Residential Frequently Asked Questions (FAQ)

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.

Questions Applicable to All Residential Levels of Care

1. How do I determine whether sites at my facility should combine beds? Is the provider allowed to choose how we divide and staff our programs or will the Department of Social Services (DSS) tell us what we are eligible for?

   A. DSS has posted a fee schedule which is based on a program's DPH licensed capacity. There are two fee schedules. One is for single level of care at a particular site in which the programs and treatment are independent from each other. The other is for if programs are implementing more than one level of care within the same program and sharing treatment resources ("flex beds").

   Levels of care at the same address who will remain separate and receive the rate associated with the tier for the total number of beds at that level of care. Providers should use the "Single Site SUD ASAM Residential Fees by Level of Care and by Total Beds at Location" fee schedule in this scenario.

   For example, an 8-bed 3.1 and a 16-bed 3.5 are located at the same address; the 3.1 program will receive the rate for the 0-13 bed tier and the 3.5 will receive the rate for the 14-24 bed tier. This scenario would use the "Single Site" fee schedule.

   See Question 2 for an example of when to use the "SUD ASAM Residential Fees by Level of Care and Total Beds at Address (Flex Beds)" fee schedule.

   Staffing expectations should be maintained in accordance with the standards. Any requests to waive staffing criteria must be submitted to The Departments for review and approval.

2. What if I want to explore flex beds at my facility (e.g. 20-bed 3.7 with the ability to flex some beds to a 3.1 when clients need continued care)?

    A. Agencies should seek additional guidance from DSS if they are interested in this option. With regard to rate, the 20-bed program referenced in the example would remain in the 14-24 bed tier regardless of how they flex their beds. For example, if this program was presently flexing 8 beds to a 3.1, leaving 12 beds in 3.7, they would not then bump these two levels of care to the 0-13 bed tier. They would remain at the tier associated with their total capacity for that original program (in this example, 20-bed 3.7).

3. Can programs share staff?

    A. Provided that the minimum expectations for each program are met, staff hired by the agency can work in more than one program. For example, if an agency has an 8-bed 3.5 program and an 8-bed 3.5PPW program, each program requires 20 hours of nursing staff per week. One FTE (40-hour) nurse could be hired to provide the 20 hours required at each program. A 20-hour part-time nurse could not provide simultaneous, overlapping coverage to the two programs.

4. Why is there a significant decrease in the rate when moving from the 0-13 bed tier to the 14-24 bed tier?

    A. The difference in rate tiers account for program efficiencies as programs increase in size. Rate development information is posted to the DSS Website

5. Do I calculate my bed count by current contract(s) or by Department of Public Health (DPH) licensed capacity?

    A. Bed count should be calculated based on DPH licensed capacity.

6. What do I need to do if one of my programs moves to a new location? What if this move affects the rate category (e.g. moving from a single institution to multiple institutions or vice versa)?

    A. Providers should notify the Department of Social Services (DSS) of any moves and/or changes in licensed capacity. If changes in licensed capacity result in a change to the program's rate tier, the provider will receive the rate associated with this updated capacity. In addition, providers should always consult with the licensing state agency, DPH, related to changing capacity, level of care and moving locations.

7. What if I want to add a new level of care to my agency's available programming (e.g. currently operate a 3.5 but want to use available licensed capacity to build out a 3.1)?

    A. Please notify the state agencies of your intention to add a new level of care or modify your bed configuration in any way. The Departments would like to maintain stability in the system at the outset of the program; therefore, we would prefer to maintain the status quo on bed configuration at least through 6/30/22. Additionally, state-only funds utilized for covering room and board costs are finite and therefore cannot be guaranteed to any new programs or providers.

8. Will state agencies still "own" their beds?

    A. In some circumstances, Judicial Branch Court Support Services Division (JBCSSD) or Department of Correction (DOC) may pre-pay for a bed; otherwise the program should fill the bed.

9. Will there be a reconciliation with Medicaid or state agencies?

    A. This is still under discussion and development.

10. Are Licensed Alcohol and Drug Counselors (LADCs) included in those who are independently licensed and able to sign off on the work of a behavioral health practitioner with an associate license?

    A. Yes.

11. Do the individualized treatment plan and comprehensive biopsychosocial assessment need to be completed by a behavioral health practitioner with an associate license?

    A. Yes, this would be the minimum credentials for the individual completing these. Clarification has been added to the standards.

12. DPH regulations speak to individualized program plans (treatment plans) being initiated at the time of admission; the standards add language that it must be completed within a certain timeframe – does this conflict with DPH's expectations?

    A. DPH has expressed alignment with the language in the standards so long as programs continue to initiate these plans at the time of admission.

13. Does the MA clinician require, at minimum, an associate license?

    A. Any clinical activities must be completed by an individual whose minimum credentials are a master's prepared behavioral health practitioner with an associate license. Standards have updated for language consistency throughout.

14. How are certified peers defined?

    A. Certified peers are individuals with lived SUD experience, are in recovery and who have obtained certification by one of the state-approved certification boards.

15. Are progress notes required for both individual and group formats?

    A. Yes, progress notes are required regardless of modality (individual, group, couples, family).

16. If my program is contained in a house-like setting with residents' rooms on different floors, does the minimum staffing requirement apply to each floor?

    A. An update was made to the standards to include an exception for smaller providers**. If providers wish to request exceptions to the minimum staffing requirements outlined in the provider standards, a request can be submitted to The Departments for review and approval**. The ability to make this request is also noted in the standards.

17. What is the expectation on compliance with the standards after the 24-month implementation period is over?

    A. The Departments will continue to support providers in their efforts to come into compliance following the 24-month implementation period. The provisional certification period is 24 months. DSS will create a process for any providers who are not meeting the standards which may include corrective action plans and possible disenrollment from the Medicaid program.

18. Will inflations be seen in the R&B rates annually?

    A. The intent is to update R&B rates as these increases become available.

19. Is there opportunity for review and modifications of the standards to accommodate adjustments over time?

    A. Yes, to the degree that the state standards exceed the expectations set forth in the current edition of ASAM.

20. Would any future adjustments to the standards impact the rates?

    A. This is dependent upon how significant the change. Small changes to the standards that are still covered by the rates would not likely result in any rate changes. More significant changes could result in an adjustment to the rate, up or down, depending on the nature of the change.

21. Can there be consideration for smaller programs (e.g. 8 bed facilities) and/or programs with longer average lengths of stay (e.g. lower levels of care) to have a reduced admission hours expectation?

    A. The expectation of accepting admissions 16 hours/day, 7 days per week shall be maintained for all programs. The state believes that this standard will improve access for individuals to receive care at the time they are ready to engage in SUD treatment and hopefully reduce risk of overdose or disengagement for individuals who would otherwise need to wait until the next day for admission. Additionally, consistency among levels of care and across program sizes will assist with system throughput as individuals prepare to transition from one level of care to the next.

22. Are the other state agencies (e.g. DCF) prepared to do their part to facilitate the admission process?

    A. The state agencies are working collaboratively to prepare for implementation of all state standards, including admission hours. This may include sharing of information and training of state agency staff to ensure their familiarity with these changes.

23. Can there be language added to the standards such that following the implementation period, there is a safety net for providers when staff call out or there are staff vacancies? Programs are unable to afford lost revenue during an audit as a result of staffing issues beyond their control on a particular day, week, etc.

    A. The State recognizes that there may be staffing challenges beyond the agencies' immediate control that may present. Where possible, the state standards allow for flexibility such that hours may be able to be moved to another day when staff are out. Programs should identify internal coverage plans to ensure that the state standards and the quality of care are not compromised during periods of staff transition.

24. What is the expectation of providers with open positions and staff shortages? This will make it difficult to be fully compliant 100% of the time as census shifts constantly.

    A. All providers have 24 months to come into compliance with ASAM 3rd and the State's standards, including staffing. The Departments will continue to assess the standards throughout the Demonstration.

25. Will there be any further communication regarding authorizations and billing processes? Providers need time to work this out within their EHRs, including building and testing. Providers also need to train staff who have not had to get concurrent authorizations, etc.

    A. Yes, providers will receive communication via provider bulletin(s), policy manual and trainings.

26. Has there been any discussion of support to programs when there is a need to quarantine clients with COVID concerns, thereby potentially reducing program capacity?

    A. Executive orders have existed to allow for flexibility to providers with regulations and standards. The State will continue to ensure alignment with any of these orders. There have also been notices regarding funding (e.g. ARPA dollars, COVID relief funds) that providers can seek to receive.

27. What about the flu?

    A. While we encourage providers to take precautions to prevent the transmission of influenza, influenza is not subject to accommodations like that with the COVID-19 public health emergency. Agencies have managed several prior seasons of this virus and are encouraged to continue assessing internal plans for managing this concern.

28. Where do providers stand with grant funding? Will grant dollars be made available to cover costs for the uninsured? Grant funding really is needed to help meet the gap for some of these uncertainties right now, particularly related to COVID.

