Connecticut 1115 SUD Demonstration ASAM Ambulatory Levels of Care Certification

In April 2022, The State of Connecticut Department of Social Services (DSS), working in collaboration with the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF), was approved by the Centers for Medicare & Medicaid Services (CMS) for a demonstration waiver under Section 1115 of the Social Security Act for substance use disorder (SUD) treatment for adults and children. Under Connecticut's 1115 SUD Demonstration, fee-for-service payment rates were developed within Connecticut's Medical Assistance Program (CMAP) for substance use treatment. In alignment with the milestones of the Demonstration. SUD treatment services provided in the Medicaid fee-for-service (FFS) delivery system will comply with the current American Society of Addiction Medicine's (ASAM) criteria for activities, including authorizations, utilization review decisions, multi-dimensional assessments and individualized treatment plans.

Continued access to Medicaid fee-for-service payment rates for the ambulatory levels of care and billing codes outlined below is contingent on substance use providers adopting and becoming certified in the current edition of the ASAM criteria adopted by the State for the treatment of addictive, substance-related, and co-occurring conditions and the standards outlined in Connecticut's Substance Use Disorder Services Policy and Clinical Assumptions for the level(s) of care provided.

ASAM Level of Care	***Billing Codes***
Level 1-WM - Ambulatory Withdrawal Management (WM) without Extended On-Site Monitoring Services	H0014
Level 2-WM - Ambulatory Withdrawal Management with Extended On-Site Monitoring Services	H0012
Level 2.1 – SUD Intensive Outpatient (IOP) Treatment	H0015
Level 2.5 – SUD Partial Hospitalization (PHP) Services	H0015 HH

Completed forms and acknowledgement should be submitted to Advanced Behavioral Health's 1115 Demonstration Unit at 1115Waiver@abhct.com. Application status will be communicated within 45-days of a provider agency's receipt of application completeness communication.

CONNECTICUT 1115 SUD DEMONSTRATION
AMBULATORY LEVEL OF CARE CERTIFICATION ACKNOWLEDGEMENT

Organization Name: Click or tap here to enter text.

Organization Tax ID#: Click or tap here to enter text.

On behalf of the organization and its programs listed below, I wish to apply for certification for the following ambulatory substance use treatment program(s) under Connecticut's 1115 SUD Waiver Demonstration through the State of Connecticut Department of Social Services, Department of Mental Health and Addiction Services and/or Department of Children and Families.

To qualify for certification, I acknowledge that each of the programs listed below meet the following criteria:

		Criteria
☐	Yes	1. Each of the programs listed on the Certification Application maintain an active facility license not suspended, under consent order or other corrective action plan for the ASAM level of care with the State of Connecticut Department of Public Health and, as applicable, with the Department of Children and Families for which certification is sought.
☐	No	
☐	Yes	2. The organization has policies identifying use and application of the current edition of American Society of Addiction Medicine criteria for all programs listed below.
☐	No	
☐	Yes	3. The organization currently has policies and procedures related to monitoring of medication(s) and toxicology screenings that are in place for all programs listed below, as applicable.
☐	No	

I acknowledge, with my signature below, that the information above is accurate and true to the best of my knowledge.

Date: _____

Signature: _____

Print Name: _____

Title: _____

State of Connecticut 1115 Substance Use Disorder Demonstration
Ambulatory Level of Care Certification Application Form

Directions: Please utilize this form to identify all service locations where the following ASAM levels of care and services are being provided. All ambulatory levels of care offered at each listed location must be identified and all sections must be completed.

ASAM Level of Care	*Billing Codes*
Level 1-WM - Ambulatory Withdrawal Management (WM) without Extended On-Site Monitoring Services	H0014
Level 2-WM - Ambulatory Withdrawal Management with Extended On-Site Monitoring Services	H0012
Level 2.1 - Intensive Outpatient (IOP) Treatment	H0015
Level 2.5 - Partial Hospitalization (PHP) Services	H0015 HH

Completed forms should be submitted with the attached acknowledgement to Advanced Behavioral Health's 1115 Demonstration Unit at 1115Waiver@abhct.com.

