Residential Level 3.1 RJOT Minutes

January 18, 2019

Attendees:

- Minutes: Call from 9:30-10:30 am attendees:
- BHA Attendees: Cynthia Petion, Marian Bland, Kimberly Qualls and Steve Reeder
- Medicaid Attendees: Nicholas Shearin
- Beacon Attendees: Stephanie Clark, Karl Steinkraus, Dr. Enrique Olivares and Joana Joasil
- Provider/Agency Attendees: Kennedy Hinman (Hudson Health Services), Mary Gamble (Brantwood Family Services), Beth Waddell (The Ranch), Christina Trenton (Wells House), Bryce Hudak (Universal Psychological Center), Mayra Diaz (Tuerk House), Rhonda Moreland (Allegany Co. HD), Phoebe Twigg Allegany Co. HD), Angela Williams (Brooke's House), Barbara Trovinger(Universal Psychological Center)

Announcements:

- Beacon and the Department will be setting up a separate meeting to address provider enrollment authorization and payment issues. This invite will go out to those who have indicated that they have had an issue with enrolling as a 3.1 provider. If you are having issues and have not already been in contact with Beacon, Medicaid or BHA, please email marylandproviderrelations@beaconhealthoptions.com to be added.

Providers who have submitted authorizations and claims for level 3.1 members under a different level of care, such as IOP, should contact Beacon for assistance in correcting these errors to reflect the appropriate level of care authorization and claims billing codes. Please email these errors to marylandproviderrelations@beaconhealthoptions.com for assistance.

1. For peers who are employed at a halfway house, must they already be certified peer recovery support specialists?

   If not, must they be actively working towards certification (i.e. obtaining supervision from an approved peer supervisor)?

   No, it is not required that peers be certified peer recovery support specialists but we do encourage providers to employ certified peers. If the peer is uncertified, they must be working towards their certification. Please note that all certified peers should be supervised by a registered peer supervisor.

2. Our facility has individual units and the families provide their own meals with the supervision of the Facility Monitors. The Facility Monitor will work in shifts and responsible for maintaining and documenting the everyday operations of each resident and the unit to assure that the environment is safe and the facility is secure. Will this have to change?

   The Department would like to better understand this arrangement. The Behavioral Health Administration will reach out to you directly to further discuss. Providers should be aware that the room and board rate is set to cover food. Utilizing member food entitlements, such as food stamp cards, is not appropriate. Those food cards should remain in the possession of the members to use as they need.

3. Room and Board - It was mentioned that this rate includes food. Does this mean three meals a day? Or staples in the house? Our ladies receive TCA and Food Assistance and supply food for themselves, currently.

   See above answer to #2.

4. Administrative Days - Please provide more information on consumers who are hospitalized for more than three days, or who have a child in who is hospitalized, and are in our women and children's program. We are not a specialty provider, but are considering becoming one. An example, we have two women whose children were sent to Baltimore and DC after an RSV diagnosis. These women have been out of the house for over a week at the hospital with their child. We have been in constant contact with them via telephone. They still meet medical necessity criteria for ASAM 3.1. Questions: (1) Would these days be considered for Administrative Days? (2) Could a face-to-face telehealth-like call take place to count as a clinical hours versus being worried about the administrative days getting authorized?

   If the mother is at the hospital with their child, this is an appropriate use of administrative days as long as the mother is remaining at the hospital. If the mother will be at the hospital for an indefinite amount of time, the provider should examine if it is appropriate to discharge the mother until she is able to return. Providers may discuss these circumstances with Ms. Tucker's team for further clarity. Suzette Tucker may be reached at the following email address: suzette.tucker@maryland.gov.

   Administrative days may be approved by calling into the Beacon clinical department and discussing the specifics of your case. Requests for administrative days will be evaluated on a case-by-case.

   Regarding telehealth (telehealth like), the Residential program is not an approved telehealth provider and note that telehealth services must always be provided by a licensed clinician. However, clinical/therapeutic and support services under the 3.1 are an important part of the service. If outreach and support occurs, and the individual is staying overnight at the 3.1 program, then this would not require an "administrative" day. All services should be tailored to the individual need of residents and in this scenario the support offered by the Program would be part of the process. If the resident does NOT stay overnight at the Residential program nor return the next day while at the hospital, that is when the Administrative leave days would be used. Services should be connected to the recovery/maintenance plan and fully documented in the consumers chart.

If the member is not staying at the program and the hours do not add up to the 5 hours required, then you should be using the administrative days?

The Department will take this question offline for further review and provide guidance shortly.

At what point would the state recommend a medical discharge?

Providers should collaborate with the attending physician on the stay and prognosis and the patients potential need for stepping down. Once you are able to get this full picture, you should be able to tailor whether you will leave open the bed for a period or if they need to be discharged from the facility. Providers are also able to call into the Beacon clinical department and discuss their case for further guidance.

5. PWC: Sometimes women are referred to our Women with Children program from Child Protective Services (CPS). CPS often wants the women admitted into treatment before they will allow their child(ren) to stay with them. This can delay the child(ren) admission to our program a few days upwards to a few weeks. In the meantime, we are providing coordination of care with CPS and other outside agencies for preparation of the arrival of the child(ren). In addition, sometimes the child(ren) only come for overnight weekend visits or day visits to start. How should the authorization be obtained for the above situations?

   In this type of situation, the program should ask CPS to supply a letter that commits to a reasonable timeframe, such as 30 – 45 days. Providers need to be approved through Ms. Suzette Tucker's unit at BHA. Providers should obtain authorizations for the PWC program and are able to be reimbursed using the PWC fee schedule. If providers are unable to obtain the letter of commitment and the child is not able to join the mother, services will evaluated to determine when to switch to a non-PWC residential setting. We appreciate the challenges in determining whether your program wishes to enroll as a specialty provider. Please feel free to reach out to Suzette Tucker, Director of BHA's Office of Gender-Specific Services at suzette.tucker@maryland.gov to assess your program's readiness to provide these enhanced services and to obtain an application to become a specialty provider

6. Moving patients in residential 3.1 within our program: If we have 3.1 authorization at one location but we move the patient to another one of **our** location for clinical reasons- do we need to terminate the initial authorization and submit a new authorization under the new location or can we contact Beacon to have the remaining authorization on the first location flipped to the second location as long as it's the same level of care type?

   Currently, the provider would need to obtain a new authorization because every service you provide at every location is associated with your unique Medicaid and NPI combination.

7. Administrative days: Do Administrative Days count towards the 3.1 authorization or do we notify Beacon and obtain a separate authorization for just Administrative Days? How many administrative days can be used, is there a limit per year or per episode? Can Administrative Days be used for patients who are 8507 and are sanctioned for a week - meaning they are sent back to jail by the Judge for a week due to non-compliance or a relapse- but we are holding their bed and place in treatment as they will be automatically returned to our program?

Providers do not need to obtain a separate authorization for administrative days. However, they must call the Beacon clinical department to discuss reason for needing administrative days. Beacon will maintain record of this within the existing authorization. Administrative days are evaluated on a case-by-case basis for need and length of stay. In regards to the court-sanctioned members, this is an appropriate use of administrative days.

8. Are PRP services eligible for billing while the client is enrolled in a 3.1?

   No, these services are considered duplicative. If providers would like more information on the Medical Necessity criteria and combination of services, they can visit the Beacon Health Options website at http://maryland.beaconhealthoptions.com/provider/prv_man.html. Providers may also send any additional questions for review to Dr. Enrique Olivares at Enrique.olivares@beaconhealthoptions.com.