DMC ODS Q&A

Fiscal/Billing:

- *Since only one program can bill for case management per service (same client) when transitioning between different levels of care, which program may bill for it?*

  The provider transitioning the client to another level of care should bill for the service.
- *If a clinical service is not provided on a given day (residential) will the provider still receive reimbursement for room and board?*

  Yes, the provider may still be reimbursed for the room and board rate for each day that the client resides at the program whether or not they receive treatment. The participant must meet the minimum hours of treatment per week per ASAM level of care.
- *In terms of provider budget, how should providers create a projection of clients/staff that will be required to provide Waiver services?*

  To determine the number of counselors required to deliver treatment services providers must establish a counselor productivity model (non-productive hours and direct service hours), project annual client admissions, and determine the average hours of service that a client receives during a typical treatment episode, adjusted for average group size for the group sessions. Other factors to consider include clients who periodically fail to show for appointments and the number of clients who do not complete treatment. Multiply the projected admissions by the average hours of treatment, then divide by the direct service hours to obtain the number of counselors. DBH-SUD has developed a tool to assist providers with evaluating treatment models and counselor needs which is available upon request.
- *As salaries go up with Waiver implementation, will the requirements of staff go up as well?*

  Staff requirements outside of what is already required in DBH SUD Services "Key Staffing Standards" will be up to the individual provider.
- *Regarding men in residential treatment with children ("Papa Natal"), how will providers be able to bill for the children living in the program with their father?*

  Residential providers will bill the established treatment rate for services provided to the father. Providers may build childcare expenses into their negotiated room and board rates as do existing perinatal residential programs.
- *Can providers enter into a contract and share a primary Medi-Cal billing clerk among themselves? With rate setting, can this be built into the DMC rates?*

  Yes, providers may build the cost of a Medi-Cal billing clerk into their budgets and several providers can use the same clerk. This service should be included on the "contracted services" line item.
- *How does the County foresee Avatar alleviating billing issues?*

  Avatar will help alleviate some billing issues because certain protections are built into the program. For instance, Avatar will not allow billing to be submitted if there is no progress note or if there is missing information on certain key documents (ex. Date, signature). Avatar also has a tracking function that will prompt providers to ensure key timeframes are met.

Screening/Assessment:

- *Will providers be able to do ASAM screening/assessment over the phone?*

There are no restrictions on providers with regard to how they conduct screenings. Assessments however, must be done face-to-face. Telehealth counts as face-to-face.

- *What process is the County planning to use to determine the initial authorization and referral process?*
  All pre-screened clients will receive a pre-authorization for Level of Care. DBH is not requesting TARs if the client is pre-screened and referred by SUD Services or the 24/7 Access Line. The pre-authorization through SUD Services or the Access Line will be acceptable in place of a TAR for the episode. The provider would have to ensure that the client is in the correct Level of Care. Once a level of care determination is made through the screening process, the provider will be notified of the referral through Avatar. For clients who have not come through SUD Services or the Access Line, once the provider completes the assessment, the provider will be required to submit TAR paperwork within prescribed timeframes to the County for approval. This process is still under development – providers will be notified if there any changes to this process.
- *Is the screening tool something providers should be using instead of an assessment?*
  No. Providers have the option of screening clients. However, assessments are required.
- *Is a standardized assessment required? What other "things" will get standardized?*
  Yes, a standardized assessment tool will be required. In addition, many other standardized forms are being developed, including admission agreement, release of information, physical exam form, discharge forms, medical necessity/diagnosis criteria, treatment plan, progress note, and others. All of the standardized forms will be available in Avatar and will also be provided to non-Avatar users. In addition to the standardized assessment tool, providers may be mandated to use some of the other developed forms as well.
- *Will the providers be required to do their own assessment if the County's access line gets overwhelmed?*
  The County's access line will not conduct assessments (screening only). Providers are required to complete their own assessments.

TARS

- *Is there a timeframe for sending in TAR paperwork?*
  Timeframes are currently being developed. Additional information on this item will be provided at a later date.
- *Will the TAR process be long term?*
  Yes.
- *Are TARs required for Detox?*
  Yes.

General:

- *Will the County create a shared place to post questions?*
  Yes. Questions about the DMC ODS waiver may be submitted using the following email address: dmcwaiver@co.fresno.ca.us.
- *What percentage of clients will come through the different County's access points?*
  It is unknown at this time.
- *How will the County determine what provider gets a referral when one needs to be made? How will placements be made?*

Referrals are determined in a number of ways, and will differ according to modality. Referrals take all of the following into consideration in no particular order: Geographic location, transportation, childcare, co-occurring availability, trauma informed, client choice, and counselor's clinical judgment. If all things are equal, referrals will be assigned round-robin.

- *Will the access line change how providers do orientations?*
  Each provider may establish its own orientation process.
- *How will providers know if the beneficiary has Medi-Cal?*
  Initially if a client comes through SUD Central, their Medi-Cal status will be checked prior to the County making the referral for treatment. Providers will be responsible to check Medi-Cal eligibility for those clients that are not referred through SUD Central via the DMC Eligibility application on the Medi-Cal website. Additionally, providers will be required to verify continued Medi-Cal eligibility monthly, and evidence will need to be maintained in the client file.
- *When will the waiver be implemented in Fresno County?*
  Our plan is now undergoing federal review (CMS). Other counties have reported that there was a lot of "back-and-forth" with both DHCS and CMS, so it is difficult to predict. However, we are hoping to "go live" in the Fall of 2018.
- *In regard to Perinatal services, what will happen when the beneficiary is outside the 60 day window?*
  DMC will not pay for perinatal services outside of the prescribed timeframes. However, the County is developing funding priorities for non-DMC funded services. "Expanded" perinatal is one of the items that will be considered.
- *Is there a limitation to the caseload size per counselor? (Counselor/client ratio).*
  The County's recommended case management counselor/client ratio is between 1:20-50 depending on how the program designs this function. Some programs may opt to assign dedicated case managers which would allow a higher caseload; others may require treatment counselors to perform this function which would necessitate a lower caseload.