Connecticut Medical Assistance Program
Policy Transmittal 2021-29
Deidre S. Gifford, MD, MPH, Commissioner

Provider Bulletin 2022-39
May 2022
Effective Date: June 1, 2022
Contact: Keri.Lloyd@ct.gov

TO: Free-Standing Substance Use Disorder (SUD) Residential Treatment Facilities

RE: Implementation of Medicaid and Children's Health Insurance Program (CHIP) Reimbursement for SUD Treatment at Free-Standing Residential Treatment Facilities

Effective for dates of service on and after June 1, 2022, the Department of Social Services (DSS) will reimburse substance use disorder (SUD) residential treatment services in 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. Collectively, Medicaid and CHIP are known as the Connecticut Medical Assistance Program (CMAP). SUD services in residential treatment facilities are covered for adolescents who are at least 13 years of age and adults of any age. This coverage implements the state's SUD demonstration waiver under section 1115 of the Social Security Act (Demonstration), which was recently approved by the U.S. Centers for Medicare and Medicaid Services (CMS).

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 (Judicial) will be eligible to enroll in the Connecticut Medical Assistance Program (CMAP) under a provisional certification, so long as the provider complies with all applicable requirements, including those described below. SUD residential providers with a DCF license serving children must receive provisional certification from DCF or its designated agent. SUD residential providers with a Department of Public Health (DPH) license serving adults must receive provisional certification from DMHAS or its agent. SUD residential providers that hold both licenses and serve children and adults must receive provisional certification from DCF and DMHAS or their agents.

Upon receiving written notice of provisional certification, the provider may initiate enrollment into CMAP. Providers must submit their provisional certification approval document as part of their enrollment documentation and an acknowledgement of the 24-month deadline for full ASAM certification signed by the Chief Executive Officer, Executive Director or equivalent. Providers who are already enrolled in CMAP as a 63/001 (Drug and Alcohol Abuse Center; Inpatient) Provider Type and Specialty do not require a new enrollment but must submit their certification, acknowledgement and an addendum to the provider enrollment agreement to their existing enrollment no later than May 31, 2021. All reenrollment deadlines remain in effect; the enrollment period will not be extended as a result of this process.

Provisional certification is required for each level of care and is valid for up to 24 months from the enrollment effective date in CMAP. To qualify for and maintain provisional certification, providers must successfully complete a provisional certification application process, meet initial criteria and progressively achieve staffing and program milestones during the provisional certification period, including implementation of the American Society of Addiction Medicine (ASAM) guidelines that have been adopted by

the state, which is currently the ASAM 3rd edition. All references to ASAM criteria below refer to the third edition of ASAM currently adopted by the state. The state will notify providers if there is a change to the state's implemented edition of the ASAM clinical guidelines.

Any provider that does not maintain provisional certification while progressing toward full certification, or who fails to achieve full certification from DMHAS or DCF, or their designated agent, within 24 months of the enrollment effective date, will be disenrolled from CMAP for this service.

Ongoing Enrollment and Full Certification:
During the provisional certification period, DMHAS and DCF, or their designated agent(s), will conduct an initial assessment and ongoing monitoring of all providers to ensure continuous progress to meet the ASAM requirements, state standards and project milestones is occurring. A monitoring tool will be shared with providers so they can self-assess throughout the provisional certification period and will be utilized by each state agency and/or designated agents during compliance visits.

All providers must maintain provisional certification and achieve full certification in order to maintain enrollment in CMAP. At the end of the provisional certification period, all certified providers must maintain full compliance with all ASAM requirements and state standards and receive full certification from DMHAS and/or DCF or their designated agents, or they will be disenrolled from CMAP. If at any time a provider loses their full certification status, the provider must regain full certification before reenrollment with CMAP can occur. A second provisional certification period will not be provided. Full certification status designations will be valid for three years from date of approval. DMHAS, and/or DCF or their designated agents will be responsible for conducting compliance monitoring and recertification activities under this Demonstration.

Provider Type/Specialty and Taxonomy:
All residential providers will enroll in CMAP as a 63/001 (Drug and Alcohol Abuse Center; Inpatient) Provider Type and Specialty using taxonomy 324500000X (Substance Use Rehabilitation Facility). As a reminder, the NPI and taxonomy must match what is on the NPPES website.

