

Behavioral Health Recovery Program Policy Handbook

Updated July 1, 2026



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In accordance with the authority granted in Section 17a-485i of the Connecticut General Statutes (C.G.S.), notice is hereby given that, effective July 1, 2025 the Commissioner of Mental Health and Addiction Services intends to implement policies pertaining to the Behavioral Health Recovery Program (BHRP) as follows:

Section 1: Definitions

1. **“American Psychiatric Association” (APA) Clinical Practice Guidelines** - Evidence-based recommendations for the assessment and treatment of psychiatric disorders which are intended to assist in clinical decision making by presenting systematically developed patient care strategies in a standardized format.
2. **“American Society of Addiction Medicine (ASAM) Criteria”** - Comprehensive set of standards for placement, continued service, and transfer of individuals with substance use disorders (SUD) and co-occurring conditions.
3. **“Appeal”** - A formal request for review of a clinical or recovery support service provider’s service authorization or payment decision.
4. **“Authorization”** - The Contractor’s process for approving payment for covered services prior to the delivery of the service or initiation of the plan of care based on a determination by the Contractor as to whether the requested service is medically necessary and medically appropriate.
5. **“Authorized Representative”** - A person designated by the eligible recipient or a person authorized by law to act on behalf of an eligible recipient for the purpose of filing an appeal, or grievance.
6. **“Available Resources”** - Community or financial resources that cover services offered under the Behavioral Health Recovery Program.
7. **“Behavioral Health Recovery Supports Services”** - Transitional supportive services provided as an adjunct to clinical treatment services to assist eligible recipients in achieving and maintaining recovery.

8. **“Behavioral Health Recovery Supports Provider”** - An entity that has been contracted or otherwise recognized by DMHAS to provide behavioral health recovery support services under the Behavioral Health Recovery Program.
9. **“Behavioral Health Recovery Program (BHRP)”** - A program administered by DMHAS that provides behavioral health clinical and/or recovery support services for individuals who are subsidized under the CT Medicaid Husky Health insurance (federal Medicaid Program Title XIX) pursuant to Sections 1902(a)(10)(A)(i)(VIII) and 1902(k)(2) of the Social Security Act.
10. **“Behavioral Health Clinical Recovery Services”** - Services designed for the treatment of a substance use disorder(s) or both a substance use disorder and psychiatric disorder.
11. **“Behavioral Health Clinical Recovery Services Provider”** - A behavioral health provider, under agreement with the CT DSS Medicaid Husky Health insurance (federal Medicaid Program Title XIX) to provide services designed for the treatment of a substance use disorder(s) or both a substance use disorder and psychiatric disorder.
12. **“Biopsychosocial Assessment”** - A service to holistically assess an individual’s biological, psychological and social factors which are integrated and analyzed according to the role each plays in the context of an individual’s substance use and recovery. The bio-psychosocial assessment shall be completed during the admission process.
13. **“Case Management”** - Includes the process for assessment followed by recovery planning and discharge planning intended to link individuals to clinical recovery supports or basic recovery supports.
14. **“Cash Assistance”** - Financial assistance provided by the state or federal government to individuals who meet specific employability, disability, income, asset, citizenship or other eligibility requirements as defined by these entities.
15. **“CFR”** - The Code of Federal Regulations.
16. **“Commissioner”** - The Commissioner of the Department of Mental Health and Addiction Services.
17. **“Co-occurring Disorder (COD)”** - A concurrent psychiatric disorder and substance use disorder.
18. **“Credentialing/Re-credentialing Process”** - The process by which it is determined that a provider applying or re-applying to participate in BHRP has the requisite qualifications to provide behavioral health clinical or recovery support services to eligible recipients in order to be eligible to receive reimbursement from DMHAS.

19. **“DMHAS”** - The Department of Mental Health and Addiction Services or its designated agent.
20. **“DSS”** - The Department of Social Services.
21. **“Designated Agent”** - An organization under contract with DMHAS to provide utilization management, claims processing, or other administrative support services necessary for the operation of the Behavioral Health Recovery Program.
22. **“Diagnostic and Statistical Manual of Mental Disorders” (DSM, most recent edition)** - The American Psychiatric Association’s current manual for the identification and diagnosis of mental disorders. This manual includes the descriptions, symptoms and other criteria for diagnosing mental disorders including the identifying codes for reporting a classification of mental and substance use disorders.
23. **“Direct Payment”** - Payment issued by DMHAS or its designated agent directly to entities for behavioral health clinical or recovery support services provided to eligible recipients.
24. **“Discharge Plan”** - The written summary of an individual’s behavioral health service’s needs, developed in order to arrange for appropriate care after discharge or upon transfer from one level of care to another.
25. **“Eligible Recipient”** - An individual who receives behavioral health clinical or recovery support services through the Behavioral Health Recovery Program under CT Medicaid Husky Health insurance (federal Medicaid Program Title XIX).
26. **“Faith Recovery Support Services”** - Services provided in a religious or spiritual setting by spiritual leaders or staff via individual or group meetings that are designed to help persons in recovery forge supportive connections with self-selected faith communities to discover positive interests and valued social roles.
27. **“Family”** - The individual’s chosen natural support system which may include biological relatives, significant others, friends, and other supports.
28. **“Grievance”** - A complaint against a service provider in matters other than the denial, reduction, or termination of services offered under the BHRP.
29. **“Husky A”** - Connecticut’s implementation of health insurance under federal Medicaid program (Title XIX) for pregnant women, parents or caretaker relatives who have a child/children on Husky A.

30. **“Husky C”** - Connecticut’s implementation of health insurance under federal Medicaid program (Title XIX) for residents aged 65 or older, or who are aged 18 through 64 who are blind, or who have another disability. Formally known as Medicaid for the Aged/Blind/Disabled.
31. **“Husky D”** - Connecticut’s implementation of health insurance under federal Medicaid program (Title XIX) for low-income adults aged 19 through 64, also known as Medicaid for low-income adults (LIA).
32. **“Independent Housing”** - Short-term assistance provided to secure affordable and safe housing via a lease agreement with a landlord.
33. **“Job Readiness”** - Activities including, but not limited to, recent job searches, vocational/educational classes, and vocational/educational groups.
34. **“Licensed Behavioral Health Professional”** - An individual holding professional licensure in Connecticut for one of the following professions: physician who is board-certified in psychiatry, clinical social worker, marriage and family therapist, psychologist, nurse clinician who holds a clinical nurse specialty in psychiatry, licensed professional counselor, or alcohol and drug counselor (including certified alcohol and drug counselors).
35. **“Partial Denials”** - Any portion of a service request, duration, intensity or level of care determined to be ineligible in an otherwise eligible request.
36. **“Prior Authorization”** - The Contractor’s process for approving payment for covered services prior to the delivery of the service or initiation of the plan of care based on the Contractor’s determination that the requested service is medically necessary and medically appropriate.
37. **“Provider”** - A credentialed and contracted or subcontracted provider that can receive payment for BHRP Covered Services.
38. **“Payor of Last Resort”** - A state agency that will only make payments for behavioral health clinical or recovery support services to the extent that no other source of payment is available.
39. **“Quality Management”** - The process of reviewing, measuring, and working to continually improve the quality of services delivered.
40. **“Recovery”** - A process of restoring or developing a positive and meaningful sense of identity apart from one’s condition and rebuilding one’s life despite, or within the limitations imposed by that condition.

41. **“Recovery Management Services”** - Activities intended to assist individuals to identify and utilize relapse prevention skills and to increase self-sufficiency, such as obtaining gainful employment and independent living in their communities. These activities include linkage to clinical or recovery support services and are reflected on an individualized recovery plan incorporating the input of individuals and their natural supports.
42. **“Recovery Oriented Vocational Services”** - Services directed toward improving and maintaining employment and include: skills assessment and development, job coaching, job placement, resume writing, interviewing skills, and developing job retention skills.
43. **“Recovery Plan”** - A written plan, based on the individual’s strengths, needs, and preferences, developed with the individual or the individual’s authorized representative, and completed during the admission process.
44. **“Substance Use Disorder” (SUD)** - Disorders characterized by the recurrent use of alcohol and/or drugs causing clinically significant impairment or distress, including health problems, disability, and failure to meet major responsibilities at work, school, or home.
45. **“Substance Use Disorder Services”** - Services delivered for the care and treatment of individuals with substance use disorders that include biopsychosocial assessments; individual, group and family counseling; vocational counseling and educational groups; and work therapy only as approved by DMHAS.
46. **“Supported Recovery Housing Services”** - A clean, safe, drug and alcohol-free transitional living environment credentialed under the Behavioral Health Recovery Program with on-site case management services available at least eight (8) hours per day five (5) days per week.
47. **“Supported Recovery Housing Provider”** - An entity that has been contracted by DMHAS or a designated agent to provide supported recovery housing services for the Behavioral Health Recovery Program.
48. **“Transportation”** - Conveyance provided by bus pass, ride sharing or gas cards to and from Behavioral Health Recovery Program Services and supported recovery and shelter housing services.
49. **“Wellness Services”** - Activities directed towards improving one’s overall health and well-being and enhancing the eligible recipient’s recovery and that may not be covered by Medicaid.