Agency Information		
Agency Name: Click or tap here to enter text.		**Date:** Click or tap to enter a date.
Agency Corporate Address: Click or tap here to enter text.		
Agency Contact: Click or tap here to enter text.	**Phone:** Click or tap here to enter text.	**Email:** Click or tap here to enter text.
Site Information		
Site Name: Click or tap here to enter text.	**DPH Facility License Number**: Click or tap here to enter text. **DCF Facility License Number**: Click or tap here to enter text. **Medicaid Provider ID:** Click or tap here to enter text.	
Site Address: Click or tap here to enter text.		
Requested ASAM Level of Care for Certification (select all that apply to this site): ☐ **Level 1-WM - Ambulatory Withdrawal Management (WM) without Extended On-Site Monitoring Services** Services Provided to: ☐ Adults (Ages 18 and over) ☐ Children (Individuals under the age of 18)		
☐ **Level 2-WM - Ambulatory Withdrawal Management with Extended On-Site Monitoring Services** Services Provided to: ☐ Adults (Ages 18 and over) ☐ Children (Individuals under the age of 18)		
☐ **Level 2.1 - Intensive Outpatient (IOP) Treatment** Services Provided to: ☐ Adults (Ages 18 and over) ☐ Children (Individuals under the age of 18)		
☐ **Level 2.5 - Partial Hospitalization (PHP) Services** Services Provided to: ☐ Adults (Ages 18 and over) ☐ Children (Individuals under the age of 18)		

Agencies submitting requests for more than one site should use additional copies of this page to submit information for <u>each</u> site.

Section A- SUPPORTING DOCUMENTATION AND DESCRIPTIONS	
Supporting documentation required by all applicants. Items with an * should be submitted for each site on the application request.	
Program Staffing Data*: All program staff who provide direct client services and/or oversee the program must be included. Please provide date of hire and valid credentials including effective and expiration dates.	
Detailed Weekly Program Schedule: Provide a copy of the weekly schedule of activities designed to meet individualized treatment needs in alignment with the minimum required treatment hours outlined in the Connecticut SUD Services Policy and Clinical Assumptions Grid.	
Program Medical/Behavioral Health Emergency Policy-Provide a copy of the program's policy or procedures related to addressing medical, psychiatric or behavioral health emergencies and crisis intervention.	
Assessment and Treatment Plan Procedures: Provide a copy of agency policies for completing intake, biopsychosocial assessments, treatment and discharge plans that incorporate the ASAM Dimensional Criteria.	
Medication Policy and Procedures- Provide a copy of the program's medication policies and procedures including those that outline how the program introduces, educates, refers and supports individuals with medications for opioid use disorder and alcohol use disorder needs.	
Program's Level of Care (LOC) Assessment – Provide a copy of the program's LOC Assessment used to determine the appropriate level of care for an individual. The LOC Assessment must incorporate the ASAM Criteria©, which includes a comprehensive biopsychosocial assessment addressing each of the six dimensions with rating, rationale, strengths and needs. All programs participating in the Connecticut 1115 SUD Demonstration should utilize the most recent edition of the American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related and Co-occurring disorders (Currently Connecticut's Demonstration is utilizing the 3rd edition). Clinical documentation should support and justify placement within this level of care and provide clear evidence that the individual's needs were assessed for each of the six dimensions.	
Sections B-D	
This section must be completed by all applicants.	
This portion of the application is a self-assessment of the ambulatory program. Please answer all questions regarding the program services, staffing, support systems, and assessment/treatment plan review.	
Section B – Program Services	
Is the program providing medication for opioid use disorder and alcohol use disorder? (MOUD/MAUD)	☐Yes ☐No
Does the program preclude admissions of individuals based on MAT profile and active medication prescriptions?	☐Yes ☐No
Does the agency employ a physician (or NP/PA), currently licensed in the State of Connecticut, designated to direct the medical services of the facility, appropriate for the LOC that you seek?	☐Yes ☐No
Have all Clinical Supervisors, Masters Level Behavioral Health Providers and Non-licensed staff, providing therapeutic services, completed the following ASAM Trainings?	
	☐Yes