    A. Providers that currently receive state grant funds in support of these services should work with their state agency funders to develop specific plans to continue receiving grant funding.

29. Are programs permitted to reduce staffing on holidays?

    A. As long as programs maintain compliance with the expectations of the standards, providers can make adjustments to their typical programming and staffing to accommodate holidays. **Minimum staffing expectations are still required to maintain safety.** Programs should also consider the availability of staff (e.g., through on-call) to ensure the ability to accommodate an admission during the 16 admission hours that day.

30. If a resident needs to go into a building (e.g. to take a shower), does this require two staff in the building? Or can programs adhere to the DPH guidelines in which one staff person is required?

    A. Only one staff person is required in these types of situations – this is captured in the standards with the following "Each facility shall have at least one staff person in each building, when a resident is known to be present and who shall have immediate access to back up staff, for urgent or emergency situations. This is inclusive of the positions described above."

31. Can you clarify what is meant by technicians and certified peers "may assist in providing the additional remaining hours of weekly programming"?

    A. Certified peers and technicians are among those staff who can provide/facilitate the non-clinical hours of weekly programming. Replaced "may assist in providing" with "may provide" for clarity.

32. The standards reflect referring to an associated lab policy for additional guidance on toxicology screens; where do we find this policy?

    A. Please see PB 2022-39 for guidance on toxicology screens.

33. Being prescriptive on staffing limits providers' flexibility to accommodate vacations, holidays, staff vacancies, etc. Could the state limit its guidance to activities and staff performing instead of providing ratios and hours required?

    A. The State, in partnership with providers, has included flexibility when appropriate and possible. However, the State remains committed to enhancing the quality of services and safety of staff and treatment recipients and have decided to maintain minimum staffing requirements where applicable.

34. Can the standards align with any licensing requirements?

    A. The state has partnered with DPH and reviewed the current licensing requirements to minimize any differences between the two. **In instances where they currently differ or may differ in the future, providers should adhere to the greater standard to ensure compliance.**

35. Can the state evaluate the requirement by DPH that program staff receive a physical exam every three years and the requirement by DCF that program staff undergo background checks every year?

    A. These requirements are not within the purview of this demonstration waiver. DCF Licensing has clarified that an annual background check is not a regulatory requirement.

If this requirement is stipulated from another source at DCF, please identify this source and follow up with DCF directly for further consideration and feedback.

36. Is there any consideration for approaching DPH to scale back the associate licensure requirement for clinical services?

    A. These requirements are not within the purview of this demonstration waiver.

37. Programs are concerned about being able to fill positions given staffing crisis across disciplines.

    A. The State recognizes and shares in these concerns. As adjustments to the rates begin on day one of the implementation, it is our hope that this will provide programs with support to hire qualified professionals within the 24-month implementation period.

38. The standards reflect a high level of individual clinical supervision – can some of this be adjusted to accommodate a group supervision format?

    A. The State has decided to maintain the expectations outlined in the standards and opine that it will improve the quality of care provided to members and ensure appropriate support to staff in implementing the state standards. The State will continue to assess the Standards throughout the Demonstration.

39. Who will be the credentialing agency?

    A. The certification/credentialing entities are DCF and DMHAS based on their statutory authorities. DCF and DMHAS may contract with a vendor to provide support to the agencies.

40. What reporting will be required? Will we continue State agency reports and add Medicaid?

    A. Each funding source may have their own reporting requirements. Providers should maintain compliance with any such reporting requirements.

41. Does the reporting of critical incidents need to be included in the standards?

    A. Removed these references in each level of care and added a blanket statement on page 1 that “All Providers must adhere to state licensing and funding requirements for their respective level(s) of care.”

42. Will authorizations occur by phone or via a website?

A. The authorization process is still being finalized – providers will be given additional information and training once this process is complete.

43. What will the initial authorization period be? Will the patient be "appropriate" for this level of care for the entire authorization, or will we have to continue to evaluate during this time frame

    A. Initial authorizations timelines and continued stay reviews are under development and will be specific to the level of care. Providers should continue to assess progress toward completion of treatment goals during an existing authorization.

44. Can additional information be provided on what was included in the Room and Board rate?

    A. Please refer to the DSS website (https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project/Related-Resources) for information on rate development.

45. Can providers still bill residents' SNAP benefits a per diem rate while they are in the program?

    A. Yes. DSS will provide formal guidance to providers wishing to pursue this option which will require providers to return the SNAP benefits to the individual under certain circumstances.

46. Can providers utilize a central admission process for efficiencies in operations? Would this have an impact on the service coordination position, medical staff, or any other positions, if pursued?

    A. Any centralized admission processes will not have an impact on what is minimally required for each staffing position dedicated to any particular program/level of care. Additionally, agencies should ensure that daily admission hours are met (i.e., 16 hours per day, 7 days per week or 24 hours per day, 7 days per week as applicable to the respective levels of care).

47. DPH may make modifications to their licensing regulations – will this impact the standards?

    A. The State may review the standards if significant changes to licensing regulations are made; a blanket statement has been included in the standards to reflect that providers should adhere to any current licensing regulations. DPH has also been included in conversations pertaining to this demonstration to ensure current alignment.

48. Startup costs – Is there any consideration for the additional computers, equipment, software licenses etc for all the new staff?

    A. There is no additional Medicaid reimbursement for these costs.

49. What can we expect relative to CMS audits during the onboarding period?

    A. The implementation period allows for a gradual, step-wise process for providers to become fully compliant with the ASAM standards we have set forth by the end of the 24-months. During the implementation period, provider progress toward compliance will be assessed using a vendor that will monitor implementation and assist providers to meet the standards that we have set forth. There will not be a formal DSS audit related to the ASAM level of care criteria, but as enrolled Medicaid provider, all providers must remain adherent to enrollment and billing requirements.

50. What technical support will be provided for ASAM, authorization process and all related requirements?

    A. The State agencies and/or their contractors will provide support and training to providers as well as measuring progress toward compliance.

51. Does the rate contain considerations for expenses related to coverage during extreme weather and other circumstances that require additional employee pay?

    A. The rate considers actual costs. We do not have assumptions that are this nuanced.

52. When JBCSSD is the funder in a program where the contract requires we hold a bed until such time that the client is released, will the daily bed rate be the same as the Medicaid rate? If not, can these beds be converted to DMHAS beds?

    A. The rate will be the same regardless of funding source and the state agencies will resolve these expenditures so that providers are only submitting billing information to one entity. Individuals referred by JBCSSD to programs contracted with JBCSSD should receive priority access for admission. In some instances, JBCSSD may opt to pay for bed holds up to 48 hours to help facilitate transition into the program. Beyond that, programs should admit community clients presenting for admission if there are presently no JBCSSD clients occupying those beds.

53. What happens with a patient who is remanded to residential care after they complete their stay in jail/prison? They may have not used in 30 or more days; do they still qualify?

    A. Abstinence in a controlled environment is different than recovery and alleviation of symptoms across the six ASAM dimensions. Aside from withdrawal management, we believe that most individuals who are incarcerated will continue to meet medical necessity for residential care as they transition from incarceration to treatment.

54. Was the wage data that was utilized for the rate development from the 2020 Bureau of Labor Statistics (BLS) data? If so, the data from this time period does not account for the wage increases providers have had to implement during the pandemic in order to hire and retain staff.

    A. Yes, the rates were developed using the 2020 BLS Occupational Employment and Wage Statistics. This is the most current information available, and the 2021 data is anticipated to be released in Spring 2022. A 4% rate increase on certain behavioral health codes was also added to enhance wages provided to agency staff.

55. Is the service coordinator a full-time position?

    A. Yes. We will be consulting with providers and monitoring the utilization of all positions throughout the demonstration and will make adjustments as deemed necessary.

56. Is the Tech Supervisor a required position?

    A. No, the Tech Supervisor is not a required position, provided techs at the facility are receiving the required amount of supervision as outlined in the standards, they may receive supervision from another position. This position does offer promotional opportunity for non-clinical staff and therefore may be a position that programs want to consider including.

57. Is there opportunity to relax the clinical supervisor position? The Standards currently reflect 40 hours/week regardless of facility size.

    A. The State maintains the expectation for the clinical supervisor but will continue to assess throughout the demonstration and will make adjustments as deemed necessary. Clarification has been added to the standards for each level of care that a clinical supervisor must be on site <u>at least</u> 40 hours per week with at least one evening shift per week. <u>Larger programs may require additional clinical supervisor hours to ensure all supervision requirements are met as detailed in the "Technicians per FTE Supervisor" section below.</u>

58. Are progress notes completed by a Master's prepared behavioral health practitioner currently reviewed AND signed by an independently licensed behavioral health practitioner?

    A. Yes, the standards indicate that "Notes for clinical services provided by a master's prepared behavioral health practitioner with an associate license shall have the review and signature of an independently licensed behavioral health practitioner/clinical supervisor."

