Legislative Regulation Review Committee

2009-042a

Department of Mental Health and Addiction Services

GENERAL ASSISTANCE REGULATIONS

STATE OF CONNECTICUT
REGULATION
OF

Name of Agency

Department of Mental Health and Addiction Services

Concerning

Subject Matter of Regulation

DMHAS General Assistance Behavioral Health Program

Section 17a-453

The Regulations of Connecticut State Agencies are amended by adding sections 17a-453a-1 to 17a-453a-19, inclusive, as follows:

(NEW) Section 17a-453a-1. Scope

These regulations are issued pursuant to subsection (b) of section 17a-453a of the Connecticut General Statutes and govern the operation of the behavioral health managed care program for eligible recipients of medical services under the state-administered general assistance program.

(NEW) Sec.17a-453a-2. Definitions

As used in sections 17a-453a-1 to 17a-453a-19, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Acute care services" means short-term inpatient treatment for a psychiatric disability, substance use disorder or both and includes the following covered behavioral health services: acute psychiatric hospitalization, medically managed inpatient detoxification and medically monitored residential detoxification;

(2) "ASAM PPC-2R" means the American Society of Addictions Medicine Patient Placement Criteria, Second Revision;

(3) "Authorized representative" means a person designated by an individual or a person authorized by law to act on behalf of an individual;

(4) "Behavioral health services" means services designed for the treatment of persons with psychiatric disabilities, substance use disorders or both;

(5) "CARF" means the Commission on Accreditation of Rehabilitation Facilities;

(6) "Certified alcohol and drug counselor" means a person that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(7) "CFR" means the Code of Federal Regulations;

(8) "Clinical contact" means communication with direct observation of an individual in order to establish a therapeutic relationship and assist with the amelioration of identified problems;

(9) "Clinical risk" means the potential for injury or harm to self, others or property;

(10) "Commissioner" means the commissioner of the Department of Mental Health and Addiction Services (DMHAS);

(11) "Contracted provider" means a provider that is credentialed and has a contract with DMHAS to provide a covered behavioral health service under the general assistance behavioral health program as established pursuant to section 17a-453 of the Connecticut General Statutes;

(12) "Co-occurring disorder" means a concurrent psychiatric disability and substance use disorder;

(13) "Critical incident" means any event that has serious effects on an individual or others;

(14) "Designated agent" means an organization under contract with DMHAS to provide utilization management, process providers' claims for payment or provide other support services necessary for the operation of the general assistance behavioral health program established pursuant to section 17a-453a of the Connecticut General Statutes;

(15) "Discharge plan" means the written summary of an individual's behavioral health services needs, developed in order to arrange for appropriate care after discharge or upon transfer from one level of care to another;

(16) "DMHAS" or "department" means the state of Connecticut Department of Mental Health and Addiction Services;

(17) "DPH" means the state of Connecticut Department of Public Health;

(18) "DSS" means the state of Connecticut Department of Social Services;

(19) "DSM-IV" means the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition;

(20) "EMS-ID" means the unique identifier assigned to each individual applying for or receiving general assistance under Department of Social Services' (DSS) programs;

(21) "Eligible recipient" means an individual eligible for medical services under the state-administered general assistance program, pursuant to section 17b-192 of the Connecticut General Statutes, and in need of behavioral health services, as determined by DMHAS;

(22) "Emergency medical services" means services delivered to individuals suffering from medical emergencies, including psychiatric or substance use disorder emergencies. These emergency medical services include the detection and reporting of medical emergencies; initial care, transportation and care for individuals en route to health care facilities; medical treatment for the acutely ill and severely injured within emergency departments and referrals to continued care;

(23) "Facility" means the physical structure, building or portions thereof in which mental health or substance use treatment services or both are delivered;

(24) "GABHP" means the general assistance behavioral health program established pursuant to section 17a-453a of the Connecticut General Statutes;

(25) "General hospital" means a facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(26) "Individualized treatment" means treatment designed to meet a particular individual's needs, guided by a recovery plan that is directly related to a specific assessment of the individual;

(27) "Joint Commission" means the entity formerly known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO);

(28) "Level of care" means a discrete set of behavioral health services as specified in the ASAM PPC-2R or other DMHAS-authorized level-of-care placement criteria;

(29) "Licensed behavioral health professional" means a person that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations who has experience in the treatment of psychiatric disabilities, substance use disorders or both.

(30) "Medical coverage" means a plan or program that pays for medically necessary behavioral health services;

(31) "Medical necessity" or "medically necessary" means appropriate and necessary for the symptoms, diagnosis or treatment of a psychiatric disability or substance use disorder or both, as specified in DSM-IV or its successor, ASAM PPC-2R or its successor or other DMHAS authorized level-of-care placement criteria;

(32) "Panel or profile test" means certain multiple laboratory tests performed on a single specimen;

(33) "Prior authorization" means the process of obtaining prior approval from the designated agent to deliver a covered behavioral health service;

(34) "Private freestanding mental health day treatment facility" means a facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(35) "Private freestanding psychiatric hospital" means a facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(36) "Provider" means a person or entity that delivers behavioral health services;

(37) "Psychiatrist" means an individual that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(38) "Psychologist" means an individual that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(39) "Recovery" means a process of restoring or developing a positive and meaningful sense of identity apart from one's psychiatric disability or substance use disorder and then rebuilding one's life within the limitations imposed by that disability or disorder;

(40) "Recovery plan" means a written plan that directly relates to an individual's biopsychosocial assessment and that is developed with the involvement of the individual or his or her authorized representative as specified in section 17a-453a-9 of the Regulations of Connecticut State Agencies. A recovery plan also may be referred to as a treatment plan;

(41) "Rehabilitation" means the restoration of an optimum state of health by medical, psychological and social means for the specific purpose of reducing the use of substances or mitigating the effects of substance use disorders;

(42) "Relapse" means a recurrence of psychoactive substance use by an individual who has previously achieved and maintained abstinence for a significant period of time beyond withdrawal;

(43) "SAMHSA" means the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services;

(44) "State-operated facility" means a hospital or other facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations that delivers treatment for individuals with psychiatric disabilities or substance use disorders or both that is operated in whole or in part by the state of Connecticut; and

(45) "Substance use disorders services" means services delivered for the care and treatment of individuals with substance use disorders that include medical, psychiatric and biopsychosocial assessments; individual, group and family counseling; peer counseling; vocational counseling and education groups.

(NEW) Sec. 17a-453a-3. Eligibility

(a) In order to be eligible for covered behavioral health services under the GABHP, the individual shall:

(1) Be determined eligible by DSS for medical services pursuant to section 17b-192 of the Connecticut General Statutes;

(2) Be determined by DMHAS staff or the designated agent to need covered behavioral health services available through the GABHP established pursuant to section 17a-453a of the Connecticut General Statutes. Such determination shall be based upon an evaluation of medical necessity that includes, but is not limited to, evaluation of:

(A) The individual's mental status;

(B) Problems identified by the individual; and

(C) The individual's history of behavioral health services; and

(3) Meet the criteria for a diagnosis of one or more psychiatric disabilities, substance use disorders or both as specified in the following range of DSM-IV diagnostic codes:

(A) 291.1 to 292.9, inclusive; or

(B) 295.0 to 315.9, inclusive, except for diagnosis 307.89, Pain Disorder Associated with a Medical Condition.

(b) An individual who receives a covered behavioral health service and who does not satisfy the requirements of subsection (a)(1) of this section at the time he or she receives the covered behavioral health service may be eligible under GABHP established pursuant to section 17a-453a of the Connecticut General Statutes, provided that:

(1) The individual is subsequently determined by DSS to be eligible retroactively for medical services to a date that includes the date on which the covered behavioral health service was delivered;

(2) A contracted provider requests prior authorization from the designated agent before delivering the covered behavioral health service; and

(3) All other requirements of this section are met.

(NEW) Sec. 17a-453a-4. Covered behavioral health services

Section 17a-453a

The following behavioral health services shall be covered behavioral health services within the GABHP:

(1) Acute psychiatric hospitalization: A medically necessary, inpatient behavioral health service delivered in a private freestanding psychiatric hospital, general hospital or state-operated facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations that involves 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 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 psychiatric hospitalization may be delivered to individuals committed under a Physician's Emergency Certificate (PEC), pursuant to section 17a-502 of the Connecticut General Statutes, and may occur on a locked psychiatric unit;

(2) Ambulatory detoxification: A medically necessary, non-residential behavioral health service delivered in a private freestanding psychiatric hospital, general hospital, state-operated facility or other facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations to offer ambulatory chemical detoxification. Ambulatory detoxification uses prescribed medication to alleviate physical or psychological effects experienced by an individual as a result of withdrawal from a specific psychoactive substance and shall be delivered only after an evaluation has been conducted and a determination has been made that the individual is medically able to tolerate an outpatient detoxification. Ambulatory detoxification shall involve an assessment of needs, including those related to recovery supports and motivation of the individual regarding his or her continuing participation in the treatment process. Individuals shall receive a minimum of one (1) hour per week of substance use disorders services;

(3) Ambulatory detoxification with on-site monitoring: A medically necessary, non-residential behavioral health service delivered in a private freestanding psychiatric hospital,

general hospital, state-operated facility or other facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations to offer ambulatory chemical detoxification. Ambulatory detoxification with on-site monitoring shall deliver psychiatric and other behavioral health services that address the individual's problems as identified through a comprehensive biopsychosocial assessment. Ambulatory detoxification with on-site monitoring uses prescribed medication to alleviate physical or psychological effects experienced by an individual as a result of withdrawal from a specific psychoactive substance and shall be delivered only after an evaluation has been conducted and a determination has been made that the individual is medically able to tolerate an outpatient detoxification. Ambulatory detoxification with on-site monitoring shall involve an assessment of individual needs, including those related to recovery supports and motivation of the individual regarding his or her continuing participation in the treatment process. Individuals shall receive a minimum of one (1) hour of substance use disorders services per week;

(4) Chemical maintenance treatment: A medically necessary, non-residential behavioral health service delivered in a facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations to offer chemical maintenance treatment. Chemical maintenance treatment involves regularly scheduled administration of SAMHSA-approved medication, prescribed at individual dosages and shall include a minimum of one (1) clinical contact per month. More frequent clinical contacts shall be delivered if indicated in the individual's recovery plan;

(5) Initial intake evaluation: The first evaluation of an individual to determine whether it is medically necessary for the individual to be admitted to a covered behavioral health service;

(6) Intensive outpatient-mental health: A medically necessary, non-residential behavioral health service delivered in a private freestanding psychiatric hospital, general hospital, a state-operated facility or other facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations to offer psychiatric

outpatient services for adults. Each individual shall receive three (3) to four (4) hours per day, three (3) to five (5) days per week (i.e., a minimum of nine (9) hours per week) of individualized treatment that includes at least one (1) individual or group therapy session per day. Treatment shall focus on reducing symptoms, improving functioning, maintaining the individual in the community, preventing relapse and reducing the likelihood that care may be required in a more restrictive setting;

(7) Intensive outpatient-substance use: A medically necessary, non-residential behavioral health service delivered in a private freestanding psychiatric hospital, general hospital, state-operated facility or other facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations to offer intensive outpatient substance use services. Each individual shall receive three (3) to four (4) hours per day, three (3) to five (5) days per week (i.e., a minimum of nine (9) hours per week) of individualized treatment that includes at least one (1) individual or group therapy session per day. Treatment shall focus on relapse prevention and the individual's ability to manage his or her recovery;

(8) Intensive residential treatment: A medically necessary, residential behavioral health service delivered in a private freestanding psychiatric hospital, general hospital, state-operated facility or other facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations. Intensive residential treatment shall be delivered in a 24-hour setting to treat individuals with substance use disorders who require an intensive rehabilitation program. Intensive residential treatment is delivered within a fifteen (15) to thirty (30) day period and includes a minimum of thirty (30) hours of substance use disorder services per week;