Introduction to the ASAM Criteria	☐No
From Assessment to Service Planning and Level of Care	☐Yes ☐No
Multi-Dimensional Assessment	☐Yes ☐No
If no, please provide a training plan for these personnel to receive the required trainings through the Change Companies.	
Have all Clinical Supervisors, Masters Level Behavioral Health Providers, and Non-licensed staff providing therapeutic services completed the Motivational Interviewing and Stages of Change Trainings provided by the Change Companies or equivalent trainings by an accredited continuing education provider within the last three years?	
Motivational Interviewing	☐Yes ☐No
Transtheoretical Stages of Change	☐Yes ☐No
If no, please provide a training plan for these personnel to receive the required trainings through the Change Companies or an accredited continuing education provider.	
Section C – Support Systems	
Does the program offer timely access to additional support systems and services, including medical, psychological, and toxicology services either through consultation or referral	☐Yes ☐No
• <u>For 2.5 (PHP) certification applications</u>: Is psychiatric and other medical consultation available within 8 hours by telephone and within 48 hours in person?	☐Yes ☐No ☐N/A
• <u>For 2.1 (IOP) certification applications</u>: Is psychiatric and other medical consultation available within 24 hours by telephone and within 72 hours in person?	☐Yes ☐No ☐N/A
• <u>For 1-WM certification applications</u>: Is telephone or in-person consultation with a designated prescriber and emergency services available 24 hours a day, seven days a week and in order to discharge an individual to a higher level of care, if necessary?	☐Yes ☐No ☐N/A
• <u>For 2-WM certification applications</u>: Is telephone or in-person consultation with a designated prescriber and emergency services available 24 hours a day, seven days a week and in order to discharge an individual to a higher level of care, if necessary?	☐Yes ☐No ☐N/A
Does the program have direct affiliations with other levels of care (e.g. for purposes of discharge planning)? Select all levels of care for which the program has direct affiliations with below:	☐Yes ☐No
☐ 0.5 Early Intervention	☐ 1.0 Outpatient Services
☐ 2.1 Intensive Outpatient Services	☐ 2.5 Partial Hospitalization Services
☐ 3.1 Clinically Managed Low-Intensity Residential Services	
☐ 3.3 Clinically Managed Population-Specific High-Intensity Residential Services	
☐ 3.5 Clinically Managed High-Intensity Residential Services (Adults)	

Clinically Managed Medium Intensity Residential (Adolescents)	
☐ 3.5PPW Clinically Managed High-Intensity Residential Services Pregnant and Parenting Women	
☐ 3.5E Medically Monitored Intensive Inpatient Services, Co-Occurring Enhanced	
☐ 3.7 Medically Monitored Intensive Inpatient Services	
☐ 3.7E Medically Monitored Intensive Inpatient Services, Co-Occurring Enhanced	
☐ 4.0 Medically Monitored Intensive Inpatient Services, Co-Occurring Enhanced	
☐ 1-WM Ambulatory Withdrawal Management without Extended On-site Monitoring	
☐ 2- WM Ambulatory Withdrawal Management with Extended On-site Monitoring	
☐ 3.2-WM Clinically Monitored Residential Withdrawal Management	
☐ 3.7-WM Medically Monitored Inpatient Withdrawal Management	
☐ 4.0-WM Medically Managed Intensive Inpatient Withdrawal Management	
Please indicate which services are offered through referrals:	
☐ Medical Services	☐ Psychiatric Services
☐ Mental Health Services	☐ MAT Services
☐ Laboratory Services	☐ Toxicology Services
Please indicate which services are offered onsite or co-located:	
☐ Medical Services	☐ Psychiatric Services
☐ Mental Health Services	☐ MAT Services
☐ Laboratory Services	☐ Toxicology Services

Section D – Assessment/Treatment Plan Review/Discharge	
Does the program's assessment and treatment plan documentation include:	
A biopsychosocial assessment that clearly identifies the individual's risks, strengths and needs in each of the ASAM Six Dimensions and provides justification for placement within the program's level of care.	☐Yes ☐No
A biopsychosocial assessment that includes behavioral health diagnoses, cognitive needs and a screening for trauma.	☐Yes ☐No
Initial treatment plans that demonstrate clear evidence that the risks, strengths and needs identified in each of the ASAM Six Dimensions have been incorporated and contains strengths, needs, abilities and preferences (SNAP) and reflects coordination of substance use treatment, mental health, recovery support, social housing, vocational services or integration of care as applicable.	☐Yes ☐No
Individualized Treatment plan(s) demonstrate evidence of discharge planning beginning at admission and ongoing dimensional need reassessments.	☐Yes ☐No
Evidence that the individual will participate in the treatment planning process (e.g. signature).	☐Yes ☐No

Please check the roles of those included in the program's interdisciplinary team responsible for developing and/or reviewing assessments, initial treatment plans, treatment plan reviews and discharge plans:	
☐ Physician	☐ Licensed Clinical Social Worker
☐ Licensed Psychologist	☐ Licensed Marital and Family Therapist
☐ Licensed Professional Counselor	☐ Licensed Alcohol and Drug Counselor
☐ Advanced Practice Registered Nurse	☐ Physician Assistant
☐ Licensed Master Social Worker	☐ Licensed Professional Counselor Associate
☐ Licensed Marital and Family Therapy Associate	☐ Certified Alcohol and Drug Counselor
☐ Certified Peer Support Specialist	☐ Other

