

(Standing by)

(Standing by)

>> LAURA REED: Hi, everyone. This is Laura Reed, your health advisor at DMAS. Welcome. We are going to give it a couple of minutes and then get started. We have two MMTs (phonetic) to get through so time is limited and precious. Let's see. Dr. Oplaska (phonetic), I see your phone number. Do you want to do a mic check? Dr. Ward, do you want to do a mic check?

>> ALYSSA WARD: Mic check.

>> LAURA REED: Sounds good. For those that just joined us, welcome. It's about 2:00. We are going to give it a couple more minutes and then get started. Shamica Ward.

>> Good afternoon, everyone. Can you hear me okay?

>> LAURA REED: We can. Dr. Ablasca, do you want to do a mic check? There she is.

She's in chat saying hello. All right. Well, a couple of things before we get started. This is being recorded. This is already started. So we'll put this recording up on our website. It usually takes between 3 and 5 days to get it up there after we record it and send it to our web master.

And then I also want to go over a quick addition. We are now using closed captioning services by Hamilton relay. In the chat as well as on the screen you can see the link that you would use to access closed captioning. You can cut and paste that into an additional browser window. It's best to have both windows opened at the same time so you can see the content and also read the content.

Text will run simultaneously with the presentation. If you have any questions about this service you can contact our civil rights coordinator and the e-mail is on your screen. Thank you guys so much for being here. And I believe I'm going to hand it over to either Dr. Ablasca or Shamica Ward.

>> Hi, can you all hear me?

>> Yes, we can.

>> Good. I have this two-device thing going on for the entire pandemic so I joined in by both video -- I may have missed your opening comments, Laura. Sorry if I'm repeating myself. So welcome to the PHP/IOP work group. This group has met before many moons ago. So we just wanted to refresh where we are and really focus on the service-specific areas of enhancement that are going live within the next 12 months or so.

So Shamica Ward, Dr. Ward, Dr. Alyssa Ward and I will be your co-leads for this work group today. And before this meeting we have sent out the service definitions for both PHP and IOP that we hope you had the opportunity to review. And then also a survey -- I know some of you have sent back comments around it.

And so I'll just take a moment to sort of recognize who has joined us here. And I will just read the names through and then go through the phone numbers, if I haven't already called.

So when I call your name, if you could just briefly unmute yourself and let us know which organization you are with, that would be very helpful. And then hopefully we won't take too much time to do that so we can get into the meat of the questions that you have.

So Alex Harris.

>> Alex Harris: Hi, yeah, Alex Harris. I'm the policy and legislative affairs director at DDHDS.

>> Andrew boredell?

>> Hi, I'm so sorry --

>> Angie boredell senior program advisor with the department of medical assistance services.

>> Ann catlet.

>> Good afternoon, I'm from anthem.

>> Thank you. Bill El wood.

>> Hi.
>> And then billings Collins.
>> Virginia prem year.
>> Brian Campbell, welcome back. From dms, I don't see his audio connected there.
>> Yeah, this is Brian with DMAS.
>> Annamarie, captioner? Alias here. I think that's our --
>> That's our closed captioner.
>> And who do we have here under DCCS?
>> Angle with the children services.
>> Dave nare?
>> Dave nare.
>> Emily?
>> Good afternoon this is Emily from the office of DBGS.
>> Ever an alias IVJ37142.
>> That's me, Rhonda, office of licensing.
>> Jay bens for the office of licensing.
>> Janice?
>> Good afternoon I'm with Magellan.
>> And Jennifer fason? If you're speaking you're on mute, Jennifer fason. The next one is Jay Sherman?
>> Hi, this is Jay Sherman.
>> Kathleen bers?
>> Hi, I'm with anthem.
>> Thank you. Larry Pope?
>> Hi I'm trying to unmute. Larry Pope executive director with well behavioral health.
>> Let Tisha?
>> Hi, I'm from blue ridge health carry.
>> Thank you. Lori?
>> Hi, senior director behavioral health at Virginia hospital center.
>> Margaret steal?
>> Good afternoon, I'm the director of adult community behavioral health.
>> Maria?
>> Director of outpatient services, center for behavioral health.
>> Melissa?
>> Hi, I'm with dominion youth services.
>> Molly cheek?
>> I'm here representing the Virginia network of private providers.
>> Nina?
>> Good afternoon, Nina. I'm the director of the office and child and family services at BBHDS.
>> Shamica Ward, I'll let you introduce yourself.
>> Good afternoon, I'm the behavioral health program specialist with DMAS.
>> Stephanie?