(9) Intermediate or long-term treatment or care: A medically necessary, residential behavioral health service delivered in a facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations to offer intermediate or long-term treatment or care and rehabilitation. Each individual shall receive substance use disorder services to address significant problems with his or her behavior and functioning in

major life areas due to a substance use disorder and to reintegrate such individual into the community. Intermediate or long-term treatment or care shall be delivered in a structured recovery environment and shall comply with the following applicable requirements:

(A) If the facility is licensed for and delivers intermediate or long-term residential treatment, a minimum of twenty (20) hours per week of substance use disorder services shall be delivers to each individual;

(B) If the facility is licensed for care and rehabilitation and delivers long-term care, a minimum of twenty (20) hours of substance use disorder services shall be delivered to each individual per week; and

(C) If the facility is licensed for intermediate or long-term residential treatment and delivers transitional or halfway-house services, a minimum of four (4) hours per week of substance use disorder services shall be delivered to each individual;

(10) Laboratory services: Specimen testing and analysis used to establish the diagnosis and treatment of behavioral health disorders and delivered by a facility that is:

(A) Certified pursuant to the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA), 42 CFR 943; and

(B) Licensed by DPH as a clinical laboratory pursuant to section 19a-490 to 19a-491, inclusive, of the Connecticut General Statutes;

(11) Matrix intensive outpatient: A medically necessary, non-residential, evidence-based, sixteen (16)week individualized behavioral health service that is delivered in a facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations to offer outpatient treatment. Matrix intensive outpatient is designed to give individuals with substance use disorders the knowledge, structure, and support to enable them to achieve abstinence from substances and initiate recovery;

(12) Medically managed inpatient detoxification: A medically necessary, inpatient behavioral health service delivered in a private freestanding psychiatric hospital, state-operated facility or general hospital that meets and maintains all applicable licensing and certification

requirements of federal and state statutes or regulations that involves treatment of substance use disorders, where the individual's admission is the result of a serious or dangerous condition that requires rapid treatment for a substance use disorder. Medically managed inpatient detoxification is used when on-site, 24-hour medical and nursing supervision are required to deliver intensive evaluation, medication titration, symptom stabilization and intensive, brief treatment. Medically managed inpatient detoxification shall deliver evaluation for substance use disorders and withdrawal management. For individuals who have co-occurring disorders, psychiatric assessment and management shall be available. Medically managed inpatient detoxification may be delivered to patients committed under a Physician's Emergency Certificate (PEC), pursuant to section 17a-684 of the Connecticut General Statutes;

(13) Medically monitored residential detoxification: A medically necessary, inpatient behavioral health service delivered in a state-operated facility or in a facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations to offer residential detoxification and evaluation that involves treatment of a substance use disorder. Medically monitored residential detoxification shall be used when 24-hour medical and nursing supervision are required. Medically monitored residential detoxification shall deliver 24-hour substance use evaluation and withdrawal management;

(14) Observation bed-mental health: A medically necessary, inpatient behavioral health service delivered in a private freestanding psychiatric hospital, state-operated facility or general hospital that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations that involves supervised stabilization, clinical monitoring and, when necessary, laboratory testing to facilitate the formulation of an appropriate diagnosis and suitable treatment of an individual who is in urgent need of care and treatment for a psychiatric disability. Observation beds may be used for no more than twenty-three (23) hours before discharge or transfer to another level of care is required;

(15) Observation bed-substance use: A medically necessary, inpatient behavioral health service delivered in a private freestanding psychiatric hospital, general hospital, state-operated facility or residential detoxification facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations that involves supervised stabilization, clinical monitoring and, when necessary, laboratory testing to facilitate the formulation of an appropriate diagnosis and suitable treatment program for an individual who is in urgent need of care and treatment for a substance use disorder. Observation beds may be used for no more than twenty-three (23) hours before discharge or transfer to another level of care is required;

(16) Outpatient-mental health: A medically necessary, non-residential behavioral health service delivered in a general hospital, psychiatric outpatient clinic for individuals, private freestanding psychiatric hospital, state-operated facility or other facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations that involves the evaluation, diagnosis and treatment of individuals;

(17) Outpatient-substance use: A medically necessary, non-residential behavioral health service delivered in a private freestanding psychiatric hospital, general hospital, state-operated facility or other facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations to offer outpatient treatment that includes, but is not limited to, professionally directed evaluation, treatment and recovery support activities that shall be delivered in regularly scheduled sessions, usually weekly, but no less frequently than every thirty (30) days;

(18) Partial hospitalization-mental health: A medically necessary, non-residential behavioral health service delivered in a general hospital, private freestanding psychiatric hospital, state-operated facility or freestanding mental health day treatment facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations that involves intensive psychiatric treatment services. Partial hospitalization-mental health shall deliver to each individual a minimum of four (4) hours per day, three (3) to five (5) days per

week (i.e., a minimum of twelve (12) hours per week) of individualized treatment based on a recovery plan that includes at least one (1) individual or group session per day. Partial hospitalization-mental health may be delivered on a day, evening or weekend schedule. Partial hospitalization-mental health is designed to serve individuals with significant impairments resulting from psychiatric disabilities to avert hospitalization, thereby increasing an individual's level of independent functioning;

(19) Partial hospitalization-substance use: A medically necessary, non-residential behavioral health service delivered in a general hospital, private freestanding psychiatric hospital, state-operated facility or other facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations to offer day or evening treatment that includes, but is not limited to, access to psychiatric, medical and laboratory services for individuals recently discharged from an inpatient facility or whose admission to inpatient care might be averted by treatment in a day or evening program. Partial hospitalization-substance use delivers to each individual a minimum of four (4) hours per day, three (3) to five (5) days per week (i.e., a minimum of twelve (12) hours per week) of substance use disorder services, based on an individualized recovery plan that includes at least one individual or group therapy session per day.

(NEW) Sec. 17a-453a-5. Limitations, exclusions and non-payment of behavioral health services

(a) Limitations: The following limitations shall apply:

(1) DMHAS payment for outpatient therapy shall be limited to one (1) session per contracted provider, per day, for each eligible recipient for each of the following therapies, unless additional behavioral health services are authorized in advance by the designated agent:

(A) Individual therapy;

(B) Group therapy; or

(C) Family therapy;

(2) Unless authorized in advance by the designated agent, medication management delivered by the same practitioner, on the same day, for the same eligible recipient and for the principal purpose of medication monitoring or management shall not be paid separately from individual or group therapy;

(3) Group therapy sessions shall be limited to a maximum of twelve (12) individuals per group session, excluding the supervising clinician(s); education groups shall be limited to a maximum of twenty-four (24) individuals per group session, excluding the supervising professional(s);

(4) DMHAS payment for the following shall be limited to one (1) each for each eligible recipient during a twelve (12) month period, if authorized in advance by the designated agent:

(A) Neuropsychological testing; or

(B) Psychological testing;

(5) Contracted providers of chemical maintenance treatment shall deliver behavioral health services at their licensed facility location, unless otherwise authorized in advance by DMHAS;

(6) DMHAS payment for laboratory services shall be limited to one (1) unit per allowable laboratory service per eligible recipient per day, unless authorized by the designated agent;

(7) DMHAS payment for initial intake evaluations conducted by contracted providers shall only be considered when:

(A) The individual is eligible for medical services pursuant to section 17b-192 of the Connecticut General Statutes at the time of the evaluation or is found to be eligible retroactively for such benefits on the date on which the evaluation occurred;

(B) The eligible recipient does not begin treatment in a level of care other than outpatient-mental health or outpatient-substance use with the same contracted provider not later than ten (10) calendar days after the date of his or her initial evaluation;

(C) The contracted provider registers the procedure not later than fifteen (15) calendar days after the date of the evaluation;

(D) The contracted provider has not received payment for an initial intake evaluation for the same eligible recipient within the previous six (6) months; and

(E) The contracted provider has neither sought nor received payment for emergency room behavioral health services on the same day as the date of the initial intake evaluation.

(b) Excluded services: The following shall be excluded under the GABHP:

(1) Any behavioral health services delivered to an eligible recipient with a primary diagnosis which is outside the range of DSM-IV diagnostic codes of 291.1 to 292.9, inclusive; 295 to 307.88, inclusive or 307.90 to 315.9, inclusive;

(2) Behavioral health services that DMHAS determines to be experimental in nature;

(3) Behavioral health services that the designated agent determines are not medically necessary;

(4) Behavioral health services which the designated agent determines to be similar or identical that are delivered to the same eligible recipient;

(5) Behavioral health services, consultation or information delivered over the telephone;

(6) Activities that DMHAS determines are primarily for vocational or educational guidance that relate solely to a specific employment opportunity, job skill, work setting or development of an academic skill;

(7) Therapies, treatments or procedures that relate to transsexual or gender-change medical or surgical procedures; and

(8) Activities, treatment or items delivered to an eligible recipient for which the contracted provider does not usually charge others.

(c) DMHAS shall not pay a contracted provider of inpatient or residential services for the following:

(1) The day of discharge or transfer, unless the eligible recipient is discharged or transferred on the same day as he or she is admitted;

(2) A leave of absence or pass from an inpatient or residential facility that occurs without staff permission or against staff advice;

(3) 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; and

(4) Emergency room behavioral health services delivered on the same day as an acute psychiatric hospital admission or a medically managed inpatient detoxification admission to the same facility.

(d) DMHAS shall not pay a contracted provider for the following:

(1) Electroconvulsive therapy, unless delivered by a licensed psychiatrist and pre-authorized by the designated agent;

(2) Hypnosis, unless delivered by a licensed psychiatrist or psychologist and pre-authorized by the designated agent;

(3) Psychological or intelligence testing, unless delivered by a licensed psychologist and pre-authorized by the designated agent;

(4) Neuropsychological testing, unless delivered by a licensed psychologist and pre-authorized by the designated agent;

(5) Behavioral health services delivered by a staff member who is not a licensed behavioral health professional or who is not a Connecticut certified alcohol and drug counselor, unless the following conditions are met:

(A) The individual 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 services to eligible recipients;

(B) For acute psychiatric hospitalization, intensive outpatient-mental health, observation bed-mental health, outpatient-mental health and partial hospitalization-mental health only, the individual 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.

(6) Behavioral health services delivered by staff of a licensed facility at a location other than that which is specified on the facility's license;

(7) Any laboratory service delivered by a laboratory that is not in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA), 42 CFR 493;

(8) Individual laboratory tests, where it is determined by DMHAS that a panel or profile test should be conducted instead.

Sec. 17a-453a-6. Prior authorization review

(a) The prior authorization review shall determine whether covered behavioral health services are medically necessary and determine the appropriate level of care. Contracted providers shall obtain prior authorization from the designated agent by contacting the designated agent by telephone before admitting a potentially eligible or eligible recipient to a covered behavioral health service, except that contracted providers shall obtain authorization for covered outpatient services as specified in section 17a-453a-8 of the Regulations of Connecticut State Agencies.

(b) The contracted provider shall provide the designated agent with the following information for the purpose of prior authorization review of covered behavioral health services requested for a potentially eligible or eligible recipient:

(1) Identifying information;

(2) DSM-IV provisional or admitting diagnosis or diagnoses;

(3) Level of care requested;

(4) Clinical presentation of the potentially eligible or eligible recipient and justification for the requested covered behavioral health service, including such factors as mental status, natural supports and strengths;

(5) Recovery plan objectives;

(6) Current symptoms of a psychiatric disability, a substance use disorder or both;

(7) Clinical risk assessment and relapse potential;

(8) Medication(s) used;

(9) Substance(s) used; (10) Whether the potentially eligible or eligible recipient is voluntarily agreeing to treatment;

(11) Legal status of the potentially eligible or eligible recipient, if known;

(12) Potentially eligible or eligible recipient's preference for a covered behavioral health service and contracted provider;

(13) Treatment location;

(14) Provisional discharge or aftercare plan or both;

(15) Projected date of discharge;

(16) Name of the potentially eligible or eligible recipient's primary care physician, if any; and

(17) All other information that the designated agent may require.

