prioritize admissions for their target population based on the outcomes of these screenings so long as the results are not discriminatory or based on abstinence or other prohibited practices under the Demonstration.

   Once a member is admitted, the provider is responsible for any referral and transfer processes should the member not meet medical necessity for the requested level of care. Providers who have opted into the flex bed model may keep the member for treatment at the recommended level of care should this be a level of care the program is licensed, certified and enrolled in Medicaid to provide. Providers are expected to utilize rigorous discharge management processes to ensure that members have continuity of care at the appropriate level of care for their individualized needs.

   If the program has a waitlist of target population members seeking admission, priority can be given to target populations on the waitlist. Any member not admitted should be informed and educated about other program(s) offering the indicated level of care for admission.

If the program does not have a waitlist and has vacancies to accept new admissions, providers should accept the member seeking admission at the lower level of care, particularly if no other such beds are available in the state.

Please note: If an admission for a member has been accepted by the program and the member is awaiting official admission (e.g. following a court hearing for a member being referred by Judicial), the program must honor that agreement to admit the member even if another member presents seeking the higher level of care during that interim time period between agreement and formal admission.

2. **Do we have to allow members to step down to this level since we are approved for this level of care, with or without another client needing the 3.7 bed? Due to the 3.5 being a longer LOC it could end up that more people in the program meet the 3.5 LOC as opposed to the 3.7 LOC. Are we able to determine the best mix of 3.5 and 3.7 clients in our programs to best meet our needs in covering our costs even if this means turning away clients that need a 3.5 admission and/or step down?**

    A. Providers should utilize their clinical discretion and member preference to identify if continued stays at lower levels of care are clinically in the best interest of the individual. Providers should document in the member's medical record the rationale for maintaining or transferring a member and document the member's participation in this decision making. Providers should utilize the ASAM Adult and Adolescent Continued Service and Transfer/Discharge criteria as part of these decisions.

    In no instances should discriminatory practices occur or decisions based on abstinence or other prohibited practices under the Demonstration. Providers with a waitlist at higher levels of care are encouraged to utilize rigorous discharge management processes to ensure that members needing lower levels of care are discharged timely to an appropriate level of care for their individualized needs. Providers are also encouraged to work with community resources to develop sober housing, etc. necessary to facilitate timely discharges.

3. **If opting into the flex bed model to allow provision of a lower level of care (e.g. ASAM 3.5 flexing down to ASAM 3.1), should we accept an admission for a member who knowingly meets the criteria for the lower level of care?**

    A. Providers may accept a member who meets criteria for any of the levels of care the provider is licensed, certified and enrolled in Medicaid to provide. Additionally, providers can maintain a member who has successfully completed the higher level of care and is ready to transition to a lower level of care that the

provider is enrolled to provide. Providers may also work with members to find more appropriate facilities for lower levels of care (i.e., programs with more community integration opportunities) through rigorous discharge planning.

4. **Will the Department consider setting the reimbursement rate for the 3.5 LOC based on the number of beds used vs the number licensed at the 3.7RE LOC. For example, if 4 of the 16 are consistently used for 3.5 can the reimbursement rate be set in the corridor rather than the corridor for 16?**

    A. The State is still considering this question and will provide further guidance in the near future.

5. **What happens when a member has been identified and approved to be safely transferred to a less intensive level of treatment within the ASAM framework but the program experiences referral denials from programs providing that level of care?**

    A. In those circumstances where a program determines that the member can be safely transferred to a less intensive level of treatment and identifies an appropriate level of care within the ASAM Framework, but the referral is being declined by the program offering that level of care, the State Partner agencies are available for consultation and support in addressing referral and admission decisions for individuals with complex needs. Agencies experiencing referral denials based on above mentioned areas or any other biopsychosocial dimensions should communicate these concerns to the State Partner agencies so that the appropriate training resources, support and interventions can be provided. The program currently treating the member should also communicate those barriers in discharge planning to Carelon BH at the time of the concurrent reviews.

    Contact information for the State Partner agencies are at the bottom of the Admission Guidance document posted to our website.

6. **When a member moves from one level of care to another within the same program (e.g., 3.7 to 3.5) what are the documentation requirements?**

    A. The State anticipates some efficiencies in admission interventions and documentation when a member transitions to a new level of care within the same program. The proposed efficiencies are being vetted by DPH to ensure our expectations align with theirs. Once this information is finalized it will be shared.

7. **We are getting feedback from Carelon BH that two of our 3.7RE members whom we have had since early February, are appropriate for BOTH 3.5 and 3.1. How can that be possible?**

A. It is possible given the length of time these members have been in the 3.7RE that, although the 3.5 was initially the most appropriate level of care, now the member is sufficiently stable to be treated in a 3.1. However, if the 3.1 is not available at this point in time, it would be preferable to step down the member to a 3.5 while trying to arrange for the member to go to a 3.1.

   In order to review the specifics of each of these cases, we recommend that you contact Carelon BH directly to discuss. The State Partner agencies can also be contacted for additional support, as needed.

8. **When we get our flex auth reports, why are members who are flexibly authorized for 3.7RE never recommended for 3.7R? What is the difference between these 2 levels of care from your perspective?**

   A. Both are an ASAM 3.7 level of care and have the same multidimensional ASAM admission criteria. Therefore, the information needed to justify placement at 3.7RE would mirror that required for 3.7.

      The difference for a 3.7RE is that the member admitting also meets the diagnostic criteria for a mental health disorder and, at the time of admission, may have reluctance to engage in activities necessary to address a co-occurring psychiatric disorder. 3.7 programs are expected to be co-occurring capable but do not require the presence of a mental health disorder in order to admit.

9. **What is the long-term plan for the Pregnant and Parenting Women (PPW) programs?**

   A. The PPW programs are not currently eligible for participation in the Flex Bed Option. The State Agencies are reviewing this option while considering the specialized needs of these programs and the specialty population they serve. Should any changes be made to allow participation of the PPW programs in the Flex Bed Option, additional information and guidance will follow.