Maryland Department of Health

Behavioral Health Administration

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

Mitchell Building- 1st Floor Conference Room

Tuesday, June 26, 2018

9:30a-11:00a

Attendees: Barbara Bazron, Deputy Secretary of Health, BHA; Brendan Welsh, BHA; Adelaide Weber, BHA; Nancy Rosen-Cohen, NCADD; Elaine Hall, Medicaid; Nicholas Shearin, Medicaid; Amy Woodrow, Medicaid; Rachel Faulkner, NCADD; Chris Carman, Mosaic Community Services; Jackie Pettis, Beacon Health Options; Joan Sperlein, REACH Health Services; Lauren Grimes, OOOMD; Brandee Izquierdo, MABPCB; Sue Doyle, MABHA; Gordie Burke, MCV; Marian Bland, BHA

Phone: Marla Oros, Mosaic Group; Lisa Kugler, Beacon Health Options; Rebecca Frechard, Medicaid

Welcome and Introductions

Review of Charter

Group Goals

-Review funding models which will support the delivery of peer recovery support services currently being delivered in other states

-Request for Beacon Health Options to give the group some data and information on what other states are reimbursing for and the rates they are being reimbursed

-This information will be used to develop a report for the Maryland General Assembly and the Governor with findings and recommendations on issues related to how reimbursement of the certified peer recovery specialists can be achieved

-Statutory changes or regulatory changes, a state plan amendment, or waiver under Federal Social Security Act is required to support the expansion of Medicaid's funding program to include the reimbursement for peer recovery support services

Dr. Bazron's Comments

-This is an important component to ensure sustainability of peer related services

-Opening the state plan is an arduous process

-Are there any other consistent funding streams available

-Think broader than Medicaid as the only funding source (ie: funds of other agencies)

-Remember that we are not only focused on the opioid issue but other substance use issues, mental health issues, gambling issues

-The mission within the BHA is to provide an integrated system of care to meet the needs of our citizens regardless of how they come to us

Peer Workforce General Information per MABPCB

-166 Peers currently certified
-111 CPRS currently working in the public behavioral health system funded in part by BHA
-271 total number of individuals in the public behavioral health workforce that identify as peers
-Examples of diverse locations peers currently working
    -Hospitals, detention centers, WRC, RCC, Health Departments, casinos, OTP, Outpatient Treatment, Inpatient Treatment, etc.
-Examples of Services provided by peers
    -One on One support, groups, isolation programs, care coordination, recovery planning, ACT, SBIRT, etc.

Barriers/Issues

-Infrastructure
    -WRC, RCC, RCO are not traditionally set up to deliver MA reimbursable services
        -no clinicians at the WRC, RCC, RCO
        -this may not necessarily be a barrier but there is a need to expand the possibility of an accreditation for peer run services in those organizations
        -develop collaborations and community partnerships with BH Authorities and CSAs
            -Expand on the idea of accreditation
                -When it comes to peer services, it is not about reimbursing for billable fee for service as much as it is about reimbursing for the agency or the organization as a whole
                -There are specific standards that have to be met within the WRC or RCO
                -MD is unique because it is an integrated service (integrated certification), other than W.V. (have Medicaid reimbursable services)
                    -Currently, other states are back pedaling when it comes to reimbursable services because they are able to reimburse on the mental health side but not the substance use side
                    -When looking at data for Medicaid reimbursable states, they are separated, so the data does not differentiate whether it is substance use or mental health, but it looks like only 7 states reimburse for substance use
                    -MD has the opportunity to learn from other states' mistakes