Provider Monitoring:
DMHAS and DCF, directly and/or through their designated agent(s), will monitor providers during the provisional certification period and throughout the entire duration of the Demonstration, including any extensions. Providers that achieve full certification must 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 and their agents, depending on the topic of the training. Provider training will include, but not be limited to, the following topics:

- CMAP enrollment
- Provisional certification process
- Authorization procedures
- Billing procedures
- Motivational interviewing
- SNAP Benefits Management
- The ASAM Criteria, 3rd edition

Although the state is arranging for this training to help providers adapt to the new requirements and procedures for SUD services, each provider is independently responsible to understand and comply with all applicable requirements and procedures.

Existing Authorizations:
There are several scenarios whereby a provider may have an existing authorization from a state agency (DCF, DOC, Judicial) or an agent of a state agency (Beacon Health Options [Beacon] or Advanced Behavioral Health [ABH]) to provide services to a CMAP member that was in effect immediately before the effective date noted above. All existing authorizations with ABH will be honored for through the authorization end-date given by ABH, even if that date extends beyond June 1, 2022 based on the understanding that those previous authorizations ensured that the services met the Medicaid program's requirements, including, but not limited to, the statutory definition of medical necessity in section 17b-259b(a) of the Connecticut General Statutes. All authorizations from ABH will be transitioned to Beacon, the CMAP behavioral health Administrative Services Organization (ASO).

For dates of service from June 1, 2022 through June 30, 2022, prior authorization will not be required. Effective July 1, 2022 for dates of service of July 1, 2022 and forward, prior authorization will be required and obtained through Beacon, as outlined below. Beacon will outreach to providers to ensure appropriate review of all prior authorization and concurrent review requests for CMAP eligible members in alignment with medical necessity and ASAM criteria for dates of service beginning on July 1, 2022.

New Authorizations:
For any new admissions of CMAP eligible members on or after July 1, 2022, providers will need to seek authorization from Beacon and document that admission to the ASAM Level of Care (LOC) is supported using a multidimensional psychosocial assessment as outlined in the ASAM criteria. Treatment plans consistent with the requirements of ASAM criteria based on the multidimensional assessment must be developed and documented for all CMAP eligible members. This is applicable to all CMAP eligible members regardless of the referring entity, including other state agencies. For example, if a Judicial facility refers a member to a residential facility and that individual is eligible for CMAP, the provider must seek authorization from Beacon.

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 and should therefore be billed separately by the external laboratory directly to CMAP.

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 (PA) or advanced practice registered nurse (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 Physician/PA/APRN 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, if applicable, must be authorized directly by the U.S. Department of Agriculture (USDA) Food and Nutrition Service (FNS) as a SNAP retailer. Providers must designate an employee as an authorized representative. The provider must provide DSS with a list of currently participating residents, monthly, that includes a statement signed by a responsible agency official attesting to the validity of the list. As the state's SNAP agency, DSS 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 Electronic Benefit Transfer (EBT) account through a refund, transfer or other means. All correspondence to DSS regarding SNAP should be directed to: Todd Mallard (todd.mallard@ct.gov).

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

- Notify DSS. If possible, the center must provide the household with a change report form to report to DSS 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 DSS 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 individual with its EBT card if it was in the possession of the treatment center. The treatment center must return to DSS 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 DSS 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, DSS, at its option, may require the center to give the household a portion of its allotment. If the center is authorized as a retailer, DSS 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, DSS 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 DSS, and DSS must effect the return instead. These procedures are applicable at any time during the month.

Billing Guidelines:

Providers may bill for the treatment services for every CMAP eligible 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.**

The amount, frequency, and duration of covered SUD services must be provided in accordance with the member's individualized treatment plan and ASAM criteria and must also comply with the Medicaid program's statutory definition of medical necessity in section 17b-259b(a) of the Connecticut General Statutes. The applicable levels of care for the provision of SUD services and the service components covered within each setting, each of which aligns with the ASAM levels of care, are as detailed below.