Section 2: Covered Services

The following behavioral health clinical and recovery support services shall be covered within the Behavioral Health Recovery Program:

Clinical Recovery Supports

1. **Acute or Subacute psychiatric hospitalizations:** A medically necessary, inpatient behavioral health treatment service delivered in an institute for mental disease that meets and maintains all applicable licensing requirements of federal and state statutes or regulations pertaining to treatment of a psychiatric disability or co-occurring disorder, where an individual's admission is the result of a serious or dangerous condition that requires rapid stabilization of psychiatric symptoms. Acute or subacute psychiatric hospitalization is used when 24-hour medical and nursing supervision are required to deliver intensive evaluation, medication titration, symptom stabilization and intensive, brief treatment. Acute or subacute psychiatric hospitalization may be delivered to individuals committed under a physician's emergency certificate (PEC) or probate commitment, pursuant to section 17a-502 of the Connecticut General Statutes, and may occur on a locked psychiatric unit.

Basic Recovery Supports

1. **Basic Needs:** Goods which are provided to eligible recipients through the issuance of gift cards, transportation supports, Identification replacement, food resources, training/education assistance or other resources as defined and approved by DMHAS.
2. **Faith Recovery Support Services:** Assistance provided in a religious or spiritual setting by spiritual leaders or staff via individual or group meetings that are designed to help persons in recovery forge supportive connections with self-selected faith communities to discover positive interests and valued social roles.
3. **Independent Housing:** Short term assistance provided to secure and maintain affordable and safe housing via a lease agreement with a landlord.
4. **Recovery Management Services:** Activities intended to assist individuals in identifying and utilizing relapse prevention skills and increasing self-sufficiency such as obtaining gainful employment and independent living in their communities. These activities can include linkage to clinical or recovery support services and will

be reflected on an individualized recovery plan that incorporates the input of individuals and their natural supports.

5. **Recovery Oriented Vocational Services:** Assistance provided by a vocational provider directed toward improving and maintaining employment which may include: skills assessment and development, job coaching, job placement, resume writing, interviewing skills, and developing job retention skills.
6. **Shelter Recovery Housing:** A facility where the primary purpose is to provide temporary or transitional shelter, for the homeless or for specific populations of the homeless.
7. **Supported Recovery Housing Services:** A clean, safe, drug and alcohol-free transitional living environment with on-site case management services available a minimum of eight (8) hours per day five (5) days per week.
8. **Transportation:** Conveyance to and from Behavioral Health Recovery Program clinical recovery supports services and supported recovery housing services via bus pass or other means of passage.
9. **Wellness Services:** Activities directed toward improving overall health and well-being that enhance the eligible recipient's recovery and that are not covered by Medicaid.
10. **Other:** Any other support deemed appropriate and approved by DMHAS, or its designated agent that is intended to and has a high likelihood of enhancing the eligible recipient's recovery.

Section 3: Eligibility for Services

In order to be eligible for clinical or recovery support services under the Behavioral Health Recovery Program, an individual shall:

Clinical Recovery Supports

1. Be determined eligible by DSS under the CT Medicaid Husky Health insurance (federal Medicaid Program Title XIX).
2. Be determined by DMHAS staff or the designated agent to need covered clinical recovery supports. Such determination shall be based upon an evaluation of necessity that includes, but is not limited to:

- a. Evaluation of problems identified by the individual;
- b. Evaluation of the individual's history of behavioral health treatment services; and
- c. Meeting the criteria for a diagnosis of one or more psychiatric disabilities, substance use disorder or either primary psychiatric and co-occurring substance use or primary substance use and co-occurring psychiatric as specified in the following ranges of DSM-V-TR (or most recent version) disorders: ICD-10-CM Codes: F22-F29; F31.12-F39; F31.9-F39; F34.81-F39; F40.218-F41.9; F42.2-F42.9; F43.10-F43.9; F44.81-F44.9; F45.1-F45.9; F50.89-F50.9, F51.01-F51.5; F52.32-F52.9; F64-F64.9; F63.81-F91.9; F10.20-F19.99; F63, F65.3-F65.9; F06.8-F99; F90.0-F90.9, excluding ICD-10-CM codes for Caffeine-Related Disorders, Personality Disorders, & Tobacco-Related Disorders; , "mild" specifier; "in partial remission" specifier, "in sustained full remission" specifier.

Basic Recovery Supports

1. Be determined active by DSS under the CT Medicaid Husky Health insurance (federal Medicaid Program Title XIX); and
2. Be determined by a behavioral health clinical or recovery support provider to:
 - a. Be actively engaged in behavioral health clinical services; and
 - b. Be in need of behavioral health recovery support services and have no available resources to meet such need(s).

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

The following limitations, exclusions and non-payment for behavioral health clinical and recovery support services shall apply:

Behavioral health clinical recovery supports Limitations, Exclusions and Payment Exclusions

Limitations

1. Group therapy shall be limited to a maximum of twelve (12) individuals per group session, excluding the supervising clinician(s); and
2. Education groups shall be limited to a maximum of twenty-four (24) individuals per group session, excluding the supervising professional(s).

Exclusions and payment Exclusions

1. Any clinical recovery supports delivered to an eligible recipient with a primary diagnosis which is outside the range of DSM-V-TR disorders: ICD-10-CM Codes: F22-F29; F31.12-F39; F31.9-F39; F34.81-F39; F40.218-F41.9; F42.2-F42.9; F43.10-F43.9; F44.81-F44.9; F45.1-F45.9; F50.89-F50.9; F51.01-F51.5; F52.32-F52.9; F64-F64.9; F63.81-F91.9; F10.20-F19.99; F63, F65.3-F65.9; F06.8-F99; F90.0-F90.9,
2. Services that DMHAS determines to be experimental in nature;
3. Services that the designated agent determines are not medically necessary;
4. Services which the designated agent determines to be similar or identical that are delivered concurrently to the same eligible recipient;
5. Therapies, treatments or procedures that relate to gender affirming medical or surgical procedures;
6. Activities, treatment or items delivered to an eligible recipient for which the contracted provider does not usually charge others;
7. The day of discharge or transfer, unless the eligible recipient is discharged or transferred on the same day as he or she is admitted;
8. A leave of absence or pass from an inpatient or residential facility that occurs without staff permission or against staff advice;
9. A leave of absence or pass from an inpatient or residential facility with staff permission, if the absence is longer than 24 hours, unless authorized in advance by the designated agent;
10. Electroconvulsive therapy;

11. Hypnosis;
12. Psychological or intelligence testing;
13. Neuropsychological testing;
14. Clinical recovery supports delivered by a staff member who is not a licensed behavioral health professional, unless the following conditions are met:
 - a. The staff member is employed by or under contract with a licensed facility whose medical director or clinical supervisor has determined that the staff member is qualified to deliver behavioral health treatment services to eligible recipients;
 - b. For acute psychiatric hospitalization, the staff member is actively pursuing behavioral health licensure and is under the direct supervision of licensed behavioral health professional with at least two (2) years of experience in the delivery of behavioral health treatment services; and
 - c. The supervising clinician has signed the eligible recipient's recovery plan;
15. Clinical recovery supports delivered by staff of a licensed facility at a location other than that which is specified on the facility's license.

Behavioral health recovery supports Limitations, Exclusions and Payment

Exclusions Limitations

1. Behavioral health recovery support shall be limited to goods and services intended to assist the eligible recipient to progress toward recovery goals; and
2. Behavioral health recovery supports will only be authorized when no other available resources are identified.

