Residential Level 3.1 RJOT Minutes

January 10, 2018

Attendees:

- BHA – Dr. Bazron, Marian Bland, Kimberly Qualls, Steve Reeder, Lisa Davis, Sheba Jeyachandran, Cynthia Petion
- Medicaid – Rebecca Frechard, Nicholas Shearin
- Beacon Health Options – Stephanie Clark, Dr. Lisa Kugler, Karl Steinkraus, Joana Joasil, Dr. Enrique Olivares
- Provider/Agency – Melissa Crawford (Cameo House), Sarah Drennan (Frederick Co. HD), Rhonda Moreland (Allegany Co. HD), Pheobe Twigg Allegany Co. HD), Heather McGrath (Avery House), Malika Curry (Avery House), Mary Ann Bruce (Howard Co. HD), Lisa Mankin (Damascus House), Elizabeth Wilbourne (Harbour House), Roger Riley (Harbour House), Darlene Jackson-Bowen (Wicomico Co. HD), Faythe Johnson (Powell Recovery Ctr.)

Welcome and Introduction

Establish Purpose and Timing of Meeting

- The Department requests that providers send questions by Monday close of business so that the State and Beacon have time to review questions and provide the most complete answers during the call. Questions and topics should be related to the implementation and outstanding provider issues as we roll out this new service. Questions should be submitted to marylandproviderrelations@beaconhealthoptions.com.

Questions:

1) A client does not like self-help groups, such as AA/NA, etc., but is interested in building a sober support network. Would it be feasible to include in the clients tx plan, that they will attend a sober support group, such as SMART or a Refuge Recovery Meeting within 30 days? If so, could this count towards the 5 hours of therapeutic services for a given week? Who would document these services if allowed? And, how would this be documented as an hour of service that week? Would a miscellaneous note based on self-report of the client suffice?

   12 Step programs do not count toward the 5 hours of therapeutic services in a week. Programs that facilitate relapse prevention type of groups that are customized and personalized to treatment goals of their particular clients are considered appropriate services under the minimum 5 hours of services per week. Non Program staff should never be given access to a patient's chart. Services that are performed as part of the minimum 5 hours of therapeutic and supportive services must always have representation from a Program's qualified staff. While that staff member does not have to be directly providing the service or facilitating the meeting, they need to be part of the registration process, oversite as appropriate, and conclusion of the

service to determine whether the activity offered is congruent with the individualized treatment plan. That staff member (peer support, CAC, LC) that is under the direct liability of the 3.1 Program would then be the appropriate individual to confirm the individual attended the activity. While this documentation may not need to be performed daily, a weekly assessment by the CAC or LC provider would incorporate the attendance and noted benefit to the individual receiving services. This is an all-inclusive rate that is billed daily but documentation could be performed weekly as long as each of the services that are eligible for inclusion under the model of a therapeutic/supportive environment are documented, such as by an attendance sheet, and observed by the Program qualified staff.

The Department and Beacon are developing a model of appropriate documentation to use as a guide/example for providers. This will be available within the next 30 days. (??

2) We have a yoga instructor that volunteers with our organization, but she is does not have any statewide certification. If attendance at yoga was in the treatment plan as coping skill/relapse prevention, would this count towards the 5 hours of therapeutic hours? Would the yoga teacher be required to do a note for providing this service?

   Similar to the question above, when Yoga, or any other therapeutic, supportive activity supports an individual's path toward recovery, performed on site and observed by one of the required staffing (peer, CAC, or LC) then this activity is part of the minimum of 5 hours per week of therapeutic hours. An attendance sheet from the yoga instructor or staff is initial documentation that the activity occurred and an observational note from the Program staff person, as appropriate, could be added to briefly summarize an individual's responsiveness to that activity (i.e. participant actively participated vs. participant stated they didn't like the activity) A brief note and template or workflow should be developed and followed by the program. A full note should be documented weekly by the LC level staff who is responsible for reviewing the benefit of the treatment plan to the individual and make modifications/recommendations as needed.

