IV. Utilization Management and Care Management

The primary vision that guided the development of the CT BHP was to develop an integrated public behavioral health service system that offers enhanced access as well as increased coordination of a more complete and effective system of community-based recovery/resiliency focused services and supports.

The CT BHP's clinical philosophy emphasizes a care management system that offers easy and timely access to the most appropriate, high quality, recovery/resiliency focused mental health and/or substance use disorder services for HUSKY Health enrolled individuals. The utilization management system supports CMAP providers in delivering clinically necessary and effective care with minimal administrative burden. Both Utilization Management (UM) and Care Management (CM) activities are conducted by independently licensed behavioral health clinicians. These care managers and intensive care managers operate under the supervision of Connecticut licensed clinicians. Together, UM and CM provide the foundation to support HUSKY Health providers in the delivery of high-quality treatment services and supports with minimal administrative barriers.

Utilization Management (UM) is designed to ensure that HUSKY Health enrolled individuals receive the most appropriate, integrated and effective treatment—and therefore the best clinical outcomes. This is accomplished through prospective concurrent and retrospective assessments of the necessity and appropriateness of the allocation of health care resources and services given, or proposed to be given, to an individual.

Care Management (CM) is designed to ensure that needed services, both traditional and non-traditional are coordinated with and on behalf of the child, family or adult, regardless of funding streams.

Both UM and CM encompass management of care from the point of engagement through discharge. Throughout this process, our approach embraces the principles of recovery and resiliency. The *President's New Freedom Commission on Mental Health* endorsed the recovery philosophy, for people who have serious mental illness. However, it is clear that the same principles are equally important and applicable to children, families and adults. Therefore, CT BHP's approach to care management incorporates a substantial role for Peer Specialists and includes system-wide training in the recovery philosophy for individuals and families. More information on this topic can be found in the Recovery and Resiliency section of this Manual.

WORKING WITH CARE MANAGERS

Care management is a set of activities designed to ensure that services authorized by Beacon Health Options, on behalf of HUSKY Health members, are integrated to certify the best clinical outcomes. CT BHP services should be coordinated with services provided through other funding streams to ensure consistency and continuity in the overall delivery of services to an individual, child and family.

All Beacon Health Options Care Managers assist with the determination of medical necessity of requested services and work with HUSKY Health providers, individuals and families to coordinate services. Beacon Health Options has two different levels of Care Management: routine Care Management and Intensive Care Management. All clinicians serving in these roles are master's degree trained, independently licensed behavioral health practitioners, or licensed Bachelor of Science in Nursing (BSNs) in the State of Connecticut.

CARE MANAGEMENT

Care Management activities are generally web based through the secure ProviderConnect platform. Care Management is provided for recipients whose treatment needs may be acute, intermittent or chronic, but whose utilization is within expected parameters. This level of Care Management is performed as part of the process of authorizing services as the Care Manager works with the HUSKY Health provider on treatment, discharge, aftercare and follow-up.

UTILIZATION MANAGEMENT CRITERIA

The goal of Utilization Management (UM) is to ensure that all authorized services meet the Departments' definition of medical necessity.

Medical Necessity

Please Note: Any and all decisions to deny a service are based on the following medical necessity definition. For purposes of the administration of the medical assistance programs by the Department of Social Services, "medically necessary" and "medical necessity" refer to those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (3) not costlier than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (4) based on an assessment of the individual and his or her medical condition.

Level of Care Guidelines

The above standards for medical necessity and medical appropriateness of care have been translated into Clinical Level of Care Guidelines. These guidelines are based on recommendations from Connecticut clinicians with expertise in the diagnosis and treatment of people who have mental illness and/or substance use disorders and HUSKY Health members and parents of children with behavioral health service needs. The guidelines also reflect opinions of national experts, citations from standard clinical references and guidelines of professional behavioral health organizations. The CT BHP reviews these guidelines annually. Any recommendations for changes are forwarded to the statutorily mandated Clinical Management Committee for review. Suggested changes are forwarded for review and approval to the Connecticut Behavioral Health Partnership Oversight Council Operations Sub-Committee. Any changes made to the criteria are reflected in the annual quality management program evaluation. The CT BHP uses the most recent edition of ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders (Published by the American Society of Addiction Medicine, Inc.) as the substance use level of care guidelines. Level of Care Guidelines can be accessed on the CT BHP website: www.CTBHP.com. The Level of Care Guidelines assists clinicians reviewing authorization requests from HUSKY Health providers but cannot be used to deny authorization. Denial of authorization for services is solely based on the Medical Necessity definition referenced above.

