FAQ – Service Alignment for 3.0 Levels of Care
7-2020

I. SETTING

I.Q.1: Will providers need to create distinct 3.7 units to be able to treat patients or can individuals needing 3.5 and 3.7 services be treated in the same unit?

I.A.1: The key factor to the delivery of 3.7 services is that individuals with medical needs requiring 24/7 medical attention receive that intensity of care. While this may not require a separate unit, it should be delivered in a setting in which the clinical resources and atmosphere is conducive to meeting the needs of those individuals who have more involved medical conditions. This may mean that rooms/beds designated for 3.7 patients be at a particular location on the unit for proximity to the nurses' station, ease of accessibility to other areas of the unit, quietness and privacy, etc. to best accommodate medical needs and individual limitations. However, DDAP has made no indication that the services must be in a separate, distinct unit.

I.Q.2: Currently, there are a handful of providers that our SCA contracts with that have 2 different 3.5 rates entered in PACDAA for the 20-21 fiscal year. There is a rate for 3.5 High, and a different rate for 3.5 Highest (separate from the co-occurring rates). Since these are essentially being treated as the same level of care, will the timeline document that is being developed also address the plan for how these rates will be reconciled?

I.A.2: Currently there are different rates for these levels of care, because the rates that were entered in the PACDAA Rate setting did not change for the current 2020-2021 fiscal year. If a provider is still currently providing previously determined distinct services, they could still receive the corresponding rate if they are contracted to receive it. Changes to the rates will occur with 2021 XYZ rate setting and contracts. Additional direction will be given moving forward.

II.SUPPORT SYSTEMS

II.Q.1: Are there posted regulations regarding specifics of treatments allowed in these levels of care. For instance, could we admit a patient from the hospital that needs continued IV antibiotics? I have never read anything that stated we could not, but I do want to clarify that I'm not missing something that I should be aware of.

II.A.1: There is nothing in the Pennsylvania regulations that specifically prohibits admission. For either the 3.1 or 3.5, admission would be determined by the facility's policy and procedure regarding populations served and the ability to provide the service, either on site by its own staff or visiting staff, or having the individual visit a medical provider offsite for monitoring. Any of these situations would be in line with the description of support services as described in the ASAM criteria and delivery of services.

By virtue of its programming and purpose, a 3.7 LoC should be able to accommodate an individual on IV medication.

II.Q.2: Are the facilities responsible for providing case management services internally or are they responsible for coordinating with external providers in order to offer case management services? What will it look like post discharge? Will this look similar to a Certified Recovery Specialist (CRS)?

II.Q.2: DDAP has been working with SCAs to increase the availability of case management services at the county level as a separate and distinct service from clinical care. Where separate and distinct case management services exist at the home/referring county, they should be utilized. Coordination with case management services that are provided through the referring county will allow for seamless, continuity of care upon discharge and allow the case manager to follow through with the provision of services as the individual transitions back to their community.

If separate case management services do not exist, then the provider should coordinate services as best as possible.

II.Q.3: If case management is a service that occurs separately from the residential service provider, can CRS services still be provided by the residential provider?

II.A.3: Case management and CRS services are different. Case management services are provided by a case manager. Recovery support services are provided by a Certified Recovery Specialist. Certified Recovery Specialists may be employed by a treatment provider to serve a supportive role while an individual in in residential services. In most cases, the interaction with this CRS is limited to the time that the individual is in treatment.
In those cases where CRS services are offered within the community and a connection has already been made prior to admission to residential services, the relationship between a CRS and an individual in residential treatment can continue during and after treatment.

II.Q.4: If a client is from a county far away, would telephone or virtual meetings meet the expectation?

II.A.4: If distance or circumstance precludes a case manager from meeting in person with the individual and his or her counselor, or individually while in residential services, then telehealth contacts would meet this expectation.

III. STAFF

III.Q.1: Can you explain staffing credentials in greater detail? I don't have a full understanding of the requirement and am concerned it will make hiring more difficult, especially in rural areas.