59. For progress notes, how do we meet the standard of documenting the "credentials of the practitioner completing" if the practitioner does not have any formal credentials?

    A. All entries into the client record should be signed by the person making the entry and their position and credentials. If a staff person does not have licensed credentials the position title meets this requirement.

60. If a client had a documented PPD as part of a physical within 30 days of admission, is an additional tuberculosis test needed in the 72 hours after admission?

    A. The current standards require a separate tuberculosis screen be obtained within 72 hours of admission. This requirement may be completed through completion of the Connecticut Tuberculosis (TB) Risk Assessment and taking appropriate action based on its results. Many providers have their own policy and procedures for TB screening, but at a minimum should follow the 1115 Waiver Standards.

61. Can a RN or LPN take a verbal order from a prescriber and transcribe it into the medical record?

    A. According to DPH, "Medication shall be administered only upon written and signed orders of a practitioner acting within the scope of a license. (a) Verbal orders for medications or treatment shall be taken only by personnel authorized by law. The order shall include the date, time, and full signature of the person taking the order and shall be countersigned by the practitioner within 48 hours." DPH has verified that an RN may take verbal orders.

62. Is the expectation for non-clinical staff to be trained in ASAM and DSM?

    A. The expectation is that non-clinical staff will participate in trainings related to an introduction to ASAM criteria, motivational interviewing and the Transtheorectical Stages of Change Model. These will be coordinated initially by Advanced Behavioral Health. We encourage providers to use their professional and clinical judgement to identify additional trainings that might help support implementation of changes involved in the 1115 SUD demonstration waiver. There is no expectation that non-clinical staff participate in formal DSM trainings, but introductory training should cover the areas identified in the standard. The state will look for opportunities to provide an initial round of trainings in this area during the first 6 months of the waiver.

63. Can LPNs administer medications?

    A. Yes.

64. What psychiatric services, if any, can be billed for outside of the residential treatment rate?

A. All residential treatment center services (e.g., ASAM 3.1, 3.2-WM, 3.3, 3.5, 3.7 and 3.7-WM) are considered all-inclusive of SUD Medicaid 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 is billed separately.

65. What is the effective date that psychiatric services are included in the rate and cannot be billed separately?
    A. 6/1/22 in alignment with the guidance provided in PB 2022-39.

66. Does the State expect residential providers to use a particular assessment tool or format that should be built into electronic health records (EHR)?

    A. Adolescent residential providers are required to utilize the GAIN and can use additional supplemental assessment tools as indicated. The GAIN has been updated to crosswalk with the ASAM multidimensional clinical criteria.
    Adult residential providers are not required to use a particular format but must ensure that the assessment of an individual aligns with the ASAM 3rd Edition.

67. ASAM has identified that it is acceptable for individual providers to incorporate the paper-based ASAM Criteria Intake Assessment Interview Guide into their EHRs as long as they do not modify the content or add clinical decision support (e.g., create rules such that specific risk ratings or question responses lead to pre-determined Level of Care recommendations). If an EHR wants to integrate the paper-based assessment into its product system-wide, they will need to discuss Criteria licensing with our Senior Director of Health Technology, Bill Liu (bliu@asam.org). What happens when someone no longer meets medical necessity but has nowhere to go?

    A. Providers should be engaging in discharge planning from the time of admission and should familiarize themselves with the ASAM Dimensions. Providers are strongly encouraged to utilize Z codes on their authorizations and claims to assist in assessing Social Determinants of Health (SDOH) that may impact successful discharge, including when the recovery environment puts the individual at risk for disruption in recovery.

    The Departments will work with the ASO to reduce disruptions to the service system as we transition to ASAM 3rd.

68. If testing must be done at a lab what is required to prove medical necessity for the standing order which does not exceed 4 tests per week? We need and appreciate clear guidance to ensure we are in compliance.

    A. 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.

69. Is the review of toxicology screens by a qualified medical personnel review necessary? We have always used it as a clinical tool.

    A. While toxicology results can be used as a clinical tool, the guidance included in PB 2022-39 requiring the documented review and interpretation of the results by appropriate medical personnel was guidance received by DPH. As such, this expectation remains.

70. Where can we get the ASAM 6 dimensions of care assessment scoring tool?

    A. The free assessment tool provided by ASAM can be found at https://www.asam.org/asam-criteria/criteria-intake-assessment-form

71. What are the expectations for residential SUD treatment facilities to manage acute issues (like a sore throat) vs chronic conditions (such as hypertension or diabetes) for someone in our residential program?

    A. It is recommended that agencies consult with their medical directors, internal policies, external regulatory bodies, and agency-specific medical resources to assess the types of medical profiles they can support safely within their programs. The Demonstration, with the addition of medical staff and service coordination resources in residential SUD treatment facilities hopes that historic barriers in access to these levels of care for medical reasons will decrease. Providers are not expected to admit clients with biomedical conditions they cannot safely support internally or through partnerships with community medical providers.

72. Who should be managing any needed medication adjustments if the client has an outside doctor? Would we be required to assume all medical care?

A. It is recommended that agencies consult with their medical directors, internal policies, external regulatory bodies, evidence-based medical practices and develop care coordination relationships with the prescribing medical provider to address any medication adjustments during a client's residency. SUD residential facilities should consult with their specific site license and medical providers to assess to what extent they can assume medical care for clients. Agencies should utilize service coordinators, under the direction of medical staff, to assist clients in establishing or reconnecting with the appropriate medical providers.

73. To what extent are we expected to manage any medication for addiction treatment (MAT) dose adjustments per medication- also realizing that methadone is not accessible to us as we are not a dispensary. Many residential providers don't have PC and are not suboxone providers. Would the APRN/MD we hire for residential levels of care be responsible for it for all clients, even if they have a suboxone prescriber outside of InterCommunity?

    A. The state partners recognize the challenges associated with continued MAT coverage within residential SUD treatment facilities. Under the 1115 SUD Demonstration agencies are required to maintain their capacity to internally manage medication for addiction treatment and/or develop partnerships with community providers to increase access to these services. Residents' ability to obtain and/or maintain access to MAT is a requirement for all SUD levels of care, including residential. SUD residential facilities should consult with their specific site license, internal medical providers, and the prescribing provider to assess to what extent they can internally manage MAT dose adjustments. Agencies should utilize service coordinators, under the direction of medical staff, to assist clients in establishing or reconnecting with the appropriate MAT providers. The APRN/MD as part of the agency's medical team would be responsible for providing services within their scope of practice and in consultation with the appropriate medical professionals/licensing bodies. Some of these responsibilities may include coordination with a resident's external primary prescriber to facilitate directions to the internal agency staff (e.g. nursing) around dosing changes the prescriber has made, administration instruction, symptoms to monitor for and any other relevant directives.

74. We understand that the client is required to do 20 hours a week of programing and there is flexibility on how many hours a day we offer and how we structure. The question is, are we only able to bill for every day that week if the client attends all 20 of the required hours for the week? For example, the client is discharged on a Wednesday and only does 12 hours of treatment, can we bill for Sunday, Monday, and Tuesday? Another example, if the client is at the hospital all day Thursday, does not do any programming- we do not bill for Thursday, but can we bill for the other 6 days, say she attends 18 hours the rest of that week, not making the 20 because she was out for a day?

Response- As of 6/1/2022, agencies providing residential SUD services are expected to schedule clients for at least the minimum number of hours outlined in the Demonstration's standards. Some agencies have reported success in ensuring they meet the minimum hour threshold by creating, where possible, weekly individualized schedules for clients that exceed the number of hours required (e.g., scheduling for 25 hours rather than the required 20 hours). This affords agencies built-in flexibility and safeguards to ensure the total hours are still met even when a client is unable to attend a particular group or treatment session on any given week. Recognizing that agencies may require time to staff their programs to meet the Demonstration's standards, there is some flexibility with what types of staff can provide these hours (e.g., licensed behavioral health clinicians versus non-licensed staff). All staff should perform duties only within their scope of practice.

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 PM 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. Please note that if clients are consistently not meeting the minimum treatment hour threshold, in this case, 20 hours, this would be problematic upon audit from a quality and certification perspective. Program staff should outline each client's weekly schedule, including the 20 hours of services, in their record and document any reasons for this expectation not being met, i.e., the client is hospitalized and the duration for which they were hospitalized. Efforts should be made to reschedule clients for missed services. To the specific examples:

> Example 1: Client is discharged on a Wednesday and only does 12 hours of treatment, can we bill for Sunday, Monday, and Tuesday?
>
> A. Yes.
>
> Example 2: the client is at the hospital all day Thursday, does not do any programming- we do not bill for Thursday, but can we bill for the other 6 days, say she attends 18 hours the rest of that week, not making the 20 because she was out for a day?
>
> A. Yes. You would also be able to bill for Thursday if the member returned from the hospital and occupied the bed for anytime up until 11:59PM and into the next morning. If a member is admitted to a hospital overnight, the residential program may not bill for the night the member spends at the hospital.