Non-compliant Service Location Exclusions

When service locations do not maintain compliance with all applicable laws, regulations, and ordinances regarding zoning, building, fire, health and safety;

Independent Housing Exclusions

1. When the eligible recipient is not named in the lease as either the lessee or an authorized occupant;
2. Located outside of the State of Connecticut;
3. At a licensed behavioral health clinical services facility;
4. At a contracted supported recovery or shelter housing location; and
5. Where the eligible recipient must follow written or stated rules that are not part of the rental agreement or are not permissible by law.

Supported recovery or shelter housing Exclusions

1. Facilities not currently certified and contracted by DMHAS or its designated agent (see subsections 9 and 10 Credentialing and Contracting of these policies);
2. Not authorized by DMHAS or its designated agent;
3. The day of discharge or transfer, unless the eligible recipient is discharged or transferred on the same day as he or she is admitted;
4. A leave of absence that occurs without staff permission;
5. A leave of absence or pass if the absence is longer than 24 hours, unless authorized in advance by DMHAS, or its designated agent; and
6. Services that cannot be substantiated by appropriate documentation.

Transportation Exclusions

1. Provider or entity is not currently contracted by DMHAS; and
2. Transport is to locations other than behavioral health clinical recovery services and basic recovery support providers contracted by the Behavioral Health Recovery Program.

Basic Needs Goods Exclusions

1. Purchase of goods other than clothing and personal items for the intended eligible recipient.

Recovery Management Services, Faith Recovery Support Services, Recovery Oriented Vocational Services Exclusions

1. Provider or entity is not currently certified and contracted by DMHAS or its designated agent (see subsections 9 and 10 Credentialing and Contracting of these policies);
2. Provider or entity is not authorized by DMHAS or its designated agent.

Section 5: Service Authorizations

The following processes for authorizations of behavioral health clinical and recovery support services provided in the Behavioral Health Recovery Program shall apply:

Behavioral health clinical recovery services Prior Authorization Process

1. The prior authorization review for clinical recovery support services shall determine whether covered clinical recovery support(s) are medically necessary and confirm the appropriate level of care. Clinical recovery supports providers shall obtain prior authorization from the designated agent by contacting the designated agent before admitting a potentially eligible recipient or eligible recipient to covered clinical recovery support(s) services.
2. The clinical recovery supports provider shall provide the designated agent with the following information for the purpose of authorization review of covered clinical recovery supports requested for a potentially eligible recipient or eligible recipient:
 - a. Identifying information;
 - b. DSM-V (or most recent edition) provisional or admitting diagnosis or diagnoses;
 - c. Level of care requested;
 - d. Clinical presentation of the potentially eligible recipient or eligible recipient and justification for the requested clinical recovery support(s), including such factors as mental status, natural supports and strengths;
 - e. Recovery plan objectives;

- f. Current symptoms of a primary psychiatric disability, a substance use disorder or both;
 - g. Clinical risk assessment and relapse potential;
 - h. Medication(s) used;
 - i. Substance(s) used;
 - j. Whether the potentially eligible recipient or eligible recipient is voluntarily agreeing to treatment;
 - k. The potentially eligible recipient or eligible recipient's preference for a covered clinical recovery supports provider;
 - l. Treatment location;
 - m. Provisional discharge or aftercare plan or both;
 - n. Projected date of discharge;
 - o. Name of the potentially eligible recipient or eligible recipient's primary care physician, if any; and
 - p. All other information that the designated agent may require such as legal involvement.
3. The designated agent shall render a decision regarding prior authorization within the following time parameters: an authorization received before noon (12 PM), a determination (approval or denial) will be made before 5PM on the same business day, when pending before 7PM, a determination (approval or denial) will be made before noon the following business day, when pending after 7PM, a determination (approval or denial) will be made by 5PM the following business day, after the receipt of all information that the designated agent determines is necessary and sufficient to render a decision.
4. The approval or denial of an authorization will be made available electronically within two (2) business days and denials in writing within three (3) business days from determination from the Information Management System and sent it to the provider.
5. Upon completion of the review, the designated agent shall:

- a. Authorize the requested covered clinical recovery support(s) for a specific number of days as outlined in the utilization management parameters;
 - b. Authorize or refer to a different covered clinical recovery support(s) than requested as appropriate; or
 - c. Deny authorization, when the information received by the designated agent does not demonstrate that the requested covered clinical recovery support(s) is medically necessary.
6. Prior authorization of covered clinical recovery support(s) is not a guarantee that DMHAS will pay a clinical recovery support provider's claim for payment.

Behavioral health recovery support services Prior Authorization Process

1. The behavioral health clinical or recovery services provider shall apply for prior authorization of recovery support service(s) on behalf of an eligible recipient through submission of the web-based application to DMHAS, or its designated agent, after ensuring that all fields have been completed accurately.
2. At a minimum, the application shall include:
 - a. The eligible recipient's identifying information;
 - b. The type(s) of basic recovery support(s) being requested;
 - c. Individual's behavioral health recovery services information, including the eligible recipient's admission date, type of treatment, provider and provider identifying information; and
 - d. A valid release of information, provided to DMHAS, or its designated agent signed by the eligible recipient consenting to the release of confidential information related to the behavioral health recovery supports application.
3. DMHAS, or its designated agent, may request additional information relevant to the type of behavioral health recovery support(s) being requested when necessary.
4. The provider shall ensure that an application for behavioral health recovery support(s) is submitted to DMHAS, or its designated agent, not later than thirty (30) business days after the provider has conducted an assessment to determine the eligible recipient's need for the support(s).

5. Upon receipt of a properly completed application for behavioral health recovery support(s), DMHAS or its designated agent may authorize such request, provided the following determinations have been made:
 - a. The information required by the eligibility subsection of these policies has been verified by DMHAS or its designated agent;
 - b. The requested behavioral health recovery support(s) is a covered service as described in subsection 2 of these policies;
 - c. DMHAS, or its designated agent, has determined that there are no other available resources for which support(s) are being requested;
 - d. The eligible recipient has not exceeded the maximum behavioral health recovery support(s) program utilization management parameters allowance; and
 - e. Funding is available to provide the requested behavioral health recovery support(s).
6. The designated agent shall notify the applying provider regarding the disposition of the request for authorization for behavioral health recovery support(s) not later than five (5) business days after a complete application is received. Notification will prompt provider to log in to the website to view details. Specific instruction on how to navigate to determinations is provided in the User Manual.
7. The approval or denial of an authorization will be made available electronically within two (2) business days and denials in writing within three (3) business days from determination from the Information Management System and sent it to the provider.
8. Authorization of requests for behavioral health recovery support services may extend for a period not to exceed thirty (30) days. After the first approved thirty (30) day period, requests for continued authorizations may be made in accordance with Section 5 of these policies.
9. Prior authorization of covered behavioral health recovery support(s) is not a guarantee payment for a behavioral health recovery support service provider's claim.

1. The continued authorization review shall determine whether previously authorized covered clinical recovery support(s) continue to be medically necessary. If a provider of a previously authorized clinical recovery support(s), determines that additional care may be needed beyond that which has been previously authorized, the provider shall contact the designated agent by telephone not less than four (4) hours prior to the expiration of the existing authorization for acute psychiatric hospitalization and not more than forty-eight (48) hours prior to the expiration of the existing authorization for other clinical recovery supports in order to obtain a continued authorization.
2. The provider of clinical recovery support(s) shall furnish all information that may be requested by the designated agent for the purpose of determining continued authorization of clinical recovery support(s) requested for a potentially eligible recipient or eligible recipient, including, but not limited to, the following:
 - a. Identifying information;
 - b. DSM-V (or most recent edition) current diagnosis or diagnoses;
 - c. Level of care requested;
 - d. Clinical presentation of the potentially eligible recipient or eligible recipient and justification for the requested clinical recovery supports, including such factors as mental status, and strengths;
 - e. Recovery plan objectives;
 - f. Current symptoms of mental illness or primary mental health and co-occurring substance use disorders or both;
 - g. Clinical risk assessment and relapse potential;
 - h. Medication(s) used;
 - i. Substance(s) used;
 - j. Whether the potentially eligible recipient or eligible recipient is voluntarily agreeing to treatment;
 - k. Potentially eligible recipient or eligible recipient's preference for a clinical recovery support(s) and provider;
 - l. Treatment location;

- m. Provisional discharge or aftercare plan or both;
 - n. Projected date of discharge;
 - o. Name of the potentially eligible recipient or eligible recipient's primary care physician, if any; and
 - p. All other information that the designated agent may require such as legal involvement.
- 3. The designated agent shall render a decision regarding continued authorization, designated agent shall render a decision regarding prior authorization within the following time parameters: an authorization received before noon (12 PM), a determination (approval or denial) will be made before 5PM on the same business day, when pending before 7PM, a determination (approval or denial) will be made before noon the following business day, when pending after 7PM, a determination (approval or denial) will be made by 5PM the following business day, after the receipt of all information that the designated agent determines is necessary and sufficient to render a decision.
 - 4. The approval or denial of an authorization will be made available electronically within two (2) business days and denials in writing within three (3) business days from determination from the Information Management System and sent it to the provider.
 - 5. Upon completion of the review, the designated agent shall:
 - a. Authorize the requested clinical recovery support(s) for a specific number of days over a specified time period as outlined in the utilization management parameters;
 - b. Authorize or refer to different clinical recovery support(s) than requested as appropriate; or
 - c. Deny authorization when the information received by the designated agent does not demonstrate that the requested clinical recovery support(s) is medically necessary.
 - 6. Continued authorization of a clinical recovery support(s) is not a guarantee payment for a clinical recovery support provider's claim.