Determining Appropriate Services

The Care Manager reviews the HUSKY Health enrolled individual's clinical condition and determines the most appropriate services based on the appropriate Level of Care Guidelines.

As part of that review process, the HUSKY Health provider and the clinician:

- Review, discuss and evaluate physical and behavioral health information about the individual who has been provided by qualified professionals who have personally evaluated the individual within their scope of practice, who have taken into consideration the individual's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals as appropriate.
- Consider the views and choices of the individual or the individual's legal guardian, agent or surrogate decision maker regarding the proposed covered service as provided by the clinician

or through independent verification of those views and considers the services being provided concurrently by other service delivery systems, and
- Ensure that decisions regarding benefit coverage for children covered by CMAP are in accordance with the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

In order to evaluate the appropriateness of a requested service, the Care Manager and the requesting HUSKY Health provider review four parameters:

- Severity of condition
- Intensity of service
- Psychosocial, cultural, linguistic factors, and
- Least restrictive setting

SEVERITY OF CONDITION

The severity of current signs, symptoms, and functional impairments resulting from the presence of a psychiatric diagnosis are evaluated in determining what specified level is most appropriate at a given point in time. In addition, the presence of certain "high risk" clinical factors warrant consideration in evaluating an individual to determine their severity of condition. These factors include, but are not limited to:

- Repeated attempts at self-harm or aggressiveness to others, with documented suicidal or homicidal intent
- Significant co-morbidities (e.g., psychiatric/medical; psychiatric/substance use, psychiatric/intellectual disability/developmental disability; substance use or medical condition)
- Coexisting pregnancy and substance use disorder
- Medication non-adherence
- Unstable diagnostic disorder
- History of individual or family violence
- Multiple family members requiring treatment
- Decline in ability to maintain previous levels of functioning, or
- Significant impairment in one or more areas of functioning

INTENSITY OF SERVICE

The level of care authorized should match the individual's condition, taking into consideration their strengths and limitations (e.g., physical, psychological, social, cognitive) and psychosocial needs. It is the expectation of the CT BHP that treatment planning will be: individualized, specifically state what benefits the individual can reasonably expect to receive: outline what actions the individual is expected to take; and include discharge planning. Family members of minors or adult individuals, with consent, should take an active role in all treatment and discharge planning activities.

PSYCHOSOCIAL, CULTURAL, AND LINGUISTIC FACTORS

These considerations represent factors that either are aggravating an individual's clinical condition, or need to be addressed to assure effective treatment. An inappropriate or more intensive level of care may result if the issues are not addressed.

Common stressors/barriers to progress may include:

- Primary language/Absence of services in primary language
- Psychosocial factors
- Lack of culturally appropriate services
- Inadequate housing or homelessness

- Lack of effective family or social support
- Gender-specific issues
- Physical disability or illness
- Recent or imminent stressors
- Recent significant change in school or work performance
- Inability for self-care
- Active legal issues
- Recent or imminent re-entry to the community, and
- Transportation access

LEAST RESTRICTIVE SETTING

In general, people respond better to treatment and have better clinical outcomes when they can remain in their homes as an integral part of their families and communities. Therefore, the Care Manager and requesting HUSKY Health provider should carefully consider whether the treatment and setting being requested is the least restrictive environment in which the most appropriate care and treatment can be safely provided.

OVERVIEW OF AUTHORIZATION AND REGISTRATION OF SERVICES

Authorized Services are those for which the treating HUSKY Health provider must register services to obtain authorization for treatment and concurrent (continuing stay) reviews for an extension of the previous authorization**.** The CT BHP offers a web-enabled application for registration of services that require authorization (i.e. Inpatient, Partial Hospitalization Program (PHP), Outpatient*, Intensive Outpatient (IOP), Ambulatory Withdrawal Management, Methadone Maintenance, Psychological Testing, Autism Spectrum Disorder Services (ASD), Home-Based and Home Health services.) For additional information, see Registering Services on the Web: Page 20. Categories of services that require registration are:

- Psychiatric Hospitalization
- Inpatient Withdrawal Management
- Residential Withdrawal Management
- Residential Rehabilitation
- Psychiatric Residential Treatment Facility (PRTF)
- Residential Treatment Center (RTC) for Children through DCF
- Adult Medicaid Rehabilitation Option (MRO) Group Homes through DMHAS
- Child Therapeutic Group Homes through DCF
- Partial Hospitalization (PHP)
- Intensive Outpatient Services (IOP)
- Methadone Maintenance
- Ambulatory Withdrawal Management
- Extended Day Treatment (EDT)
- Home-based Services for Ages 21 and under
    - Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS)
    - Multidimensional Family Therapy (MDFT)
    - Multi-systemic Therapy (MST)
    - Functional Family Therapy (FFT)
- *Outpatient Services – *(Please note: Per Provider Bulletin PB 2021-26 – Effective for dates of service 5/21/21 and forward, only Psychiatric Diagnostic Evaluation Codes (90791, 90792 and 90785) require authorization for Individual/Group Practitioners, Community Mental Health Clinics, Outpatient Hospitals, Federally Qualified Health Centers and Enhanced Care Clinics. Rehabilitation Clinics still require prior authorization for outpatient individual, family and group therapy.)*

- Case Management for HUSKY A & B members <21 and HUSKY C & D members <18 (after initial 3 hours)
- Autism Spectrum Disorder (ASD) Services
- Psychological Testing, and
- Home Health Services for Behavioral Health Concerns
- Spravato®/Esketamine*

* Per DSS Provider Bulletin PB 2020-83, effective January 1, 2021 the Department of Social Services (DSS) implemented a Prior Authorization (PA) requirement for the coverage of esketamine nasal spray, marketed as Spravato®, for HUSKY A, HUSKY B, HUSKY C, and HUSKY D Health members. The U.S. Food and Drug Administration (FDA) approved Spravato® (esketamine) nasal spray, in conjunction with an oral antidepressant, for the treatment of depression in adults who have tried other antidepressant medicines but have not benefited from them (treatment-resistant depression) and acute suicidal ideation.

- Spravato® Provider Prior Authorization Request Form: https://www.ctbhp.com/uploads/Spravato-Provider-Authorization-Form.pdf
- Spravato® Pharmacy Prior Authorization Request form https://www.ctbhp.com/uploads/Spravato-Pharmacy-Prior-Authorization-Form.pdf

While some services requiring authorization can be conducted via telephonic reviews, most are completed via the CT BHP web registration system (ProviderConnect). Registration is conducted at the time of the initiation of services when the individual is accepted for treatment. For services that require registration, please visit the For Providers homepage of the CT BHP website at www.CTBHP.com.

THE PROCESS OF SERVICE REGISTRATION/AUTHORIZATION

In order to complete a review that is both efficient and comprehensive enough to establish the appropriate level of care and service necessary, an established set of questions are presented for the HUSKY Health provider as they relate to the particular HUSKY Health member's need and service. These questions can be viewed in their entirety on the For Providers homepage of the CT BHP website: www.CTBHP.com.

REGISTERING SERVICES ON THE WEB

The CT BHP offers a web-enabled application for registration of services that require authorization (i.e. Inpatient, PHP, Outpatient, IOP, Ambulatory Withdrawal Management, Methadone Maintenance, Psychological Testing, ASD, Home-Based and Home Health services.) Access to this application is located on the For Providers homepage of the CT BHP website: www.CTBHP.com. The "For Providers" homepage provides access to the ProviderConnect Online Account Services form to obtain an ID and password, user manuals and training videos. The following steps outline the procedures for accessing and utilizing ProviderConnect:

Step 1: Before accessing the system, HUSKY Health providers and/or system users must print, complete and submit an **Online Services Account Request Form** to obtain a User ID and Password. This ID and password will establish secure access to the system.

Step 2: Our comprehensive user manuals and our training videos provide screen shot by screen shot reference guides to entering registrations for system users. HUSKY Health providers are strongly encouraged to review the user manual or watch our training videos before attempting to complete registrations and/or re-registrations/concurrent reviews.

ProviderConnect links directly to the CT BHP management information system so authorization numbers are automatically generated and subsequent authorization letters are then available to print.