75. Can a program make "a week" start on the day of admission or must it be a Sunday/Monday start? So each client would have a different "week" schedule.

    A. Providers may structure their weekly services in any way that best supports their specific client and programmatic needs. Providers must be able to demonstrate, upon

audit, that each client was prescribed and scheduled for no less than 20 hours of services in a seven-day period.

76. Can graduate level clinical interns, under the supervision of a licensed clinician, perform some of the clinical duties such as group or individual therapy once the waiver begins? Our agency often takes on a handful of masters level clinical interns each year.

    A. Graduate level interns may be utilized for up to 25% of clinical services within residential SUD facilities. They may also perform additional clinical tasks such as the biopsychosocial assessment, treatment plan development and discharge planning. Changes to the standards have been made reflecting these permissions.

77. Some agencies have master's level providers who are ineligible to apply for their LPC because their master's program didn't meet the qualifications for DPH licensure. Are these considered license eligible?

    A. These individuals would not be considered license eligible as they do not meet the qualifications for licensure and cannot apply for the license. Additionally, master's graduates who are eligible for licensure are not permitted to perform clinical duties until they obtain licensure or a temporary permit (as applicable for certain disciplines). We encourage agencies to consider professional development opportunities for these staff in the provisional certification period such that they may qualify for licensure prior to the agency's final certification.

78. Is there a grace period for newly graduated clinicians to continue providing clinical services while they await licensure?

    A. No. Current state regulations do not allow for this type of "grace" period or a "license-eligible" status.

79. Were the group capacity requirement of no more than 12 per clinical group and 25 for non-clinical groups effective 6/1/2022?

    A. Yes. The State Partners would like to hear from agencies who are experiencing significant barriers to meeting this requirement.

80. Are the clinical hour requirements in effect as of 6/1/2022? Specifically, are clinicians required to provide the clinical hour percentages outlined in the standards?

    A. The total number of treatment hours need to be in place as of 6/1/2022. Clients need to be prescribed and scheduled for these treatment hours. There is some flexibility over the next 24 months as to what staff can provide these hours and at what percentage. The State Partners recognize that it may take some time for agencies to meet the total number of hours required to be provided by clinical staff due to current labor issues.

81. Do providers have flexibility in Master's level providers providing the clinical services in the provisional certification period (24 months)?

    A. Yes, there is flexibility on who provides the services during the provisional certification period.

82. Definition of 1x/week for UDS – if a client admits on Thursday and we want to do a random test the following Tuesday, does that go against the expectations set forth?

    A. Please see question #67 above; more than one test per week requires appropriate medical necessity explanation documented in the individual's treatment record.

83. Physicals – a lot come directly from Department of Correction (DOC) – especially in 3.7 and 3.5. Is DOC considered "a licensed facility"? How far back is the physical good for?

    A. DOC referrals are anticipated to be community clients, not individuals transferring directly from a DOC facility. Therefore, it is anticipated that these individuals will require physicals as outlined in the standards and any applicable licensing regulations.

84. If we have two levels of care in one building, are we able to have a 3.5 and 3.7 client in the same group?

    A. No. Symptom severity and treatment needs vary by level of care and therefore treatment groups should be tailored to meet the needs of the population served at each level of care and not combined.

85. Is Room and Board (R&B) funding for licensed capacity or contracted capacity?

    A. For residential programs already part of the provider network, R&B is funded for the program's DPH licensed capacity and we expect that providers fill beds based on their licensed capacity. Any new programs and/or increases in bed capacity are not guaranteed funding for R&B. Such requests for additional beds should be discussed with the Departments.

86. Masters level interns (students) can now provide some treatment (clinical) services (with a 25% cap). This includes biopsychosocial & treatment planning. Does this student need to be physically supervised while doing this work? i.e. does a licensed clinician need to be physically with the student while they are doing this work?

    A. The statutes don't clearly define the supervision requirements for students, but the schools and their accrediting bodies usually have requirements. The employer may

have their own policies too. We are not aware of any requirements for the supervisor to physically sit beside the student. Those types of arrangements are usually between the school and the agency.

87. What does the pre-authorization process for criminal justice involved entail?

    A. For any residential treatment providers covered under the 1115 Demonstration Waiver that directly contract with or who provide services through another state agency to the Department of Correction or the Judicial Branch, Court Support Services Division, these agencies, or programs must seek a "pre-authorization" from Beacon at the time of referral for all probation, parole, or pretrial defendants. This "pre-authorization will act as an initial approval for the level of care and will be good for 60 days as long as the individual's treatment status has not changed. Once the individual is admitted to the treatment program, the program must request a new authorization from Beacon. This "pre-authorization" will not be required for same day placements.

88. Regarding the authorization process, much of the information required for the pre cert and/or the authorization would come from the treatment plan and the evaluation. Is there flexibility in the initial authorization timeframes?

    A. Providers now have up to 2 business days to submit the initial authorization request so that the biopsychosocial can be completed

89. Will State agency specific reporting requirements continue?

    A. Any contractor reporting requirements remain in effect unless otherwise notified by the State agency.

90. When is telehealth permitted?

    A. The standards have been updated to identify which services can be conducted by telehealth and under what circumstances, including alignment with current telehealth policy(ies). If telehealth or by phone is not explicitly indicated, the expectation is that service delivery occurs in person.

91. Are Evaluations allowed to be done now, during the current Public Health Emergency (PHE), and will they continue after, to be completed by Telehealth? We would like to be able to complete a full biopsychosocial on a potential patient prior to them coming to our facility to be sure they meet criteria. Telehealth allows us to do so.

    A. Evaluations are permitted to be completed by telehealth under the PHE and DSS anticipates that the future telehealth policy will continue to permit evaluations to be

completed by synchronous audio/video telehealth (audio only will not be permitted). Please note that for residential clients, the biopsychosocial assessment must be contained within the client's record as part of the residential treatment episode and the completion of this assessment is included in the residential rates. We encourage providers to consider the client's experience when developing their admission processes such that repeat information sharing required by the client is minimized to the degree possible.

92. Can psychiatric services be billed for separately?

    A. Psychiatric services are covered under the all-inclusive per diem treatment rate and are not permitted to be billed for separately. Residential providers who contract out for these services must pay the outside entity for these contracted services. The standards have been updated to remove the minimum number of on-site psychiatric and physician hours per week from the standards to allow greater flexibility to providers. Providers must still ensure adequate on-site coverage to meet the related interventions and client care within any required timeframes.

93. Are individuals who are classified as Qualified Medicare Beneficiaries (QMB) or are otherwise dually eligible for Medicare and Medicaid/CHIP eligible for residential services under the 1115 Waiver?

    A. The 1115 Demonstration Waiver does not change any of the coverage rules for dually eligible Medicare-Medicaid beneficiaries. If the Dually Eligible individual has full benefits under Medicaid, the beneficiary will have coverage for medically necessary SUD services covered under the Medicaid State Plan. Qualified Medicare Beneficiaries (QMB) who are not eligible for full benefits under Medicaid will receive Medicaid coverage only to pay their providers for whatever eligible Medicare cost-sharing the person would otherwise have needed to pay out-of-pocket (or through a Medi-gap policy). However, this Medicaid category is limited only to paying for Medicare cost-sharing, it is not a full Medicaid benefit so it does not include coverage of SUD residential services. These individuals can be admitted to SUD residential treatment programs using DMHAS grant funds, per the guidance below.

    The intent for those SUD residential providers participating in the 1115 SUD Demonstration receiving grant funds through the Department of Mental Health and Addiction Services for residential substance use treatment is to use this funding for the provision of services to individuals who have no other method of payment. This includes individuals without private or public health care coverage or without access to or eligibility for such coverage and non-Medicaid populations whose healthcare coverage does not extend to residential SUD treatment (e.g., Medicare). All clients must meet the ASAM and medical necessity standards outlined in the Connecticut's 1115 SUD

Demonstration. This is something your agency should assess; while Beacon Health Options will be providing authorization reviews for clients without insurance, there is no third-party review of medical necessity for any other non-Medicaid insured clients. Treatment for all individuals accessing these levels of care should continue to follow all contractual expectations and all applicable regulatory and licensing guidelines. Agencies should continue to track the Insurance/Client Status for these populations and report this data monthly on the provided census template to the Department of Mental Health and Addiction Services, Office of the Commissioner - Health Care Finance Unit monthly. The points of contact for the 1115 Provider Census reporting are Christina Arias, Christina.Arias@ct.gov and David Fernandes, David.Fernandes@ct.gov. Agencies should report any operational issues regarding admission, treatment and discharge for these non-Medicaid client populations to their identified point of contact within the Department of Mental Health and Addiction Services' Community or Statewide Services Divisions.

94. While attempting to refer an individual to a lower level of residential care following successful completion of a higher level of care, we have received a denial from a program on the basis that they don't accept clients whose primary insurance is Medicare. How do we proceed?