III.A.1: Certification is not required at the time of hire. There are different credential levels for clinical staff, each related to a particular degree that an individual may have. The expectation is that a new hire would have the time necessary to acquire the training, experience and supervision necessary as designated by PCB to qualify for certification, PLUS 1 additional year to obtain the certification. You are encouraged to get full details from the PCB website, but the simplified chart below should help to clarify:

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Requirements for PCB Credentials at a Glance *For complete details see https://www.pacertboard.org/certifications*				
Certification	**Education**	**Experience**	**Training/Education**	**Supervision**
CAAC Certified Associate Addiction Counselor	High School Diploma or Associates Degree	3 yrs. FT or 6,000 hrs. PT in last 7 years	300 hours SUD	300 hours
CADC Certified Alcohol & Drug Counselor	Bachelor's Degree	2 yrs. FT or 4000 hrs. PT in last 7 yrs.	300 hours SUD	200 hours
CAADC Certified Advanced Alcohol & Drug Counselor	Master's Degree	1 yr. FT or 2000 PT in last 7 yrs.	180 hours SUD	100 hours
CCS Certified Clinical Supervisor	Certification OR Master's Degree	5 yrs. FT/10,000 hrs. PT as counselor AND 2 yrs. FT/4,000 hrs. PT as clinical supervisor	30 hours clinical supervision trainings	200 hours

Using the CADC certification above and considering the individual is a new FT hire with human service experience outside of the D&A field, he or she would have 2 years in the current position to acquire the necessary 300 hours of SUD specific training (some of which may be counted from his or her college transcript as applicable) and supervision hours. This individual would have an additional year beyond those 2 to apply for and successfully acquire the certification; totaling 3 years from the point of hire to actually obtain full PCB certification.

Using the CADC certification above and considering the individual is a new FT hire but has been employed for 1 year within the previous 7 years at another D&A provider. This employee could use the documented supervision hours and training acquired at the previous employer, plus 1 year of employment at the present employer to total the 2 required FT years to meet the combined requirements for employment, training and supervision. In this case, it would take 1 year of employment plus one additional year to actually apply and acquire the certification, for a total of 2 years from hire with the employer before obtaining full PCB certification.

III. Q.2: Employment requirements – with the change in employment requirements (i.e., staffing ratio, supervision ratio, and education/certification requirements), will this require additional supervision of the staff? Some facilities may not be able to meet the employment requirements initially, will they have a specific amount of time to transition?

III.A.2: The presentation indicated nothing about a change in staffing or supervision ratios, in fact, it was stated that staffing ratios remains consistent as noted in the regulation. Supervision required for counselors is determined by the program (see § 709.26. Personnel management). In delivering quality services, especially by those with minimal experience, there should be regular, ongoing individualized

and group supervision and case consultation. If programs do not have adequate clinical supervision in place, they will have the year between now and July 1, 2021 to establish protocol for the delivery of adequate clinical supervision.

PCB defines "Supervision as a formal or informal process that is evaluative, clinical, and supportive. It can be provided by more than one person, it ensures quality of clinical care, and extends over time. Supervision includes observation, mentoring, coaching, evaluating, inspiring, and creating an atmosphere that promotes self-motivation, learning, and professional development." DDAP concurs with this definition.

III.Q.3: Will there be an opportunity for providers to discuss the potential impact of costs & recruitment and retention concerns regarding the requirement for certification and licensure?

III.A.3: Yes, DDAP will engage in ongoing discussions about how to best move forward with implementing the certification/licensure process.

III.Q.4: Does DDAP have plans to offer resources for provider staff to obtain licenses/credentials to provide care as outlined in the ASAM Criteria?

III.A.4: DDAP is currently exploring potential resources and will provide updates to the field if resources become available.

III.Q.5: When DDAP refers to "approved MI training for clinical supervisors and counselors", does this mean that DDAP will require a specific DDAP facilitated MI training for staff, or will providers need to submit to DDAP our intended MI training curriculum and training materials for DDAP review and approve?

III.A.5: The requirement for DDAP-approved Motivational Interviewing training goes into effect for Clinical Supervisors on July 1, 2023 and for all other clinical staff on July 1, 2026. Over the last 2 years, DDAP has created and piloted a very effective MI training that has both a classroom and an application component that assures participants have a proficiency in applying the MI concepts and principles presented in the classroom training with fidelity. DDAP is ramping up this training availability for wider access and for delivery to occur both in in-person and online presentations. With this said, we anticipate that the DDAP-approved training will be that which has been developed and is provided by DDAP. Should access and capacity to adequately deliver this training become an issue, this may be reconsidered at a later time.

Regarding the foundational awareness of MI that is required as of 7/1/2021, this can be from any personally or agency identified resource, so long as it is recorded in the employee training record.

III.Q.6: Can you provide some suggested resources for MI training that will meet the "foundational awareness requirement"?