>> Good afternoon, I'm the director of mental health at children's hospital.

>> Sue?

>> Sue, I work in behavioral health at DMAS.

>> And Laura, do you want to introduce yourself or have you already done that?

>> LAURA REED: I did. I'll be happy to do it again. Lauer Reed, vocational health program advisor at DMAS.

>> Dr. Ward did you also already introduce yourself?

>> ALYSSA WARD: I did not. I'm Alyssa Ward. Thanks, everyone, for being here today.

>> DR. APLASCA: Was there anyone I missed in there's a couple phone numbers, one ending in 11, 1 ending in 19.

>> Dr. This is Jennifer. I'm testing to make sure you can hear me.

>> DR. APLASCA: We can. Anybody else that I missed? All right. So we will go ahead and jump in to our agenda. So we are going to look at the PHP MNC and there are different sections in the document that you received beforehand, if you would like to pull those up individually. And they are similar to those of IOP with, of course, differences in each of those categories but these are really the components of each of those documents that are included.

And I will hand it over to Shamica who will facilitate and I'll be moderating questions in the chat with Dr. Ward and probably to answer questions as we go along and we do have some time at the end for questions as well. So Shammika?

>> Thank you so much, Dr. Ablasca and good afternoon, everyone. I'm going to go ahead and get started so that we can address everything that has been given to us for feedback and hopefully we will have time for questions. I'm going to start off with the PHP MNC criteria. If you're trying to figure out where to find your copy it was sent out on March 17th. You can see both of these documents as attachments.

So thank you in advance for those who had the opportunity to provide some feedback for us and so we are going to go through the feedback for each of these sections and kind of address the feedback or whatever questions or comments you may have and for those of you who did not get the opportunity to add to our feedback we will open that up for you guys to do so at this time.

So looking at the service and definition section, the first response that I see here there's a question which we will the average length of stay remain 4 to 6 weeks depending on clinical need?

>> So I can respond to this one and just wanted to add onto this conversation that this is the first pass look through for this very special group of stakeholders who have been with us from the beginning with you just want to make sure it's really clear as I did in the reminder e-mail that these are going up for public comment. There's going to be a continuing period. We may be integrated feedback from what we hear today so just remember, too, that this is not the last that these will be seen or reviewed. So this question about average length of stay. We put this in here as kind of a general reminder that PHP is a short-term service. That is rooted in the fact that when the budget assumptions our actuary looked at average length of stays for the existing PHP programs in Virginia and found that, for example, the average hospital length of stay are 35.6 days and the average community mental health center hospitalization programs, the average length of stay is 65 days.

So -- (Background noise) -- I think I just heard somebody. We do have kind of some data around what average stays tend to be but everything is subject to medical necessity criteria and the individual needs of the person so these are just kind of general Gestalts about the service. Further questions? Happy to take them.

>> Thank you. The next question is with this and most of the following questions how will DMAS collect data concerning the distribution services including increases or decreases in numbers of providers, individuals supported and adequacy of the system in general. What is your measure for success and how will you assess that the behavioral health system is enhanced. If you need me to go back and read some of that, I can do that.