1. The behavioral health recovery support provider may apply for continued authorization of behavioral health recovery support service(s) on behalf of an eligible recipient through submission of the web-based application to DMHAS, or its designated agent, after ensuring that all fields have been completed accurately.
2. At a minimum, the application shall include:
 - a. The eligible recipient's identifying information;
 - b. The type of behavioral health recovery support(s) being requested;
 - c. Behavioral health clinical services information, including the eligible recipient's admission date, type of treatment, provider, and provider identifying information;
 - d. A valid release of information, provided to DMHAS, or its designated agent, signed by the eligible recipient consenting to the release of confidential information related to the behavioral health recovery support(s) application;
 - e. Evidence of specific steps taken by the eligible recipient toward employment and independent functioning; and
 - f. Any other information requested by DMHAS, or its designated agent, needed to determine ongoing qualification.
3. The designated agent shall notify the applying provider regarding the disposition of the request for a continued authorization for behavioral health recovery support(s) not later than five (5) business days after a complete application is received. Notification will prompt provider to log in to the website to view details. Specific instruction on how to navigate to determinations is provided in the User Manual.
4. The approval or denial of an authorization will be made available electronically within two (2) business days and denials in writing within three (3) business days from determination from the Information Management System and sent it to the provider.
5. Continued authorization of a covered behavioral health recovery support is not a guarantee that DMHAS will pay a behavioral health recovery support provider's claim for payment.

Section 6: Recovery and Discharge Planning

Recovery Planning

A recovery plan shall be developed by behavioral health clinical or recovery support providers with each eligible recipient.

Behavioral health clinical support provider recovery planning

The recovery plan shall:

1. Be developed with participation from the eligible recipient or, if the eligible recipient does not participate in its development, shall contain a written explanation as to why the eligible recipient did not participate;
2. Include the following:
 - a. Eligible recipient's preferences, interests, strengths and areas of health;
 - b. Specific outcomes that the eligible recipient desires related to the eligible recipient's preferences, interests, strengths and areas of health; and
 - c. Activities, supports, housing, employment and other recovery supports that may assist with the achievement of the eligible recipient's desired outcomes;
3. Be reviewed regularly and, if necessary, revised; and
4. Contain signatures of the eligible recipient, clinical provider or case manager responsible for the recovery plan, if required by these policies.

Behavioral health supported recovery housing provider recovery planning

The recovery plan shall:

1. Be developed with participation from the eligible recipient or, if the eligible recipient does not participate in its development, shall contain a written explanation as to why the eligible recipient did not participate;
2. Include the following:
 - a. Eligible recipient's preferences, interests, strengths and areas of health;
 - b. Specific outcomes that the eligible recipient desires related to the eligible recipient's preferences, interests, strengths and areas of health; and

- c. Activities, supports, housing, employment and other recovery supports that may assist with the achievement of the eligible recipient's desired outcomes;
3. Be reviewed regularly and, if necessary, revised; and
4. Contain signatures of the eligible recipient, clinical provider or case manager responsible for the recovery plan, if required by these policies.

Discharge Planning

A discharge plan shall be developed by the behavioral health clinical or recovery supports provider with each eligible recipient.

Behavioral health clinical support provider discharge planning

1. Be developed with participation from the eligible recipient or, if the eligible recipient does not participate in its development, shall contain a written explanation as to why the eligible recipient did not participate; and
2. Reflect the following:
 - a. Discharge date;
 - b. Identifying information;
 - c. DSM-V, or its replacement, discharge diagnosis;
 - d. Progress made toward the accomplishment of recovery plan objectives;
 - e. Clinical presentation at the time of discharge, including such items as his or her mental status and response to treatment;
 - f. Clinical risk and relapse potential;
 - g. Medication(s) used during the present treatment episode;
 - h. Circumstances of discharge, including whether the eligible recipient left upon completion of treatment or under some other discharge status and the details of that status;
 - i. Involvement in discharge planning;

- j. Details of the discharge or aftercare plan or both for the eligible recipient, including the level of care recommended by the discharging provider and details of arrangements made to secure that care;
 - k. Living arrangement(s) and address upon discharge; and
 - l. Arrangements for any medication(s) that may be needed by the eligible recipient following discharge.
3. Except when the eligible recipient leaves the facility unexpectedly, the provider of clinical recovery supports shall contact the designated agent to request a discharge review not more than two (2) business days, and not less than four (4) hours, before the eligible recipient's scheduled departure. Reviews of unexpected discharges shall be conducted not later than one (1) business day following the date of the eligible recipient's discharge. If an eligible recipient leaves a facility but is expected to return, the provider of clinical recovery supports may delay the discharge review until either the eligible recipient returns or a decision is made to discharge the eligible recipient. The clinical recovery support provider shall conform to generally accepted standards of professional practice regarding the duration of time such provider shall delay a discharge decision for an eligible recipient who left the program unexpectedly and has not returned.

Behavioral health supported recovery housing provider discharge planning

The discharge plan shall:

- 1. Be developed with participation from the eligible recipient or, if the eligible recipient does not participate in its development, shall contain a written explanation as to why the eligible recipient did not participate; and
- 2. Reflect the following:
 - a. Discharge date;
 - b. Identifying information;
 - c. Progress made toward the accomplishment of recovery plan objectives;
 - d. Status at the time of discharge, including relapse potential, engagement in behavioral health clinical services, and employment;

- e. Circumstances (reason) of discharge and the details of that status;
- f. Involvement in discharge planning;
- g. Details of the discharge for the eligible recipient, including any additional behavioral health recovery supports being recommended by the clinical or recovery support provider and details of arrangements made to secure such supports;
- h. Living situation or arrangement(s) and address upon discharge; and
- i. Arrangements for any medication(s) belonging to the recipient following discharge.

Section 7: Quality Management

Providers of behavioral health clinical and supported recovery housing services shall:

1. Comply with all state and federal requirements pertaining to the communication, storage, dissemination, and retention of confidential information regarding potentially eligible recipients and eligible recipients including the Health Insurance Portability and Accountability Act (HIPAA); 45 CFR 164, 42 CFR 2; and 17a-688(c) and Chapter 899 of the Connecticut General Statutes; and other such laws and regulations as may apply. In addition, the provider shall assume responsibility for obtaining any release of information that may be necessary to meet contractual data transmittal, and basic or clinical recovery supports coordination requirements.
 - a. The provider recognizes the restrictions of 42 CFR Part 2 upon the disclosure and use of alcohol and substance use disorder patient records which are maintained in connection with the performance of any federally assisted alcohol and substance use disorder program;
 - b. If the provider is a Qualified Service Organization under 42 CFR Part 2, then the Contractor acknowledges that in receiving, storing, processing or otherwise dealing with any patient records from the programs, it is fully bound by 42 CFR Part 2; and
 - c. The provider will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by 42 CFR Part 2.
2. The provider recognizes that records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance

of any program or activity relating to substance use disorder education, prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided by law, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under 42 USC 290dd-2 and the regulations prescribed to carry out the purposes of that section.

3. Report every critical incident to the DMHAS Office of the Commissioner, or designee, including review summary and recommendations, in the form and manner specified by DMHAS.
4. Submit to DMHAS or its designated agent timely and accurate information in the format specified by DMHAS or its designated agent. This information includes, but is not limited to, the following:
 - a. Demographic data regarding the eligible recipients served;
 - b. Descriptions of the behavioral health clinical or recovery supports received;
 - c. Descriptions of the behavioral health clinical or recovery support provider's staff sufficient for DMHAS to assess the behavioral health clinical or recovery supports provider's cultural competency;
 - d. Eligible recipients' outcomes;
 - e. Census counts;
 - f. Eligible recipients' services records or charts;
 - g. Results of risk assessment screenings (when appropriate).

