BHP Operations Sub-committee - Minutes

DATE AND TIME OF MEETING: Date: August 6, 2021 Time: 2:30 - 4:00 Location: via zoom	Internal	External	Recorder: Jen Kurowski, Beacon Health Options Co-Chairs: Terri DiPietro and Heather Gates	Draft	Final
		x		X	

TOPIC	DISCUSSION/RECOMMENDATION
1. The 1115 Waiver **a. Medicaid Rates by LOC- Staffing patterns that Mercer has used to build rates** **b. Room and Board Rates- details of costs to create rate** **c. Grant Funding- plan for current grant funding supporting the SU residential programs** **d. Enhanced Match- how much and how will it be re-invested** SUD FFS Fee Development - ASAM SUD FFS Fee Development - Regi SUD FFS Fee Development - Resic SUD FFS Fee Development - Wag SUD-Demo-CT Clinical Assumption SUD-Demo-CT Clinical Assumption	• Bill Halsey extended thanks to the state agency partners and Mercer for all the work that has been done on this so far. • Will plan deeper dive meetings on this topic. • We are targeting a 10/1 start date but this will be aggressive. • Bill H. reviewed the attachments and said you should consider these to be final documents unless we find any errors. • Transitioned to the upper bound hourly wage, which has made some dramatic changes in the rates. • There are some differences in the Mercer rate setting assumptions and the state clinical rate setting assumptions. In many cases, the standards have been modified to allow a decrease vs some assumptions from the Mercer rates. Most notable is we did reduce individual therapy hours across the board. • If you see any inconsistencies that seem higher than our standards, such as nursing, we asked Mercer to go back and look at this to see what the rate supports. • Rate structure supports a service coordinator. The action of service coordination can be performed by a variety of individuals. Standards also indicate a dedicated service coordinator. • State clinical assumption grid will eventually translate to our standards. • Occupancy expectations remain at 90% as in the original document. The 90% is anticipated to reflect the average over time. • Rate changes vary but tend to be between 17-20%. • Bill H. pointed out the table titled Total Beds at Location all Levels of Care – You could add up all your beds, total them and read down on the table. We still need to determine whether you will aggregate or disaggregate your beds. These reflect the current thinking on the rate structure. • Heather G. asked for clarification on different LOC on the same campus? Is it the provider's choice whether to add them up to figure out the rate or is it the department's decision? Bill encourages looking at both scenarios but do not have that information today but will need to get back to the group on this. • Heather G. asked if there was a break at 0-8 beds or 0-12 previously? Keri Lloyd explained that it was 0-12 previously and is now 0-13. Heather indicated that 0-8 beds continues to get challenging for occupancy. • Heather G. commented that we should not assume that the grants will make up for inadequacies for occupancy or for room and board. • Gary Steck asked for clarification on prorating. • Gary S. asked about court required testing. It would be helpful for this discussion to happen on the front end in terms of guidance on how many tests can be submitted. • Once the waiver is approved, then the lab testing will be covered. Will provide guidance on what is considered to be a reasonable number of labs. For methadone, a threshold was set but there is opportunity to exceed that

if there is medical necessity and would request that this all gets documented in the chart.

- Vladrose Santiago asked - For a 40 bed, based on assumptions this would be 5 staff overnight. Has this changed? Keri L. indicated that minimum staffing requirements were updated and (25-64 beds would have 3 staff) 5 would be the absolute maximum. This same type of bucketing was done with the peers and nursing staff.
- Heather asked when we will get the final standards that goes with these rates? Bill indicated this was included in today's attachments, labeled as the Clinical Assumption Grid. This is the final plan. If you see a glaring hole in the final standards, please reach out.
- Aneta Godlewski asked about the rate setting assumptions grid talks about 40 hours but that does not appear in the clinical assumptions grid. Bill H. said there are some inconsistencies between the rate assumptions grid and the standards. Bill indicated that if you don't see it on the standards, that can be translated to maximum flexibility. This would reflect 2 full-time doctors for Aneta's facility. Rate assumptions were provided in order to show what went into the rates but providers will not be held to the rate assumptions. DSS tried to build up the medical responsibility costs.
    - ***Providers will be held to the state standards not the rate assumptions.***
- Ben Shaiken – offered general feedback to say thank you that there seems to have been a significant amount of input and the shift in rates is good to see. Ben commented that he appreciates that 10/1 is an aggressive timeline but these are complicated calculations for providers to run in order to build staffing models to be in compliance. Less than 60 days seems exceedingly aggressive also for providers to make these significant changes in their programs, particularly with the current staffing shortage in the state. Hoping the Department is willing to make adjustments if the providers run calculations and find a need to make suggestions for modifications.
- Asher asked about the minimum staffing per shift. Curious about where we landed with the 3rd shift. Bill H. said we landed on 2 minimum and then depending on level of care, would determine what additional staffing would be needed. One staff member may need to be a nurse.
- Maria Sullivan asked for clarity about all BH practitioners must have a master's degree and a license? And all treatment plans and discharge summaries must be treated by that level of practitioner? Bill indicated that there was direct feedback from DPH on this. This doesn't mean that other staff can't contribute to the plans but believe that the main person must be an associate or level. Also applies to the biopsychosocial assessment.
- There is a document called Rate Setting Assumptions (Mercer document showing what went into the rate structure). And then there are the state standards. There is also a Bureau of Labor Statistics document. Important step is to look at the rate and to look at the standards. Where there are inconsistencies, then look at the standards.
- Gary S. asked for clarification on how transportation is wrapped into this? Transportation seems unclear. Bill indicated that driver transportation to NEMT to facility to medical appointments as well is wrapped in here.
- Stacey Lawton asked for clarification. ASAM says age 13 and older. Bill said we can update the adult one to say 18 and over and that there is a separate assumption for adolescents. Will make this update for clarity purposes.