(c) The designated agent may require a DMHAS designated mobile crisis team or another organization identified by DMHAS to collect information necessary for prior authorization of acute psychiatric hospitalization, following a face-to-face evaluation of the potentially eligible or eligible recipient.

(d) The decision regarding prior authorization shall be rendered by the designated agent not later than three (3) hours after the receipt of all information that the designated agent determines is necessary and sufficient to render a decision.

(e) Upon completion of the review, the designated agent shall:

(1) Authorize the requested covered behavioral health service for a specific number of days or sessions of treatment over a specified time period;

(2) Authorize a different covered behavioral health service than requested; or

(3) Deny authorization, when the information received by the designated agent does not demonstrate that the requested covered behavioral health service is medically necessary.

(f) Prior authorization of a covered behavioral health service is not a guarantee that DMHAS will pay contracted provider's claim for payment.

(NEW) Sec. 17a-453a-7. Continued stay authorization review

(a) The continued stay authorization review shall determine whether previously authorized covered behavioral health services continue to be medically necessary. If a contracted provider determines that additional care may be needed beyond that which has been authorized for a potentially eligible or eligible recipient, the contracted provider shall contact the designated agent by telephone not less than four (4) hours prior to the expiration of the existing authorization for acute care services and not more than forty-eight (48) hours prior to the expiration of the existing authorization for other covered behavioral health services in order to obtain a continued stay authorization.

(b) The contracted provider shall furnish all information that may be requested by the designated agent for the purpose of determining continued stay authorization of covered behavioral health services requested for a potentially eligible or eligible recipient, including, but not limited to, the following:

(1) Identifying information;

(2) DSM-IV current diagnosis or diagnoses;

(3) Level of care requested;

(4) Clinical presentation of the potentially eligible or eligible recipient and justification for the requested covered behavioral health service, including such factors as mental status, natural supports and strengths;

(5) Recovery plan objectives;

(6) Current symptoms of mental illness or substance use disorders or both;

(7) Clinical risk assessment and relapse potential;

(8) Medication(s) used;

(9) Substance(s) used;

(10) Whether the potentially eligible or eligible recipient is voluntarily agreeing to treatment; (11) Legal status of the potentially eligible or eligible recipient, if known;

(12) Potentially eligible or eligible recipient's preference for a covered behavioral health service and contracted provider;

(13) Treatment location;

(14) Provisional discharge or aftercare plan or both;

(15) Projected date of discharge;

(16) Name of the potentially eligible or eligible recipient's primary care physician, if any; and

(17) All other information that the designated agent may require.

(c) The decision regarding continued stay authorization shall be rendered by the designated agent not later than three (3) hours after the receipt of all information that the designated agent determines is necessary and sufficient to render a decision.

(d) Upon completion of the review, the designated agent shall:

(1) Authorize the requested covered behavioral health service for a specific number of days or sessions of treatment over a specified time period;

(2) Authorize a different covered behavioral health service than requested; or

(3) Deny authorization when the information received by the designated agent does not demonstrate that the requested covered behavioral health service is medically necessary.

(e) Continued stay authorization of a covered behavioral health service is not a guarantee that DMHAS will pay a contracted provider's claim for payment.

(NEW) Sec. 17a-453a-8. Alternative authorization review

(a) Web-based registration or outpatient treatment review (OTR) submission shall be the alternative methods to prior authorization review and continued stay review. The web-based

registration and OTR submission shall be in the format as determined by DMHAS or its designated agent.

(b) The alternative authorization review shall be designed to determine whether the following covered behavioral health services are medically necessary:

(1) Outpatient-substance use;

(2) Outpatient-mental health; and

(3) Chemical maintenance treatment.

(c) The contracted provider shall furnish such information as may be requested by the designated agent for the purpose of alternative authorization review of the designated covered behavioral health services requested for a potentially eligible or eligible recipient, including, but not limited to, the following:

(1) Identifying information;

(2) DSM-IV current diagnosis or diagnoses;

(3) Level of care requested;

(4) Clinical presentation of the potentially eligible or eligible recipient and justification for the requested covered behavioral health service, including such factors as mental status, natural supports and strengths;

(5) Recovery plan objectives;

(6) Current symptoms of psychiatric disability or substance use disorders or both;

(7) Clinical risk assessment and relapse potential;

(8) Medication(s) used;

(9) Substance(s) used;

(10) Whether the potentially eligible or eligible recipient is voluntarily agreeing to treatment;

(11) Legal status of the potentially eligible or eligible recipient, if known;

(12) Potentially eligible or eligible recipient's preference for a covered behavioral health service and contracted provider;

(13) Treatment location;

(14) Provisional discharge or aftercare plan or both;

(15) Projected date of discharge;

(16) Name of the potentially eligible or eligible recipient's primary care physician, if any; and

(17) All other information that the designated agent may require.

(d) The decision regarding alternative authorization shall be rendered by the designated agent not later than five (5) business days after the receipt of all information that the designated agent determines is necessary and sufficient to render a decision.

(e) Upon completion of the alternative authorization review, the designated agent shall:

(1) Authorize the requested covered behavioral health service for a specific number of days or sessions of treatment over a specified time period;

(2) Authorize a different covered behavioral health service than requested; or

(3) Deny authorization when the information received by the designated agent does not demonstrate that the requested covered behavioral health service is medically necessary.

(f) A contracted provider shall submit a written request to the designated agent to obtain authorization for an initial intake evaluation, not more than fifteen (15) calendar days following the initial evaluation, and only if the potentially eligible or eligible recipient does not begin treatment with the contracted provider within ten (10) calendar days.

(g) Alternative authorization of a covered behavioral health service specified in this section will not guarantee that DMHAS will pay providers' claims for payment.

(NEW) Sec. 17a-453a-9. Recovery and discharge planning

Except for those providing laboratory services, all contracted providers shall meet the following requirements:

(a) The contracted provider shall develop a recovery plan with each eligible recipient:

(1) The recovery plan shall 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) The recovery plan shall reflect:

(A) The 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;

(C) Activities, supports and covered behavioral health services that may assist with the achievement of the eligible recipient's desired outcomes;

(D) Regularly scheduled review and, if necessary, revision of the recovery plan; and

(E) Review by, and signatures of the eligible recipient, counselor or clinician responsible for the development of the recovery plan with the eligible recipient, and his or her supervisor if the counselor or clinician is not licensed or certified.

(b) The contracted provider shall develop a discharge plan with each eligible recipient:

(1) The discharge plan shall 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) Discharge plan review: Contracted providers are required to participate in a discharge plan review for all eligible recipients admitted into the following covered behavioral health services:

(A) Acute psychiatric hospitalization;

(B) Medically managed inpatient detoxification;

(C) Medically monitored residential detoxification;

(D) Intensive residential treatment;

(E) Intermediate or long-term treatment or care.

(c) Except when the eligible recipient leaves the facility unexpectedly, the contracted provider 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:

(1) 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 contracted provider may delay the discharge review until either the eligible recipient returns or a decision is made to discharge the eligible recipient. The contracted provider shall conform with generally accepted standards of professional practice regarding the duration of time such contracted provider shall delay a discharge decision for an eligible recipient who left the program unexpectedly and has not returned; and

(2) The discharge plan review for an eligible recipient shall include the following:

(A) Identifying information;

(B) DSM-IV discharge diagnosis;

(C) Progress made toward the accomplishment of treatment objectives;

(D) Clinical presentation at the time of discharge, including such items as his or her mental status and response to treatment;

(E) Clinical risk and relapse potential;

(F) Medication(s) used during the present treatment episode;

(G) 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;

(H) Involvement in recovery and discharge planning;

(I) Details of the discharge or aftercare plan or both for the eligible recipient, including the level of care recommended by the discharging contracted provider and details of arrangements made to secure that care;

(J) Living arrangement(s) and address upon discharge; and

(K) Arrangements for any medication(s) that may be needed by the eligible recipient following discharge.

(NEW) Sec. 17a-453a-10. Quality management

(a) Compliance with confidentiality requirements: The contracted provider shall comply with all state and federal requirements pertaining to the communication, storage, dissemination, and retention of confidential information regarding potentially eligible or eligible recipients with a psychiatric disability, a substance use disorder or both, 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 contracted provider shall assume responsibility for obtaining any release of information that may be necessary to meet contractual data transmittal and behavioral health service coordination requirements specified in these regulations.

(b) Critical incident reporting: Except for providers of laboratory services, a contracted provider shall report every critical incident to the DMHAS Office of the Commissioner in the form and manner specified by the department.

(c) Other reporting requirements: The contracted provider shall 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:

(1) Demographic data regarding the eligible recipients served;

(2) Descriptions of the covered behavioral health services delivered;

(3) Descriptions of the contracted provider's staff sufficient for DMHAS to assess the agency's cultural competency;

(4) Treatment outcomes;

(5) Results of risk assessment screenings; and

(6) A critical incident review summary, including recommendations, in the format and manner specified by the department.

(NEW) Sec. 17a-453a-11. Provider application

(a) In order to be considered for participation in the GABHP, a provider shall request in

writing an application packet from the designated agent. The application packet shall be completed by the provider and shall include all information required by DMHAS.

(b) DMHAS shall require, at a minimum, the following information from a provider:

(1) Name, address, telephone number and contact person;

(2) Age groups and genders treated;

(3) Staff licenses, competencies and language(s) spoken;

(4) Problems and disorders treated;

(5) Level(s) of care offered and capacity for each;

(6) Treatment specialties; and

(7) A copy of the state-required facility license(s).

(c) The provider shall complete the application and return it to the designated agent not more than thirty (30) calendar days after the date of receipt. If a provider does not submit a completed application within the required time frame, DMHAS, at its sole discretion, may decide not to accept the provider's application.

(NEW) Sec. 17a-453a-12. Provider credentials

(a) The provider credentialing process is described as follows:

(1) The purpose of the credentialing process is for DMHAS to determine if a provider applying to participate in the GABHP has the requisite qualifications.

(2) The credentialing process shall include the assessment and validation of qualifications of providers to determine whether the provider is qualified to offer specific levels of care and meets the credentialing requirements specified for those levels of care in this section. If DMHAS determines that a provider has not met the required qualifications as specified in this section, DMHAS shall not contract with the provider under the GABHP.

(3) The designated agent shall collect and review documentation that includes, but is not limited to:

(A) Status of facility or professional licensure, certification or accreditation;

(B) Experience in providing behavioral health services to individuals;

(C) Evidence of adequate malpractice insurance coverage; and

(D) Descriptions detailing programmatic and staffing information for each behavioral health service and level of care proposed for credentialing.

(4) The designated agent shall review the credentials of each provider for each behavioral health service or level of care that the provider proposes to deliver and shall make a recommendation to DMHAS. DMHAS shall decide whether the provider meets the credentialing qualifications necessary to offer the proposed behavioral health service(s) or level(s) of care.

(5) The provider shall be required to submit to the designated agent additional information or clarification, if any discrepancies or questions are identified.

(6) 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 GABHP.

(7) Any provider that has been sanctioned by DSS for violations while participating in the Medicaid program shall not be credentialed for the GABHP.

(8) DMHAS shall notify the provider in writing of the outcome of the credentialing process. If DMHAS determines that the provider meets the requisite credentialing qualifications as specified in this section, then DMHAS may initiate the contracting process as specified in section 17a-453a-13 of the Regulations of Connecticut State Agencies.

(b) A provider that is denied participation in the GABHP may request reconsideration of such denial. Such request shall be submitted in writing to the commissioner of DMHAS not more than ten (10) calendar days following receipt of the denial notice.

(c) Credentialing criteria that providers shall meet to qualify to deliver covered behavioral health services under the GABHP are as follows:

(1) Acute psychiatric hospitalization as specified in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

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(A) Acute psychiatric hospitalization shall be delivered in a facility that:

(i) meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations.