Section 8: Provider Application

The following provider application requirements for the provision of behavioral health clinical or recovery support services provided in the Behavioral Health Recovery Program shall apply:

Behavioral health clinical recovery support provider applications

1. A provider of behavioral health treatment services interested in participating in the behavioral health recovery program as a clinical recovery supports provider shall submit an application during an open competitive procurement process available through DMHAS or the designated agent. The application shall be

completed by the provider and shall include, at a minimum, the following information:

- a. Name, address, telephone number and contact person;
 - b. Target population, including age groups and genders treated;
 - c. Level(s) of care or other service types offered and capacity for each;
 - d. Treatment/program specialties;
 - e. Staff licenses, competencies and language(s) spoken;
 - f. A copy of the facility license(s); and
 - g. A copy of the facility malpractice insurance certificate.
2. The interested provider shall complete the application and return it to DMHAS or the designated agent by the due date and time as requested in the competitive procurement process. If an application is not submitted within the required time frame, DMHAS shall not accept the application per the competitive procurement guidelines.

The clinical support services provider shall be required to submit to DMHAS, or the designated agent, additional information or clarification, if any discrepancies or questions are identified.

DMHAS retains the right to deny an application based on a competitive procurement process, the information contained in the application, or the current needs of the Behavioral Health Recovery Program.

Behavioral health recovery support provider

1. A provider of shelter housing or supported recovery housing, transportation, faith recovery support, recovery oriented vocational or recovery management services or other recovery support service interested in participating in the Behavioral Health Recovery Program as a behavioral health recovery supports provider shall submit an application during an open competitive procurement process available through DMHAS or the designated agent. The application shall be completed by the provider and shall include, at a minimum, the following information:
 - a. Name, address, telephone number and contact person;

- b. Target population to be served, including age groups and genders;
 - c. Service types offered and capacity for each;
 - d. Staffing patterns, competencies, and languages spoken;
 - e. A copy of the commercial liability insurance certificate; and
 - f. Verification of adherence to local zoning laws.
2. The interested provider shall complete the application and return it to DMHAS, or its designated agent, by the due date and time as requested in the competitive procurement process. If an application is not submitted within the required time frame, DMHAS, or its designated agent, shall not accept the application per the competitive procurement guidelines.

The recovery support services provider shall be required to submit to DMHAS, or the designated agent, additional information or clarification, if any discrepancies or questions are identified.

DMHAS retains the right to deny an application based on a competitive procurement process, the information contained in the application, or the current needs of the Behavioral Health Recovery Program.

Section 9: Credentialing

Behavioral Health Recovery Program Credentialing Overview

A provider seeking to deliver the services in the Behavioral Health Recovery Program shall comply with the applicable credentialing requirements

- Acute psychiatric hospitalization
- Faith Recovery Support Services;
- Recovery Management Services;
- Recovery Oriented Vocational Services;
- Supported Recovery Housing Services;
- Transportation; or
- Other Recovery support service that may be offered by the Behavioral Health Recovery Program.

1. The purpose of the credentialing process is for DMHAS, or its designated agent, is to determine if a provider applying to participate in the Behavioral Health Recovery Program has the requisite qualifications. The provider shall be required to meet all credentialing criteria as specified in this section. If any of the credentialing criteria are not met, the provider shall be denied participation in the Behavioral Health Recovery Program.
2. The credentialing process shall include the assessment and validation of qualifications determine whether the provider is qualified to deliver specific behavioral health clinical or recovery support services. If DMHAS, or its designated agent, determines that a provider has not met the required qualifications as specified in this section, DMHAS or its designated agent shall not contract with the provider.
3. DMHAS, or its designated agent, shall collect and review documentation that includes, but is not limited to:
 - a. Compliance with appropriate zoning, licensure, or accreditation as applicable to the behavioral health recovery support service;
 - b. Experience in providing behavioral health recovery supports;
 - c. Evidence of adequate insurance; and
 - d. Descriptions detailing programmatic and staffing information for each behavioral health clinical or recovery supports proposed for credentialing.
4. The provider shall be required to submit to DMHAS, or its designated agent, additional information or clarification, if any discrepancies or questions are identified.
5. A provider that has had a contract terminated by DMHAS, or its designated agent, or for violations while participating in a Medicaid program and/or has been sanctioned by DSS for violations while participating in the Medicaid program shall not be credentialed as a clinical or recovery support provider for the Behavioral Health Recovery Program.
6. The designated agent shall make a recommendation to DMHAS regarding whether the provider meets the minimum necessary credentialing qualifications to offer the proposed behavioral health recovery supports. DMHAS, in its sole discretion, shall decide whether to accept the recommendation of the designated agent.

7. DMHAS, or its designated agent, shall notify the provider of the outcome of the credentialing process. If DMHAS, or its designated agent, determines that the provider meets the requisite credentialing qualifications as specified in this section, then the contracting process may be initiated as specified in Section 10 of these policies.
8. A provider that is denied participation in the Behavioral Health Recovery Program may request reconsideration of such denial. Such request shall be submitted in writing to the DMHAS Commissioner not more than ten (10) calendar days following the date of receipt of the denial notice.
9. Credentialing criteria required to deliver covered behavioral health clinical or recovery support services under the Behavioral Health Recovery Program are as follows:

Clinical Support Services Credentialing

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

1. Meets and maintains all applicable licensing requirements of federal and state statutes or regulations;
2. Delivers acute psychiatric hospitalization on a psychiatric unit that is separate and distinct from a medical unit;
3. Except as provided by state law, maintains professional liability insurance coverage of at least three million dollars (\$3,000,000) per occurrence and ten million dollars (\$10,000,000) in aggregate or, if self-insured, provides documentation that it maintains a fiscally sound, dedicated trust or account funded for the purpose of covering professional liability;
4. Is Joint Commission-accredited;
5. Includes the following staff, licensed by the state of Connecticut and employed by or under contract with the facility in which acute psychiatric hospitalization operates:
 - a. A medical director;
 - b. A board-certified or board-eligible psychiatrist;
 - c. A psychologist;

- d. Social workers;
 - e. A physician on site 24 hours per day, seven (7) days per week; and
 - f. Registered nurses on site 24 hours per day, seven (7) days per week.
- 6. Maintains the ability to conduct an admission 24 hours per day, seven (7) days a week;
 - 7. Conducts a diagnostic evaluation, including screening for a co- occurring substance use disorder, a bio-psychosocial assessment and a risk assessment;
 - 8. Conducts a medical history and physical examination upon admission;
 - 9. Performs medication evaluation and monitoring;
 - 10. Conducts medical management and monitoring of coexisting medical problems, except that life support systems or a full array of medical services are not required;
 - 11. Performs appropriate observation and takes precautions for individuals who may be suicidal;
 - 12. Develops a recovery plan with each individual;
 - 13. Conducts individual and group therapy and, when indicated, family therapy;
 - 14. Delivers rehabilitative social and recreational therapies, when indicated;
 - 15. Delivers laboratory services, when indicated; and
 - 16. Completes discharge planning that helps ensure the continuation of appropriate treatment.

Supported Recovery Housing Services Credentialing

Supported Recovery Housing Services shall be delivered in a facility that:

- 1. Meets and maintains all compliance with all state and federal regulatory requirements as well as local zoning, fire, and safety laws.
- 2. Maintains workers' compensation as required by the State of Connecticut;

3. Maintains commercial liability insurance as required by the State of Connecticut;
4. Employs or contracts with a supervisor with authority over all services, who shall have a minimum of at least one (1) year of full-time work experience with individuals with a substance use disorder, or with a co-occurring substance use and mental health disorders;
5. Provides on-site staff eight (8) hours per day, five (5) days per week and with on-call staff availability 24 hours a day 7 days per week.
6. Maintains a sufficient number of staff to deliver the proposed supported recovery housing in order to satisfy the needs of individuals served;
7. Completes a DMHAS approved Initial Intake Assessment,
8. Develops a DMHAS approved, individualized recovery plan, designed to achieve those goals is completed after the intake assessment, and developed in collaboration with the individual;
9. Delivers to each individual a minimum of no less than 60 minutes per week to support residents in securing substance use treatment and/or community-based recovery services including employment, long-term housing, etc. necessary for sustained recovery;
10. Provides a detailed orientation to services available, program rules and expectations, their rights and responsibilities, grievance procedure and referral to other recovery support services such as self-help/mutual support groups, behavioral health treatment services including medication assisted treatment, medical services, housing, employment, and transportation;
11. Completes discharge planning with each individual specifying the continuation of appropriate treatment services, employment, and transition to permanent housing;
12. Performs directly or assists with conducting random drug/alcohol screenings on each individual at least once per week or more frequently when substance use is suspected;
13. Shall not preclude admission of individuals based on the individual participating in Medication Assisted Treatment (MAT), taking prescription medication deemed necessary by a prescribing physician, and or whose co-occurring conditions are stable and do not require medical monitoring;

14. Maintains procedures for safe storage and self-administration of all residents' medications;
15. Agrees to participate in facility inspections annually or as required to ensure contract compliance by DMHAS and/or the designated agent;
16. Agrees to participate in the program's compliance and grievance investigation procedures including allowing access to the facility to DMHAS and/or ABH within 24 hours of reported serious events.