Does the discharge planning process include:	
ASAM Transfer/Discharge criteria are applied to discharge planning processes.	☐Yes
	☐No
Presence of Transfer or Discharge Plan Discharge plans includes obtaining necessary release(s) of information to refer to appropriate aftercare services, including clinical recovery supports.	☐Yes
	☐No
Plans are written in conjunction with the individual and is documented in discharge plan.	☐Yes
	☐No
Addresses original reason for referral to treatment.	☐Yes
	☐No
Describes whether the individual's goals were met or not met.	☐Yes
	☐No
Describes type, frequency and duration of treatment/services.	☐Yes
	☐No
Specifies reason(s) for discharge.	☐Yes
	☐No
Conducted/updated/signed by an independently licensed or associate licensed behavioral health staff or graduate-level intern, with credentials included.	☐Yes
	☐No
Review and signature by independently licensed behavioral health practitioner/clinical supervisor for associate licensed or graduate level interns.	☐Yes
	☐No
Evidence of referral to or documentation of an established connection to a MAT or pharmacotherapy provider and incorporation of ongoing or continued MAT services post-discharge.	☐Yes
	☐No
Completed within 15 days of discharge.	☐Yes
	☐No

State of Connecticut 1115 Substance Use Disorder Demonstration
Ambulatory Level of Care Certification Application Form Acknowledgment

Organization Name: Click or tap here to enter text.

Organization Tax ID#: Click or tap here to enter text.

On behalf of this organization and its programs listed in the Certification Application Form, I acknowledge, with my signature below, that the information above is accurate and true to the best of my knowledge. I also acknowledge and attest that billing for SUD services will not be effective until conditional certification is approved.

Date: _____

Signature: _____

Print Name: _____

Title: _____

Ambulatory Certification Application

Please Type or Print Clearly
Federal Tax ID (TIN): Click or tap here to enter text.
Legal Name of Organization Click or tap here to enter text.
(As Registered with the IRS): Click or tap here to enter text.

Section 1: General Business Information

1. Type & Ownership of Facility

(Please check one)

☐ General Hospital	☐ FQHC
☐ Private Psychiatric Hospital	☐ State Operated Facility
☐ Residential Treatment Center	☐ Community Health Center
☐ Outpatient Clinic (Psych or Substance Abuse)	☐ Other

2. Business Classification

Ownership:	☐ Private	☐ Public	☐ State Operated Program
Status:	☐ For-Profit	☐ Not-for-Profit	

Organization Name:	Click or tap here to enter text.

Section 2: Liability Insurance Information

Name of Liability Carrier: Click or tap here to enter text.	
Limits of Professional Liability: Per Occurrence Click or tap here to enter text.	**Aggregate:** Click or tap here to enter text.
Insurance Effective Date: Click or tap to enter a date.	**Insurance Expiration Date:** Click or tap to enter a date.

Please enclose Certificate of Insurance with application

Section 3: Malpractice Claim History

Indicate all pending and closed cases that have occurred during the past five years by completing the malpractice claim information work sheet (see following page).

1. Has the Organization been named in any malpractice action? ☐Yes ☐No
2. Has the Organization had or currently have pending, any legal actions? ☐Yes ☐No
3. Has the Organization had professional liability insurance refused, revoked, declined or accepted on special terms? ☐Yes ☐No
4. Has any government agency investigated, suspended, revoked or taken other action against the Organization's license, current/former owner, officer or shareholder to conduct business? (Include Medicaid/Medicare) ☐Yes ☐No
5. Have any memberships in professional organizations been revoked, reduced, denied, or suspended by others or voluntarily given up by the Organization, current/former owner, officer or shareholder or are any actions now under way, which may lead to such sanctions? ☐Yes ☐No
6. Has any license, certification, or accreditation been revoked, denied or suspended by others or voluntarily given up by the Organization, current/former owner, officer or shareholder or are any actions now under way which may lead to such sanctions? ☐Yes ☐No
7. Have any current/former owners, officers or shareholders of the Organization been convicted of a crime, excluding misdemeanors? ☐Yes ☐No
8. Has the Organization, current/former owner, officer or shareholder been assessed a penalty, conviction, suspension, or other Sanction; or has the Organization, current/former owner, officer or shareholder currently under investigation by Medicare or Medicaid Programs? ☐Yes ☐No
9. Has the Organization, current/former owner, officer or shareholder ever been a defendant in any lawsuit with regard to the practice of mental health or substance abuse treatment where there has been an award or payment of $50,000.00 (fifty thousand dollars) or more? ☐Yes ☐No
10. Has any claim or suit for alleged malpractice been brought against the facility/program, or are you aware of any circumstances that might lead to such a claim or suit against the facility/program? ☐Yes ☐No

Number of claims (check one) ☐0 ☐1 ☐2 ☐More than 2

Organization Name:	Click or tap here to enter text.