    A. Please see Question 93 above which notes that programs should be using their DMHAS grant funds for "funding for the provision of services to individuals who have no other method of payment. This includes individuals without private or public health care coverage or without access to or eligibility for such coverage and non-Medicaid populations whose healthcare coverage does not extend to residential SUD treatment (e.g., Medicare)." If you continue to run into this scenario, please outreach to Rob Haswell at DMHAS (Robert.Haswell@ct.gov) for additional support.

95. Is it necessary for clients to obtain some form of Medicaid insurance prior to admission? If yes, is this responsibility for the referring agency or our facility? If we as the facility are responsible, is there a direct number for us to call DSS to determine their eligibility? Are there specific timelines that a client is required to obtain Medicaid insurance (for example: either before or after admission)?

    A. It is not necessary for individuals to obtain some form of Medicaid insurance prior to admission and lack of Medicaid coverage should not present as a barrier to admission. Again, the DMHAS grant funds are intended to support access to services when an individual has no other method of payment. Individuals should be admitted expeditiously and assessment of plausible eligibility can occur following admission. If your agency anticipates that the individual would be eligible for Medicaid (qualification guidelines are noted here), we recommend that the facility support the individual in applying for Medicaid coverage. This is a task that could be supported by the service coordinator. This application can be completed online. Once an individual has active

coverage, the facility can bill for dates of service from the coverage effective date forward. In some instances, eligibility may be retroactive to an earlier date and programs may retroactively bill for dates of service provided on or after the coverage effective date. If an individual is anticipated to be eligible for Medicaid, we also recommend that the program seek an authorization through Beacon Health Options – they will use a "temp member" process and will determine medical necessity as they do for current Medicaid members.

96. Is there a separate claim/form expected by DSS for individuals who have been in our program since onset of the Demonstration including those who have not met the requirements for Medicaid and have been utilizing other insurances while residing in our program?

    A. There is no separate claim/form expected by DSS for non-Medicaid residents. However DMHAS continues to expect that programs complete the census reporting document.

97. Can CADCs conduct billable treatment groups if a licensed person signs off? Do the CADCs need to meet the ASAM training requirements?

    A. CADCs can provide the non-clinical billable treatment hours as outlined in the state's standards for the respective ASAM level of care being provided. A CADC must act within the CADC's scope of practice under state law and be certified as a CADC by DPH in accordance with applicable requirements for the certification. The CADC works under the supervision of an independent licensed practitioner. CADCs should participate in the ASAM training requirements.

98. Our biopsychosocial includes a substance use, medical, and mental health section. Social workers have been advised/directed to enter the admitting diagnosis in these sections. Please confirm this meets the standard.

    A. Medical records should clearly identify all applicable diagnoses, including any applicable Z-codes reflecting social determinants of health as outlined in PB 2021-38. Where these are identified is at the discretion of the provider. For billing purposes, please note that as outlined in PB 2022-39, an SUD diagnosis must be the primary diagnosis on all claims. This guidance does not replace any other licensure and regulatory expectations for documenting diagnoses.

99. If the clinician completing the biopsychosocial assessment is independently licensed, is a supervisor's signature required?

    A. No, assessments completed by an independently licensed clinician do not require an additional signature from a supervisor.

100. If an individual transitions from one agency's SUD treatment program to another agency is a new biopsychosocial assessment required? Example: An individual completes treatment at a

3.7 LOC at Agency A and transitions to a 3.5 LOC at Agency B. The referring agency forwards the completed biopsychosocial and ASAM transfer assessment which is utilized by the referring agency to justify medical necessity.

A. Agencies should utilize collaborative consultation and referral documentation to assess the needs of individuals admitting to their facilities, but this information alone isn't sufficient to meet the standards outlined in Connecticut's Substance Use Disorder Services Policy and Clinical Assumptions Grid. An individualized, comprehensive biopsychosocial assessment of the individual should be completed within the identified timeframes. Agencies should also consult with the Department of Public Health and the public health code related to Private Freestanding Facilities for the Care or the Treatment of Substance Abusive or Dependent Persons when implementing new assessment practices.

101. If the same client returns to Agency A for SUD treatment within one year is a new biopsychosocial assessment required? Can our agency update the original biopsychosocial from the first treatment episode?

A. In this case a new biopsychosocial assessment is required. Agencies may consult the previous episode's biopsychosocial assessment for informational purposes but should be identifying the individual's current symptoms and needs through completion of a new biopsychosocial assessment.

102. At least fifteen (15) of these hours must be provided by staff whose minimum credentials are a Master's prepared behavioral health practitioner with a minimum of an associate license (LMSW, LPCA, MFTA). This seems to exclude CAC and LADC staff.

A. Staff holding an LADC are considered independently licensed behavioral health practitioners and are qualified to provide the required hours of clinical treatment. Services facilitated by certified addictions counselors (CAC), provided they meet the individual's treatment plan needs, may be counted towards the remaining hours of services, which may be non-clinical.

103. Can recovery groups facilitated by recovery support specialists be counted towards the required 30 hours of weekly programming?

A. Onsite peer support, including at a minimum, alumni groups and recovery groups or linkage to 12-step groups are a required part of the Demonstration and cannot be counted towards the required total number of hours of programming. However, certified recovery support specialists could, provided they receive the appropriate training and supervision, facilitate non-clinical recovery-oriented psychoeducational groups which would count towards the required hours.

104. Do diagnostic and med management sessions with medical staff count towards the overall weekly clinical service hours?

A. Response: Yes, provided they meet the individual's treatment plan needs these sessions count towards the overall weekly clinical service hours.

105. Would an individual with the applicable experience, masters in clinical mental health counseling, an LADC and an LPC-A meet the supervisor position requirements?

A. Yes, the individual's LADC makes them an independently licensed behavioral health practitioner and would qualify them for the supervisory position. As with any position, agencies should ensure that qualified practitioners operate within their scope of practice as applicable under state law, ensuring appropriate licensure and supervision as applicable.

106. Can a member participate in an evaluation for Intensive Outpatient (IOP) while still in residential treatment if IOP is the recommended discharge plan?

A. Yes, residential providers can refer a member for an IOP evaluation while still in residential treatment. This evaluation may occur in person or via telehealth, permitted that current telehealth policy allows this service to be provided in this modality. This evaluation should occur as close to member's discharge date.

Residential providers should ensure that they have utilized the ASAM multidimensional assessment to appropriately determine the recommended discharge level of care and other relevant aftercare services. Residential providers should **not** utilize an external evaluation to make discharge recommendations.

Members should be given the choice of where and with which agency they receive their aftercare treatment services and this should be clearly documented in the individual's discharge plan e.g. "Client was provided with a list of intensive outpatient programs near her home and identified Agency A as her preferred service provider." Residential programs should not solely refer to their own agency. Members in JBCSSD/DMHAS collaborative programs, should always attempt to use CSSD contract ABHS programs for aftercare/discharge planning.

107. What assessment efficiencies can be considered when an individual remains in the same program at the same address but flexes to a new level of care (e.g. member successfully completes ASAM 3.7 and is recommended to transition to ASAM 3.1 which the agency also offers at the same location and maintains the individual for this care transition without any discharge to the community or other facility)?

A: Agencies would need to request a waiver from the Department of Public Health (DPH) regarding the waiving of any requirements outlined in §19a-495-570 of the Regulations of Connecticut State Agencies. DPH would expect that, when indicated for the applicable service classification, individuals entering a new level of care would receive an initial toxicology, nursing assessment and new individualized treatment/program plan. Individuals entering a new level of

care should also have an updated ASAM assessment looking at all six dimensions to inform the development of the new treatment plan.

1115SUD Demonstration FAQs on Treatment Plans and Discharge Plans/Summaries

1. Can treatment plans be drafted by non-licensed staff?

A. Under Connecticut State Plan Amendment (SPA) 22-0020, the development of the treatment plan including problem formulation, needs, strengths, skills assessment and articulation of short-term, measurable treatment goals, and the activities designed to achieve those goals must occur between a qualified practitioner as defined by the plan and the individual receiving services. All individuals other than independent licensed practitioners must work under the supervision of an independent licensed practitioner or other applicable qualified supervisor.

2. Can discharge plans be drafted by non-licensed staff?

A. The State views discharge plans and summaries as two separate documents. Under the current State Plan Amendment, the development of the discharge plan is part of service coordination, and its drafting must be completed by one of the following types of qualified providers: Independent licensed practitioners; associate licensed practitioners; certified alcohol and drug counselors; registered nurses; licensed practical nurses; unlicensed counselors; peer support specialists; technicians; graduate-level interns; and associate/bachelor-level interns. Level of care determinations utilizing the ASAM Criteria and recommendations should occur between a qualified practitioner as defined by the plan and the individual receiving services. Provided there is evidence this meeting occurred, and the discharge plan is reviewed, approved, and signed by an independent practitioner, agencies can utilize their discretion on what types of qualified staff physically draft the document. All individuals other than independently licensed practitioners must work under the supervision of an independent licensed practitioner or other applicable qualified supervisor.