Transportation Services Credentialing

Transportation services shall:

1. Meet and maintain all licenses and other federal, state, and local statutes or regulations;
2. Maintain workers' compensation as required by the State of Connecticut;
3. Maintain commercial liability insurance as required by the State of Connecticut;
4. Employ or contract with a supervisor with authority over all services, who shall have a minimum of at least one (1) year of full-time work experience with individuals with substance use disorders; or with co-occurring substance use and mental health disorders; and
5. Maintain a sufficient number of staff to deliver the proposed livery transportation in order to meet the needs of individuals.

Section 10: Contracting

1. DMHAS, in its sole discretion, may offer an extension, to contract with a current contracted provider who has been credentialed to deliver a service under the Behavioral Health Recovery Program.
2. A provider who has been credentialed shall not participate in the Behavioral Health Recovery Program unless the provider has executed a contract with DMHAS, or its designated agent, to deliver a service under the Behavioral Health Recovery Program. The contract shall specify the terms and conditions to which the behavioral health clinical or recovery support services provider must adhere in order to participate in the Behavioral Health Recovery Program.
3. DMHAS, or its designated agent, shall not pay a provider who has not been

credentialed and contracted to deliver services under the Behavioral Health Recovery Program in the absence of a fully executed contract.

4. DMHAS, or its designated agent acting on DMHAS's behalf, may terminate a contract with a behavioral health clinical or recovery supports provider after giving the behavioral health recovery support provider a thirty (30) calendar days written notification or such notice as otherwise required by law and regulation. The commissioner, in his or her sole discretion, may terminate the contract for reasons that include, but are not limited to, the following:
 - a. Loss, revocation, suspension, surrender or non-renewal of any credential required by subsection 9 of these policies, such as the facility license or any other credential required as a condition of eligibility;
 - b. The behavioral health clinical or recovery support service provider has a diminished ability to provide behavioral health clinical or recovery support(s) legally, including disciplinary action by a governmental agency or licensing board that impairs the contracted provider's ability to operate;
 - c. Failure to comply with DMHAS's, or its designated agent's, credentialing and re-credentialing requirements;
 - d. Failure to notify DMHAS, or its designated agent, of any event that would affect or modify the information contained in the behavioral health clinical or recovery support provider's application for participation in the Behavioral Health Recovery Program;
 - e. Disciplinary action by any other state, governmental agency, or licensing board;
 - f. Termination of, or failure to maintain, adequate insurance coverage;
 - g. Fraud, such as, the behavioral health clinical or recovery support service provider:
 - i. Presents a false claim for payment;
 - ii. Accepts payment for goods or services delivered that exceeds the amount due for the goods or behavioral health clinical or recovery support delivered to eligible recipients;
 - iii. Solicits to deliver or delivers behavioral health clinical or recovery support(s) for any eligible recipient, knowing that such eligible recipient is not in need of such behavioral health recovery supports;

- iv. Accepts from any person or source other than the Behavioral Health Recovery Program any additional compensation in excess of the amount authorized; or
 - v. Presents a claim for payment to DMHAS or its designated agent for behavioral health clinical or recovery support(s) that were not delivered to an eligible recipient;
 - h. Failure to comply with the terms and conditions established in the contract;
 - i. Failure to comply with DMHAS's, or its designated agent's, quality management and utilization review, as specified in Sections 5 and 7 of these policies;
 - j. Failure to deliver behavioral health clinical or recovery support(s) to eligible recipients in an ethical manner;
 - k. Neglect of, or failure to, perform behavioral health clinical or recovery support(s) provider duties as specified in the contract with DMHAS, or its designated agent;
 - l. Failure to implement corrective action required by DMHAS, or its designated agent, as the result of an audit as specified in section 13 of these policies;
 - m. Any other breach of the clinical or recovery support provider's contract that is not corrected by the provider not later than thirty (30) calendar days after receipt of notice from DMHAS, or its designated agent; or
 - n. Failure to repay an overpayment made by DMHAS or its designated agent within the specified timeframe.
5. DMHAS, or its designated agent, may terminate a behavioral health clinical or recovery support provider's contract without prior notice, based upon any of the following circumstances:
- a. DMHAS determines that behavioral health clinical or recovery support provider or such operations poses imminent potential harm to the health, welfare or safety of recipients; or
 - b. Funding for the contract is no longer available.
6. DMHAS, or its designated agent, shall provide written notification to the behavioral health clinical or recovery support provider of the specific reasons for taking such action in writing within five (5) business days of contract termination.

7. If the Commissioner seeks to terminate a behavioral health clinical or recovery support provider's contract for any reason as specified in this section, the behavioral health clinical or recovery support provider shall receive written notification from DMHAS, or its designated agent, and an opportunity to respond in writing and/or in person as specified in Section 14 of these policies.
8. The contract is effective through the date specified in the contract and, if not renewed, it is considered expired without prejudice to the behavioral health clinical or recovery support provider.

Section 11: Claims Administration

Behavioral health clinical or recovery supports providers shall only be paid for covered behavioral health clinical or recovery support services when:

1. Such supports are delivered to eligible recipients who have been determined to be eligible as specified in section 3 of these policies; and
2. The behavioral health clinical or recovery support provider received all applicable prior authorizations and continued authorizations as specified in these policies.

The behavioral health clinical or recovery support provider shall verify that DSS has determined the individual eligible as defined in section 3 under BHRP.

Each claim for payment shall contain evidence that the behavioral health clinical or recovery support provider complied with all applicable prior authorization and continued authorization requirements as specified in these policies.

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

DMHAS, or its designated agent, shall not make payments to a behavioral health clinical or recovery supports provider for appointments missed by an eligible recipient. A behavioral health clinical or recovery supports provider shall not bill an eligible recipient for missed appointments.

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

supports provider mutually agree upon an alternative timetable for the provision of said cost information.

Behavioral health clinical support provider claims filing and payment

1. The clinical recovery supports provider shall file claims for payment not later than 180 calendar days after the date on which the clinical recovery supports were delivered, unless there is a delay due to the need for coordination of benefits or DMHAS finds other good cause. If the clinical recovery supports provider is unable to file a timely claim for payment because DSS has not determined an individual's eligibility for medical services then the clinical recovery supports provider shall file a claim for payment not later than 365 calendar days after the date on which the clinical recovery supports were delivered.
2. Acceptance of a behavioral health clinical support provider's claim for payment shall not be a guarantee of payment.
3. The designated agent shall accept any claims forms approved by DMHAS, including but not limited to, the CMS-1500 (formerly HCFA-1500) and the UB-04 forms.
4. Behavioral health clinical support providers shall submit claims for payment that contain all information necessary to match the invoice with the covered behavioral health clinical support delivered and, if applicable, authorization data including, but not limited to, the following:
 - a. Individual's name and address;
 - b. Individual's Medicaid ID;
 - c. Individual's current DSM edition diagnosis or diagnoses, if applicable;
 - d. Date(s) of covered behavioral health clinical support;
 - e. Type of covered behavioral health clinical support delivered to the individual;
 - f. Behavioral health clinical support provider's name and address;
 - g. Behavioral health clinical support provider's I.D. number; and
 - h. Behavioral health clinical support authorization number.
5. Payment of behavioral health clinical support providers' claims:

- a. All payments to behavioral health clinical support providers will be processed and recorded by DMHAS or its designated agent. The appropriate funds available for the Behavioral Health Recovery Program will be used as the “payor of last resort;”
- b. Behavioral health clinical support providers’ claims shall be paid in accordance with rates as specified by DMHAS;
- c. DMHAS may establish rates for the payment of covered behavioral health clinical supports by using rate setting methods including, but not limited to, the following:
 - i. A negotiated rate with a specific behavioral health clinical support provider for particular covered behavioral health clinical support or a particular level of care;
 - ii. An established per capita rate;
 - iii. Rates for eligible recipients in related diagnostic groups; and
 - iv. Bundled rates for a defined group of behavioral health clinical supports.
- d. In order to participate in the Behavioral Health Recovery Program, the behavioral health clinical support provider shall agree to accept the rates set by DMHAS;
- e. The behavioral health clinical supports provider shall be paid at the rate established by DMHAS for each covered behavioral health clinical support(s) or at the billed rate, whichever is lower;
- f. The behavioral health clinical supports provider shall not be paid for excluded or unauthorized behavioral health clinical supports services; and
- g. The clinical support provider shall not bill the eligible recipient for covered clinical or basic recovery supports.