>> That's all right. I have it in front of me. This question goes to the heart of the matter in terms of how we will be looking to evaluate the behavioral health advancement as a program. We have been working internally with our population health and quality division and office of data analytics on preliminary conversations about this on the whole. But one way that I want us to think about this as well is that everything about the way that we are approaching enhancement has changed a little bit because of the pandemic. I don't think that's hard for all of you to understand.

You're living it every day. The service system all around and the needs of our members and Virginia as a community as a whole are in a very

different place right now than they were prior to the pandemic. And I think as a clinician I imagine that is going to continue to evolve and there's a lot of people trying to predict those needs right now. If anyone saw the APA stress in America survey that came out this week, there's a lot of concerning indications coming out of those nationwide studies about the stress experience of Americans.

So we certainly have indicators that the need could be even greater than it was prior to the pandemic. And our arbiters of success are going to need to evolve and be seen in that context as well.

So this initial enhancement is this going to fix all of the issues that we have as a system? It can't alone but from the beginning there were very specific goals associated with the choosing of these services so I want you to keep those in mind. And those were directly related to the psychiatric bed crisis here in Virginia. So that was our -- the impetus for the selection of these services was that crisis.

And so some of the primary outcomes that we are looking to effect are hospitalization-related data in terms of admissions, lengths of stay, diversion from admission which one way to look at that is ER visits related to behavioral health issues and both reduction in cost and utilization across those levels of care.

So those are kind of gimmers. Those are obvious variables that we know are associated with the goal in mind.

Now network and the number of providers that jump onto these services when we are talking about PHP/IOP in a circumscribed sense, again, there was significant analysis done by the actuary to get a handle on how many PHP and IOP programs we might expect to get stood up in the system.

And it's not a huge amount. It's not like other services because particularly in PHP when we are talking about the conditions of participation in Medicare, not everybody is going to be eligible to stand up some of these programs. So we know that there are the 12 Virginia hospitals with PHP programs that participate in Medicaid now or there were at the time of this analysis, but one also participating with Medicare. And there were eight Virginia community mental health centers participating with all but one for both of those categories participating in Medicare. So there were known entities offering services for substance use disorder treatment were likely interested in doing this for behavioral health but we also know that there's a large amount of dual eligibles in those programs. And so that was taken into account as well.

And -- sorry, I'm looking at the other factors for the budget projections.

So there was an assumption that essentially there would be some type of ramp up and that they expected that about 200 individuals would participate in PHP in the first year and then that would ramp to about 600 in the next year, essentially growing and plateauing out over time.

So we have some idea. So if this question -- I don't know that those are particular goals but we will be able to check against what we expect who we thought would be likely to join the network for these services and we will be able to determine whether they are reading what we projected based on that budget projection.

We will be able to look at these services in the dash boards that we have been working on here to develop. We have a template dashboard that we developed through use of TDT data that we will be able to be mocked up for additional services and we have asked that the development of the dashboards for these services be prioritized. So then we can have those be public facing dashboards to demonstrate what we know about utilization over time of these services and there are some great filters on these dash boards that allow us to manipulate it for geographic area for a number of demographics that will provide us with a lot of good information in terms of how the services are being utilized and what access to the service is looking like.

I think our other big factor, the first one being those hospitalization issue in terms of driving perceptualization. And the second one for all of us at Medicaid particularly in light of the pandemic and expected behavioral health surges as related to that are just access. How many people are we able to serve, are there other indicators that there's a need or are we not able to meet it?

So that is where we shall begin and we will be starting our racial equity work group in April and we are going to discuss equitable access to care and who is knowledgeable or using and has access to the care across different demographics.

So those are our answers to that question but I welcome further discussion. We look to you if there are things that you think we should be looking to to define success as well.