(ii) 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; and

(iii) Is Joint Commission-accredited.

(B) If this behavioral health service is located in a general hospital, the hospital shall deliver acute psychiatric hospitalization on a psychiatric unit that is separate and distinct from a medical unit.

(C) Acute psychiatric hospitalization shall include the following staff, licensed by the state of Connecticut and employed by or under contract with the facility in which acute psychiatric hospitalization operates:

(i) A medical director;

(ii) A board-certified or board-eligible psychiatrist;

(iii) A psychologist;

(iv) Social workers;

(v) A physician on site 24 hours per day, seven (7) days per week; and

(vi) Registered nurses on site 24 hours per day, seven (7) days per week.

(D) Acute psychiatric hospitalization components shall include:

(i) The ability to conduct an admission 24 hours per day, seven (7) days per week;

(ii) Diagnostic evaluation, including screening for a co-occurring substance use disorder, a biopsychosocial assessment and a risk assessment;

(iii) A medical history and physical examination conducted upon admission;

(iv) Medication evaluation and monitoring;

(v) Medical management and monitoring of coexisting medical problems, except that life support systems or a full array of medical services is not required;

(vi) Appropriate observation and precautions for individuals who may be suicidal;

(vii) Development of a recovery plan for each individual;

(viii) Individual and group therapy and, when indicated, family therapy;

(ix) Rehabilitative social and recreational therapies, when indicated;

(x) Laboratory services, when indicated; and

(xi) Discharge planning that helps ensure the continuation of appropriate treatment.

(2) Ambulatory detoxification as specified in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

(A) Ambulatory detoxification shall be delivered in a facility that:

(i) Meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations.

(ii) Except as provided by state law, maintains professional liability insurance coverage of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) 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; and

(iii) Is Joint Commission or CARF-accredited or has a licensed physician with experience in providing behavioral health services for substance use disorders, who is responsible for supervising all medical services and is credentialed by DMHAS as specified in the credentialing criteria contained in this section;

(B) Ambulatory detoxification shall include a clinical supervisor with authority over all behavioral health services. The clinical supervisor shall have a minimum of a master's degree in the behavioral health services field and at least three (3) years of full-time work experience in substance use disorders treatment, be licensed by the state of Connecticut or certified as appropriate in his or her respective discipline and be employed by or under contract with the facility in which the behavioral health service is operated;

(C) The organization operating ambulatory detoxification shall deliver emergency psychiatric and emergency medical services or maintain written agreements enabling immediate access for individuals, when needed, to facilities that offer such care; and

(D) Ambulatory detoxification components shall include:

(i) Initial evaluation, including screening for co-occurring psychiatric disabilities;

(ii) A physical examination by a physician, physician's assistant or nurse practitioner as part of the initial assessment;

(iii) Individual assessment and medication or non-medication methods of detoxification;

(iv) Medical supervision and management of substance withdrawal as indicated by a licensed physician and inclusive of laboratory assessments;

(v) One (1) hour of substance use disorder services per week;

(vi) Significant other or family involvement in the detoxification process, when appropriate;

(vii) Development of a recovery plan for each individual;

(viii) Laboratory services, when indicated;

(ix) The ability to provide or assist in accessing transportation for individuals who are unable to drive safely for legal or medical reasons or who otherwise lack transportation;

(xi) Discharge planning that helps ensure the continuation of appropriate treatment and movement through the recovery continuum;

(xii) Referral to self-help programs; and

(xiii) Adequate testing for or analysis of drugs of abuse as specified in applicable state and federal statutes and regulations;

(E) Substance use disorder services performed by a staff member who is not a licensed behavioral health professional or Connecticut certified alcohol and drug counselor shall meet the following conditions:

(i) The staff member is employed by or under contract with the facility;

(ii) The medical or clinical supervisor has determined that the staff member is qualified to deliver behavioral health services; and

(iii) The staff member is under the direct supervision of a licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health services or a Connecticut certified clinical supervisor.

(3) Ambulatory detoxification with on-site monitoring as specified in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

(A) Ambulatory detoxification with on-site monitoring shall be delivered in a facility that:

(i) meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(ii) Except as provided by state law, maintains professional liability insurance coverage of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) 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; and

(iii) Is Joint Commission or CARF-accredited or has a licensed physician with experience in providing behavioral health services for substance use disorders, who is responsible for supervising all medical services delivered by the program and is credentialed by DMHAS in accordance with credentialing criteria contained in this section;

(B) Ambulatory detoxification shall include a clinical supervisor with authority over all behavioral health services. The clinical supervisor shall have a minimum of a master's degree in a behavioral health services field, at least three (3) years of full-time work experience in substance use disorder treatment, be licensed by the state of Connecticut or certified as appropriate in his or her respective discipline and be employed by or under contract with the facility.

(C) The organization operating the ambulatory detoxification with on-site monitoring shall deliver emergency psychiatric and emergency medical services or maintain written

agreements enabling immediate access for its individuals, when needed, to facilities that offer such care;

(D) Ambulatory detoxification with on-site monitoring components shall include:

(i) Initial evaluation, including screening for a co-occurring psychiatric disability;

(ii) A physical examination by a physician, physician's assistant or nurse practitioner as part of the initial assessment;

(iii) Individual assessment, medication or non-medication methods of detoxification;

(iv) Medical supervision and management of substance withdrawal as indicated by a licensed physician and inclusive of laboratory assessments;

(v) A minimum of one (1) hour of substance use disorder services per week;

(vi) Significant other or family involvement in the withdrawal process when appropriate;

(vii) Development of a recovery plan for each individual;

(viii) Laboratory services, when indicated;

(ix) The ability to deliver or assist in accessing transportation for individuals who are unable to drive safely for legal or medical reasons or who otherwise lack transportation;

(x) Discharge planning that helps ensure the continuation of appropriate treatment and movement through the recovery continuum;

(xi) Referral to self-help programs; and

(xii) Adequate testing for or analysis of drugs of abuse as specified in applicable state and federal statutes and regulations;

(E) Ambulatory detoxification with on-site monitoring shall have a licensed nurse on site during all hours of operation; and

(F) Ambulatory detoxification with on-site monitoring shall have available psychiatric and other behavioral health services for problems identified through a comprehensive biopsychosocial assessment;

(G) Substance use disorder services performed by a staff member who is not a licensed behavioral health professional or Connecticut certified alcohol and drug counselor shall meet the following conditions:

(i) The staff member is employed by or under contract with the facility;

(ii) The medical or clinical supervisor has determined that the staff member is qualified to deliver behavioral health services; and

(iii) The staff member is under the direct supervision of a licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health services or a Connecticut certified clinical supervisor.

(4) Chemical maintenance treatment as specified in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

(A) Chemical maintenance treatment shall be delivered in a facility that:

(i) Meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(ii) Except as provided by state law, maintains professional liability insurance coverage of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) 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; and

(iii) Meets conditions for the use of methadone or other SAMHSA-approved medications in chemical maintenance treatment of opiate dependence, as specified in 21 CFR 291 and other applicable federal regulations; and

(iv) Is Joint Commission, CARF-accredited or COA-accredited or has a clinical supervisor with authority over all behavioral health services. The clinical supervisor shall have a minimum of a master's degree in a behavioral health services-related field and at least three (3) years of full-time work experience in substance use disorders, be licensed by the state of Connecticut or certified, as appropriate in his or her respective discipline and be employed by or under contract with the facility in which chemical maintenance treatment is operated.

(B) The organization operating chemical maintenance treatment shall deliver emergency psychiatric and emergency medical services or maintain written agreements enabling immediate access for its individuals, when needed, to facilities that offer such care;

(C) Chemical maintenance treatment components shall include:

(i) Initial intake evaluation, including screening for a co-occurring psychiatric disability;

(ii) A medical history and physical examination conducted by a physician or other appropriate medical personnel;

(iii) Laboratory services;

(iv) A minimum of one (1) clinical contact per individual per month;

(v) Medication evaluation and management;

(vi) A complete bio-psychosocial assessment;

(vii) Development of a recovery plan for each individual;

(viii) Daily administration of methadone at least six (6) days per week or administration as appropriate of another SAMHSA-approved medication; ability to dispense doses for off-premises consumption as appropriate;

(ix) Psycho-educational programming;

(x) Discharge planning that helps ensure the continuation of appropriate treatment;

(xi) Adequate testing for or analysis of drugs of abuse as specified in applicable federal and state statutes and regulations;

(xii) Vocational or pre-vocational planning; and

(xiii) Referral to self-help programs;

(D) Chemical maintenance programs shall have the ability to gradually increase to or maintain medication at a therapeutic and stable level in order to block the effects of opiates for individuals receiving such care;

(E) The facility shall have a written medication diversion plan in place that assists in the identification and management of inappropriate diversion of take-home medications; and

(F) Substance use disorder services performed by a staff member who is not a licensed behavioral health professional or a Connecticut certified alcohol and drug counselor shall meet the following conditions:

(i) The staff member is employed by or under contract with the facility;

(ii) The medical or clinical supervisor has determined that the staff member is qualified to deliver behavioral health services; and

(iii) The staff member is under the direct supervision of a licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health services or a Connecticut certified clinical supervisor.

(5) Initial intake evaluation as specified in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

(A) The initial intake evaluation shall be conducted in a facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations to offer any behavioral health service.

(B) The provider shall obtain the following information from the individual to conduct the initial intake evaluation:

(i) Demographic information;

(ii) Clinical presentation, including problems and needs;

(iii) History of psychiatric disability, substance use disorder or both and history of treatment, if any;

(iv) Other disability and treatment, if any;

(v) Current prescription medications and history of medications prescribed;

(vi) Current substance use and history of substances used previously;

(vii) Risk assessment and relapse potential;

(viii) Legal status; and

(x) All other relevant information.

(6) Intensive outpatient-mental health as specified in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

(A) Intensive outpatient-mental health shall be in a facility that:

(i) meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(ii) Except as provided by state law, maintains professional liability insurance coverage of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) 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;

(iii) Is Joint Commission or CARF-accredited or has a board-certified or board eligible psychiatrist who is responsible for supervising all medical services. If intensive outpatient-mental health is operated by a non-profit mental health agency, the psychiatrist shall be credentialed by DMHAS in accordance with credentialing criteria as specified in this section; and

(iv) Includes a clinical supervisor with authority over all behavioral health services who is licensed in a behavioral health services field and has at least three (3) years of full-time work experience in mental health treatment;

(B) Intensive outpatient-mental health shall include at least three licensed behavioral health professionals;

(C) The organization shall deliver emergency psychiatric and emergency medical services or maintain written agreements enabling immediate access for its individuals, when needed, to facilities that offer such care;

(D) Intensive outpatient-mental health shall include:

(i) Initial intake evaluation, including screening for a co-occurring substance use disorder;

(ii) Diagnostic evaluation and risk assessment;

(iii) Individual and group therapy and, when indicated, family therapy;

(iv) A complete biopsychosocial assessment;

(v) Development of a recovery plan for each individual;

(vi) Psycho-educational programming;

(vii) Psychological testing, when indicated;

(viii) Medication evaluation and management;

(ix) Discharge planning that helps ensure the continuation of appropriate treatment; and

(x) Referral to self-help programs;

(E) Intensive outpatient-mental health shall deliver to each individual three (3) to four (4) hours per day, three (3) to five (5) days per week, of programming that includes not less than one (1) individual or group therapy session per day; and

(F) Any behavioral health services, other than psycho-educational programming, performed by a staff member who is not a licensed behavioral health professional shall meet the following conditions:

(i) The staff member is employed by or under contract with the facility;

(ii) The medical director or clinical supervisor has determined that the staff member is qualified to deliver behavioral health services; and

(iii) The staff member is under the direct supervision of a licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health services and is actively pursuing a DPH professional license in a behavioral health discipline.