AUTHORIZATION OF SERVICES

For those services requiring a telephonic review, the Care Manager and HUSKY Health provider will complete the review process and, in most cases, will come to an agreement about the services to be authorized and the authorization period (or number of units). For those services that are completed via the registration process, when the service units and date span are in keeping with established parameters, the services are authorized at the conclusion of the registration process in ProviderConnect. In both these situations, the HUSKY Health provider is given an authorization number and a written notice of the authorization is available to that HUSKY Health provider via ProviderConnect. In keeping with CMAP regulations, notices indicate that authorization does not confer a guarantee of payment. The basis for all decisions will be documented.

When a HUSKY Health provider makes a request for a level of care that is not consistent with the Level of Care (LOC) Guidelines, the provider is informed and the reviewer will recommend an alternative LOC, which might better meet the HUSKY Health providers stated goals, and the HUSKY Health member's identified needs. In situations where there is agreement, the care will be authorized.

Please find copies of review templates at www.CTBHP.com on the For Providers homepage section.

TEMPORARY HUSKY HEALTH MEMBER ID REQUESTS

- The CT BHP will create temporary individual's IDs ONLY for inpatient psychiatric, inpatient withdrawal management, partial hospitalization, freestanding withdrawal management, residential rehab, adult group home, home health, and Autism Spectrum Disorder (ASD) levels of care.
- The CT BHP will process temporary ID requests when a HUSKY Health provider verifies that the individual is not currently active, assists the individual in submitting an application for benefits to DSS, and secures authorization to disclose Personal Health Information to CT BHP.
- HUSKY Health providers contact the CT BHP at 877-552-8247 to request authorization for "Pending Eligible" individuals.
- A temporary ID will be created if the individual is not showing eligible.
- Utilizing the temporary ID, HUSKY Health providers can register services and obtain authorization through the ProviderConnect portal.
- Temporary ID's are reconciled with Medicaid IDs on a weekly basis.
- If the individual is granted benefits, the CT BHP will merge the authorization under the temporary ID with the HUSKY Health member's Medicaid ID and the authorization will be submitted to Gainwell Technologies.

PARTICIPATING IN A CONCURRENT (CONTINUING STAY) REVIEW

After the initial authorization is given, the second and subsequent reviews focus on identifying progress in treatment and planning for discharge. It will be the responsibility of the HUSKY Health provider to initiate the concurrent review process, specifically completing a concurrent review through ProviderConnect or contacting the Care Manager prior to expiration date of the authorization or use of all units associated with authorization (whichever comes first) to ensure continued authorization and service provision, as appropriate.

Concurrent reviews focus on the rationale for continued need of treatment – the individual's response to treatment, continuing severity of symptoms, appropriateness and intensity of the treatment plan, and the HUSKY Health provider's progress in discharge planning and arranging aftercare. Involvement of family members and/or other significant individuals in the treatment and discharge planning is also expected during this review. Just as in the initial authorization process, if conducted telephonically, the Care Manager documents all clinical information received and the basis for the services authorized.

For those services requiring a telephonic review, the Care Manager conducts the review with the HUSKY Health provider and in most cases will come to an agreement about the services to be authorized as well as the

authorization timeframe and/or number of units. For those services that are completed via the on-line registration process, the services are authorized at the conclusion of the registration process in ProviderConnect. HUSKY Health providers can access authorization timeframes by visiting the CT BHP website and viewing the Covered Services page. HUSKY Health providers should click on the link that identifies the correct provider type under the 'Authorization Schedule' header. In both these situations, an authorization number is provided to the HUSKY Health provider and a written notice of the authorization is generated via ProviderConnect. The authorization letter can also be mailed to the HUSKY Health provider at their request. The authorization notice includes language that indicates that the authorization does not confer a guarantee of payment.

When a HUSKY Health provider makes a request for a Level of Care (LOC) that does not meet Level of Care Guidelines, the HUSKY Health provider is informed. The reviewer will work with the HUSKY Health provider to make them aware of alternatives to the requested LOC in terms of type, frequency, timing, site, extent, duration and effectiveness for the individual's illness. In situations where there is agreement, the CT BHP will authorize the care. In situations when there is continued disagreement, the Care Manager will inform the HUSKY Health provider that the case needs to be referred to a Physician Peer Advisor for a Medical Necessity review.

A concurrent review decision is made upon the CT BHP receiving all necessary clinical information required to make a level of care determination. All times will be measured from the time the Care Managers or Peer Advisors have received all requested information.