- >> Thank Dr. Ward and I'll open the floor up for anybody that would like to add onto that any recommendations or suggestions related to this question on how to gather feedback or data. Okay. And did I hear someone? Okay. Hearing nothing I'll move onto the last question and it says I think in addition to skills restoration there should be a definition for skills development in case there are skills needed to be taught that never were and therefore aren't lost. So that was more so a feedback rather than a question. Sorry?
- >> We can take that into consideration, Christine.
- >> And those were all the questions that we had for service definitions section. Was there any additional feedback that anyone wanted to adhere?
- >> Shamika I think -- (multiple people speaking).
- >> Sorry. Did I miss it? I'm sorry.
- >> If you scroll down. It can be hard to see.
- >> I see it. It says what would be a covered type of community-based location if not a hospital? Just curious.
- >> So my understanding is that there could be, for example, a private provider, CSB in the community mental health clinic type setting that might be able to meet the standard and be able to participate.
- >> Thank you. All right. So what we'll do now is we will move to the service component section and the question that I see here, the first one is initial medication evaluation must be conducted or must be available. Is the physician connected to the program expected to be on sight throughout the program day? Daily medication management are the license types able to monitor.
- >> So this is a good question. The fact that the question is coming indicates this is not entirely clear so it's one thing we will go back to make sure is clear in the definition of the critical features. I don't know if you want to meant to this at all.
- >> So the initial medication evaluation must be connected or must be available is really sort of a kind of admission. There's nothing in the service definition that requires that physician to remain on site at all times during the program day because this is more of sort of integrated series of programming that happens throughout the day that is not medication-based but there is a component of PHP that is physician-distributed. So that person should be accessible, you know, in the event it's needed indefinitely within a reasonable time frame as defined in the service definition for the initial evaluation.
- >> I believe the initial is within 48 hours of admission? But I also want to make note that one thing that we are going to be in this process looking to make sure is kind of well-defined and laid out is there are terms we are working on where we are looking to define what medication management means in this context versus what we would call education or health literacy counseling which is going to be a new term that will be defined. I see Laura smiling. This is a term that we are proposing to CMS within a number of the services. Health literacy counseling will really be what most of us know as psycho education but psycho education is not a preferred term from CMS. So when you see health literacy counseling it's more a synonym for psycho education and to look out for that but psycho education can also be related to medication, learning how they effect your body or learning about routines with the medication or how to manage your medication routine to kind of promote best practice. So it can many a couple different things but we are going to be defining that.
- >> There was a question in the chat from Stephanie. If a psychiatrist time dedication is 0.75 per child per month if they spend more time due to medical necessity are they able to bill this above and beyond the time included?
- >> Yes, the answer is yes.
- >> For PHP?
- >> I believe so. I believe we just met on this.
- >> Yeah, so the 0.75, that's how the rate was established for IOP so I don't know if this is a question --
- >> Oh, IOP?
- >> Oh, sorry, this is a question for IOP.
- >> I'm sorry. Are we talking PHP and I'm on IOP?
- >> Yes. We are talking (multiple people speaking).
- >> Forgive me.

>> That's okay.

>> Stephanie I still think the answer is yes.

>> The answer is still yes, just for the next section.

>> Okay.

>> Thank you, guys. Okay. And those were all the dwhaes we had for the service componentss so I didn't know if anybody else wanted to either unmute and ask a question or put it in the chat before we move onto the next section.

>> I think there's still one more question at the very end there.

>> And I have on glasses and I can't see what is going on. Okay. You're right. Academic instruction, not covered by Medicaid so are we looking at public school or IEP related academic instruction?

>> Another good one. So we went around about this, we actually sent this over to office of of children services, we sent it to DOE, we wanted to stay away from getting into too many definitions that are things that other people pay for but that Medicaid can't. That's why it's rather vague that just refers to the fact that accommodations should be made to assure that a child or youth can participate in their required academic activities but just noting that the actual academic instruction is not reimbursable to Medicaid. Does that make sense?

>> I think Angel is here. Want to make sure that is sufficient.

>> It does. Thank you.

>> Awesome.