(7) Intensive outpatient-substance use as specified in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

(A) Intensive outpatient-substance use shall be in a facility that:

(i) meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(ii) Except as provided by state law, maintains professional liability insurance coverage of at least one million dollars ($1,000,000) per occurrence and three million dollars

($3,000,000) 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; and

(iii) Is Joint Commission or CARF-accredited or has a clinical supervisor with authority over all behavioral health services. The clinical supervisor shall have a minimum of a master's degree in a behavioral health services field, at least three (3) years of full-time work experience in substance use disorders treatment, be licensed by the state of Connecticut or certified, as appropriate in his or her respective discipline and be employed by or under contract with the facility;

(B) Intensive outpatient-substance use shall include drug and alcohol abuse counselors or other staff in related fields with experience in treatment of substance use disorders;

(C) The organization shall deliver emergency psychiatric and emergency medical services or maintain written agreements enabling immediate access for individuals, when needed, to facilities that offer such care;

(D) Intensive outpatient-substance use components shall include:

(i) Initial intake evaluation, including screening for a co-occurring psychiatric disability;

(ii) A complete biopsychosocial assessment;

(iii) Development of a recovery plan for each individual;

(iv) Orientation and referral to a self-help program;

(v) Psycho-educational programming;

(vi) Individual, group and, when indicated, family counseling;

(vii) Discharge planning that helps ensure the continuation of appropriate treatment; and

(viii) Adequate testing for or analysis of drugs of abuse as specified in applicable federal and state statutes and regulations.

(E) Intensive outpatient-substance use shall deliver to each individual three (3) to four (4) hours per day, three (3) to five (5) days per week, of substance use disorders services based on an individualized recovery plan inclusive of at least one (1) individual or group therapy session per day; and

(F) Any behavioral health services performed by a staff member who is not a licensed behavioral health professional or Connecticut certified alcohol and drug counselor shall meet the following conditions:

(i) The staff member is employed by or under contract with the facility;

(ii) The medical director or clinical supervisor has determined that the staff member is qualified to deliver behavioral health services; and

(iii) The staff member is under the direct supervision of a licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health services or a Connecticut certified clinical supervisor.

(8) Intensive residential treatment as specified in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

(A) Intensive residential treatment shall be in a facility that:

(i) meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(ii) Except as provided by state law, maintains professional liability insurance coverage of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) 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; and

(iii) Is Joint Commission or CARF-accredited or has a clinical supervisor with authority over all behavioral health services;

(B) Intensive residential treatment shall include the following staff, licensed by the state of Connecticut or certified as appropriate in their respective disciplines and employed by or under contract with the facility:

(i) A clinical supervisor with authority over all behavioral health services, who shall have a minimum of a master's degree in a behavioral health services field and at least three (3) years of full-time work experience in substance use disorders treatment and be licensed by the state of Connecticut or certified, as appropriate in his or her respective discipline;

(ii) A sufficient number of staff to meet the needs of individuals;

(C) Any behavioral health services performed by a staff member who is not a licensed behavioral health professional or a Connecticut certified alcohol and drug counselor shall meet the following conditions:

(i) The staff member is employed by or under contract with the facility;

(ii) The medical director or clinical supervisor has determined that the staff member is qualified to deliver behavioral health services; and

(iii) The staff member is under the direct supervision of a licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health services or a Connecticut certified clinical supervisor.

(D) The organization operating intensive residential treatment shall deliver emergency psychiatric and emergency medical services or maintain written agreements enabling immediate access for individuals, when needed, to facilities that offer such care; and

(E) Intensive residential treatment shall include:

(i) Initial intake evaluation, including screening for a co-occurring psychiatric disability;

(ii) A complete biopsychosocial assessment;

(iii) Development of a recovery plan for each individual;

(iv) Intensive residential treatment shall deliver to each individual a minimum of thirty (30) hours per week of substance use disorder services;

(v) Orientation and referral to a self-help program;

(vi) Discharge planning that helps ensure the continuation of appropriate treatment;

(vii) Adequate testing for or analysis of drugs of abuse as specified in applicable federal and state statutes and regulations; and

(viii) Vocational and pre-vocational planning .

(9) Intermediate or long-term treatment or care as specified in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

(A) Intermediate or long-term treatment or care shall be in a facility that:

(i) meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(ii) Except as provided by state law, maintains professional liability insurance coverage of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) 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; and

(iii) Is Joint Commission or CARF-accredited or has a clinical supervisor with authority over all behavioral health services. The clinical supervisor shall have a minimum of a master's degree in a behavioral health services field and at least three (3) years of full-time work experience in substance use disorder treatment, be licensed by the state of Connecticut or certified, as appropriate in his or her respective discipline and be employed by or under contract with the facility.

(B) Intermediate or long-term treatment or care shall deliver emergency psychiatric and emergency medical services or maintain written agreements enabling immediate access for individuals, when needed, to facilities that offer such care.

(C) Intermediate or long-term treatment or care shall include:

(i) Initial intake evaluation, including screening for a co-occurring psychiatric disability;

(ii) A biopsychosocial assessment;

(iii) Development of a recovery plan for each individual;

(iv) Orientation and referral to a self-help program;

(v) Discharge planning that helps ensure the continuation of appropriate treatment;

(vi) Adequate testing for or analysis of drugs of abuse as specified in applicable federal and state statutes and regulations;

(vii) Vocational and pre-vocational planning and one of the following shall be delivered to each individual:

(I) A minimum of twenty (20) hours per week of substance use disorders services by facilities licensed for intermediate and long-term treatment and identified as delivering intermediate and long-term residential treatment or

(II) A minimum of twenty (20) hours per week of substance use disorders services by facilities licensed for care and rehabilitation and identified as providing long-term care or

(III) A minimum of four (4) hours per week of substance use disorder services by facilities licensed for intermediate and long-term treatment and identified as providing transitional or halfway house services.

(D) Any behavioral health services performed by a staff member who is not a licensed behavioral health professional or a Connecticut certified alcohol and drug counselor shall meet the following conditions:

(i) The staff member is employed by or under contract with the facility;

(ii) The medical director or clinical supervisor has determined that the staff member is qualified to deliver behavioral health services; and

(iii) The staff member is under the direct supervision of a licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health services or a Connecticut certified clinical supervisor.

(10) Laboratory services as specified in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

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Specimen testing and analyses used to establish diagnosis and treatment of behavioral health disorders shall be delivered by a facility that is:

(A) Certified pursuant to the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA), 42 CFR 493; and

(B) Licensed as a clinical laboratory as specified in sections 19a-36-D20 to 19a-36-D38, inclusive, of the Regulations of Connecticut State Agencies.

(11) Matrix intensive outpatient as specified in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

(A) Matrix intensive outpatient shall be in a facility that:

(i) meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(ii) Except as provided by state law, maintains professional liability insurance coverage of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) 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; and

(iii) Is Joint Commission or CARF-accredited or has a clinical supervisor with authority over all behavioral health services. The clinical supervisor shall have a minimum of a master's degree in a behavioral health services field and at least three (3) years of full-time work experience in substance use disorders treatment, be licensed by the state of Connecticut or certified, as appropriate in his or her respective discipline and be employed by or under contract with the facility.

(B) Matrix intensive outpatient shall include alcohol and drug abuse counselors or other staff in related fields with experience in treatment of substance use disorders, who are licensed by the state of Connecticut or certified as appropriate in their respective disciplines and are employed by or under contract with the facility;

(C) Matrix intensive outpatient shall deliver emergency psychiatric and emergency medical services or maintain written agreements enabling immediate access for individuals, when needed, to facilities that offer such care;

(D) Matrix intensive outpatient components shall include:

(i) Initial intake evaluation, including screening for a co-occurring psychiatric disability;

(ii) A biopsychosocial assessment;

(iii) Development of a recovery plan for each individual;

(iv) Individual sessions that are scheduled weekly and consist of eight (8), one-hour meetings for the first two months, followed by one (1), one-hour meeting for the next two months;

(v) Early recovery skills groups that meet twice weekly and consist of eight (8), one-hour group sessions during the first month of treatment;

(vi) A recovery group that meets once weekly and consists of twelve (12), ninety-minute group sessions for the first three months;

(vii) A family education group that meets once weekly and consist of twelve (12), ninety-minute group sessions for the first three months;

(viii) A social support group that meets weekly and consists of ninety-minute group sessions, beginning at week thirteen;

(ix) Adequate testing for or analysis of drugs of abuse as specified in applicable federal and state statutes and regulations;

(x) Referral to a self-help program;

(xi) Discharge planning that helps ensure the continuation of appropriate treatment; and

(E) Any substance use disorder services performed by a staff member who is not a licensed behavioral health professional or Connecticut certified alcohol and drug counselor shall meet the following conditions:

(i) The staff member is employed by or under contract with the facility;

(ii) The medical director or clinical supervisor has determined that the staff member is qualified to deliver behavioral health services; and

(iii) The staff member is under the direct supervision of a licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health services or a Connecticut certified clinical supervisor.

(12) Medically managed inpatient detoxification as specified in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

(A) Medically managed inpatient detoxification shall be in a facility that:

(i) meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(ii) 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; and

(iii) Is Joint Commission or CARF-accredited.

(B) Medically managed inpatient detoxification shall deliver emergency psychiatric services or maintain written agreements enabling immediate access for individuals, when needed, to facilities that offer such care;

(C) Medically managed inpatient detoxification shall include:

(i) Initial intake evaluation, including screening for a co-occurring psychiatric disability;

(ii) The ability to conduct an admission 24 hours per day, seven (7) days per week;

(iii) A medical history and physical examination conducted upon admission, inclusive of laboratory testing;

(iv) Diagnostic evaluation and risk assessment;

(v) Medical management and monitoring of substance withdrawal;

(vi) Individual, group and, when indicated, family therapy;

(vii) A biopsychosocial assessment;

(viii) Development of a recovery plan for each individual;

(ix) Appropriate observation and precautions for individuals who may be suicidal;

(x) Referral to a self-help program;

(xi) Medical management and monitoring of co-existing medical problems; and

(xii) Discharge planning that helps ensure the continuation of appropriate treatment.

(D) Medically managed inpatient detoxification shall include the following staff, licensed by the state of Connecticut or certified as appropriate in their respective disciplines:

(i) A medical director;

(ii) A social worker or counselor experienced in the treatment of substance use disorders;

(iii) A physician on site 24 hours per day, seven (7) days per week;

(iv) A registered nurse on site 24 hours per day, seven (7) days per week; and

(v) A pharmacist.

(13) Medically monitored residential detoxification as specified in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

(A) Medically monitored residential detoxification shall be in a facility that:

(i) meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(ii) Except as provided by state law, maintains professional liability insurance coverage of at least one million dollars ($1,000,000) per occurrence and three million dollars

(iv) Diagnostic evaluation and risk assessment;

(v) Medical management and monitoring of substance withdrawal;

(vi) Individual, group and, when indicated, family therapy;

(vii) A biopsychosocial assessment;

(viii) Development of a recovery plan for each individual;

(ix) Appropriate observation and precautions for individuals who may be suicidal;

(x) Referral to a self-help program;

(xi) Medical management and monitoring of co-existing medical problems, except that life support systems or a full array of medical services are not required; and

(xii) Discharge planning that helps ensure the continuation of appropriate treatment.

(D) Medically managed inpatient detoxification shall include the following staff, licensed by the state of Connecticut or certified as appropriate in their respective disciplines:

(i) A medical director;

(ii) A social worker or counselor experienced in the treatment of substance use disorders;

(iii) A physician on site 24 hours per day, seven (7) days per week;

(iv) A registered nurse on site 24 hours per day, seven (7) days per week; and

(v) A pharmacist.