3) In a similar vein as the question above, we have many volunteers that provide services to our clients, but they are not clinicians or peers. Are they required to write a note that the service was provided – let's say 12 people attended yoga or a financial education class – would the volunteer be required to write a note for each person that attended? Since they are volunteers this may be a burdensome request and they may withdraw their volunteer services if we made this request. If a service note is required, could another staff member write a note that the service was indeed provided?

   Similar response as above – for any activity, class, effort that supports the individual's personal growth and reduction in symptoms should be noted. Our guidance is for providers to view this service as transitional. With individuals in varying levels of recovery, the treatment plans and the activities should all reflect that fluidity and growth toward the individual preparing to re-integrate into the community with appropriate supports in place.

4) COMAR regs state "Clinical Director is responsible for the supervision of the program's clinical services, counselors, peer support staff, and coordination of all care provided by outside programs". Does the clinical supervisor/director have to provide supervision to all the direct

care staff (this is the term our program uses for non-certified peers that work directly with the clients)? If yes, how many hours and how often?

Supervisors who are supervised by the Clinical Director may be designated to provide supervision to the direct care staff (peers) assuming that those supervisors meet the qualifications for providing supervision to that staff. The State recommended hours of supervision per week for non-certified and certified peers is 1 hour. The Clinical Director is under an ethical requirement that if a supervisee requires additional supervision that they ensure this takes place as appropriate.

Can a House Manager supervise direct line staff?

If the House Manager is appropriately credentialed or licensed then they could supervise direct line staff. Providers may contact Kimberly Qualls at BHA with specific staffing patterns to work through program specific nuances for assistance. Please email kimberly.qualls@maryland.gov.

5) Is a nurse required to be present in order to bill for halfway house services?

Nursing services are not required for 3.1 level of care.

6) We have a patient in our 3.1 program- he is a drug court participate and when he went to court and was sanctioned (sent to jail) by the Judge for a week. This is a common practice for court ordered patients- we will hold the bed, their belongings and medication while they are in jail. When the week is up, the patient will be transported back to our program to resume treatment.
    - How many administrative days can we use for this situation?

This is an acceptable use of administrative days. Providers should follow the appropriate protocol of calling into the Beacon clinical department in order to document the days needed within the authorization. Please note that if the consumer is away from your program and their authorization is set to expire, you will need to enter your concurrent to ensure no claims payment issues when the consumer returns to your program.

    - Who do we contact at Beacon to inform them of the need to use Administrative Days and how do we do that (call/form/electronic)?

Providers may call 1-800-888-1965 and ask to speak to a clinician. If providers experience issues utilizing the toll-free number, they may also email our clinical team directly at Marylandclinicaldept@Beaconhealthoptions.com. We monitor this mailbox during business hours and will respond within the same or by the next business day.

    - Can the contact be done by a non- clinical person from our program or does it have to be a Clinical Provider?

Calls can be completed by a non-clinician as delegated by the 3.1 Program, as long as they have the appropriate information to document the reason for the administrative days.

Additional Questions:

7) Can you please clarify previous direction that administrative days should only be for up to 3 days, but the example given today indicated up to a week would be appropriate?

Providers should remember that administrative days are approved based on the individual consumer need and medical necessity criteria. Providers that are requesting administrative days need to call the Beacon clinical team (instructions in previous question) and review the need with the clinical care manager. Administrative days will be approved on a case-by-case basis. In the example given the consumer is court ordered, by judicial authority, and would be approved by Beacon. In general, 3 days is the appropriate number of days but there is room for exceptions, particularly in the case outlined previously when the individual was court ordered to jail for a week. In that case, since it is for an 8-507 individual, the administrative days would be appropriately approved because the assumption of the court would be that the provider would hold the bed.

8) Several providers are having difficulty in obtaining their MA number through ePrep. This has caused them to be unable to enter authorizations and receive reimbursement for their Level 3.1 services. What can be done to assist providers so that they are able to deliver services and receive payment?