>> Seeing no additional questions or comments in the chat we can move onto the provider qualifications and staff requirements section. The first question I see here if an LBA were interested in being a part of one of those teams it looks like he or she would be able -- would be able as an LMHP. I don't know where to find chapter two to be sure but I know LBA es are supposed to be included in the definition of LMHP pursuant to SB 762.

>> Yes.

>> Yep.

>> Yeah, I see that, too. I think the complication that came was when I went down further in the document and it wasn't included in like that chart - (multiple people speaking) -- okay. Good. Perfect.

>> Yep. Thank you.

>> Thank you. Okay. The next question I see es do we have the capacity of trained work force to provide these services listed?

>> Angel, there are particular services that you want to bring to the area of concern or just PHP broadly?

>> I think the concern is especially in some rural areas is hard to have it available to provide the services, a lot of the ones you mentioned as well. Especially when you go up with degrees in licensure and that type of thing.

>> We agree and we understand. Ultimately there's a bit of a balance here for us. This might not be the right exact term to you so stick with me as I work through the metaphor but if you build it, they will come type thing, though recognizing it's not that simple but how will we every get that if we don't allow for the services. Part of the big puzzle of incentivizing, drawing and sustaining work force is about having rates and services that accommodate for them. So we may not have a lot of these programs. And I don't doubt in rural areas they might not have the referral base or the staffing to set these up in some places so we don't expect them to be popping up all over the place in every locality. So I think that you're right, and Virginia is going to have that issue for a while, I think, for the foreseeable time we are going to be working to try to improve work force capacity in a number of ways.

And there is some good news coming. If you've seen anything about the American rescue plan there's a lot of interesting funding in there around work force development. I've seen a lot of interesting legislation coming out of other states which I hope Virginia with pursue in the future that looks at some different ways of building a work force. I think that I can't remember which state put in where students of their final training for an LMHP type of program to start early, so certainly from the federal level there's a recognition of what is going to be intensified for behavioral health care workers. So we are hoping to be part of the incentivezation by creating these rates and services.

Another thing I want to note in regards to that is one thing we may have seen with PHP is that the way these programs are set up are the Medicare standards so that means that there is a bit of an incentive built in for having a psychologist on the team because the psychologist can bill for all of their services outside of the per diem versus other non-prescriber's LMHP's who would be built in the per diem so it does buffer the per diem to have a psychologist. While it's not intentional on our part, it's in keeping with the medical criteria. We have a lot of psychologists here in Virginia. There's a lot of data to show where most of us train is where we end up practicing and becoming licensed but a lot of psychologists leave Virginia because there aren't enough training programs or residence programs. So if there isn't a residence program, people leave. We are hoping that because a lot of this will be associated with hospitals that they will -- this will incentivize the set up of residence programs taking on internship programs that will integrate psychologists who can build outside the per diem which would hopefully build the psychologist work force.

So this is a slow and incremental process but we are hoping to contribute to the development of that work force over time.

>> Thank you. And there was a question in the chat says I see certify peer resolvers who are working towards certification. Unless a peer is certified the service they provide are not reimbursable by Medicaid. Okay. So I'm going to head back to our questions or feedback, rather, and I see nothing else for the staff requirements section. And just double checking to make sure I didn't miss it. So we are going to move on now.

>> Shamika, how many more comments or questions do we have for PHP? I'm mindful of time.

>> Thank you, Dr. Aplasca. I can't see, I'm sorry. We have quite a few.

>> Thank you.

>> We have quite a few.

>> Do we want to get all the way through PHP or do we want to split the time?

>> I think what we can do is that there are comments under PHP that maybe we can skip but maybe work through some of the actual questions for maybe another -- a couple of them and then move into IOP if you want to do that.

>> Sure.

>> No problem. I will read only questions then. And we are going to move onto the service authorization section. If groups exceed ten and it is authorized by an LMHP, where that is to be documented?

>> I don't know that right now. We would have to get back to you on that but we can put that where every it needs to be delineated.

