Maryland Department of Health

Behavioral Health Administration

HB772- MDH- Reimbursement for Services Provided by Peer Recovery Specialists Workgroup

Dix Building- Basement Conference Room

Wednesday, July 11, 2018

9:30a- 11:30a

Attendees: Barbara Bazron, Deputy Secretary of Health, BHA; Brendan Welsh, BHA; Adelaide Weber, BHA; Jackie Pettis, Beacon Health Options; Amy Woodrum, MDH; Dawn Brown, Mosaic Group; Ann Ciekot, NCADD; Sydney Rossett, MDH; Nicolas Shearin, MDH; Rianna Matthews-Brown, Johns Hopkins; Lauren Grimes, OOOMD; Christine Marshall, Mosaic; Rick Reed, MCV; Lisa Kugler, Beacon Health Options; Elaine Hall, MDH-Medicaid; Joan Sperlein, REACH; Lisa Lowe, FACE Addiction MD; Sara Hoyt, MDH

Phone: Brandee Izquierdo, MABPCB; Nancy Rosen-Cohen, NCADD; Sue Doyle, MABHA; Rebecca Frechard, Medicaid

Welcome and Introductions

Follow up from last meeting

- Information regarding 1915(i) waiver is printed and available during this meeting
- SAMHSA webinar was sent to the members of the workgroup to review
- Research on "Roster Entity" was not completed by information will be sent
- Minutes approved from last meeting

Brendan's comments

- Before designing a system that speaks of reimbursing peer services, we need to see where the services are located across our system
- Let's have a discussion on what the infrastructure looks like currently, what we see as some gaps, and what we would like to see in the future
- We want to show what the potential could be, not limiting ourselves to what we currently have
    - What peers are doing in the clinical settings
        - Intensive care coordination- creating a recovery plan, identifying goals and barriers, connecting individual to resources
            - Will probably have an easier time designing this system of reimbursement because it has been done in other states
    - Subject matter expert to do an overview of the organic/community based peer support (Lauren Grimes)
    - Organic/grassroots peer support will not be reimbursable through a Medicaid model
    - It is vital to the sustainability of workforce to look at all funding streams

Lauren Grimes Presentation

- Background Information on WRC
    - WRC operate on $116,000
    - 23 centers
    - Many open 7 days
    - Unduplicated number of 7,000 (FY17)
    - Diverse hours, services, and communities
- Uniqueness of WRC
    - No one asks for a diagnosis or medical necessity
    - The engagement is at the individual's own pace
    - Can be part of "formal" or "non- formal" treatment
- Philosophical Concerns
    - WRC would potentially loose individuals if they go to a medical model
    - Some may not want treatment, rather wanting socialization and getting basic needs met
    - Turning an informal setting into a formal one

Current System

- Where are peers providing services?
    - WRC
    - Hospitals (In EDs-MAT, Overdose Survivors, etc)
    - Non-profit Peer (Family) Organizations- provide contact navigation and family support
    - Detention Centers
    - Parole/Probation
    - Casinos
    - Local Health Dept.
    - Inpt/Outpt
    - Provider Navigation
    - Drug Courts
    - Social Services
    - Provide Narcan Education
    - Intensive Care Management-complex cases
    - Community Based Trainings/Education
    - Group Support
    - QHC
    - VA Medical Centers
    - Forensics/MH/SUD
    - Fundraising
    - ACT
    - Bereavement
- 1915 (i) waiver, peers are reimbursed for their services for residential treatment
- Also look at bundle rates

- Clarifiying question: Peers are currently reimbursed in residential treatment via bundling, will this affect our ability design a specific services?
    - The state determines the mechanisms for reimbursement, not CMS instated, so things could be changed if needed
- Are there an enhanced rate for CPRS in clinical settings instead of billing incrementally?

General Standards of Reimbursement

- Which can be Medicaid reimbursable services?
    - Meet supervision requirements, medical necessity, need access to Medicaid, documentation guidelines

Potentially Fundable	Not Fundable
Local Health Dept	Fundraising
ACT	VA Medical Centers
QHC	Outreach
OP/IOP/Residential	
Intensive Case Management*	
Group Support	
Hospital?**	

*Perhaps we need to redefine case management or use a different word (Navigation?)

Secretary's Office may be able to provide more information-Sara Hoyt**

- Elaine spoke about some sort of regulations/requirements/credential which is determined by each state
    - Depending on the mechanism for reimbursement
    - Perhaps some waivers
    - Probably not able to change the state plan
- Ann Ceikot talked about the term accreditation/credential, etc and being aware of language/vocabulary
    - Are we going to require ALL organization utilizing certified peers to bill Medicaid?
        - My hope the answer is no.
        - We need to make sure we are talking about setting of the organization (clinical vs non-clinical setting)
        - Elaine-Currently covered services is through BHA regulations that require licensure and accreditation
        - Brendan-To require ALL organizations to bill, would be detrimental

- Brandee-Agrees with Brendan, there should not be a requirements for all organizations to bill Medicaid; through research, there is a shift for some sort of accreditation for peer support, there are accrediting bodies out there that do this
- Is there a possibility of some sort of enhanced rate if there are certified peers in existing clinical settings as opposed to billing for specific services on an individual 15 minute increments?
    - A possibility for some organizations in non-clinical settings
    - Bundled rates clarification- regardless of whether an individual uses the services or not, providers will be paid a rate that would be included reimbursement for that services
        - Elaine-On the residential side for adults, we pay a daily rate that is all inclusive of the services
- Brendan- Talked about service units/service delivery and what we want our recommendations to be
- Brendan-Looking at other states and their funding models, peer work is called care coordination. Would we be able to expand our definition of understanding of what that is?
    - Elaine-The way the state has defined the word case management is very specific, if we were going for a waiver, we would include that too. This is just something to remember.

Gaps/Expansion/Future Considerations

- Special Projects
    - Example: some WRCs are doing homeless outreach, it was be great to have statewide expansion of special services
    - If WRCs had more staff (some WRCs operate with part time staff or volunteers), they could do more programs and services across the board
- Expansion of Outreach Efforts
- Intellectual Disability Services, Complex medical issues, TAY, Geriatric
    - Have peer support be expanded outside of behavioral health
- Anti-Stigma Projects
- Network of Community Based Peer Support Organizations
- Peer Respite Services

Formal Recommendation

To support ongoing recovery services, and positively impact the total cost of care, this workgroup recommends that in addition to the current infrastructure which supports peer recovery services, the state of Maryland pursue MA reimbursement for defined services provided by the certified peer recovery specialists, in designated settings.

- Motion to approved recommendation from the group.

Next Meeting: July 24, at 9:30am