-Supervision issues
    -"What defines a clinician?"
        -Can we broaden this definition (ie: RNs, other staff that are genuinely interested in peer support)
    -Many Medicaid reimbursable services done by a certified peer have to be supervised by a licensed clinical professional, however, Medicaid specifies that it is deemed by the state and those rules and regulations of the state
        -MD is unique because the state has the RPS, Registered Peer Supervisor), credential which provides the opportunity for a peer to operate under a RPS and that RPS can operate under a licensed clinical medical professional
        -Also need to look at expansion: NY state is back pedaling now because they all operate under a clinical services model and that creates barriers for the substance use side.
            -They have counselors and professionals on the substance use side that may not be licensed clinical professionals
    -Sue Doyle provided an example in Carroll County
        -all of the peers at the HD work under RPS but also work at other programs
        -the County has also done it backwards
            -If other programs have hired peers and they do not have an RPS, the HD offers the supervision (group and individual supervision)
            -As the LBHA, enter into an interagency agreement with other programs for consistency
            -The County works many partnerships for supervision
    -Marla Oros provided information regarding supervision in the hospital setting.
        -Peers are employees of the hospitals that they work in
        -In the EDs, peers report to either the Lead BH person (SW, Crisis Intervention Specialist, Nursing Director, or more centralized and coordinated through Regional Medical Directors of Psychiatry Office-clinician that coordinates all peers across the hospitals)
    -Lack of Supervisor Trainings
        -Marla Oros spoke about the difficulty in getting the RPS Training
            -Mosaic would like to ability to offer the training
            -Suggested other organizations besides MABPCB have the ability to offer peer trainings
        -Brandee Izquierdo clarified the RPS trainings
            -Any provider is able to develop a RPS training and submit it to MABPCB for review
            -MABPCB has an RPS application which requires applicants to already to supervising or will be supervising peers
                -This prevents farming out of RPS
                -Now has a refresher course
        -Currently, there are 203 RPS in MD, two times as many certified peers
                -RPS exist in MD, there need to be partnerships

-Philosophical dilemma

-Lauren Grimes spoke about the priority/importance of the preservation of the grassroots, peer run nature of the WRC

-The concern is the service delivery of peer support

-The understanding was that for services to be Medicaid reimbursable, WRCs would have to be housed under a provider organization and would be reporting to a clinician, which would change the nature of the peer support that WRC give

-Nancy Rose-Cohen spoke about the same issues with NCADD's Recovery Leadership Program

-A clinician may handle a situation very differently than a peer, it doesn't mean that one is right and the other is wrong

-The two approaches are very different, but there needs to be a collaborative effort

-Dr. Bazron spoke about the Listening Sessions and the need for clear role designations and how would they work together

-Trainings

-Initial certification

-Re-certification

-Registered Peer Supervisor trainings

-Possible Accreditation/Licensure/Credential/Roster Entity

-Is there an assumption that the programs will have to be accredited for reimbursement?

-Possible leveraging the opportunity because there are organizations that are peer run, it's about the sustainability for that organization that BHA can only offer them so much funding in grants and how can one operate the organization from a set of standards and guiding principles

-Accreditation is required for Medicaid reimbursement in MD

-Elaine Hall discussed that Medicaid needs some sort of licensure from BHA

-There is still much work to be done with this model

-Too early to tell

-Depends on how BHA wants to license programs

-Medicaid regulations require that programs are licensed by BHA, it would be up to BHA or this workgroup to decide what it would look like

-Question: Does a licensure of an outpatient treatment center model that peers would be providing support, would the licensure of the outpatient model be enough to meet the licensure requirement for reimbursement or would they need a special program licensure?

-Answer: That depends

-Jackie Pettis suggested possible “Standards of Excellence” like MANO currently does for non-profit organizations in MD

-Will receive a certificate meaning that minimal qualifications are met

-Dr. Bazron spoke about the credentialing process of Recovery Residences

-Standards have to be met in order to qualify for any funding from BHA

-Medical Necessity

-Medical codes, definition of medical necessity, and medical necessity criteria

-**Lisa Kugler** to provide information

-Would this term apply for peer services?