>> Okay. Thank you. All right. The next one is pretty long so please bear with me. I'm trying to find a way to see the whole thing because it's kind of chopped off. So while I'm trying to get my handle on the second question I'll go to the third question which says will the client be able to let the agency or provider as well as immediate provider if they have concerns or not receiving the appropriate number of services via phone or text or e-mail, et cetera, are the group sessions in person and through telehealth to allow for ten?

>> Will the client be able to let the agency provider know if they have concerns or not receiving the appropriate number of services... um, Angel, could you say more about that? If they know they should be getting something and realize they're not getting it?

>> Right. Sometimes we find a lot of the families end up going for one thing and get another service not necessarily the one they're paying for and it's hard to get the person there to get to the service or another way into the service. That's kind of what it's talking to.

>> Okay. I don't know the answer to that question right now. I mean, to me that's somewhat like a question on the provider side of how they would complain within individual programs. If they were a Medicaid member they could contact their MTO or the BHSA to say I don't think I'm getting what I'm supposed to be getting or there's something else I think I need so peer coordination through the MCO. Do other people have that?

>> Yeah, I think you would start with if the member felt comfortable speaking to the provider, you would start with the provider generally speaking most providers have a way of receiving concerns or complaints, a process for that that they would have to educate the member on generally speaking. Some programs will be big enough to have a human rights coordinator. And if they don't feel comfortable doing that then I think there are multiple avenues, one of them being MCO in terms of care coordination, if they think it's something that's just being overlooked and the provider needs some education then that's the route I would go. It's purposeful in some way which who knows. There are avenues for that in terms of how to contact licensing or for Medicaid fraud and things like that.

>> Okay. Is there additional feedback here?

>> No. Just that the standard -- any standards for in-person hold the same for telehealth. But I will say during the pandemic I've held some groups over telehealth and they can get unwieldy over a certain number so that can be what the clinician feels is therapeutic in terms of the number. So I would leave that to clinical judgment based on the telehealth piece. Right now it's really tricky so....

>> Thank you. Okay. This next one here is about the service unit so it says one unit of service is one day. The minimum number of service hours per week is 20 hours with at least four hours of service per day a minimum of five days a week. If providers are billing by the day do they have to attest they put in at least four hours? Is the number of weeks one week?

>> That was my question. I was just confused about the way the whole thing was written and how documentation and authorization seemed to be combined in that area. And I was just thinking I put in authorizations. Am I going to know how many hours if it's a day if the service unit is a day and it's going to be four hours but changes to six the service unit is still a day. So I fell like the way that was written I'm working with people on other regs, too. Sometimes the way they're written can be confusing when you're the provider and doing the authorization. So I wanted to make sure since this would be what people were following and how the forms would come up that it was a little more clear as to what I would do to do authorization. And then Shamika, I don't think you have to read the second comment.

>> Thank you. All right. And thank you, Dr. Aplasca for being the time keeper. We did finish all of the questions for this particular section so we are going to switch over to IOP for the remainder of the time being.

So let me go ahead and switch over. And the very first question that we have in the service definition section says requires weekly med management. If someone has a prescriber outside of mental health IOP services will the participant be expected to engage in weekly Medicaid management -- med management with the program prescriber? P.

>> Shamika, can you repeat the question again?

>> Sure. This is in regards to the weekly med management portion if someone has a prescriber outside of the mental health IOP services, will the participant be expected to engage in weekly med management with the program prescriber?

>> We need to flush out detail. This is a discussion that has come up a lot in the last few weeks ago if someone has an outside provider, what do they do for the time period that they're in the IOP and we are going to put some of that in (indiscernible) (sound muffled) it's a timely comment and we will have more guidance on that.

>> Thank you. The next question, could the age limits for the youth include five years old consistent with school-aged youth?

>> I don't think that this time because the (sound muffled) I think it's something we could look at and get feedback. Again, we don't anticipate this relationship with youth ending at the start of implementation. We would like to it evolve into a learning collaborative so something we could look at for younger children with this type of services and see whether it's something we could ask for in the budget in the future.