III.A.6: Resources include, but are not limited to:

https://ireta.org/resources/motivational-interviewing-toolkit/

https://www.youtube.com/watch?v=2qgdj2oBfOs

https://attcnetwork.org/centers/south-africa-hiv-attc/motivational-interviewing

https://www.naadac.org/finding-ambivalence-MI-webinar

III.Q.7: Staff Training/Continuing Education – During annual licensing reviews, will DDAP review all employee HR files to ensure that the staff have all the required trainings?

III.A.7: It will be the responsibility of the provider to monitor that all required trainings are obtained. As stated, yes, there will also be a monitoring process in place to assure that requirements have been met.

III.Q.8: Will DDAP create a tool to identify that Clinical staff can demonstrate MI and SOC since it will be a requirement going forward?

III.A.8: There will be a monitoring tool that will be utilized by the parties responsible for monitoring ASAM alignment compliance.

III.Q.9: Does DDAP have plans to offer resources for provider staff to obtain licenses/credentials to provide care as outlined in the ASAM Criteria.

III.A.9: See III.A.3

IV. THERAPIES

IV.Q.1: In the addendum for PA specific expectations, in particular the group therapy expectation: is the expectation for 2 groups that are 2 hours in length each (2 groups with 4 hours total) or for a minimum of 2 groups that are least an hour each? If the expectation is for 4 hours of group across 2 sessions, then how do we individualize for clients who have difficulty sitting for such a long period of time?

IV.A.1: The intent is for 2 groups, that last 2 hours each, totaling 4 hours of group therapy per day. Individualization based upon difficulty sitting can be addressed via a number of ways: allow fluidity in the room, for example, if individuals need to stand, allow them to do so; if some group participants are more comfortable sitting on therapy balls or in bean bags, accommodate them in that way; allow for a 10 minute stretch break that doesn't impede the therapeutic climate of the group, etc.

IV.Q.2: Since the 2, 2-hour groups/day is not part of ASAM why is it linked to the ASAM transition?

IV.A.2: While this requirement is not linked specifically to ASAM, it is linked to the 1115 waiver. The waiver is linked to the use of ASAM and therefore part of the transition. The Centers for Medicare and Medicaid Services (CMS) requires that residential hours be defined/delineated for payment of service.

IV.Q.3: How are programs to include life skills, family and individual programming, case management, specialty groups, meetings, and outside appointments if most of the daily schedule is taken up by 2 2-hour sessions?

IV.A.3: 3.5 and 3.7 are intended to be "intensive" therapeutic levels of care delivered in a 24-hour setting. While an individual would not be expected to be engaged in clinical activity all of his or her waking hours, the fact that this setting affords a greater concentration of interventions, it does not seem unreasonable that 4 hours of the day would be focused on group intervention, leaving a significant number of remaining hours of the day for the other services described.

IV.Q.4: Has the expectation of 2, 2-hour groups been piloted anywhere and if so, was it successful in improvement of outcomes?

IV.A.4: DDAP & DHS consulted with a national expert on the ASAM Criteria who has knowledge of programing across the country, we reviewed sample criteria established by other states when submitting their 1115 waiver requirements in meeting therapy guidelines, and we had interdepartmental discussions that included other stakeholders to determine what expectations should be established for treatment in Pennsylvania's residential settings.

IV.Q.5: How would recreational interventions be documented? Would para-professional staff (tech staff) be able to document?

IV.A.5: Recreational *interventions* must be tied to a specific need identified in the assessment and addressed through a particular goal on the individualized treatment plan. The progress note, charted for a group or for each person, should be individualized to reflect the progress of the treatment plan and can be noted by the person overseeing the intervention.

IV.Q.6: Will all residential levels of care, halfway house as well as 3.5 and 3.7 be required to accept all forms of FDA approved MAT in order to receive funding?

IV.A.6: Yes. Given that a contractual requirement for the receipt of public funds is that providers be aligned with the ASAM Criteria refusal of admission based on the use of an FDA medication to treat SUD would preclude a provider from receiving funds. To further explain this…The ASAM criteria is based on individualized treatment and best practice. If a provider restricts admission of an individual based upon the use of a particular FDA-approved medication, then they can neither claim to offer individualized care or best practice if the needs of the person can best be met by the use of *that* particular FDA-approved medication. This, in and of itself, indicates that the program - at a foundational level - has not aligned with the ASAM Criteria.

IV.Q.7: Will the facilities be able to make the decision to taper an individual off of MAT or will they need to maintain them since all forms of MAT need to be offered in order to receive funding? What will this look like since we know all forms of MAT should be offered and people should not be discriminated against, or forced to taper off of MAT?

