MN 1115 SUD Waiver Demonstration Project

To: All Interested Providers

Re: MN 1115 Request for Proposals (RFP) Project and Application Questions

June 6th, 2018

Questions

Question 1: Here is our history, we increased our residential beds from 13 to 23 last year and found out from Charlie we were considered an IMD program. We immediately (April 1st) let the license beds go with SLF and decreased to 16 beds to be in compliance because the majority of our patients are Medicaid funded so we could not exist . We currently want to go back to 20 beds so we can maintain viability but will again be classified as a IMD program so are interested in relicensing our beds with SLF and DHS and apply for the 1115 waiver or does this exclude us from being eligible at this point? Our frustration is the 5 week waiting list and not serving the community effectively with the limited beds due to the IMD classification. We have access to inpatient, residential, IOP and OP with additional recovery support options so we are set up for the IMD continuing care perfectly.
Answer 1: Any provider is able to apply for the demonstration. The eligibility requirements posted are the responsibility of the applicant to broker.
In order to participate, you will need to become an IMD by notifying licensing that you would like to increase your bed capacity and therefore be classified as an IMD; then if you are increasing your bed capacity, a re-inspection with the MDH and DHS will need to be scheduled.

Question 2: I am going to be an individual contractor to complete assessments and I am also providing supervision for an organization who will also be looking to provide assessments. I cannot attend the RFP today, but would like to be a vendor for SW MN. How do I go about this, for myself and the organization I will be providing supervision for?
Answer 2: You will need to enroll with Minnesota Health Care Programs (MCHP) Provider Enrollment. This question seems to be more related to SUD Reform- not sure how it connects to the 1115 waiver. All primary applicants will reach out to whatever needed ASAM service levels they do not have (needed because the primary applicant does not offer the service level), and will then ask partners to complete a memorandum of agreement (MOA) for the service level(s) they want/need to partner with in order to offer all the levels of ASAM service in the continuum of care (COC). So in short, the applying agency, will get a MOA to you, or might complete one and ask you to sign as a part of their application to DHS, as long as you as a referring partner, are capable of providing the service levels the primary applicant does not.

Question 3: I understand that implementation of the project is to begin in July of this year. Is it possible for selected organizations to have a slightly later implementation timeline such as August or September 2018?
Answer 3: Applicants who are chosen will also have to have a contract executed before they can begin, so we expect that not all programs will start at the same time.

Question 4: The possible WM rates were discussed briefly yesterday but I didn't hear anything specific to residential or PHP (Day Treatment) rates discussed. Do you have any indication of what those rates will be? More generally, we are assuming that rates will fall somewhere between Medicaid rates and "typical" commercial rates—is this an accurate assumption?
Answer 4: The WM rates were discussed today because there currently are no CMS approved rates for those services in the State Plan. There are no plans to change any other rates. The existing rates for residential and non-residential treatment will stay the same in this project.

Question 5: I infer from the RFP that it is permissible to have a plan in place to offer, but not necessarily actually be offering, all ASAM levels of care when the project launches. Is this correct?
Answer 5: Yes**.** Please see related responses below.

Question 6: Related to the previous bullet point: if we are able to offer all but 1 or 2 levels of care in our system would an MOA for the care gaps be required with the application or can we spend more time vetting potential partners with the goal of cementing these relationships by fall 2018?
Answer 6: You will need to do both. Present as complete a continuum as you are able, but are required to build a network with ASAM levels of service you do not provide

Question 7: If we are having difficulty getting partners to respond, in particular in the areas that there are very few providers in the state, would there be assistance by DHS to help broker these relationships. In particular, we are thinking medically managed inpatient treatment (Fairview/Regions) and partial hospitalization/day treatment (Vinland).
Answer 7: No, we are not brokering. We recognize that there are few providers in some levels of ASAM service levels, and as such you will need to provide about the referring possibilities

Question 8: We are 20 miles from the SD border and 40 from the IA border, so we treat people from those states and work closely with providers in those states as well. Can MOA's with out-of-state partners satisfy the RFP requirement for a network of services, as long as they meet the ASAM criteria?
Answer 8: Do these providers meet the ASAM criteria and follow placement service levels? As long as the providers meet the requirements of the MOA are the same.