INTENSIVE OUTPATIENT CONCURRENT REVIEWS

The CT Behavioral Health Partnership will accept concurrent reviews on the date the HUSKY Health member re-presents to treatment or **one business day** after. This will provide the most up to date clinical information and attendance history.

Example 1: HUSKY Health provider has IOP authorization for John Smith from 5/29/19 – 6/12/19:

- If John Smith continues with IOP treatment on 6/13/19, the concurrent review must be completed on 6/13/19 or 6/14/19 with a 6/13/19 requested start date, or;
- If John's next attended session is on 6/18/19, the concurrent review must be completed on 6/18/19 or 6/19/19 with a requested start date of 6/18/19, or;
- If John's next attended session is on 6/27/19, the concurrent review must be completed on 6/27/19 or 6/28/19 with a requested start date of 6/27/19.

NOTE: In the event that the next attended session is on a Friday, the concurrent review must be completed on that Friday or the following business day (Monday) with Friday as the requested start date.

PLEASE NOTE: If HUSKY Health member re-presents to treatment 30 days after the last authorized date, the authorization request will be considered an initial review; not a concurrent review.

DATE EXTENSIONS

In the event that all service units are ***not utilized*** prior to the end date of an authorization, HUSKY Health providers can request to have an existing authorization expiration date extended. The CT BHP will allow one date extension request on an initial authorization for the following levels of care - Intensive Outpatient (IOP), Extended Day Treatment (EDT), Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS), Multidimensional Family Therapy (MDFT), Multisystemic Therapy (MST), Functional Family Therapy (FFT) and Autism Spectrum Disorder (ASD) services.

This one-time date extension request must be submitted utilizing the ProviderConnect inquiry function outlined in the CT BHP Registered Services User Manual.

Beyond the initial authorization line and one-time date extension request (if required), all requests for continuing authorizations will have to be completed as a standard concurrent review through the ProviderConnect portal. This will ensure that we are receiving the most up to date clinical information and assist in assessing the HUSKY Health members continued need for treatment.

ASD Providers: Please note that initial requests for authorization and for date extensions should only occur once treatment staff is identified and services will be commencing or continuing from initial authorization.

BACKDATING REQUESTS

In the event that all service units are utilized prior to the end date of an authorization, HUSKY Health providers can request an existing authorization expiration date to be backdated, so that a concurrent review can be entered via the ProviderConnect portal. Backdating requests can be requested for Intensive Outpatient (IOP), Extended Day Treatment (EDT), Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS), Multidimensional Family Therapy (MDFT), Multisystemic Therapy (MST), Functional Family Therapy (FFT), and Autism Spectrum Disorder (ASD) services.

HUSKY Health providers must submit a backdating request of authorization utilizing the ProviderConnect inquiry function outlined in the CT BHP Registered Services User Manual.

A Care Manager can only authorize treatment. Any decision to deny, partially deny, reduce, suspend or terminate services must be made by a Peer Advisor. Peer Advisors must be a doctoral level psychologist, a psychiatrist, an American Society of Addiction Medicine (ASAM) certified physician, or a certified addiction medicine specialist.
Peer Advisors will be involved only in reviewing cases that fall within their area of clinical expertise.

MEDICAL DIRECTOR / PEER ADVISOR

If the Care Manager is unable to authorize the care requested by the HUSKY Health provider, the Care Manager will refer the request to a Medical Director/Peer Advisor. The CT BHP Medical Directors, contracted psychiatrists, or doctoral level psychologists may conduct consultations.

Peer Advisors review those requests in which services do not appear to meet level of care guidelines and/or those in which the Care Manager may identify a potential quality of care issue.

The Peer Advisor reviews the available clinical information and attempts to contact the referring HUSKY Health provider for a telephonic consultation. If the Peer Advisor can reach the referring HUSKY Health provider, the case is reviewed with the HUSKY Health provider. If the Peer Advisor is unable to reach the referring HUSKY Health provider, the Peer Advisor will render the decision to authorize (or not) the requested services based on the available clinical information within appropriate timeframes.

The Peer Advisor or Care Manager will inform the HUSKY Health provider telephonically of the decision. A written notification is also sent to the HUSKY Health enrolled individual and HUSKY Health provider in accordance with requirements of the CT BHP. The written notification includes a rational for not approving the request, a description of the rights to appeal the decision, and the process by which to file that appeal.