>> Also, I want to put out there, Dr. Ward, that in some ways these areas are guidelines and because of eTSTT we would not say that a five year old received this service. They would have to meet medical necessity and there would have to be a reason why they would need that service. It's the same for other evidence of services that have age ranges. We put that out there and said this what is the evidence base is but ultimately because of our code regulations we cannot necessarily say a five year old could not get it as with any other service.

>> Thank you.

>> Thank you. The next question was similar to the one we received in PHP regarding how we are going to collect data so I'm thinking that the answer is the same. Am I right?

>> Yes.

>> Okay.

>> Yes.

(Laughter).

>> Okay. So there's no additional questions for the service definition section. I'm going to move onto the critical features unless there's another question.

>> (Speaking quietly) one thing I would would say to see and look for in terms of outcomes with the services of hospitalization is I'm curious if we see the cascade happen and we can look at that analytically do we see that happening where people do move down the stair steps. Do we see people move from PHP to IOP to outpatient service? How does that play out in Virginia with the development of these services and cohorts? I'm interested to see that. I think that would be a good thing to look at as well. Go ahead, Shamika.

>> Thank you. Okay. Critical features and service component sections. We only have one question here and it says the statements seem to contradict. Clarifying the two would be helpful. Youth and adult therapeutic groups shall not exceed ten individuals. Group size may exceed this based on the license of the mental health state professional. The individual did not participate for any reason. Would this prompt discharge or some other decision-making?

>> I think we can clarify the first statement so we will clean up that language to be a little bit more specific about what those exceptions might mean. I'm not sure --

>> (Multiple people speaking).

>> So I can try to clarify a little bit. There were two separate questions. I think that service requirement is similar to the ones stated in the stabilization regulations currently which is a service that we offer here at intercept health.

And so one of the experiences we have is that that evaluation is available within 72 hours. However occasionally will have someone who is non-compliant or miss that appointment. So just what would the next steps be, what would the provider responsibility be in the event the provider may be available but the individual didn't follow through for whatever reason.

>> That's a good point. We will go back and look at that and see what we can add in here, add some stipulation if things happen or somebody is available but weren't able to participate in what comes next.

>> Thank you. There's one question in the chat that says since MH IOP is allowed to be provided in the school do we see this as a replacement for TDT?

>> Molly, it's looking really different from TDT because -- Laura is answering for me. Go ahead. If goals are very different, the MNC are very different. We put that in because we know in a lot of other states, for example IOPs set up in schools is like an after-school situation particularly in places that have school-based clinics. So this is less of a pull out from the classroom and more of standard programming that is happening in a clinic type setting that happens to coexist at the school. So we think it would look really different. It wouldn't necessarily compete with TDT because it would be for very different purposes.

>> Thank you. Okay. For the provider qualification as staff requirement sections there was only a comment there, no questions. So I'm going to move along to the service authorization section. The first question is exceeding group size of ten, where would this be documented?

>> We will tell you (Speaking quietly) (sound muffled).

>> Okay. Next one says given the provider has one business day to submit a service off request from admission, is the process considered prior off and is dependent on documented MNC or is the process considered registration, assuming the initial stay is automatically approved? If the process is prior authorization are a certain number of unit automatically approved to ensure provider reimbursement in the event the request is denied?

>> So (muffled sound) for these services. Sorry, I'm just thinking... I'm trying to think --

>> If first question it's definitely prior authorization and not registration. I think we are currently in discussion with if their around utilization.

>> We don't have that in writing yet what that would look like.

>> Okay. Thank you. We will move over now to the admission criteria and the first question is natural supports, this is related to youth MH IOP or also adult MH IOP?

>> Natural supports were meant to be indicated across the developmental span. This language was put in there to emphasize that these programs shouldn't be siloed in the setting. To assure good transition back into the community and the person shouldn't be engaged in a silo type setting where they don't acknowledge the need for that community transition. So that's why it's there for both adults and youth. It could be whatever natural supports how that is defined for that individual.