Question 9: If a provider elects not to be part of the 1115 waiver process it is my understanding from those meetings with the State that they will not be eligible for federal monies. Do you know if that is the case?
Answer 9: The IMD exclusion will only apply for those participating in the demonstration. If a provider decides not to participate in the demonstration waiver, they will be paid by the CCDTF for the services they provide, however there will be no Federal Financial Participation (FFP). This means the state share will be 77.05% and the county share will be 22.95% of each claim paid.

You are correct, that no one provider in MN will meet all service levels for the 1115 demo and in response, MN has built Memorandums of Agreement into the RFP itself, in order for opt-in providers to build needed partnerships and in order to offer all service levels by referral and/or services provided by the applicant.

Question 10: We will need to form partnership for residential treatment services. We actually are in transition with some of our beds and could theoretically develop our own residential program as well. Currently, all 40 beds are licensed by MDH for Detox and 10 are licensed for residential. However, if we wanted to use the 10 beds for residential we would need to get those licensed for residential with DHS. When they were used in that capacity previously a contracted vendor used the space and held the Rule 31 license.
Answer 10: Yes, you would need to license the beds with DHS under 245G, but I don't understand the "40 beds licensed by MDH for Detox" as detox licensing is under DHS as Rule 32.

Question 11: Why was withdrawal management (ASAM 3.2WM or 3.7WM) not included in Appendices A or B of this RFP? We are currently providing opioid withdrawal management through STR and other grants in our Pathfinder unit. We also offer most of the other levels of care, with the notable exception of partial Hospitalization which does not exist in our region and would be effectively inaccessible unless locally available (daily transportation). We are also an IMD.
Answer 11: Our original plan for this 1115 demonstration project focused on the provision of the levels of care covered by ASAM 0.5 to 4.0 that are already approved under our State Plan. DHS then decided to ask Centers for Medicaid Services (CMS) for additional approval to include the two levels of withdrawal management during the first year of the project even though they are not yet approved.
We did state our intention to allow the provision of withdrawal management on page 7 of the posted RFP. On page 13 of the RFP we also state that providers who are capable of providing withdrawal management services will be allowed to do so as long as they can also provide all the other ASAM levels of care, either directly or through their network.
You are correct that perhaps this would be clearer if we had added the two ASAM WM Levels, 3.2 and 3.7 to Attachment B and Attachment C.
For organizations who apply for the 1115 SUD Demonstration project and that indicate that they are interested in providing either of the levels of withdrawal management, can request an addenda so that they can provide the necessary assurances and descriptions of care relating to either or both of those WDM levels of care.

Question 12: Would we need to apply for Withdrawal Management 4.0, if we think we qualify?
Answer 12: The standards under 245F do not cover ASAM WM 4.0, so I am not sure how you would be able to apply for this. It is not reimbursable, we do not have a rate for it or a code.

Question 13: Do we need MOAs with Withdrawal Management Providers to qualify for participation?
Answer 13: This is an optional element of the waiver, and since there are actually no licensed WM providers in Minnesota at present- Rule 32 is not the same you would not have to have an MOA. But if a client you are working with needed those services, you would want to have a plan for where you would send them.

Question 14: Can our entire group submit one BIG memorandum of understanding?
Answer 14: No. There must be a lead agency. There can be a number of MOAs with that Agency.

Question 15: We are not located in Minnesota, can we still participate?
Answer 15: If you are a provider enrolled with MHCP and work with Minnesota residents, yes.

Question 16: Why doesn't the Substance Use Disorder reform satisfy this Waivers requirements?
Answer 16: These are two different things, the SUD Reform does not have anything to do with the IMD Exclusion, and the expectations and conditions of the 1115 Demonstration have nothing to do with SUD Reform

Question 17: What if licensing does not like the way we modify our electronic medical record to meet ASAM?
Answer 17: You will have to meet the 245F and 245G requirements. You can be proactive and submit forms to licensing.

Question 18: If I am a participating IMD, do we need to meet culturally specific programming needs as well?
Answer 18: The expectation remains, just as with 245G, to admit people they are able to serve and facilitate referrals for persons who need services you do not offer.

Question 19: Are we restricted to only those referring agencies that we have MOAs with under this project?
Answer 19: No.

Question 20: How will participating patients be counted for the project?
Answer 20: The Patient Medical Index (PMI) number will track all participants

Question 21: Can the primary applicant and the referring agency within the project both bill for the client?
Answer 21: More specifics are needed, but if this organization means treatment coordination, there are limits.