Grant funding:

- Colleen Harrington explained that there are 10% uninsured. As source shifts from grants to Medicaid, DMHAS funding will not continue as is. We anticipate there will be ongoing grant funding for the uninsured population. We don't want to favor or unfavor providers bringing in uninsured people. There is still active discussion around

	what grant funding will remain in place for uninsured individuals. • It is important to look at the Medicaid rates to see how this will help move you forward. This bucket is separate from the grant. • Gary S. asked for clarification. Colleen H. will get back to Gary. • Colleen mentioned that we understand that 2020 does not represent what utilization looked like prior to COVID. We are looking to determine what utilization looked like pre-COVID and current 1115 proposed rates. • Gary S. commented In earlier discussions I noted my concern about meeting medical necessity for the proposed/suggested length of stay. When we had 'grants', this wasn't much of an issue. It is very common our there isn't available housing for clients at the planned discharge date. Now, with medical necessity, holding someone because of a housing challenge will be a financial problem… thank you Colleen. My question is if it turns out that 11% of a program are covered by a grant/contract with DMHAS, does the full 100% of the revenue have to be reported to DMHAS? • Aneta G. there is about 15-20% at any given time for those who we cannot submit claims to DMHAS but if the number is 10%, we will fall short. • Heather indicated that we need to look at this , Year 1 of implementation, Year 2 where things should start to even out, and Year 3 where the rules should fully be in place. Encourage the state to look at this from a 3 stage perspective. Colleen will bring this back but cannot commit to a 3-year plan. • Shelly wants to echo about the rate of uninsured. Should assume 10/1 the grants will significantly be reduced and if so, will there be adjustments due to COVID? • Glenn Connan commented It very important we do not have to complete DMHAS Budget, 8 Month Report and then AFR for 100% of staffing for 10% or the Revenue because this would be incredibly burdensome. • Stacey Lawton asked for someone to speak to the CSSD requirements in the standards? Mike Aiello responded to this. If court does not let someone discharge, CSSD will pay – this was built in. Plan to educate the court as much as possible around the cost implications on this. The provider will not go unpaid for this. • Vladrose Santiago – will all urine screens be paid for by CSSD? Mike Aiello commented that this still needs to be considered. Vlad indicated that we are currently seeing a lot of pushback in this area. • Ece Tek asked how Vlad is able to submit the medical drug screen? • Alan Aleia asked for clarity on the thinking around room and board as well as what the position is on grants and whether that will continue? • Stacey Lawton asked for the 3-5 and 37WM will still run significant deficits, depending on the occupancy.

2. State Plan Amendment (SPA) Planning and Timetable	• Rate structure and structure all sits within the state plan amendment. • CMS has reviewed our draft state plan and provided informal feedback on this. • We don't know for certain until we officially submit the state plan amendment. We do have an advanced copy and could likely submit this soon. • The vast majority of the new revenue coming from this project are going to the rates we just discussed in this meeting. There are other aspects of investment that this demonstration affords us, such as value based reimbursement, need to stand up a level 3.2 level of care, there is also a robust certification and monitoring component in this where they will provide feedback in order to get to the ASAM standard. Will likely include interim goals (3 month, 6 month, etc.). We want and need providers to be successful on this. • There won't be a pool of dollars to apply for. It is already built in to the entire cost structure. • Heather asked if we can see how this all breaks out financial? Bill said yes, we will have to isolate all of our SUD claims very cleanly. • We can discuss in the fall the timing of all of this. • It will need to include outpatient. • Will likely need a new code for SUD PHP. • Reimbursement for ASAM 1 is not anticipated to change since it is already ASAM 1. • Heather asked about acute inpatient psych hospital guidelines? Is there desire for additional feedback on this or was the feedback provided adequate to finish this? Bill commented that we don't need formal feedback or approval on this. Lois Berkowitz indicated that the feedback was helpful and was incorporated into the guidelines but this is not a LOC and does not require that we go through the feedback process. The LOC is inpatient but this is the add-on; it is the same service and is not a distinct level of care.
3. New Business and Announcements / Adjourn	• Meeting adjourned at 4:00 p.m.
4. Upcoming Meetings	• September 3, 2021 at 2:30 p.m. via Zoom, hosted by Beacon Health Options • Will add grant funding to the September agenda for further discussion. • Will follow-up by level of care.