-Need for a cost- benefit analysis (**Elaine Hall** to collect some data to start)

-What are the benefits of peer support service into this model or in lieu of treatment

-High utilization rates, individuals use duplicate services from Beacon Health Options,

-What would it look like to implement peer support services, which is cost effective, and not cycling people in and out of the public behavioral health system?

-Lack of outcomes for peer support (no standardization for data collection)

-How do we define success in recovery support services?

-Recovery Data Platform (**Brandee Izquierdo** to send information)

-Service Provider types

-Accreditation, licensure, credential, or roster entity?

-**Brendan Welsh** to speak with MCF and Tom Merrick regarding 1915(i) waiver and their lessons learned

-Unit of billable services

-Certain services are not billable

-ie: individual requested peer to accompany them to a court hearing, the support time from start of support to actual hearing is not billable

-There is the ability to bill for part of the service but not all

-The support can last longer than 15 minutes, 30 minutes

-Look to see other supplemental billing for services not being paid now

-To keep the authenticity of peer support/shared mutual relationship

-**Brendan Welsh** to send out a webinar to view

- SAMHSA developed a lessons learned to reimbursement for peer support

-GA: 15 minute intervals for group sessions

-A concern was how to bill for auxiliary services, incremental billing or daily service billing?

-The need to preserve the integrity of peer run services that some programs will not Medicaid reimburse and will remain grant funded

-Oxford House

-WRC

-Lauren Grimes asked to clarify “nesting within model” (associated with an organization that is Medicaid reimbursable)

-Any peer that is nested within either a provider organization or health department that already has the capacity that reimburses through Medicaid for

other services, that already has that infrastructure, it would make sense for them to reimburse for peer services

-Organizations like the WRC, that are grassroots organizations, that are peer run, they do not have the capacity to reimburse through Medicaid, it with hurt the integrity of program

-Consensus from the EDs is that this would change how things are run, not peer run but provider run

-Lisa Kugler spoke about other states that have both Medicaid reimbursable services and other peer run organizations that are grant funded or state funded

-Lisa Kugler to provide information outlining what other states are currently operating under to help illustrate this

-Dr. Bazron about DC having both Medicaid fee for service billing and state funding for WRC

-Sue Doyle spoke about PA (Pro-Act) and also did a blended service

-Continued supplemental funding

-MA-FFS/WRC state only funding

-MNC

Data/Resources/Supports Needed

-No standardized data collection mechanism/source

-**Sue Doyle** will provide information regarding data collected from Carroll County

-MNC, services, rates, billing codes

-Defining services

-Defining roles, responsibilities of providers

-When collecting data, it is important to make sure whether the data is mental health data and/or substance use data

-Historically, there is more information (data) regarding mental health than substance use

-Need to look outside of the public behavioral health system, many reimbursable services are through private insurers

-Do we know how many programs are currently embedding peers in existing Medicaid billed services? What program types are currently out there?

-Survey OTP?

- Residential Substance use programs are currently set up with an all inclusive daily rate and regulations state that peers must be on staff, so there is an existing structure in Medicaid

Models to research

-West Virginia integrated model

-7 states reimburse for SUD

-**Brandee Izquierdo** will provide additional information

-New Hampshire

-Georgia

-**Brendan Welsh** will provide additional information

-Maryland 1915(i) waiver

-**Brendan Welsh** to consult with Tom Merrick and MCF

-ACT

-Daily, Monthly limits

-Gives a lot of freedom/flexibility to see clients

-BJA (Bureau of Justice Assistance)

-**Brandee Izquierdo** to provide additional information

-NC "Roster Entity"

-State identified standard

-Trainings, role description, feedback process

-**Brendan Welsh** to do more research on this

Question to Medicaid

-Is there anything that the workgroup is not looking at?

-Biggest step is to define what it is this is going to look like

-Medicaid will then take it back to see how to make it fundable

Next Meeting

-Doodle Poll will be sent out via email to determine the next 3 workgroup dates and times

-**Brendan Welsh** will send this out