OTHER REVIEWS CONDUCTED BY CT BHP

In addition to conducting prior authorization and concurrent reviews, Care Managers may also conduct retrospective reviews for various reasons – eligibility being granted retrospectively, emergency admission, or no presentation of an individual's identification card, etc.

Retrospective reviews for medical necessity is a review conducted after services have been provided to the individual. Retrospective reviews may also occur when a decision regarding the authorization of a service previously administratively denied is overturned on appeal. Under these circumstances, the service would be retrospectively reviewed for medical necessity.

Retrospective reviews for medical necessity typically involve the review of the medical record for the dates of service in question. HUSKY Health providers are encouraged to submit a copy or portion of the medical record that will best assist in determining medical necessity, along with their request for a retrospective review. When all the necessary clinical information accompanies the request, a decision will be rendered within 30 calendar days. However, if the request is made verbally, the HUSKY Health provider will be notified by mail that additional information is needed and will be given 45 calendar days to respond to the request. If the information is not received within that time frame, the appropriate administrative or clinical denial is issued. In the instance when the information is received within the timeframe, the review of the record will be conducted, and a decision made within 15 calendar days of the receipt of the necessary information.

RETROACTIVE ELIGIBILITY

Most retrospective reviews are the result of the HUSKY Health enrolled individual being granted backdated eligibility and the HUSKY Health provider subsequently asking for the authorization of services rendered during the now covered period. When an individual is granted retroactive eligibility, HUSKY Health providers who provided services to the individual during the now covered period can request that those services be reviewed for medical necessity, within 90 days of eligibility being updated. These retroactive medical necessity reviews are a subset of retrospective reviews and follow the policy and procedures that govern retrospective reviews. For a retroactive review to be conducted, the effective date of eligibility must span the date(s) of service.

PROCESS FOR HIGHER LEVELS OF CARE

The CT BHP assists HUSKY Health providers with obtaining authorizations for HUSKY Health enrolled individuals that become retroactively eligible during or after higher level of care services. Higher level of care services includes inpatient psychiatric, inpatient withdrawal management, partial hospitalization, freestanding withdrawal management, residential rehabilitation, adult group home, home health, and Autism Spectrum Disorder (ASD) services. When a HUSKY Health provider verifies, with the DSS automated eligibility system, that an individual has been made retroactively eligible, they can submit a request for retroactive authorization for higher level of care services.

All retrospective eligibility requests for higher levels of care must be submitted within 90 calendar days from the valid eligibility change date in ProviderConnect. The CT BHP will process all requests within 30 calendar days from the date of receipt from the HUSKY Health provider. HUSKY Health providers can check if authorization has been approved by contacting Denials and Appeals at 860-263-2161. Requests should be submitted to CT BHP with a cover sheet (including full name and phone number of submitter/requestor, individual's Medicaid ID #, full name, date of birth, level of care being requested and dates of service needed) along with the necessary supporting documentation* to the following:

Connecticut Behavioral Health Partnership
ATTN: Quality - Retroactive Eligibility Authorization
Enterprise Drive, Suite 3D
Rocky Hill, CT 06067
OR
Fax: 855-575-6532 (toll free)
OR
Email: ctbhpappeals@beaconhealthoptions.com

*The following table lists the required accompanying documentation by level of care:

HLOC Retroactive Eligibility Review Request - Documentation Requirements						
	ED Summary, if applicable	***Admission Summary***	***Discharge Summary***	***Labs***	***Medications***	***Progress/ Visit Notes***
Inpatient, Psychiatric						
Precertification	*X*	*X*	*X*	*X*	*X*	
Concurrent	*X*	*X*	*X*	*X*	*X*	*X*
Inpatient, Psychiatric State-operated facility						
Precertification	*X*	*X*	*X*	*X*	*X*	
Concurrent	*X*	*X*	*X*	*X*	*X*	*X*
Inpatient Withdrawal Management Freestanding						
Precertification	*X*	*X*	*X*	*X*	*X*	
Concurrent	*X*	*X*	*X*	*X*	*X*	*X*
Inpatient Withdrawal Management Hospital						
Precertification	*X*	*X*	*X*	*X*	*X*	
Concurrent	*X*	*X*	*X*	*X*	*X*	*X*
Substance Use Residential Rehabilitation						
Precertification	*X*	*X*	*X*	*X*	*X*	
Concurrent	*X*	*X*	*X*	*X*	*X*	*X*
Partial Hospitalization						
Precertification	*X*	*X*	*X*	*X*	*X*	
Concurrent	*X*	*X*	*X*	*X*	*X*	*X*
Group Notes should be included in Concurrent Requests						
Adult MH Group Home						
Precertification	*X*	*X*	*X*	*X*	*X*	
Concurrent	*X*	*X*	*X*	*X*	*X*	*X*
Home Health Care						
Precertification		*X*	*X*		*X*	
Concurrent		*X*	*X*		*X*	
Plan of Care/485 should be included in Precertification and Concurrent Requests						
Autism Services						
Precertification		*X*	*X*		*X*	
Concurrent		*X*	*X*		*X*	
Autism Assessment & Program Book should be included in Precertification and Concurrent Requests						