>> Thank you. Moving to the next section there were no additional questions there so moving to the next section for exclusion criteria. Nothing

there. Okay. So for continued care criteria, I see a comment and no questions this. Is good. So let's move along. I see nothing for the discharge session. So we will move to the service limitation section. The first one is a comment so this second I believe is more so a question. What is the rationale for excluding less expensive services such as mental health skill building and therapeutic day treatment that serve as direct support to individuals in settings not supported by MH IOP. The omitting the concurrent of these services will create a service gap in the community and school settings. Obviously the services should not be provided during the same hour. Consideration should be given for concurrent authorizations in close provider coordination.

>> We talked about service limitations for both (muffled sound) in terms of duplication and what all someone would potentially participate in in a span of hours. So I think there could be arguments made from some of these in some ways but we were trying to go with a practical way the programs were set up when we felt, you know, was going to be become duplication of service. So I hear what you're saying and we may continue that conversation but we really feel at this point that given what we looked at with the services that we just feel like having these both at the same time would end up being duplicative.

And that they could return to these potentially, you know, if they still needed them at another point but that we wouldn't have folks participating at the same time.

>> So there's a follow up question in the chat which reads what about collaboration with those who had been serving the individual prior to PHP and IOP?

>> Care coordination is certainly part of this service. It's one of the elements of the service. So we would anticipate that the team working with the kids, family, or adult would be talking with who every was providing the services prior to them coming into this more intensive program.

Just to understand what led them to the point because this would really be a step up in care to something more very discreet and intensive and intentional for a short period of time. But would those providers receive payment for talking with care coordinator? Well, as the referral is being set up and they're being moved over depending upon the overlap in those services as the referral is happening, I'd have to sit down and look at that about how the -- during that period both parties might be paid in the rate that they're paid for the coordination that's happening during the referral process. But it is a limitation I will say broadly and the Virginia system that we don't have care coordination codes that allow for this and it makes it a little tricky.

For example, in California as a practicing clinician I was able to bill management codes when I was doing essentially case management activities talking with former providers, future providers. But in Virginia we don't all have that option here so it makes it a little tricky. I agree, Christie, it's concerning. We do want the reinforce coordination. So it's something we will be mindful of and we can keep thinking about in terms of how to improve that coordination process.

>> Thank you. And I believe that's everything that I have on the spreadsheet. With regard to the billing guidance section there was a comment that says there are many questions about the per diem and the skills restoration so I believe that's where we will take the time to reach out to these questions individually and address them. We thank you for your feedback and contributions to the discussion today.

>> Yes. Thank you.

>> (Multiple people speaking).

>> We did it.

>> I want to let everybody knows that your feedback is noted that we will actually be considering the feedback. It may not appear in terms of the time frame was a very short time frame between now and next week when our goal is to get this information posted for public comment. You may or may not see any changes but just know the feedback will be considered during the 30-day public comment period and you'll also have the opportunity to go in town hall and comment as well if you so choose to do so.

So I just wanted to let you guys know that. Our goal is April first but I can't say that's exactly going to happen. That's a goal. We will keep you guys informed and let you know when it's posted if you wish to comment. And we appreciate your feedback and thank you guys so much. And Alexis is saying the survey is still opened. Yes. We are going to talk internally about how long we are going to keep that opened. We will probably -- I'll reach out to everybody and let people know how long we are going to keep that opened. So we appreciate everybody.

Another reminder this has been recorded. It will go up on our website. And you guys can e-mail us if you need anything or have any questions or concerns. We appreciate you all very much. Thank you.

>> Have a great afternoon.

>> Bye, everyone. Thank you.

>> Thank you.

>> Thanks so much. Have a great day.

>> Thank you.

(Event concluded at 2:00 p.m. CT)