(13) Medically monitored residential detoxification as specified in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

(A) Medically monitored residential detoxification shall be in a facility that:

(i) meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(ii) Except as provided by state law, maintains professional liability insurance coverage of at least one million dollars ($1,000,000) per occurrence and three million dollars

($3,000,000) 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; and

(iii) Is Joint Commission or CARF-accredited or has a physician with experience in providing substance use disorder services, who is responsible for supervising all medical services. The physician shall be credentialed by DMHAS in accordance with credentialing criteria as specified in this section.

(B) Medically monitored residential detoxification shall include the following staff, licensed by the state of Connecticut or certified as appropriate in their respective disciplines and who are employed by or under contract with the facility:

(i) A clinical supervisor with authority over all behavioral health services, who has a minimum of a master's degree in a behavioral health services field and at least three (3) years of full-time work experience in substance use disorders treatment and who is licensed by the state of Connecticut or certified as appropriate in his or her respective discipline and employed by or under contract with the facility;

(ii) A registered nurse on site 24 hours per day, seven (7) days per week;

(iii) A physician who is on-call during those hours when a physician is not physically present;

(iv) A physician eligible to be certified by the American Board of Psychiatry or Neurology or a licensed clinical psychologist;

(v) A pharmacist; and

(vi) A social worker or counselor experienced in the treatment of substance use disorders.

(C) Medically monitored residential detoxification shall deliver emergency psychiatric and emergency medical services or maintain written agreements enabling immediate access for individuals, when needed, to facilities that offer such care;

(D) Medically monitored residential detoxification shall include:

(i) Initial intake evaluation, including screening for a co-occurring psychiatric disability;

(ii) Screening and initial evaluation by a registered nurse;

(iii) Medical supervision and management of withdrawal from a substance, as indicated by a licensed physician and inclusive of laboratory assessments;

(iv) Individual, group and, when indicated, family therapy;

(v) A biopsychosocial assessment;

(vi) Development of a recovery plan for each individual;

(vii) Referral to a self-help program;

(viii) Psycho-educational programming; and

(ix) Discharge planning that helps ensure the continuation of appropriate treatment.

(E) Any behavioral health services performed by a staff member who is not a licensed behavioral health professional or a Connecticut certified alcohol and drug counselor shall meet the following conditions:

(i) The staff member is employed by or under contract with the facility;

(ii) The medical or clinical supervisor has determined that the staff member is qualified to deliver behavioral health services; and

(iii) The staff member is under the direct supervision of a licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health services or a Connecticut certified clinical supervisor.

(14) Observation bed-mental health as specified in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

(A) Observation bed-mental health shall be in a facility that:

(i) Meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(ii) 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; and

(iii) Is Joint Commission-accredited;

(B) Observation bed-mental health shall deliver emergency psychiatric and emergency medical services or maintain written agreements enabling immediate access for individuals, when needed, to facilities that offer such care;

(C) Observation bed-mental health includes the following staff, licensed by the state of Connecticut or certified as appropriate in their respective disciplines:

(i) A board-certified or board-eligible psychiatrist, who is responsible for supervising all medical services; and

(ii) A registered nurse and other licensed or certified behavioral health professionals.

(D) Observation bed-mental health deliver to each individual up to twenty-three (23) hours of supervised stabilization, clinical monitoring and, when necessary, laboratory testing to facilitate the formulation of an appropriate diagnosis and suitable disposition for individuals in urgent need of care; and

(E) Observation bed-mental health components shall include:

(i) The ability to conduct an admission 24 hours per day, seven (7) days per week;

(ii) Crisis intervention, as required;

(iii) Initial intake evaluation, including screening for a co-occurring substance use disorder;

(iv) Diagnostic evaluation and risk assessment;

(v) A medical history and physical examination conducted upon admission;

(vi) Medication evaluation and management;

(vii) Appropriate observation and precautions for individuals who may be suicidal;

(viii) Laboratory services, when indicated; and

(ix) Discharge planning that helps ensure the continuation of appropriate treatment.

(15) Observation bed-substance use as specified in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

(A) Observation bed-substance use shall be in a facility that:

(i) meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(ii) Except as provided by state law, maintains professional liability insurance coverage of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) 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; and

(iii) Is Joint Commission or CARF-accredited or has a physician with experience in providing substance use disorders services, who is responsible for supervising all medical services. The physician shall be credentialed by DMHAS in accordance with credentialing criteria as specified in this section.

(B) Observation bed-substance use shall include the following staff, licensed by the state of Connecticut or certified as appropriate in their respective disciplines and employed by or under contract with the facility:

(i) A registered nurse;

(ii) An alcohol and drug counselor; and

(iii) A clinical supervisor with authority over all services, who has a minimum of a master's degree in a behavioral health field and at least three (3) years of full-time work experience in substance use disorders treatment and is licensed by the state of Connecticut or certified, as appropriate in his or her respective discipline and employed by or under contract with the facility.

(C) The organization operating observation bed-substance use shall deliver emergency psychiatric and emergency medical services or maintain written agreements enabling immediate access for individuals, when needed, to facilities that offer such care;

(D) Observation bed-substance use shall deliver to each individual up to twenty-three (23) hours of supervised stabilization, clinical monitoring and, when necessary, laboratory testing to facilitate the formulation of an appropriate diagnosis and suitable disposition for individuals in urgent need of care;

(E) Observation bed-substance use components shall include:

(i) Crisis intervention, as required;

(ii) Initial intake evaluation, including screening for a co-occurring psychiatric disability;

(iii) Diagnostic evaluation and risk assessment;

(iv) Medication evaluation and management;

(v) Discharge planning that helps ensure the continuation of appropriate treatment;

(vi) Laboratory services, when indicated; and

(vii) A physical examination and medical history conducted upon admission; and

(F) Any behavioral health services performed by a staff member who is not a licensed behavioral health professional or a Connecticut certified alcohol and drug counselor shall meet the following conditions:

(i) The staff member is employed by or under contract with the facility;

(ii) The medical director or clinical supervisor has determined that the staff member is qualified to deliver behavioral health services; and

(iii) The staff member is under the direct supervision of a licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health services or a Connecticut certified clinical supervisor.

(16) Outpatient-mental health as specified in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

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(A) Outpatient-mental health shall be in a facility that:

(i) Meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(ii) Except as provided by state law, maintains professional liability insurance coverage of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) 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; and

(iii) Is Joint Commission or CARF-accredited or has a board-certified or board-eligible psychiatrist who is responsible for supervising all behavioral health services. If Outpatient-mental health is operated by a nonprofit psychiatric facility, the psychiatrist shall be credentialed by DMHAS as specified in this section.

(B) Outpatient-mental health shall include a clinical supervisor with authority over all behavioral health services, who is licensed by the state of Connecticut in a behavioral health services field and has at least three (3) years of full-time work experience in mental health treatment.

(C) The facility operating Outpatient-mental health shall deliver emergency psychiatric and emergency medical services, or maintain written agreements enabling immediate access for individuals, when needed, to facilities that offer such care;

(D) Outpatient-mental health components shall include:

(i) Initial intake evaluation, including screening for a co-occurring substance use disorder;

(ii) Diagnostic evaluation and risk assessment;

(iii) Individual and group therapy and, if indicated, family therapy;

(iv) A complete biopsychosocial assessment;

(v) Development of a recovery plan for each individual;

(vi) Psychological testing, when indicated;

(vii) Medication evaluation and management;

(viii) Discharge planning that helps ensure the continuation of appropriate treatment; and

(ix) Referral to self-help programs.

(E) Any behavioral health services performed by a staff member who is not a licensed behavioral health professional shall meet the following conditions:

(i) The staff member is employed by or under contract with the facility;

(ii) The medical director or clinical supervisor has determined that the staff member is qualified to deliver behavioral health services; and

(iii) The staff member is under the direct supervision of a licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health services and is actively pursuing a DPH license in a behavioral health discipline.

(17) Outpatient-substance use as specified in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

(A) Outpatient-substance use shall be in a facility that:

(i) meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(ii) Except as provided by state law, maintains professional liability insurance coverage of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) 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; and

(iii) Is Joint Commission or CARF-accredited or has a clinical supervisor with authority over all behavioral health services. The clinical supervisor shall have a minimum of a master's degree in a behavioral health services field and at least three (3) years of full-time work experience in substance use disorders treatment, be licensed by the state of Connecticut or

certified, as appropriate in his or her respective discipline and be employed by or under contract with the facility.

(B) Outpatient-substance use shall include Connecticut certified alcohol and drug abuse counselors or other staff in related fields with experience in treatment of substance use disorders, who are licensed by the state of Connecticut or certified as appropriate in their respective disciplines and employed by or under contract with the facility;

(C) The organization operating Outpatient-substance use shall deliver emergency psychiatric and emergency medical services or maintain written agreements enabling immediate access for individuals, when needed, to facilities that offer such care;

(D) Outpatient-substance use components shall include:

(i) Initial intake evaluation, including screening for a co-psychiatric disability;

(ii) A biopsychosocial assessment;

(iii) Development of a recovery plan for each individual;

(iv) Individual and group therapy and, when indicated, family therapy;

(v) Referral to a self-help program;

(vi) Discharge planning that helps ensure the continuation of appropriate treatment; and

(vii) Adequate testing for or analysis of drugs of abuse as specified in applicable federal and state statutes and regulations.

(E) Any behavioral health services performed by a staff member who is not a licensed behavioral health professional or a Connecticut certified alcohol and drug counselor shall meet the following conditions:

(i) The staff member is employed by or under contract with the facility;

(ii) The medical director or clinical supervisor has determined that the staff member is qualified to deliver behavioral health services; and

(iii) The staff member is under the direct supervision of a licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health services or a Connecticut certified clinical supervisor.

(18) Partial hospitalization-mental health as specified in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

(A) Partial hospitalization-mental health shall be in a facility that:

(i) Meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(ii) Except as provided by state law, maintains professional liability insurance coverage of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) 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; and

(iii) Is Joint Commission or CARF-accredited or has a board-certified or board-eligible psychiatrist who is responsible for supervising all behavioral health services. The psychiatrist shall be credentialed by DMHAS as specified in this section.

(B) Partial hospitalization-mental health shall include the following staff, licensed by the state of Connecticut or certified as appropriate in their respective disciplines and employed by or under contract with the facility:

(i) A clinical supervisor who is licensed by the state of Connecticut in a behavioral health services field and has at least three (3) years of full-time work experience in mental health treatment;

(ii) A registered nurse or other licensed behavioral health professionals;

(iii) Staff from the disciplines of nursing, psychology, social work and occupational therapy;

(iv) Other behavioral health professionals available on a full-time, part-time or consultative basis, as may be appropriate to individual needs.

(C) The organization operating Partial hospitalization-mental health shall deliver emergency psychiatric and emergency medical services or maintain written agreements enabling access for individuals, when needed, to facilities that offer such care;

(D) Partial hospitalization-mental health components shall include:

(i) Initial intake evaluation, including screening for a co-occurring substance use disorder;

(ii) Diagnostic evaluation and risk assessment;

(iii) A biopsychosocial assessment;

(iv) Individual and group therapy and, when indicated, family therapy;

(v) Rehabilitative social and recreational therapies;

(vi) Development of a recovery plan for each individual;

(vii) Laboratory services, when indicated;

(viii) Pre-vocational and vocational planning;

(ix) Medication evaluation and management;

(x) Psycho-educational and self-help programming; and

(xi) Discharge planning that helps ensure the continuation of appropriate treatment.

(E) Any behavioral health services other than psycho-education and self-help programming performed by a staff member who is not a licensed behavioral health professional shall meet the following conditions:

(i) The staff member shall be employed by or under contract with the facility;

(ii) The medical director or clinical supervisor has determined that the staff member is qualified to deliver behavioral health services; and

(iii) The staff member is actively pursuing behavioral health licensure and is under the direct supervision of a licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health services; and

(F) Partial hospitalization-mental health shall deliver to each individual a minimum of four (4) hours per day, three (3) to five (5) days per week, of programming based on an

individualized recovery plan that includes not less than one (1) individual or a minimum of one (1) group therapy session per day.