PROCESS FOR LOWER LEVELS OF CARE

For Intensive Outpatient, Extended Day Treatment, Home Based Services (IICAPS, MST, MDFT, and FFT), Outpatient*, Psychological Testing, Methadone Maintenance, and Ambulatory Withdrawal Management services:

- HUSKY Health providers can submit a Registered Services Retroactive Eligibility Template or a Psychological Testing Registration Template to CT BHP within 90 calendar days from the valid eligibility change date in ProviderConnect. (Both forms can be located under the Templates header on the "For Providers" homepage of the CT BHP website).
- The CT BHP will verify that individual's eligibility has been retroactively granted, create an authorization and submit the authorization to Gainwell Technologies.
- HUSKY Health providers can check individual's eligibility in ProviderConnect. Please refer to Provider Alert (PA2016-03)

  **(Please note: Per Provider Bulletin PB 2021-26 – Effective for dates of service 5/21/21 and forward, only Psychiatric Diagnostic Evaluation Codes (90791, 90792 and 90785) require authorization for Individual/Group Practitioners, Community Mental Health Clinics, Outpatient Hospitals, Federally Qualified Health Centers and Enhanced Care Clinics. Rehabilitation Clinics still require prior authorization for outpatient individual, family and group therapy.)*

DISCHARGE & AFTER CARE PLAN

In order to support optimal connect to care rates; Care Managers will verify discharge information to establish that the treated individual is ready to discharge from the treating level of care.

In order to determine that an individual has connected to treatment at the aftercare facility following discharge from a more acute level of care, Beacon Health Options staff will contact the individual and/or aftercare service HUSKY Health provider who has been identified during the acute care discharge review process.

CT BHP BYPASS PROGRAMS

"Bypass programs" refers to a program where HUSKY Health providers that meet or exceed performance targets on key indicators bypass the selected usual administrative requirements in the utilization management process. This allows for the authorization of care for longer periods of time, thus decreasing the number of concurrent reviews required for a stay or service.

INPATIENT BYPASS PROGRAM CRITERIA

The enhanced Inpatient Bypass program, implemented in 2019 and currently on hold until further notice, incorporates case-mix data, which is a more equitable length of stay evaluative process by capturing the clinical complexity of HUSKY Health members treated within inpatient facilities and generating an expected length of stay accordingly for these individuals. The bypass metrics include the following:

- Length of Stay (LOS) difference,
- LOS Improvement/Maintenance
- 7-day readmission rate
- Behavioral Health Emergency Department (ED) visit within 7-days post IPF discharge rate
- Discharge Form completion rate
- Bed Tracking completion rate

HOME HEALTH BYPASS PROGRAM CRITERIA

The Home Health Bypass program continues to use two measures consistent with previous years: BID rate and ED rate. To meet criteria to be in the bypass program, a HUSKY Health provider must meet the

BID (i.e., twice daily medication administration) rate of 20% or less based on the data in the current quarter being assessed. Additional measures are monitored but not required for inclusion in the Bypass Program: QD (once daily medication administration) rate and ED (emergency department) visit rate. To meet the criteria for the Bypass Plus Program, HUSKY Health providers must have a BID rate of 15% or less and an ED rate of 32% or less. In both cases, initial authorizations are longer than standard and concurrent review timeframes are extended as well.

INTENSIVE CARE MANAGEMENT

Intensive Care Management activities include identifying children and adults who are encountering barriers to care and providing short term assistance and problem solving to eliminate those barriers. Each Intensive Care Manager (ICM) can support approximately 30-40 children and/or adults at any given time.