The Behavioral Health Unit is working closely with ePrep to attempt to resolve all outstanding provider files. If providers are still having an issue with obtaining an MA number please contact Nicholas Shearin (Nicholas.shearin@maryland.gov) for additional assistance or mdh.bhenrollment@maryland.gov. While the Medicaid BHU is available for assistance, keep in mind they are not the ePrep vendor. Providers need to be very responsive when ePrep and BHU request additional information. Delays provider response, or overall non-responsiveness WILL impact your ability to be enrolled in Medicaid. The extra work to assist 3.1 providers is because you are new to the system but bear in mind that ALL provider types must enroll through ePrep and follow their instructions to enroll with Medicaid.

Additionally: ePrep has specific help lines to assist you. If you do not get a satisfactory response from ePrep the second step is to outreach to the Department's enrollment unit (EMILY GIVE ENROLLMENT UNIT EMAIL AND/OR phone). If you still do not get a response then you may email: mdh.bhenrollment@maryland.gov – which is the Medicaid BH Unit. Beacon is not able to assist providers with Medicaid enrollment. This is a function of MDH/Medicaid and is a separate process and separate vendor. If you contact Beacon for Medicaid enrollment it will further delay your response as Beacon will try to assist you, but they cannot impact Medicaid enrollment.

For Medicaid's BHU part, as long as there is evidence that the provider is working toward enrollment and passes all staffing requirements and meets eligibility, Beacon is authorized to set up a workaround to ensure that authorizations are obtained and payment is made. This process, however, is an advance, and as the enrollment issues get sorted, the claims will be re-adjudicated. The provider is responsible

for ensuring that you are obtaining authorizations for 3.1 level of care and that payment received is for Medicaid recipients. Any change in any of the status will result in a retraction of funds.

If providers have been entering their authorizations and submitting claims under an incorrect level of service they should immediately contact Beacon Health Options to have their auths and claims rectified. Please email marylandproviderrelations@beaconhealthoptions.com and a provider relations representative will work with you to correct these errors.

Beacon and the Department will be identifying a way to ensure providers are paid for their level 3.1 services correctly and swiftly during this disruption period until providers are able to obtain their appropriate NPI and MA numbers. Billing and authorization instructions will be issued soon. If your program is negatively impacted by the enrollment process, but you meet all other requirements as of 1/1/2019, MDH and Beacon will work with you to ensure that all eligible claims are paid.

9) In the FAQ #2 it states that Medicaid is only paying for two up to 30 day stays per rolling year. However, it also states that the authorization spans are 90 days for initials and 60 days for concurrents. Can you please clarify how the remaining authorization portions are paid?

As long as the consumer is meeting the medical necessity criteria for the requested authorization spans, Beacon Health Options ensures that the first 30 days are paid out of the Medicaid funding and that the remaining days are paid out of state funds. This is completely seamless to the provider and they should see no disruption in payment.

10) In the FAQ #12 it states that a client can be in level 3.1 and attend traditional outpatient services. Does the outpatient service have to be onsite or can it be off site? Does it have to be another provider or can it be an affiliated provider?

These services must be distinct services that are administered at different times by different staff at their distinct service locations. The consumer may receive services from an outpatient provider (PT 50, level 1 ASAM) and level 3.1 providers that are affiliated or unaffiliated. The Department would not expect 100% of individuals in 3.1 care would also 100% be receiving outpatient level 1 services. All services must meet medical necessity and be authorized by Beacon to be eligible for reimbursement. If you have concerns about the affiliation of their programs, please send your questions with detailed examples of the affiliation to marylandproviderrelations@beaconhealthoptions.com and it will be reviewed by Beacon and the Department.

11) Define room and board and what it covers? Does this cover meals and do we need to have a dietitian?

Room and board does cover food. Specific questions around nuances of your program should be sent to BHA at kimberly.qualls@maryland.gov for assistance.

12) Has the state considered unbundling traditional OP from OTP so that residential providers could obtain and OTP auth now that IOP is excluded from giving IOP?

This is a policy question and is not up for discussion in the context of RJOT calls. Please feel free to send your question to: mdh.mabehavioralhealth@maryland.gov and MDH will review in the same manner all policy questions are reviewed. A change of this nature which impacts coverage or reimbursement would require a regulatory change.

13) Are Halfway houses no longer covered by MDRN?

All ASAM level 3.1 services are covered by Medicaid and/or state funds. This includes halfway housing previously funded through MDRN.