Question 22: Medicaid, under the project would allow for/covers two non-consecutive 30 day placements, will the consolidated treatment fund cover the extra?
Answer 22: This will flow through CCDTF and then assigns the county and federal shares in the system, just as in a non-participating IMD

Question 23: Who makes clinical decisions In particular step downs (Licensing or SUD Staff)
Answer 23: Under 245F and 245G the provider is responsible for this and then for supporting their decisions through their documentation.

Question 24: Can we appeal any decisions made? How?
Answer 24: Appeal rights would be the normal 245A Appeal rights.

Question 25: If we are an IMD and do not participate, will our reimbursement rate be different?
Answer 25: No

Question 26: As the primary applicant, aren't there just more responsibilities and the same resources?
Answer 26: Yes

Question 27: Why would a provider want to participate?
Answer 27: This is an opportunity to build a collaborative network that can offer better seamless care for clients as they move through the continuum

Question 28: How do Detox and Withdrawal Management differ?
Answer 28: Detox is licensed under Rule 32, and provides "sub-acute services" and requires less medical oversight, and is not reimbursable under the CCDTF or Medicaid. WM is licensed under 245F, requires specific medical oversight, and is reimbursable both by the fund and Medicaid, once it is added to the State Plan, which is scheduled to happen on July 1, 2019. We are adding the WM services to this waiver as a pilot, if approved by CMS as part of our application, and it will be reimbursed by the state under the 1115 only until it is added to the State Plan in July of 2019.

Question 29: What will the per diem be for Withdrawal Management? What billing codes will be used?
Answer 29: The rate for ASAM WM 3.2 is $475 which includes room & board, and for ASAM WM 3.7 is $590, which includes room & board- these rates have not yet been approved. The codes have not yet been approved.

Question 30: Two IMDs want to join together on the application for the 1115. Do both of us need to be the primary applicant?
Answer 30: There can only be one primary applicant on each application.

Question 31: Will 24/7 nursing and room and board costs be different?
Answer 31: Please see the answer to question 29. The room and board is currently proposed to be set at $75.29, but when we submit our proposal to CMS to add these services to the State Plan the rates could be different.

Question 32: Will there be limits to MOAs?
Answer 32: There are no limits to the MOAs.

Question 33: In terms of reimbursement, for WDM, will MA and PMAP be reimbursing?
Answer 33: Yes.

Question 34: If something is already paid by CMS, does it apply to the budget neutrality of this project?
Answer 34: No, all PAID services through CMS are considered pass-through.

Question 35: Will DHS analyze this project through claims?
Answer 35: Yes.

Question 36: Can we bill for service level 0.5 under the project?
Answer 36: No, this waiver does not add to the State Plan Amendment, there are no additional dollars.

Question 37: Under the CS options for the EBPs, we may have trouble meeting three of the four named in the RFP
Answer 37: We are looking at adding an additional choice, so that a program can pick three from a list of five

Question 38: Will there be exclusions, for providers with proprietors with a conditional license?
Answer 38: No, if a program is under a conditional license and is meeting the conditions

Question 39: Are we able to limit services to adults only (age 18 and over) under this demonstration project?
Answer 39: Providers should create networks that offer services across the continuum, and if they themselves do not offer a service, such as treatment for adolescents, they can have an MOA with a program that does.

Question 40: Is billing for services to this population accomplished at the county, state or federal level?
Answer 40: Billing for this would follow the same billing processes that are currently used for your services.

Question 41: Related to the previous bullet point (question), does participating in this demonstration project in Minnesota obligate the organization to accept Medicaid in any form in any other state (we have clinical operations in numerous states)?
Answer 41: No. This is a demonstration project in Minnesota and has no influence on services, or reimbursements in any other State.

Question 42: If accepted, are we obligated to participate for the entire 5 year length of the project or are we able to terminate the agreement early if unforeseen issues emerge?
Answer 42: You are able to terminate early according to any contract with the State.

Question 43: I understand the RFP does not specify a page limit for the response but is there a rule of thumb we can use in crafting the response—5 pages, 20 pages, 50 pages? We want to provide a level of detail consistent with previous successful responses for similar projects.
Answer 43: The RFP states limits for the sections, where a limit is required. Please use your judgement in submitting answers that you feel present the requested information succinctly. This RFP is not similar to anything previously released.