Beacon Health Options in collaboration with the Partners have established criteria for referral to an Intensive Care Manager (see below for examples). Beacon Health Options conducts analyses on an ongoing basis to proactively identify HUSKY Health members that meet the criteria and then refer these individuals to the ICM program for follow-up.

If the referred individual does not have an established source for their behavioral health care needs, the ICM will help connect the individual to care and will follow-up to see that they connected and engaged in those services. If an individual is already receiving behavioral health (BH) services, the ICM will coordinate case conferences with the individual/parent/natural supports and/or HUSKY Health providers to determine and/or identify opportunities to improve the individual's plan of care. If a child has complex service needs and would benefit from wrap-around services, the ICM may present the child and family needs to a Community Collaborative for additional resources or in the case of an adult HUSKY Health member refer the member to a Local Mental Health Authority (LMHA) and/or other community resource such as a Community Care Team (CCT). Finally, for those individuals with co-morbid medical conditions, the ICM will coordinate with the Medical ASO and/or medical provider.

SAMPLE ICM REFERRAL CRITERIA

- Delay of discharge from emergency department or hospital setting
- Multiple emergency department visits in short period of time
- High risk hospital discharge (i.e., multiple risk factors, recent prior admissions)
- History of unsuccessful connections to care
- Disruptions in placement due to behavior
- Serious medical co-morbidities, and/or
- Transition risk – age 17 years and receiving multiple behavioral health services

SAMPLE PLAN/INTERVENTIONS

- Coordinate with involved state agencies, hospitals and HUSKY Health member specific team
- Participate in care planning with individual and/or their family members
- Identify alternative services and supports (social determinants of health resources, non-traditional services) that had not been considered by HUSKY Health provider or family
- Monitor success of connection to care and intervene if connection is disrupted
- Facilitate access to and/or enrollment of HUSKY Health provider with special qualifications (e.g., language specialty), and/or
- Assist with coordination of Wellness Recovery Action Plan (WRAP) with the appropriate state agency and HUSKY Health provider

PEER BASED SERVICES

Peers are adult individuals with experience receiving services via the Medicaid Network, who are in long-term recovery, and who utilize their lived experience to provide education and outreach to HUSKY Health members. Peers can be parents of children with behavioral health needs or adults who are receiving or have received

behavioral health or substance use services. (For Additional information on Peer Services: See Page 43).

CRITICAL ELEMENTS IN TREATMENT AND RECOVERY PLANS

The CT BHP expects all HUSKY Health providers to develop a treatment and recovery plan with the HUSKY Health enrolled individual and the individual's family as appropriate. The content of the treatment plan may vary depending on the complexity of the individual's needs, the array of services being provided, and the duration of the episode of care.

Nevertheless, Care Managers and Intensive Care Managers collaborate with HUSKY Health providers about the individual's treatment and discharge plan as part of every review process or during participation in onsite rounds.

The following list includes key elements that the CT BHP expects to be documented as part of person-centered treatment, recovery and/or discharge planning:

- HUSKY Health member strengths and resources
- Primary therapist
- Primary Care Physician
- Date of most recent treatment plan update
- Measurable goals
- Behavioral objectives
- Treatment modalities and frequency, including
  - Individual therapy
  - Family therapy
  - Group therapy
  - Partial hospitalization
  - Medication management
  - Case management
  - Substance Use Services, and/or
  - Other
- Medical conditions
- Medications (type, dosage)
- Family and other natural supports, and involvement
- Community resources involvement
- Consultations
- Substance use concerns/treatment
- Treatment obstacles and strategy for overcoming obstacles
- Date of planned discharge, and
- Wellness Recovery Action Plan (WRAP)

OTHER REVIEWS CONDUCTED BY CT BHP

CT BHP HUSKY Health providers are required to cooperate with all record reviews conducted by Beacon Health Options. Findings of the reviews will be shared with the HUSKY Health provider. If findings are not favorable to the HUSKY Health provider, the HUSKY Health provider is offered an opportunity to provide additional information and/or implement an improvement or quality improvement plan.

Focused Chart Reviews

Beacon Health Options may conduct focused chart reviews of a HUSKY Health provider whenever concerns are raised about a particular individual's care or about the services, a HUSKY Health provider is offering to multiple HUSKY enrolled individuals. Such reviews may be conducted on site and without prior notice to the HUSKY Health provider.