MALPRACTICE CLAIM INFORMATION WORKSHEET

If the answer to any of the questions in Section 3 on Page 3 was yes, please complete this page. Please specify to which question the detailed explanation applies.

Please complete this section for each claim identified in Section 3, Malpractice Claim History.

1. Patient's Name: Click or tap here to enter text. (if applicable)	Date of Occurrence: Click or tap to enter a date.	Date Claim Filed: Click or tap to enter a date.
Allegations: Click or tap here to enter text.		
Status of Claim: ☐ Pending ☐ Settled		Date of Settlement: Click or tap to enter a date.
Case Settled: ☐ In Court ☒ With Prejudice ☐ Out-of-Court ☐ Without Prejudice		$ Paid to claimant on your behalf Click or tap here to enter text.
The information above applies to #_____ on Page 3.		

2. Patient's Name: Click or tap here to enter text. (if applicable)	Date of Occurrence: Click or tap to enter a date.	Date Claim Filed: Click or tap to enter a date.
Allegations: Click or tap here to enter text.		
Status of Claim: ☐ Pending ☐ Settled		Date of Settlement: Click or tap to enter a date.
Case Settled: ☐ In Court ☐ With Prejudice ☐ Out-of-Court ☐ Without Prejudice		$ Paid to claimant on your behalf Click or tap here to enter text.
The information above applies to #_____ on Page 3.		

Organization Name: Click or tap here to enter text.

3. Patient's Name: Click or tap here to enter text. (if applicable)	Date of Occurrence: Click or tap to enter a date.	Date Claim Filed: Click or tap to enter a date.	
Allegations: Click or tap here to enter text.			
Status of Claim:	☐ Pending	☐ Settled	Date of Settlement: Click or tap to enter a date.
Case Settled:	☐ In Court ☐ With Prejudice	☐ Out-of-Court ☐ Without Prejudice	$ Paid to claimant on your behalf Click or tap here to enter text.
The information above applies to #_____ on Page 3.			

Please include any documentation that further explains any of the above referenced items.

If you answered yes to any questions 1-10 on page 3, please attach description of the occurrence (citing dates and other relevant information).

Ambulatory Certification Application Checklist

To ensure timely processing of your application, please submit the following documents and the completed checklist with the application (please check boxes accordingly):

☐ Ambulatory Level of Care Certification Acknowledgement signed by authorized official (original signature required)
☐ Proof of Certificate of Need (CON) Determination from Office of Healthcare Strategy
☐ Approved LP-173 Form from the Connecticut Department of Public Health or photocopy of current facility license
☐ As applicable for child serving programs, photocopy of current DCF license
☐ Supporting Documentation outlined in Section A of the Application:
- ☐ Program Staffing Data
- ☐ Detailed Weekly Program Schedule
- ☐ Program Medical/Behavioral Health Emergency Policy
- ☐ Assessment and Treatment Plan Procedures
- ☐ Medication Policy and Procedures
- ☐ Program's Level of Care Assessment

☐ Template of treatment plan (inclusion of SNAP, strengths, needs, abilities and preferences)
☐ Policy for Continued stay, transfer and discharge documentation
☐ Discharge Summary template that includes ASAM
☐ Training plan for any staff who have not completed the required trainings outlined in Section B of the Application
☐ Completed Certification Application signed by authorized official (original signature required)
☐ Copy of current medical malpractice, comprehensive professional, general and/or umbrella liability insurance certificates that identifies the limits of liability and policy period
☐ Malpractice Claim Information Worksheet (if applicable)
☐ Accreditation(s):
- ☐ JCAHO (The Joint Commission) accreditation letter and/or certificate
- ☐ CARF (Commission on Accreditation of Rehabilitation Facilities) accreditation letter and/or certificate
- ☐ COA (Council on Accreditation) accreditation letter and/or certificate
- ☐ Our facility is not accredited by any of the above organizations.

Please email all materials to:

Advanced Behavioral Health, Inc.*
Email: 1115Waiver@abhct.com
213 Court St., 8th Floor
Middletown, CT 06457

We suggest you keep a copy of all completed materials!

If you have any questions, please email 1115Waiver@abhct.com.

*Advanced Behavioral Health, Inc. is contracted by the Department of Mental Health and Addiction Services and the Department of Children and Families to assist with the certification and monitoring of programs under the 1115 SUD Demonstration Waiver