IV.A.7: A treatment provider should not taper an individual off of a MAT simply because use of medications is contrary to their treatment philosophy. MAT is best practice for treatment, especially for OUD and is a personal decision made between an individual and his or her treating physician and not that of the treatment facility. It would be unethical to admit an individual on MAT just to preserve a referral source/funding stream with the mindset to convince him or her to discontinue the MAT and begin a tapering once admitted.

Facilities that are unwilling to embrace the evidence-based practice of medication assisted treatment should accept individuals who have third-party insurance or are self-pay and who are not reliant on public funds in order to avoid practices that may be interpreted as discriminatory or unethical.

IV.Q.8: Can you provide an example of what is looks like for a residential facility providing the 3.5 level of care to be required to accept clients on methadone? Short of being an OTP, are you required to transport them daily, allow take home in the facility?

IV.A.8: A residential provider that accepts individuals on methadone could do this a couple of different ways:

- An NTP/OTP can deliver medication to the residential/treatment provider consistent with DDAP and CSAT regulation and guidelines.
- A residential provider could opt to transport an individual to the NTP/OTP, if within a reasonable distance.
- A residential/treatment patient can use take home medication provided by the NTP the client is enrolled in.
- The client could guest dose at another NTP while enrolled in a residential/treatment facility. The client would remain enrolled in the NTP and the residential treatment program.
- The residential provider could also have a licensed NTP/OTP on the same campus which would allow easy access to care between types of service or care.

IV.Q.9: What if there is no methadone clinic in the area (rural). Would setting up one or more of the agency's 3.5 facilities, local to a methadone clinic meet the requirement for the entire agency if others could not, due to lack of access to a methadone clinic?

IV.A.9: PA regulation regarding take-home privileges indicates "**§ 715.16. Take-home privileges** (e) With an exception granted under subsection (d), a narcotic treatment program may not permit a patient to receive more than a 2-week take-home supply of medication." In such cases where distance would be prohibitive for the residential provider to obtain the take-home medication every two weeks, two options could be considered:

1. If the individual is in agreement and the provider has an alternate facility in proximity to an NTP that can provide guest dosing, a referral to the other location can be made; or,

2. Where admission of individuals on methadone absolutely cannot be facilitated because of the distance of the residential provider from the NTP, a waiver to this expectation would be granted.

IV.Q.10: During the webinar it was stated providers cannot deny admission based on medications- does this include MAT as well as all psychotropic medications, such as benzodiazepines? Does this apply to HWH, 3.5, and 3.7 levels of care? If it does not apply to all three levels of care- which levels of care does it apply to?

IV.A.10: The webinar indicated that individuals could not be denied admission based on use of FDA-approved medications to treat SUD. The use of psychotropic medications was not addressed in the presentation. While particular discussion and parameters for the delivery of co-occurring capable and co-occurring, enhanced services have not yet been outlined, it is likely that programs would be expected to appropriately manage and treat individuals with more severe conditions and complications that may warrant medications such as benzodiazepines.

IV.Q.11: Are there specific evidence-based practices providers will need to incorporate into programming? If yes, what are they? Are there specific training requirements for these practices? If yes, what are they?

IV.A.11: Some evidence-base practices have been indicated as "required", such as use of MAT, motivational interviewing, case management services. Others have been provided as examples, such as cognitive behavioral therapy, rational emotive therapy, etc. DDAP is currently providing trainings in some of these categories, while trainings in other evidence-based practices and modalities are available through college courses and trainings offered through other resources such as PCB, ATTC network, etc. The main issue is that EBPs are being utilized.

IV.Q.12: (added 7/31/2020) There is a requirement for at least 5 hours per week of professionally directed treatment (individual, group, family therapy, medication management and/or psycho-education) for the 3.1 LoC. However, there was no breakdown between individual versus group counseling per hour. What will be the specific requirement for therapy hours delivered at the halfway house level of care?

IV.A.12: The 5 hours per week of therapeutic interventions delivered at the 3.1 LoC may be delivered in any combination of professionally directed therapy as long as it is based upon the individual's 6-dimensional assessment and individualized treatment plan. Self-help or house meetings would not be considered part of the clinical hours.

V. ASSESSMENT/TREATMENT PLAN REVIEW

V.Q.1: What is "evidence of neutrality" when conducting a Level of Care Assessment (LOCA)?