3. When are Treatment Plans, Biopsychosocial Assessments and Discharges considered completed under the Demonstration?

A. Once the treatment plan/biopsychosocial or discharge plan is completed and signed by an independently licensed practitioner as defined by the Demonstration's State Plan Amendment it is considered completed and in final status. If it is completed and signed by any other qualified practitioner, it would need to be reviewed and signed by an independently licensed practitioner to be considered in final status. For certification purposes auditors will give partial credit for the treatment plan/biopsychosocial or discharge summaries that are completed by a qualified practitioner within the timeframes outlined in the standards and will give full credit for documents that are subsequently reviewed and signed by an independently licensed clinician for final status within the following timeframes:

Documentation Type	ASAM Level of Care	Completion Timeframe	Final Status
Biopsychosocial Assessment	3.1, 3.3	Within 72 Hours of Admission	5 Calendar Days
	3.5, 3.5PPW, 3.7R, 3.7RE, 3.2WM, 3.7WM	Within 48 Hours of Admission	5 Calendar Days
	2.1 2.5 1-WM 2-WM	Initiated for level of care determination prior to admission and completed within 72 Hours.	15 Calendar Days
Initial Treatment Plan	3.1, 3.3, 3.5, 3.5PPW	Within 72 Hours of Admission	5 Calendar Days
	3.7R, 3.7RE	Within 48 Hours of Admission	5 Calendar Days
	3.2WM, 3.7WM, 1-WM 2-WM	Completed within 48 hours of admission	
	2.1 2.5	Within 72 Hours of Admission	30 Calendar Days

Discharge Summaries	All ASAM Levels of Care	Within 15 Working Days from Discharge Date

Agencies should continue to utilize clinical discretion and comply with all applicable licensure timelines regarding the completion of these documents.

4. At clinics where clients are dually enrolled in MOUD or MAUD programs and ambulatory levels of care e.g., intensive outpatient are separate treatment plans required or can the facility utilize an integrated treatment plan?

   A. Integrated plans are acceptable provided there is clear delineation of when the subsequent episode began and that the services identified are aligned with an updated dimensional assessment and level of care determination e.g. start dates, updated signatures etc. Plan should be updated to reflect the goals associated with each LOC. Timeframes for treatment plan reviews and discharge plans should be met for the respective levels of care being provided and progress appropriately noted.

5. Nursing Assessment – Our physicals are completed by APRN which includes a detailed substance use assessment. Can this count as a nursing assessment or does it need to be a separate form?

   A. If completed within the appropriate timeframes outlined in the Connecticut State Standards, this would meet the requirement.

6. Can the supervision hours be reviewed and updated to incorporate feedback from the providers over the first 18 months of the Demonstration?

A.

Changes to Supervision Expectations under CT 1115 SUD Demonstration January 2024

Agencies should consult State Plan Amendment 22-0020 for definitions of practitioner qualifications and supervision guidelines. The following guidance pertains only to the expectations of the 1115 SUD Demonstration and does not replace or supersede any other regulatory or professional licensure expectations. It is recommended that agencies utilize their clinical and professional discretion in setting additional supervision expectations for personnel. State Plan Amendment 22-0020, the Connecticut Substance Use Disorder Services Policy and Clinical Assumptions Grid and other provider resources can be found at https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project/Provider-Resources.

ASAM Level of Care	Professional Discipline	Current Standard	Updated Standard
ASAM 2.1 Intensive Outpatient Treatment (IOP) ASAM 2.5 Partial Hospitalization (PHP)	Independently Licensed Clinical Staff	Two hours per month for independently licensed clinical staff. Group supervision may be utilized once per month.	No Change
	Associate licensed or Unlicensed staff	One hour per week. Group supervision may be utilized once per month.	One hour per week for associate licensed and unlicensed staff. **Group supervision may be utilized twice per month**.
	Certified Peers	One hour per week. Group supervision may be utilized once per month.	One hour per week for associate licensed and unlicensed staff. **Group supervision may be utilized twice per month**.
ASAM 3.1 ASAM 3.3 ASAM 3.5 ASAM 3.5 PPW ASAM 3.7 ASAM 3.7RE ASAM 3.2 WM ASAM 3.7WM	Independently Licensed Clinical Staff	One hour per week. Group supervision may be utilized once per month.	Two hours per month for independently licensed clinical staff. Group supervision may be utilized once per month.
	Associate licensed or Unlicensed staff	One hour per week. Group supervision may be utilized once per month.	One hour per week for associate licensed and unlicensed staff. **Group supervision may be utilized twice per month**.

	Certified Peers	One hour per week. Group supervision may be utilized once per month.	One hour per week for associate licensed and unlicensed staff. **Group supervision may be utilized twice per month**.
	Technicians	Technicians receive supervision 30 minutes for every 40 hours worked. Techs must receive monthly group clinical supervision with a potential shift overlap (All staff meeting at least once a month).	No Change

1115 SUD Demonstration FAQs on Reassessment

1. **Question:** Does a full comprehensive assessment need to be completed when a client is transitioning internally between levels of care or can a reassessment (transfer assessment) be conducted to update the biopsychosocial information and inform the level of care determination and treatment planning? If so, what documentation is required for these types of assessments under the Demonstration?

   Response: The following is intended to provide guidance for substance use treatment providers to meet the expectations of the 1115 SUD Demonstration. This guidance does not replace the documentation expectations of any other regulatory agency, accreditation body, or funder. Agencies are encouraged to consult with these entities when developing their policies and protocols. Additionally, agencies should utilize their clinical discretion and evidence-based practices when making assessment decisions.

Billing Guidance:

Agencies should consult Provider Bulletin PB-2022-86 for billing guidance related to this issue.

Documentation Expectations:

When internal transitions between levels of care occur and the agency elects to utilize a reassessment process as opposed to a new comprehensive diagnostic evaluation the following clinical documentation must be, at a minimum, present in the individual's medical record to meet the certification requirements of the 1115 SUD Demonstration:

Evidence of reassessment of individual's dimensional needs as outlined in the most recent edition of the ASAM Criteria:

- Evidence that the individual's strengths, needs and risk ratings in each of the six dimensions of the ASAM criteria were reviewed and that the individual meets the transfer criteria for the admitting level of care. (ASAM, p. 303-306) prior to transfer.
- Evidence of updated assessment of family/support system involvement in treatment.
- Documentation in the client's medical record clearly outlining that the client has been discharged from the current level of care and will be entering a new level of care within the same facility/agency. This documentation should include the original reason for referral, the individual's progress towards the established plan, the type, frequency and duration of treatment or services, the reason(s) for discharge to the new level of care, the individual's participation in discharge planning and information regarding release(s) of information obtained, Medication Assisted Treatment status and any aftercare services referred to.
- Completed within the same admission timelines as outlined in the Connecticut Substance Use Disorder Services Policy and Clinical Assumptions Grid.
- Copy of Carelon's authorization letter authorizing new level of care.

Treatment Plans

- New treatment plan informed by updated ASAM Assessment.
- New goals and activities.
- Updated within timeframes outlined in the Connecticut Substance Use Disorder Services Policy and Clinical Assumptions Grid.
- Reflects case management by on-site staff, coordination of addiction treatment, mental health, recovery support, social, housing, vocational services and integration of care.
- Includes integration of updated discharge plan.
- Treatment plan reflects the client's participation and includes the client's signature.
- Conducted/updated/signed by independently licensed or associate licensed behavioral health staff or graduate-level intern and reviewed and signed by a licensed behavioral health practitioner/clinical supervisor.
- Treatment plans are reviewed by a multidisciplinary team of qualified practitioners in collaboration with the individual

Toxicology Reports

- Evidence of a new toxicology report upon admission into the new level of care.

Nursing Assessment

- Evidence of an updated nursing assessment for transfers to 3.7R, 3.7 WM, 3.5, 3.5PPW programs.

Level of Care Specific Questions

3.1

1. Can physician extenders (NP/PA) also perform the duties outlined for a physician?

    A. Yes, standards updated to reflect this.

2. Can a physician licensed as a psychiatrist sign off on behavioral health clinical documentation?

    A. Yes; their credentials exceed the minimum criteria.

3. Can on-site psychiatric time include telehealth psychiatric services?

    A. Yes; standards updated to reflect this.

4. Should a physical exam be scheduled within five days of admission or does the actual appointment need to occur within those five days?

    A. With guidance from DPH, added clarity for 3.1, 3.3, 3.5, 3.5PPW that an appointment for a physical exam must scheduled within five days of admission and that the appointment itself must occur within 30 days of admission.

5. Do notes for non-clinical hours completed by associate licensed BH practitioner need co-signature of independently licensed BH practitioner?

    A. No, clarity added to standards indicating that clinical notes require review and signature.

6. Would psychiatric time (psychiatric evaluation, medication management) count toward the clinical hours of weekly programming?