(19) Partial hospitalization (day or evening treatment)-substance use as specified in section 17a-453a-4 of the Regulations of Connecticut State Agencies:

(A) Partial hospitalization (day or evening treatment)-substance use shall be in a facility that:

(i) Meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations;

(ii) Except as provided by state law, maintains professional liability insurance coverage of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) 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; and

(iii) Is Joint Commission or CARF-accredited or has a licensed physician with experience in providing services for substance use disorders who is responsible for supervising all behavioral health services and is credentialed by DMHAS in accordance with credentialing criteria contained in this section.

(B) Partial hospitalization (day or evening treatment)-substance use shall include a clinical supervisor with authority over all behavioral health services, who has a minimum of a master's degree in a behavioral health services field and at least three (3) years of full-time work experience in substance use disorders treatment, who is licensed by the state of Connecticut or certified as appropriate in his or her respective disciplines and employed by or under contract with the facility;

(C) The organization operating Partial hospitalization (day or evening treatment)-substance use shall deliver emergency psychiatric and emergency medical services or maintain written agreements enabling immediate access for individuals, when needed, to facilities that offer such care;

(D) Partial hospitalization (day or evening treatment)-substance use shall deliver to each individual a minimum of four (4) hours per day, three (3) to five (5) days per week, of programming, inclusive of at least one (1) individual or group therapy session per day;

(E) Partial hospitalization (day or evening treatment)-substance use components shall include:

(i) Initial intake evaluation, including screening for a co-occurring psychiatric disability;

(ii) A biopsychosocial assessment;

(iii) Development of a recovery plan for each individual;

(iv) Individual and group therapy and, when indicated, family therapy;

(v) Psycho-educational programming;

(vi) Vocational or pre-vocational planning;

(vii) Orientation and referral to a self-help program;

(viii) Discharge planning that helps ensure the continuation of appropriate treatment; and

(ix) Adequate testing for or analysis of drugs of abuse as specified in applicable federal and state statutes and regulations.

(F) Any behavioral health services performed by a staff member who is not a licensed behavioral health professional or a Connecticut certified alcohol and drug counselor shall meet the following conditions:

(i) The staff member is employed by or under contract with the facility;

(ii) The medical director or clinical supervisor has determined that the staff member is qualified to deliver behavioral health services; and

(iii) The staff member is under the direct supervision of a licensed behavioral health professional with at least two (2) years of experience in the provision of behavioral health services or a Connecticut certified clinical supervisor.

(d) Credentialing criteria for practitioners with medical responsibility.

(1) Any physician responsible for providing medical supervision in a level of care for which the provider is seeking to be credentialed shall apply for separate credentials.

(A) The physician applicant shall:

(i) Hold a current, valid and unrestricted license to practice medicine in the state of Connecticut;

(ii) Be certified by the American Society of Addiction Medicine (ASAM) or have at least two (2) years of experience in the treatment of substance use disorders (for substance use disorder treatment services only);

(iii) Maintain professional liability insurance coverage of one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in aggregate;

(iv) Possess a current Drug Enforcement Administration (DEA) certificate;

(v) Not be subject to any current Medicaid or Medicare sanctions.

(B) As part of the credentialing process, DMHAS shall consider the following factors when determining the physician applicant's suitability to participate in the GABHP:

(i) Any malpractice claim(s) made against the physician applicant that has (have) been settled or otherwise resolved, whether or not a lawsuit was filed in relation to the claim(s);

(ii) Any lawsuit, other than a malpractice lawsuit, that is related to the physician applicant's competency to practice or to the physician applicant's conduct in the course of his or her practice, filed against the physician applicant or settled, adjudicated or otherwise resolved;

(iii) Insofar as permitted by law, any record of criminal convictions;

(iv) Any discipline imposed on the physician applicant for violation of the rules, bylaws or standards of practice of any governmental authority, health care facility, group practice or professional association or society;

(v) Physician applicant's privilege to possess, dispense or prescribe a controlled substance has been surrendered, suspended, revoked, denied or restricted by any state or federal agency;

(vi) Physician applicant withdrew a medical license application or was denied a medical license for any reason;

(vii) Professional liability insurance carrier terminated, restricted, limited, imposed a surcharge or co-payment or placed any condition(s) on the physician applicant's professional liability insurance related to his or her professional conduct or competency or whether the physician applicant ever voluntarily terminated, restricted or limited his or her insurance coverage related to an inquiry from the liability insurance carrier;

(viii) Applicant has been diagnosed with a medical condition that limits or impairs his or her ability to practice medicine;

(ix) Applicant engaged in the use of chemical substance(s) in a way that interferes with his or her ability to practice medicine; and

(x) Applicant participated in continuing education related to his or her area of practice.

(e) Re-credentialing.

(1) DMHAS shall re-credential contracted providers every two (2) years. The re-credentialing process shall include updates of information collected in the original credentialing process and review of additional data that includes, but is not limited to:

(A) Eligible recipient complaints;

(B) Results of quality reviews and contracted provider profiles;

(C) Results of utilization management activities;

(D) Results of eligible recipient satisfaction surveys;

(E) Re-verification of hospital privileges;

(F) Re-verification of current licensure or certification or both;

(G) Re-verification of current malpractice and liability insurance or self-funding resources; and

(H) Updates on insurance claims, if any.

(2) Any contracted provider who has been sanctioned by DSS for violations while participating in the Medicaid program shall not be re-credentialed for the GABHP.

(NEW) Section 17a-453a-13. Provider contract

(a) DMHAS, in its sole discretion, may extend an offer to contract with a provider who has been credentialed for covered behavioral health services under the GABHP.

(1) A provider who has been credentialed for a covered behavioral health service may not participate in the GABHP unless the provider has executed a contract with DMHAS to deliver a covered behavioral health service to eligible recipients. The contract shall specify the terms and conditions that shall govern the GABHP and to which the contracted provider must adhere in order to participate in the GABHP.

(2) DMHAS shall not pay for covered behavioral health services that are delivered to eligible recipients in the absence of a fully executed contract with DMHAS, unless covered behavioral health services were delivered by an out-of-network provider as specified in section 17a-453a-19 of the Regulations of Connecticut State Agencies.

(b) DMHAS may terminate a contract with a contracted provider after giving the contracted 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 contracted provider's contract for reasons that include, but are not limited to, the following:

(1) Loss, revocation, suspension, surrender or non-renewal of any credential required by section 17a-453a-12 of the Regulations of Connecticut State Agencies, such as the contracted provider's facility license or any other credential required as a condition of eligibility;

(2) The contracted provider has a diminished ability to provide covered behavioral health services legally, including disciplinary action by a governmental agency or licensing board that impairs the contracted provider's ability to practice;

(3) Loss of Drug Enforcement Administration (DEA) certification;

(4) Failure to comply with DMHAS credentialing and re-credentialing requirements and criteria as specified in section 17a-453a-12 of the Regulations of Connecticut State Agencies;

(5) Failure to notify DMHAS of any event that would affect or modify the information contained in the contracted provider's application for participation in the GABHP;

(6) Disciplinary action by any other state, governmental agency or licensing board; and

(7) Termination of, or failure to maintain, adequate malpractice insurance coverage.

(d) Termination reconsideration process:

(1) A provider terminated from participation in the GABHP may request reconsideration of such termination. Such request shall be submitted in writing to the commissioner not more than ten (10) calendar days after the date of receipt of such termination notice;

(2) The commissioner, in his or her sole discretion, shall determine whether to reinstate a provider;

(3) The commissioner may reinstate a provider to participate in the GABHP. Such participation may be subject to conditions and limitations as determined by DMHAS.

(4) Following a decision to terminate a contracted provider's participation or upon the expiration of the ten (10) calendar day period for the provider to request reconsideration of termination, the commissioner shall publish a notice of termination in the Connecticut Law Journal. The commissioner may take any steps necessary to inform the public of the provider's termination from the GABHP.

(e) The commissioner may seek to terminate a contracted provider's contract after giving the contracted provider thirty (30) calendar days' written notice, based upon any of the following circumstances:

(1) Fraud, such as, the contracted provider:

(A) Presents a false claim for payment;

(B) Accepts payment for goods or services delivered that exceeds the amount due for the goods or covered behavioral health services delivered to eligible recipients;

(C) Solicits to deliver or delivers covered behavioral health services for any eligible recipient, knowing that such eligible recipient is not in need of such covered behavioral health services;

(D) Accepts from any person or source other than the GABHP any additional compensation in excess of the amount authorized as specified in section 17a-453a-14 of the Regulations of Connecticut State Agencies; or

(E) Presents a claim for payment to DMHAS or its designated agent for covered behavioral health services that were not delivered to an eligible recipient;

(2) Failure to comply with the terms and conditions established in the contract;

(3) Failure to comply with DMHAS quality management and utilization review, as specified in section 17a-453a-10 of the Regulations of Connecticut State Agencies;

(4) Failure to deliver covered behavioral health services to eligible recipients in an ethical manner;

(5) Neglect of or failure to perform contracted provider duties as specified in the contract with DMHAS;

(6) Failure to implement corrective action required by DMHAS as the result of an audit as specified in section 17a-453a-16 of the Regulations of Connecticut State Agencies; and

(7) Any other breach of the contracted provider's GABHP contract that is not corrected by the contracted provider not later than thirty (30) calendar days after receipt of notice from DMHAS or its designated agent.

(f) If the DMHAS commissioner seeks to terminate a contracted provider's contract for any reason as specified in subsection 13(e) of this section, the provider may request an administrative hearing as specified in section 17a-453a-17 of the Regulations of Connecticut State Agencies.

(g) The contract is effective through the date specified in the contract and, if not renewed, it is considered expired without prejudice to the provider.

STATE OF CONNECTICUT
REGULATION
OF

Name of Agency
Department of Mental Health and Addiction Services

Section 17a-453a

(NEW) Sec. 17a-453a-14. Administration of contracted providers' claims for payment

(a) Contracted providers shall only be paid for covered behavioral health services that:

(1) Are delivered to eligible recipients; and

(2) The contracted provider received all applicable prior authorization, continued stay authorization and alternative authorization as specified in sections17a-453a-6 through 17a-453a-8 of the Regulations of State Agencies, to deliver to eligible recipients.

(b) Contracted providers' claims for payment shall only be considered for covered behavioral health services that:

(1) Are delivered during time period in which the individual was determined eligible by DSS for medical services pursuant to section 17b-192 of the Connecticut General Statutes; or

(2) Are delivered during the time period in which the individual was determined retroactively eligible by DSS for medical services pursuant to section 17b-192 of the Connecticut General Statutes.

(c)The contracted provider shall verify that DSS has determined the individual eligible for medical services pursuant to section 17b-192 of the Connecticut General Statutes, unless the contracted provider is submitting a claim for payment as specified in (b)(2) of this section.

(d) Each claim for payment shall contain evidence that the contracted provider complied with all applicable prior authorization, continued stay authorization and alternative authorization requirements as specified in sections 17a-453a-6 through 17a-453a-8 of the Regulations of the Connecticut State Agencies.

(e) The contracted provider shall file claims for payment not later than 180 calendar days after the date on which the covered behavioral health services were delivered, unless there is a delay due to the need for coordination of benefits or DMHAS finds other good cause. If the contracted provider is unable to file a timely claim for payment because DSS has not determined

an individual's eligibility for medical services pursuant section 17b-192 of the Connecticut General Statutes, then the contracted provider shall file a claim for payment not later than 365 calendar days after the date on which the covered behavioral health services were delivered.

(f) Acceptance of a contracted provider's claim for payment shall not be a guarantee of payment.

(g) 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-92 forms.