V.A.1: Whether intended or implicit, bias toward the services delivered at the facility where the assessment is being conducted might occur. To prevent this, it is best that an independent process for LOCAs occur. In many cases, SCAs or their contracted providers are conducting an independent assessment and then making a referral. However, there are those situations where the LOCA is being done by a potential treating provider. In those cases, evidence of neutrality will include, but not be limited to evidence of client choice, data demonstrating a sufficient number of referrals to alternate treatment providers, etc. All of the conditions of "evidence of neutrality" have not yet been determined. DDAP will be announcing this more fully in the coming months.

V.Q.2: If an individual calls the agency for treatment but has not yet had a formal assessment, would we then need to refer that individual to local SCA office for assessment prior to consideration of acceptance into treatment? If we cannot offer to assess on site, would this not present as a potential barrier to service access? What if the person did not follow up with SCA or other approved assessor when treatment would have been beneficial??

V.A.2: If the individual will be SCA funded, it depends on the provider agreement with the SCA for admission; if the SCA requires that the LOCA be done by them or one of their assessors, then that applies. If the SCA allows the provider to forgo the use of the SCA assessment, the provider should do the assessment and demonstrate evidence of neutrality. In this case, where the individual self-initiated the referral to the facility, the biggest issue of neutrality is not choice, but that the facility could provide

the appropriate level of care warranted by the assessment and if it cannot, that a referral to the more appropriate LoC has been made.

V.Q.3: How is the ASAM criteria used to conduct a discharge for someone completing the program?

V.A.3: The Continued Service and Transfer/Discharge Criteria are found on pages 299 – 306 of *The ASAM Criteria, 2013* text. There are four conditions in which it is appropriate to transfer or discharge a patient from the present level of care (p. 303). When the condition for discharge has been met as outline in the ASAM text, on pages 303-306, as a contracted provider, you would then complete a discharge ASAM form in PA-WITS using the information presented in the criteria on these pages that fit the individual's circumstances for discharge.

V.Q.4: Are facilities able to complete their own transition of care or "step downs" to continued care or would we need an approved assessor to complete these?

V.A.4: The clinician will be engaged in ongoing clinical assessment while an individual is in treatment to determine appropriateness for continued stay, transfer or discharge. Only the LOCA is done by an independent assessor. Treating clinicians/facilities definitely should be a part of the referral process when transitioning an individual to another level of care. However, if the case manager is an integral part of the treatment team while an individual is in residential care, he or she can effectively assist with the transfer of care and thereby assist with the transition of care.

V.Q.5: Will DDAP issue guidance for providers concerning assessments and the need for re-assessments?

V.A.5: DDAP has previously released guidance regarding the need for individualized care; which requires assessment and continued reassessment throughout the duration of treatment (see pages 18-19 of the Guidance Document and page 110 of *the ASAM Criteria, 2013* text. Reassessment should continue as frequently as needed for care to remain relevant.

VI. DOCUMENTATION

(no questions were submitted regarding documentation)

VII. MISCELLANEOUS

VII.Q.1: Licensing address minimum expectations but ASAM is an alignment with quality – Who will be responsible to make sure that everyone is adhering to the expectations after the DDAP implementation?

VII.A.1: There will be a monitoring process(es) in place to assure that alignment with ASAM is occurring.

VII.Q.2: The webinar presentation advised providers to administer a self-assessment for ASAM 3.7 and at the providers discretion to maintain any provisional designations previously made. Is there any guidance for payers if they do not agree with the provisional assessment?

VII.A.2: The preliminary designation is just that…preliminary! Next, a provider wanting to maintain the designation will need to assure DDAP and DHS they can provide the service.

DDAP, DHS, Providers and Payers will have additional discussions about expectations so that all parties can be on the same page with alignment of services. Ultimately, it will become a contracting issue if payers do not believe a provider can sufficiently deliver a service. But, since we are just beginning to define what 3.7 is and who is capable of delivering the service; hopefully, all parties will be on the same page by the time of contracting.

VII.Q.3: Does DDAP have any information regarding a timeline of guidance for:

- Co-Occurring conditions
- Withdrawal Management
- Updates to billing codes
- Regulatory codes (exceeding MA allowable times)

VII.A.3: DDAP or DHS will be in communication about all the topics noted above at a future date. The field will be notified via Listserv.

VII.Q.4: What is the 1115 Waiver?

A: In short, the 1115 waiver, is an application process that DHS/ OMHSAS has submitted to the Centers for Medicare and Medicaid Services (CMS) to address the admission limitations created by the IMD exclusion. The waiver required the use of an evidenced based admission tool and service delivery practice of which Pennsylvania chose the ASAM Criteria.