    A. Yes.

7. Can 3.1 and 3.5 programs utilize telehealth sessions to meet requirements for clinical hours?

    A: The use of telehealth sessions shall be used only in extenuating circumstances when in-person contact is determined to be inappropriate. For example, client A is confirmed to be COVID positive and must isolate. The provider shall document reason for telehealth session.

3.3

1. The standards indicate that a transfer to another level of care can be at a higher or lower level of care, with 3.5 listed as an example for the higher level of care. Why would they transfer to a higher level of care?

    A. ASAM 3rd Edition speaks to an individual being ready for discharge from a 3.3 level of care when assessment indicates that the individual is no longer cognitively impaired. The program should complete an updated assessment of the individual's severity of illness and rehabilitative needs which may support transition to either a higher or lower level of care.

2. The standards indicate two different timeframes for completion of the biopsychosocial assessment (within 48 hours and within 72 hours). Which is correct?

    A. The standards have been updated with consistent language indicating that the biopsychosocial must be completed or updated within 72 hours.

3. Can the on-site psychiatric services be conducted via telemedicine?

    A. Yes, clarification added to the standards.

3.5

8. There appears to be variance between the rate setting assumptions and the clinical assumptions for the hours of weekly programming; can you explain?

    A. There may be several areas in which these two documents do not perfectly align. Providers will be held to the expectations outlined in the clinical assumptions. Where the rate assumptions are greater than the clinical assumptions, this typically reflects where the State has reduced expectations but did not reduce the rate. Where the rate assumptions are lower than the clinical assumptions, we have verified that the rate still supports the activities in the standards given reductions made elsewhere in the standards.

9. Does the registered nurse (RN) need to complete the nursing assessment or can this be a Licensed Practical Nurse (LPN)?

    A. Conducting nursing assessments is beyond the scope of an LPN and therefore must be completed by an RN.

10. Can there be consideration for completion of the nursing assessment within 72 hours instead of 48 hours?

A. The standards have been updated to allow 72 hours for completion.

11. Do the standards align with DPH regulations outlined in 19a-495-570 for completion timeframes of the biopsychosocial assessment?

    A. DPH regulations under this section do not speak to expectations regarding the biopsychosocial assessment. However, providers should always ensure compliance with all state licensing requirements in addition to the provider standards.

12. Will JBCSSD referrals be limited to the current JBCSSD contracted providers?

    A. Currently, that is the intention but there remains discussion on JBCSSD access to beds in the future state. However, if an individual does not meet medical necessity for the levels of care currently in the collaborative, JBCSSD will seek authorization from the court for placement in the recommended level of care and may make a referral to that program as a community referral. The State will continue to assess access across the system which may result in future changes.

13. Will PREA be required for JBCSSD involved clients?

    A. Yes, this remains an expectation by JBCSSD for all providers in the collaborative. If community placement at a level of care outside of the collaborative is pursued, PREA compliance will not be expected.

14. Activities related to JBCSSD referrals exceed that of non-JBCSSD involved clients; will there be a rate differential for JBCSSD-referred clients for whom additional expectations are included?

    A. JBCSSD Contractor Requirements are outlined in the last page of the standards document. We have verified that the rates support these additional activities and will not have a rate differential for individuals involved with JBCSSD.

15. Can staff other than the RN supervise the self-administration of medication?

    A. Level 3.5 does not identify a specific staff person or credential to supervise the self-administration of medication. Providers should utilize their discretion to identify and train appropriate staff on supervising this process. Providers should also review and comply with any regulations regarding the self-administration or medication outlined by DPH.

16. Can there be flexibility on the nursing hours such that Clinical Services Assistants (CSAs) can be utilized for this time?

A. The State will be maintaining the standard that the nursing hours ("onsite 40 hours per week per 16 residents") be provided by an RN or LPN and that at least one nurse be an RN. We will be consulting with providers and monitoring the utilization of all positions throughout the demonstration and will make adjustments as deemed necessary.

17. Can 3.1 and 3.5 programs utilize telehealth sessions to meet requirements for clinical hours?

A: The use of telehealth sessions shall be used only in extenuating circumstances when in-person contact is determined to be inappropriate. For example, client A is confirmed to be COVID positive and must isolate. The provider shall document reason for telehealth session.

3.5 PPW

1. No sharing of staff for this LOC is problematic for purposes of keeping it open.

    A. The State believes that 3.5PPW programs require staff who are trained on the specialized needs of the population served and maintain that minimum staffing requirements cannot be combined with other programs.

2. More rural area programs may struggle more with occupancy – may be worth looking at how do we help support these programs to maintain access.

    A. Thank you for raising this concern; the State will continue to assess access statewide.

3. Medical necessity remains a concern for this level of care. Providers would like to be available to consult with state agencies on these strategies.

    A. The State agrees and welcomes additional conversation on helping support these individuals when no longer meeting medical necessity for this level of care.

4. How many of these standards can be met with telehealth?

    A. Telehealth permissions have been included in the standards document, where applicable.

5. Has the state considered any guidance on what a safe environment (Dimension 6) would be such that it may still aid in women meeting medical necessity if they do not have a stable recovery environment to return to?

A. Medical necessity assesses the total clinical presentation, including but not limited to and individual's living/recovery environment. The State continues to explore options for individuals who no longer meet medical necessity but who may not have a safe or stable living environment to discharge to.

6. For the standard "Telephone or in-person consultation with a physician, a physician assistant or nurse practitioner and emergency services are available 24/7" Does this include both psychiatric and physical health needs? Currently we utilize the child's pediatrician and the mother/client's OBGYN for any medical concerns.

    A. Provided the pediatrician and OBGYN offices have 24/7 on-call services and this is outlined in your policies and protocols, this is acceptable.

3.5 Adolescent

1. No questions or concerns raised as of the release of this document.

3.7

1. Is there opportunity to increase the service coordinator position to manage both the admissions and discharge planning?

    A. The standards speak to minimum expectations; any increased presence will still meet compliance expectations. The service coordinator position was designed with the idea that they will assist members both entering and exiting the program.

2. Can there be consideration for utilizing an APRN under the supervision of the psychiatrist?

    A. For psychiatric services, the standards reflect "psychiatrist or psychiatric NP".

3. What is the expectation for when a physical examination should be completed? There are two different timeframes identified in the standards.

    A. The expectation is that a physical exam is completed within 24 hours of admission or a physician review and update within 24 hours of admission of a physical examination that was completed within the seven days prior to admission. The standards have been updated for consistency.

4. How would physician "oversees the treatment" be documented?

A. The physician (or NP/PA) performs and documents duties within their scope of practice, including completion or review and update the record of a physical examination and providing oversight to nursing staff who carry out the physician's medical orders.

5. The standards currently indicate that treatment plans must be updated every 30 days; however DPH regulations indicate they are required weekly. Which standard should we be following?

    A. Standards have been updated to weekly review to align with the DPH regulation.

6. How are we defining "monitoring" when it comes to nursing staff responsibilities?

    A. Nursing staff, as with all staff, should only perform duties within their scope of practice. Roles specifically outlined in the standards include monitoring an individual's progress in treatment and their self-administration of medication.

7. Can there be clarification on the nursing expectations?

    A. We have completed some updates to the nursing section for this level of care. The RN presence on every shift has been removed from the standards and replaced with "At least one nurse shall be an RN". Programs are still expected to comply with the timeframes connected to the completion of the nursing assessment by an RN as outlined in the standards. The language "For third shift, only one nursing staff is required" has also been removed. Programs will have flexibility in how they staff each shift, but must still comply with the defined nurse to resident ratios.

8. For our 3.7R – the 37.5 hours of nursing must be a RN since the standard says at least one nurse is a RN. Correct? In the instance where we have two or more PT staff filling these hours then only one has to be a RN?

    A. This is correct provided the RN is available to ensure activities associated with the RN are completed with the required timeframes.

    Example: Alcohol and other drug-focused nursing assessment by an RN initiated at the time of admission and completed within 24 hours.

9. Medication administration versus self-administration for 3.7R – can certified staff observe self-administration? Or does this have to be a nurse?

    A. An appropriately credentialed and licensed nurse is responsible for monitoring the individual's progress and for medication administration. Except that the self-administration of medication by clients may be permitted on a specific written order by the prescriber working within their scope of practice. Self-administered medications

shall be dispensed, stored, monitored and recorded in accordance with an established procedure. The revised standards reflect this update.

3.7RE

1. How are we defining "monitoring" when it comes to nursing staff responsibilities?

    A. Nursing staff, as with all staff, should only perform duties within their scope of practice. Roles specifically outlined in the standards include monitoring an individual's progress in treatment and their self-administration of medication.

2. For the standard "The RN is responsible for monitoring the individual's progress and monitoring the individual's self-administration of psychotropic medications" is it possible to expand this to an LPN

    A. No, as this is an ASAM requirement for co-occurring enhanced programs.

3. For the standard "Additional psychiatric services available through consultation or referral when an issue can be addressed at a later time, services must be available within 4 hrs via telephone or 24 hrs in person", if we have a psychiatrist on staff to meet this requirement, can a psychiatric APRN provide the additional psychiatric services?