For dates of service on and after June 1, 2022 where the provider is actively working to ensure full compliance with ASAM criteria specific to that level of care, providers may bill for services under provisional certification as they work diligently and continuously towards meeting applicable compliance requirements and full certification.

During the provisional certification period, providers may bill for services even though they may not meet the full ASAM requirements and state standards. Service duration requirements by level of care are in effect upon implementation of the program. For example, the per diem rates may be billed during the provisional certification period even if, to the extent necessary, clinical or treatment hours are performed by the staff without the full qualifications required in the provider standards. This is only applicable during the provisional certification period as providers actively work towards full compliance and full certification. Staff should continue to operate within their scope of practice as applicable under state law.

The residential treatment facility must fully comply with ASAM criteria on or before the date that its provisional certification expires. Once a facility's provisional certification expires or is revoked, Medicaid will pay the residential treatment facility for SUD services only if the residential treatment facility has obtained and maintains applicable full certification from the state or its agent(s), as detailed above, and fully complies with ASAM criteria and maintains such compliance on an ongoing basis.

Medicaid payment for residential SUD services is all-inclusive and includes payment for all of the following categories of services: assessment and individualized treatment plan development; therapy; health assessments, health monitoring, health education requiring a medical license (in one of the categories of qualified practitioners for this service) for an individual or group session with members to learn specific ways of coping and progressing in their recovery; 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 is 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 to a CMAP enrolled provider as authorized by the state in accordance with federal regulations in 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, as determined by DSS and documented during the provider enrollment process.

Medication for Addiction Treatment (MAT) Billing Requirements:

As noted above, the rates include 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 following physician administered MAT may be provided and billed in residential treatment facilities who employ or contract with a qualified and enrolled prescriber and must have the corresponding NDC listed on the claim:

HCPCS	Description
J0571	Buprenorphine, oral, 1 mg
J0572	Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine
J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine
J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine
J0592	Injection, buprenorphine hydrochloride, 0.1 mg
J2310	Injection, naloxone hydrochloride, per 1 mg
J2315	Injection, naltrexone, depot form, 1 mg
Q9991	Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg
Q9992	Injection, buprenorphine extended-release (sublocade), greater than 100 mg

Billing Codes:

Effective June 1, 2022, the following codes must be used for CMAP 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. Providers should bill both a treatment code ("Tx" in the below table) and a room and board code ("R&B" in the below table) for each billable date of service. Providers must include the modifiers for their respective ASAM Level of Care as outlined below.

ASAM Level of Care Description	Procedure Codes and Modifiers*
3.1 Clinically Managed Low-Intensity Residential Services	Tx: H2034 R&B: H0047 HF
3.2 Clinically Managed Residential Withdrawal Management	Tx: H0010 R&B: H0047 HG
3.3 Clinically Managed High-Intensity Residential	Tx: H2036 HI R&B: H0047 HI
3.5 Clinically Managed High Intensity Residential	Tx: H2036 R&B: H0047
3.5 Clinically Managed Population-Specific High Intensity Residential – Pregnant and Parenting Women	Tx: H2036 HD R&B: H0047 HD
3.7 Medically Monitored Intensive Inpatient Treatment	Tx: H2036 HV R&B: H0047 HV
3.7 Medically Monitored Intensive Inpatient Treatment – Co-occurring Enhanced	Tx: H2036 HE R&B: H0047 HE
3.7 Withdrawal Management- Clinically Monitored Inpatient Withdrawal Management	Tx: H0011 R&B: H0047 HW

An SUD diagnosis must be the primary diagnosis on all claims.

* CMAP eligible members who are referred by DOC: providers must include the modifier HZ "Criminal Justice Agency Fund" on any claim for those members who are referred by DOC.

CMAP eligible members who are referred by the Judicial Branch: providers must include the modifier H9 "Court-Ordered" on any claim for those members referred by Judicial.

Other CMAP 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. Similarly, CHIP members who are in the hospital or facility may also access other CHIP-covered services, such as medical, dental, and laboratory services.

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 "Free-Standing Substance Use Disorder (SUD) Residential Treatment Facilities" 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:
DSS, Division of Health Services, Integrated Care Unit, Behavioral Health, Keri Lloyd, at keri.lloyd@ct.gov

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