(h) Contracted providers shall submit claims for payment that contain all information necessary to match the invoice with the covered behavioral health services delivered and, if applicable, authorization data including, but not limited to, the following:

(1) Individual's name and address;

(2) Individual's EMS-ID number or Social Security number;

(3) Individual's DSM-IV diagnosis;

(4) Date(s) of covered behavioral health service;

(5) Type of covered behavioral health service delivered to the individual;

(6) Contracted provider's name and address;

(7) Contracted provider's I.D. number; and

(8) Covered behavioral health service authorization number, if applicable.

(i) Payment of contracted providers' claims:

(1) Contracted providers' claims shall be paid in accordance with rates as specified by DMHAS;

(2) DMHAS may establish rates for the payment of covered behavioral health services by using rate setting methods including, but not limited to, the following:

(A) A per-session, per-diem, per-unit of time (hour, minute) or per-episode rate;

(B) A negotiated rate with a specific contracted provider for a particular covered behavioral health service or level of care;

(C) An established per capita rate;

(D) Rates for eligible recipients in related diagnostic groups; and

(E) Bundled rates for a defined group of covered behavioral health services.

(3) In order to participate in the GABHP, the contracted provider shall agree to accept the rates set by DMHAS;

(4) The contracted provider shall be paid at the rate established by DMHAS for each covered behavioral health service or at the billed rate, whichever is lower;

(5) The contracted provider shall not be paid for excluded or unauthorized behavioral health services; and

(6) The contracted provider shall not bill the eligible recipient for covered behavioral health services.

(j) DMHAS shall not make payments to a contracted provider for appointments missed by an eligible recipient. A contracted provider shall not bill an eligible recipient for missed appointments.

(k) Coordination of Benefits:

(1) Coordination of benefits shall be the responsibility of each contracted provider. If the contracted provider identifies that an eligible recipient has other medical coverage for covered behavioral health services, the contracted provider shall seek payment first from the other medical coverage. The contracted provider shall submit documentation to the designated agent, substantiating either the amount of payment that was made by the other medical coverage or that payment was denied due to exclusion of coverage. When the other medical coverage is lower than the full DMHAS payment for the covered behavioral health service, DMHAS shall pay the difference between the other medical coverage and the DMHAS rate for the covered behavioral health services;

(2) Any payment made by DMHAS to a contracted provider for covered behavioral health services delivered to an eligible recipient who has been or is subsequently found to be eligible for any other medical coverage shall be subject to recovery by DMHAS for payments made for behavioral health services that are covered by the other medical coverage. Upon

determination that an eligible recipient has other medical coverage, any payment made by DMHAS for the behavioral health service shall, at the department's discretion, either be withheld from any payment due the contracted provider or refunded to DMHAS by the contracted provider. If the other medical coverage payment is lower than the DMHAS payment, the contracted provider may retain the portion of the DMHAS payment that represents the difference between the full DMHAS payment and the payment made by the other medical coverage, upon submission of appropriate documentation to the designated agent; and

(3) Any payment made to a contracted provider by DMHAS for covered behavioral health services delivered to an eligible recipient who is or is subsequently found to be ineligible for the GABHP as a result of a determination of eligibility for Medicaid shall be subject to recovery by DMHAS to the extent that the eligible recipient's Medicaid eligibility overlaps with the period for which covered behavioral health services were delivered and to the extent that the covered behavioral health services are reimbursable under the Medicaid program. Upon determination of an individual's Medicaid eligibility, any payment made by DMHAS for the covered behavioral health service shall, at the discretion of DMHAS, either be withheld from any payment due the contracted provider or refunded to DMHAS by the contracted provider.

(NEW) Sec. 17a-453a-15. Provider claim for payment grievance process

If a contracted provider's claim for payment is denied by the designated agent, the contracted provider may file a claim for payment grievance with the designated agent.

(a) Contracted 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 an administrative hearing from either DMHAS or its designated agent;

(b) DMHAS or its designated agent shall notify the contracted provider in writing of its first level claim for payment grievance decision within thirty (30) calendar days following the

receipt of all information as determined necessary by DMHAS to render a decision;

(c) Contracted 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 within 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; and

(d) 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 contracted provider within the time frame as specified in this section.

(e) Any second-level claim for payment grievance decision issued by DMHAS shall be final and shall conclude the grievance process. The second-level claim for payment grievance shall not include any right to an administrative hearing from either DMHAS or its designated agent.

(NEW) Sec. 17a-453a-16. Audit

(a) DMHAS or its designated agent may conduct audits of a contracted provider's clinical, programmatic, fiscal or other records to verify the accuracy of the contracted provider's claims for payment and the contracted provider's compliance with state and federal law and the contracted provider contract. Audits shall be conducted when care has been authorized, claims have been paid or when DMHAS deems it necessary to carry out its responsibilities under state or federal law.

(b) Audits may include, but are not limited to, review of the following:

(1) The contracted provider's claim(s) for payment;

(2) The covered behavioral health services delivered by the contracted provider to an eligible recipient;

(3) The contracted provider's credentialing or re-credentialing information;

(4) The contracted provider's information supplied to DMHAS regarding a request for reconsideration of contract termination;

(5) The contracted provider's compliance with state and federal law and the provider contract; and

(6) Whether the contracted provider has engaged in any fiscal irregularities.

(c) The contracted provider shall maintain records and permit DMHAS access to records as follows:

(1) All financial records related to delivery of covered behavioral health services to eligible recipients for a period of not less than three (3) years after the date of expiration or termination of the GABHP contract;

(2) Eligible recipient's medical, behavioral health service or other records;

(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.

(d) Audit methodology:

DMHAS shall select the contracted 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 clinical 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.

(e) Audit Resolution:

(1) When the audit is completed, DMHAS shall send the contracted provider a copy of the draft audit report. The contracted provider shall be given the opportunity to meet with a DMHAS representative in an exit conference to discuss the findings noted in the draft audit report;

(2) During the exit conference, the contracted provider may submit additional documentation to DMHAS as a result of the findings noted in the draft audit report or the contracted provider may request to submit such documentation subsequent to the exit conference. The contracted provider shall submit all such documentation to DMHAS not later than thirty (30) calendar days after the exit conference. DMHAS shall not consider documentation that is not submitted on time; and

(3) DMHAS shall send the contracted provider a copy of the final audit report with DMHAS's recommendations and a statement of the proposed audit adjustments, if any.

(f) Corrective Action.

(1) Not later than ten (10) business days after receipt of the final audit report, the contracted provider shall submit to DMHAS a corrective action plan to address adverse audit findings, if any, included in the DMHAS audit report. The corrective action plan shall contain the following elements:

(A) The name, address and telephone number of the contracted provider's staff person responsible for ensuring that corrective action is implemented;

(B) A detailed description of the corrective action planned; and

(C) The anticipated completion date of the corrective action.

(2) If the DMHAS audit report includes information that indicates a threat to the health or welfare of an eligible recipient, the contracted provider shall initiate corrective action not more than 24 hours following such notification; and

(3) If the contracted 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.

(g) Recovery of overpayment.

(1) If audit adjustments require recovery of excess payments made to the contracted provider, DMHAS may adjust any payment currently due the contracted provider by DMHAS or its designated agent; and

(2) If audit adjustments require recovery of excess payments made to a contracted provider who is not currently under contract with DMHAS, recovery shall be sought in an action brought by the state of Connecticut against the contracted provider.

(h) Progressive sanctions for non-compliance with GABHP standards. A contracted provider who, as a result of an audit, is found to be out of compliance with the provisions as specified in sections 17a-453a-1 to 17a-453a-19, inclusive, of the Regulations of Connecticut State Agencies shall be subject to progressive sanctions as may be determined by the commissioner, including but not limited to, the following:

(1) Reduction in the number of referrals made to the contracted provider for one or more levels of care;

(2) Reduction in the capacity for which DMHAS contracts with the contracted provider for one or more levels of care;

(3) Suspension of referrals made to the contracted provider for one or more levels of care;

(4) Termination of the contracted provider's credentials for one or more levels of care;

(5) Termination of the contracted provider's contract under the DMHAS GABHP; and

(6) Such other sanctions as the commissioner deems appropriate.

(NEW) Sec. 17a-453a-17. Administrative hearing to appeal audit recovery or progressive sanctions

Contracted providers have a right to an administrative hearing as follows:

(1) The contracted provider is subject to recovery of payments following an audit conducted by DMHAS or its designated agent as specified in section 17a-453a-16 of the Regulations of Connecticut State Agencies;

(2) The contracted provider is subject to progressive sanctions following an audit conducted by DMHAS or its designated agent as specified in section 17a-453a-16 of the Regulations of Connecticut State Agencies; and

(3) The commissioner has determined that the contracted provider's participation in the GABHP should be terminated for any of the reasons as specified in section 17a-453a-13(e) of the Regulations of Connecticut State Agencies.

(b) The contracted provider may request an administrative hearing in accordance with the following:

(1) For administrative hearing requests following a DMHAS audit where the contracted provider is subject to recovery of payment for an audit adjustment or progressive sanctions, the contracted provider's request for an administrative hearing shall be submitted in writing to the commissioner and contain a clear and concise statement of the issues the contracted provider seeks to address relating to the audit and, when applicable, the audit adjustment that is being sought by DMHAS. This request shall be submitted not more than (30) calendar days after the mailing date of notification from DMHAS of its intent to recover the audit adjustment or impose progressive sanctions on the contracted provider;

(2) For administrative hearing requests made by a contracted provider when the commissioner has determined that the contracted provider's contract to participate in the GABHP should be terminated for any of the reasons as specified in section 17a-453a-13(e) of the Regulations of the Connecticut State agencies, the contracted provider's request for an administrative hearing shall:

(A) Be submitted in writing to the commissioner, not more than thirty (30) calendar days after the mailing of notification from the commissioner of the decision to terminate the contracted provider's contract; and

Be it known that the foregoing:

[X] Regulations **[ ] Emergency Regulations**

are:

[ ] Adopted **[ ] Amended as hereinabove stated** **[ ] Repealed**

By the aforesaid agency pursuant to:

[X] Section 17a-453a of the General Statutes.

[ ] Section ..... of the General Statutes, as amended by Public Act. No. of the Public Acts.

[ ] Public Act. No of the Public Acts.

After publication in the Connecticut Law Journal on Month, XX, Year the notice of the proposal to:

[X] Adopt [ ] Amend [ ] Repeal such regulations

(If applicable): [X] And the holding of an advertised public hearing on June 26, 2008.

WHEREFORE, the foregoing regulations are hereby:

[ ] Adopted **[ ] Amended as hereinabove stated** **[ ] Repealed**

Effective:

[ ] When filed with the Secretary of the State.

(OR)

[ ] The _____ day of _____ 20___.

In Witness Whereof:	Date 04/07/09	SIGNED (Head of Board, Agency or Commission)	OFFICIAL TITLE, DULY AUTHORIZED *Commissioner*
Approved by the Attorney General as to legal sufficiency in accordance with Sec. 4-169, as amended, C.G.S.:		SIGNED 6/1/09	OFFICIAL TITLE, DULY AUTHORIZED ASSOC. ATTY. GENERAL

[ ] Approved

[ ] Disapproved

[ ] Disapproved in part, (Indicate Section Numbers disapproved only)

[ ] Rejected without prejudice.

The Legislative Review Committee in accordance with Sec. 4-170, as amended, of the General Statutes	DATE	SIGNED (Clerk of the Legislative Regulation Review Committee)

Two certified copies received and filed, and one such copy forwarded to the Commission on Official Legal Publications in accordance with Section 4-172, as amended, of the General Statutes.

DATE	SIGNED (Secretary of the State)	BY

INSTRUCTIONS

One copy of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the Attorney General for his determination of legal sufficiency. Section 4-169 of the General Statutes.

Eighteen copies of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the standing Legislative Regulation Review Committee for its approval. Section 4-170 of the General Statutes.

Each regulation must be in the form intended for publication and must include the appropriate regulation section number and section heading. Section 4-172 of the General Statutes.

Indicate by "(NEW)" in heading if new regulation. Amended regulations must contain new language in capital letters and deleted language in brackets. Section 4-170 of the General Statutes.