    A. Provided the minimum staffing requirements are met, a psychiatric APRN operating within the scope of their licensure can provide additional support services. We recommend that providers consult with their medical directors and psychiatric departments to develop appropriate coverage plans.

4. For our 3.7RE – the standard says at least one RN per shift but we only need 57.5 hours per week. This will not cover an RN on all shifts. So do we need a RN on all shifts or only an LPN/RN for the 57.5 hours? Do we decide on how the 57.5 hours are used on which shifts?

    A. The 3.7RE has certain activities that are required to be performed by the RN (e.g. The RN is responsible for monitoring the individual's progress and monitoring the individual's self-administration of psychotropic medications. A registered nurse is available to conduct an alcohol or other drug focused nursing assessment initiated at the time of admission and completed within 24 hours). As we anticipate that monitoring of self-administration of psychotropic medications will occur on all shifts, it is necessary for there to be an RN presence for the times in which these self-administrations occur. There is flexibility in how the RN may be scheduled to ensure coverage of these activities. An RN does not need to be present for the duration of each shift and may be scheduled as an overlap between shifts (e.g. 11a-7p).

5. Is a psychiatric PA with Certificate of Additional Qualification (CAQ) in psychiatry able to provide the psychiatric services outlined in the standards for the 3.7RE level of care?

    A. ASAM outlines that certain activities must be performed by a psychiatrist. Specifically, "A psychiatrist assesses the individual within 4 hours of admission by telephone and within 24 hours following admission in person, or sooner, as appropriate to the individual's behavioral health condition, and thereafter as medically necessary." This assessment is not permitted to be conducted by a PA. Additional psychiatric services can be delivered by the PA provided they are working within their scope of practice and under the appropriate supervision. The psychiatrist should be available, as needed, to ensure quality and timely psychiatric care is provided to the residents of the program (e.g. for emergency psychiatric services, review of the individual's recent psychiatric history and mental status examination when such review by a psychiatrist is indicated).

3.7WM

1. Reaching a 90% occupancy rate will be a challenge.

    A. Occupancy is not a standard; it is what was used to help set the rate and was informed by utilization data.

2. Currently the biopsychosocial and treatment plan are expected to be completed within 24 hours. Can this be extended to accommodate individuals who are often intoxicated or experiencing significant withdrawal symptoms during the initial 24 hours?

    A. The standards have been updated to increase the timeframe for completion of the biopsychosocial assessment and individualized treatment plan within 48 hours.

3. Providers will need to build out R&B code and test it because we're splitting these out.

    A. The State recognizes providers require guidance on this as soon as possible.

4. Is it possible to receive payment for R&B for the last day? Existing billing practices don't permit to bill the last day of service if they are not in the bed at midnight. Is it possible to get the source of this regulation? Might be a DSS regulation because it's not a Medicaid covered service yet.

    A. No. Additionally, Medicaid may not pay for days when a resident is not present in the facility (e.g. weekend pass).

5. Page 60 – physical exam – and page 67 – lab tests and such one says 24 hours and the other says 72 hours.

A. Removed inconsistent language from page 67; the expectation around appropriate laboratory and toxicology tests is outlined in the documentation section.

6. The intervention section and the documentation section of the standards have two different time frames for completion of the biopsychosocial assessment and the treatment plan. Which is accurate?

    A. The standards have been updated for consistency, indicating that the timeframe for completion of both is within 24 hours of admission.

7. How do we document hourly nurse monitoring?

    A. Per the standards "Hourly nurse monitoring of the individual's progress and medication administration are available, if needed." The nurse should document somewhere in the individual's record (e.g., in the nursing assessment, progress notes, when completing updated withdrawal rating scale tables and flow sheets) the recommended frequency of nurse checks as determined by the individualized needs of the client.

8. What is the education requirement for an unlicensed Counselor serving as a Service Coordinator in levels of care 3.7R, 3.7RE and 3.7WM?

    A. An unlicensed counselor is defined as someone who must (i) have at least a master's degree in a human services or related field or a bachelor's degree in a human services or related field plus two years of full-time equivalent experience providing SUD services and (ii) work under the direct supervision of an independent licensed practitioner or an associate licensed practitioner with at least two years of full-time equivalent experience providing SUD services.

9. In residential LOC 3.7R, 3.7RE and 3.7WM, is it required for drug testing to be sent to a lab or is an instant test sufficient?

    A. Instant toxicology screens are acceptable and the cost of these supplies was considered and included in the development of the residential treatment fees. Limits on toxicology screening will apply to external laboratory testing only with guidance in PB 2022-39.

10. For 3.7WM – the standard asks for regularly monitored chemical levels in urine specimens. How often is drug testing needed for a withdrawal management program? Length of stay is very short.

    A. The standards indicate that facilities shall have a provision for regular monitoring of chemical levels in urine specimens. Therefore, programs should have policies and procedures that reflect the ability to monitor chemical levels and should assess and document that the monitoring for any given member is medically necessary. Agencies should comply with DPH regulations, their internal policies and clinical discretion regarding the frequency and type of testing for this level of care.

11. Can an APRN/MSN be considered a clinical supervisor in a 3.7WM program?

    A. The qualifications for the clinical supervisor is that they shall have a minimum of a master's degree in a behavioral health treatment services field, at least three years of full-time work experience in SUD services and be independently licensed by the State in their respective discipline. Provided that these minimum requirements are met, agencies can consider filling this position with an individual who may possess additional degrees, licenses and/or certifications. Agencies should ensure that all staff are supervised by an applicable practitioner as set forth in their applicable scope of practice.

12. For 3.7R, 3.7RE and 3.7WM, can a Physician Assistant with over 16 years of psychiatric experience provide the on-site psych services?

    A. This question concerns two sets of standards. Please see the table and responses below.

LOC	Standard	Response
3.7 R	Psychiatric consultation is available at least 5 hours per week for every 16 residents through contract or consultation. A psychiatrist or psychiatric NP shall assess the individual within 8 hours of admission by telephone or within 24 hours in person. (A) Contracted or consultation psychiatric services must be made available, as needed (B) Additional psychiatric services may be made available through consultation or referral when a presenting issue could be attended to at a later time. Such services are available within 8 hours by telephone or 24 hours in person.	Provided the minimum staffing requirements are met, a psychiatric physician's assistant operating within the scope of their licensure can provide the services outlined in this standard. We recommend that providers consult with their medical directors and psychiatric departments to develop appropriate coverage plans.
3.7 RE	A psychiatrist is available on-site at least 15 hours per week for every 16 residents and assesses the individual within 4 hours of admission by telephone and within 24 hours in person. (A) Contracted or consultation psychiatric services must be made available, as needed (B) Additional psychiatric services may be made available through consultation or referral when a presenting issue could be attended to at a later time. Such services are available within 4 hours by telephone or 24 hours in person. (C) Program is ideally staffed by a certified addiction specialist physician along with a general	A licensed psychiatrist must provide the required psychiatric services at this level of care but provided the minimum staffing requirements are met, a psychiatric physician's assistant operating within the scope of their licensure can provide the support services outlined in section B. We recommend that providers consult with their medical directors and psychiatric departments to develop appropriate coverage plans.

	psychiatrist, or by a physician certified as an addiction psychiatrist.	
3.7 WM	A physician currently licensed in the State and who is eligible to be certified by the American Board of Psychiatry and Neurology (or a PA or registered nurse practitioner) is available for onsite psychiatric consultation at least 10 hours/week per 16 residents. o Contracted or consultation psychiatric services must be made available, as needed.	Provided the minimum staffing requirements are met, a psychiatric physician's assistant operating within the scope of their licensure can provide the services in this standard. We recommend that providers consult with their medical directors and psychiatric departments to develop appropriate coverage plans.

13. For 3.7WM the standards say that a masters level clinician must have an associate license of LMSW, LPCA or MFTA but does not list LADC. Is this an oversight?

    A. The standards have been updated to state "An independently licensed or associate licensed behavioral health practitioner". LADCs are considered independently licensed behavioral health practitioners and therefore meet these minimum expectations. As such, they can fulfill any of the duties in which these minimum credentials are required.

14. Our Medical Director is a seasoned medical professional for over 35 years' experience with 25 years' experience in addictions. Would this physician qualify as a Medical Director in a 3.7WM?

    A. Please see the table below.

Standard	**Response**
Medical Director: There shall be a physician, licensed in the State who is eligible to be certified by the American Board of Psychiatry and Neurology who is ideally a certified addiction medicine physician or addiction psychiatrist who is available on call during those hours when a physician is not physically present.	The medical director is required to be a licensed physician eligible for certification as outlined in the standards. It is recommended that the agency review the certification requirements at https://www.abpn.com https://www.abms.org/board/american-board-of-psychiatry-neurology/