Behavioral health recovery support provider claims filing and payment

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

2. Acceptance of a behavioral health recovery support provider's claim for payment shall not be a guarantee of payment.
3. The designated agent shall accept any claims forms approved by DMHAS, including but not limited to, the CMS-1500 (formerly HCFA-1500) and the UB-04 forms.
4. Behavioral health recovery support providers shall submit claims for payment that contain all information necessary to match the invoice with the covered behavioral health recovery supports delivered and, if applicable, authorization data including, but not limited to, the following:
 - a. Individual's name and address;
 - b. Individual's Medicaid ID;
 - c. Individual's current DSM edition diagnosis or diagnoses, if applicable;
 - d. Date(s) of covered behavioral health recovery support(s);
 - e. Type of covered behavioral health recovery support(s) delivered to the individual;
 - f. Behavioral health recovery support provider's name and address;
 - g. Behavioral health recovery support provider's I.D. number; and
 - h. Behavioral health recovery support authorization number.
5. All payments to behavioral health recovery support providers will be processed and recorded by DMHAS or its designated agent. The appropriate funds available for the Behavioral Health Recovery Program will be used as the "payor of last resort;"
6. Behavioral health recovery support providers' claims shall be paid in accordance with rates as specified by DMHAS;
7. DMHAS may establish rates for the payment of covered behavioral health recovery supports by using rate setting methods including, but not limited to, the following:
 - a. A negotiated rate with a specific behavioral health recovery supports provider for particular covered behavioral health recovery supports or a particular level of care;

- b. An established per capita rate;
- c. Rates for eligible recipients in related diagnostic groups; and
- d. Bundled rates for a defined group of behavioral health recovery supports.
- e. In order to participate in the Behavioral Health Recovery Program, the behavioral health recovery supports provider shall agree to accept the rates set by DMHAS;
- f. The behavioral health recovery supports provider shall be paid at the rate established by DMHAS for each covered behavioral health recovery supports or at the billed rate, whichever is lower;
- g. The behavioral health recovery supports provider shall not be paid for excluded or unauthorized behavioral health recovery supports services; and
- h. The clinical or basic recovery supports provider shall not bill the eligible recipient for covered clinical or basic recovery supports.

For independent housing only:

- 1. DMHAS, or its designated agent, shall pay for goods and services delivered to eligible recipients by direct payment to the appropriate entity.
- 2. DMHAS, or its designated agent, shall issue direct payments for approved services within thirty (30) business days of the authorization of such services.

Section 12: Claims for Payment Grievances

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

2. The designated agent shall notify the clinical or recovery supports provider in writing of its first-level claim for payment grievance decision not later than thirty (30) calendar days following the date of receipt of all information as determined necessary by DMHAS, or its designated agent, to render a decision.
3. A behavioral health clinical or recovery supports provider may initiate a second-level claim for payment grievance. The second-level claim for payment grievance shall be submitted in writing directly to DMHAS, or its designated agent not later than seven (7) calendar days following the date of the first-level claim for payment grievance denial decision. The second-level claim for payment grievance shall be submitted in writing and accompanied by all information as determined necessary by DMHAS to render a decision on the second-level claim for payment grievance.
4. DMHAS shall neither accept, nor review, a second-level claim for payment grievance that does not conform with the submission requirements as specified in this section, unless the designated agent has failed to respond to the behavioral health clinical or recovery supports provider within the time frame as specified in this section.
5. DMHAS shall notify the contracted provider and the individual or his or her authorized representative of its second-level appeal decision not later than seven (7) business days after DMHAS determines it has received all information necessary to render a decision. Any second-level claim for payment grievance decision issued by DMHAS, or designated agent shall be final and shall conclude the claim for payment grievance process. The second-level claim for payment grievance shall not include any right to a hearing from either DMHAS or its designated agent.

Section 13: Audit

Background

DMHAS or its designated agent may conduct audits of behavioral health recovery supports provider's clinical, programmatic, fiscal or other records to verify the accuracy of claims for payment and compliance with state law, federal law and the recovery support provider's contract or BHRP policies. Audits shall be conducted when a behavioral health recovery support has been authorized, claims have been paid or when DMHAS, or its designated agent, deems it necessary to carry out its responsibilities under state or federal law. Audits may include, but are not limited to, review of the following:

1. The behavioral health clinical or recovery supports provider's claim(s) for payment;

2. The covered behavioral health clinical or recovery supports delivered by the behavioral health clinical or recovery supports provider to an eligible recipient;
3. The behavioral health clinical or recovery supports provider's credentialing or re-credentialing information;
4. The behavioral health clinical or recovery supports provider's information supplied to DMHAS, or its designated agent, regarding a request for reconsideration of contract termination;
5. The behavioral health clinical or recovery supports provider's compliance with state and federal law and with the provider contract or BHRP policies; and
6. Whether the behavioral health clinical or recovery supports provider has engaged in any fiscal irregularities.

Maintenance and Access of Records

Behavioral health clinical or recovery support providers shall maintain records and permit DMHAS access to records as follows:

1. All financial records related to delivery of covered behavioral health clinical or recovery supports to eligible recipients for a period of not less than three (3) years after the date of expiration or termination of the Behavioral Health Recovery Program contract;
2. Eligible recipient's medical, clinical recovery supports, basic recovery supports, or other records for a period of not less than seven (7) years;
3. Fiscal records and financial statements;
4. Copies of all eligible recipients records in order to carry out its audit responsibilities; and
5. A copy of any audit report prepared by an organization other than DMHAS.

Audit Methodology

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

1. Quality of behavioral health clinical or recovery supports documentation;
2. Volume of claims for payment submitted or paid;
3. Type of claims for payment submitted or paid;
4. Quality-of-care concerns;
5. Service type;
6. Geographic area; and
7. Such other factors as deemed appropriate by DMHAS, or its designated agent.

Audit Resolution

1. When the audit is completed, DMHAS, or its designated agent, shall send the behavioral health clinical or recovery supports provider a copy of the draft audit report. The clinical or recovery supports provider shall be given the opportunity to meet with a DMHAS, or its designated agent, representative in an exit conference to discuss the findings noted in the draft audit report;
2. During the exit conference, the behavioral health clinical or recovery supports provider may submit additional documentation as a result of the findings noted in the draft audit report or behavioral health clinical or recovery supports provider may request to submit such documentation subsequent to the exit conference. The behavioral health clinical or recovery supports provider shall submit all such documentation not later than thirty (30) calendar days after the exit conference. DMHAS, or its designated agent, shall not consider documentation that is not submitted on time; and
3. DMHAS, or its designated agent, shall send the behavioral health clinical or recovery supports provider a copy of the final audit report with DMHAS's, or its designated agent's, recommendations and a statement of the proposed audit adjustments, if any.

Corrective Action

1. Not later than thirty (30) business days after receipt of the DMHAS's, or its designated agent's, final audit report, the behavioral health clinical or recovery supports provider shall submit to DMHAS, or its designated agent, a corrective action plan to address adverse audit findings, if any, included in the DMHAS's or the designated agents final report. The corrective action plan shall contain the following

elements:

- a. The name, address and telephone number of the behavioral health clinical or recovery supports provider's staff person responsible for ensuring that corrective action is implemented;
 - b. A detailed description of the corrective action(s) planned; and
 - c. The anticipated completion date of the corrective action(s).
2. If the DMHAS's, or its designated agent's, final audit report includes information that indicates a threat to the health or welfare of an eligible recipient, the behavioral health clinical or recovery supports provider shall initiate corrective action not more than 24 hours following such notification; and
 3. If the behavioral health clinical or recovery supports provider does not agree with the audit findings or believes corrective action is not required, then the corrective action plan may include a statement to that effect and specific reasons in support of such opinion.

Recovery of Overpayment

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

1. If DMHAS, or its designated agent, seeks to recover any payments to a behavioral health clinical or recovery support provider under contract with DMHAS, the behavioral health clinical or recovery support provider shall receive a thirty (30) calendar days written notification from DMHAS and an opportunity to respond in writing and/or in person as specified in section 14 of these policies; and
2. If audit adjustments require recovery of excess payments made to a behavioral health clinical or recovery supports provider who is not currently under contract with DMHAS, or its designated agent, recovery shall be sought in an action brought by the State of Connecticut against the behavioral health clinical or recovery supports provider.

Sanctions for non-compliance with DMHAS standards

1. A behavioral health clinical or recovery supports provider who, as a result of an audit, is found to be out of compliance with the provisions of these policies, may be subject to sanctions as determined by the commissioner, including but not limited to, the following:
 - a. Reduction in the number of referrals made to the behavioral health clinical or recovery support provider for one or more recovery supports;
 - b. Reduction in the capacity for which DMHAS, or its designated agent, contracts with the behavioral health clinical or recovery supports provider for one or more behavioral health clinical or recovery supports;
 - c. Suspension of referrals made to the behavioral health clinical or recovery supports provider for one or more behavioral health clinical or recovery supports;
 - d. Termination of the behavioral health clinical or recovery supports provider's credentials for one or more behavioral health clinical or recovery supports;
 - e. Termination of the behavioral health clinical or recovery supports provider's contract; and
 - f. Such other sanctions as the commissioner deems appropriate.
2. If DMHAS, or its designated agent, seeks to subject a behavioral health clinical or recovery supports provided to sanctions following an audit, the behavioral health clinical or recovery support provider shall receive a thirty (30) calendar days written notification from DMHAS, or its designated agent, and an opportunity to respond in writing and/or in person as specified in subsection 14 of these policies.

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

Any behavioral health clinical or recovery supports provider determined to have committed fraud by DMHAS' internal audit division is subject to automatic or administrative termination of Behavioral Health Recovery Program credentialing and contract, and will no longer be a credentialed and contracted behavioral health clinical or recovery supports provider for the Behavioral Health Recovery Program as noted in section 10 of these policies.

Section 14: Notice and an Opportunity to Respond for Behavioral Health Clinical and Recovery Support Providers

1. Behavioral health clinical or recovery supports providers shall receive written notification as specified in these policies and have an opportunity to respond in writing and/or in person in the following circumstances:
 - a. The behavioral health clinical or recovery supports provider is subject to recovery of payments following an audit conducted by DMHAS or its designated agent as specified in these regulations;
 - b. The behavioral health clinical or recovery supports provider is subject to sanctions following an audit conducted by DMHAS or its designated agent as specified in these; or
 - c. The commissioner has determined that the behavioral health clinical or recovery supports provider's participation in the Behavioral Health Recovery Program should be terminated for any of the reasons specified in these policies.
2. The behavioral health clinical or recovery supports provider shall request an opportunity to respond to the DMHAS, or its designated agent, determinations specified in (1) to (3) of subsection (a) of this section by submitting a written request to the commissioner, not more than thirty (30) days after the mailing of the DMHAS's, or its designated agent's, written notification to the behavioral health clinical or recovery supports provider. The request shall be mailed to: Commissioner, Department of Mental Health and Addiction Services, 410 Capitol Avenue, 4th Floor, P.O. Box 341431, Hartford, CT 06134.
3. A meeting shall be scheduled as soon as possible following the receipt of a written request from behavioral health clinical or recovery supports provider. The meeting shall be with the Commissioner's designee. At the meeting, the behavioral health clinical or recovery supports providers shall have the opportunity to respond orally and/or in writing to the DMHAS's, or its designated agent's, determinations specified in (1) to (3) of subsection (a) of this section. The opportunity to respond shall not include any right to a hearing.
4. Upon the conclusion of the meeting and/or review of the provider's written responses, the Commissioner's designee shall prepare a recommendation regarding DMHAS's intent to: (1) recover an audit adjustment; (2) impose sanctions on the behavioral health

recovery supports provider; or (3) terminate the behavioral health clinical or recovery supports provider's contract.

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

Section 15: Appeals and Fair Hearings

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

Filing Clinical Appeals

First-level appeal

1. A first-level appeal may be filed by the individual or his or her authorized representative. The first-level appeal shall be filed with the designated agent not later than seven (7) calendar days after the decision by the designated agent to deny, reduce or terminate covered behavioral health clinical or recovery support services, unless good cause is shown for late filing as determined by the designated agent. A first-level appeal is not a "contested case" pursuant to section 4-166(2) of the Connecticut General Statutes.
2. A first-level appeal shall be filed in writing with all supporting information or records. All records relating to a first-level appeal shall be kept confidential, unless disclosure is otherwise required by law or authorized in writing by the individual.
3. The designated agent, shall send written notice of the first-level appeal decision by the designated agent to the individual or his or her authorized representative and to the behavioral health clinical or recovery supports provider not later than seven (7) calendar days after the designated agent has determined it has received all information necessary to render a decision.
4. If the designated agent fails to issue a decision within seven (7) calendar days, the individual or his or her authorized representative may treat it as a denial and request further review under the second-level appeal.

Second-level appeal

1. The individual or his or her authorized representative may file a second-level appeal of a first-level appeal decision that denies, reduces or terminates covered behavioral health clinical or recovery support services. The second-level appeal shall be filed with DMHAS, or designated agent not later than seven (7) calendar days after the first-level appeal decision, unless good cause is shown for a late filing, as determined by DMHAS. A second-level appeal is not a “contested case” within the meaning of section 4-166(2) of the Connecticut General Statutes.
2. The second-level appeal shall be filed in writing with all supporting records. All records relating to the second-level appeal shall be kept confidential, unless disclosure is otherwise required by law or authorized in writing by the individual.
3. The individual or his or her authorized representative shall be sent written notice of the second-level appeal decision of DMHAS, or its designated agent not later than seven (7) calendar days after DMHAS has determined it has received all information necessary to render a decision.
4. DMHAS, or its designated agent shall neither accept nor review a written second-level appeal if a first-level appeal submitted to the designated agent is still being reviewed within the time period permitted by this section.
5. DMHAS shall notify the contracted provider and the individual or his or her authorized representative of its second-level appeal decision not later than seven (7) business days after DMHAS determines it has received all information necessary to render a decision.

Fair hearing

Any individual who requested a covered behavioral health clinical or recovery supports from the designated agent and had the covered behavioral health clinical or recovery supports denied or, if delivered, reduced or terminated without the individual’s consent and who has received an unfavorable second-level appeal from DMHAS, or its designated agent, may request a fair hearing. The process for such a hearing shall be the same as specified in sections 17a-451 (t)-10 to 17a-451 (t)-19, inclusive, of the Regulations of Connecticut State Agencies.

Filing Administrative Appeals

1. In the event that the designated agent determines that a provider did not comply with BHRP policies and procedures (e.g., not contacting the designated agent in a timely manner prior to authorization end date or prior to exhausting authorized units, whichever comes first when requesting continued stay) and subsequently

administratively denies the request for care, a provider may file an administrative appeal.

2. A first-level administrative appeal may be filed by the provider requesting the service. The administrative appeal must be filed no later than ten (10) calendar days after the decision by the designated agent to deny, reduce or terminate covered behavioral health clinical or recovery support services, unless good cause is shown for late filing as determined by the designated agent.
3. The administrative appeal must cite the denial being appealed and provide a rebuttal that includes additional information or good cause.
4. The designated agent will mail a notice of the determination to the provider within seven (7) business days following receipt of the administrative appeal. The notification shall include the principal reason for the determination. There is only one level of appeal included in the BHRP administrative appeal process. At the conclusion of the level one administrative appeal determination, the administrative appeal process is exhausted.

Section 16: Policy Availability

An electronic version of this Policy is posted on the DMHAS and/or designated agent website. A written copy of the complete text of this Policy is available at no cost, upon request, from the Department of Mental Health and Addiction Services, Attention: Managed Services Division, 410 Capitol Avenue, 4th Floor, P.O. Box 341431, MS 14MCP, Hartford, CT 06134.