# APPENDIX A
# TREATMENT PROVIDER WORK STATEMENT
# LANCASTER LCDAC SUBSTANCE USE DISORDER TREATMENT SYSTEM
# REVISED JULY 1, 2021

***Be advised that the following is not to be utilized as a stand-alone document as this Work Statement is incorporated into the comprehensive contractual agreement and is meant to be utilized in conjunction with the most current LCDAC policy/procedures, DDAP Manuals, alerts, bulletins, and memorandums.***

## I. Introduction

This is considered the work statement for contracted treatment providers. The roles of the LCDAC contracted substance use disorder treatment providers are described, along with various procedures of the Lancaster County Drug & Alcohol Commission. The Lancaster County Drug & Alcohol Commission (LCDAC) is also known as the Lancaster County Single Authority (SCA). For the purposes of this document, Lancaster County Drug & Alcohol Commission will be referenced as: LCDAC. Throughout this document, treatment facilities shall also be referenced as: contractors; providers; programs; or facilities.

## II. LCDAC Contracted Providers

LCDAC purchases treatment services through contracts with various Department of Drug & Alcohol Program (DDAP) licensed facilities. The treatment provider must maintain a full DDAP license, and contract with the Medicaid HealthChoices managed care company.

All treatment and treatment-related services are delivered by providers that are contracted with LCDAC on a fee-for-service or cost reimbursed basis.

### A. Federal Block Grant Requirements

As a provider of service funded by the Federal Block Grant Program, the following guidelines shall be adhered to. The provider shall:

a. **not** restrict or limit services based on one's membership in or affiliation with a fraternal organization, religious organization, race, color, national origin, handicap, age, or sex; and shall post conspicuously a current copy of the "State Contractors Non-Discrimination Notice."

b. ensure that effective communication will occur to persons with limited English proficiency.

c. ensure that equal access is provided to applicants for employment, employees, and to services for qualified handicapped persons according to Americans with Disability Act (ADA) requirements.

d. ensure services are provided equally, regardless of age, unless a statutory or administrative objective/mandate establishes age as a factor in the delivery of the service.

e. The provider shall also adhere to provisions stated in Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and if applicable the Pennsylvania Human Commission Act of 1955 as amended, and the Commonwealth's Contract Compliance Program under Executive Order 1984-1.

## III. Referrals

Most LCDAC referrals to outpatient, intensive outpatient, and partial hospitalization programs will be made to the providers through the facility's marketing programs and random referrals from the LCDAC administrative office, client recommendations, other human service organizations, schools, etc. Most referrals to residential programs will be made by the LCDAC Case Management staff and/or the withdrawal management service providers, with prior written LCDAC fiscal unit approval for funding. Halfway house level of care referrals also requires prior written LCDAC fiscal unit approval for funding.

## IV. Funding Eligibility

LCDAC funding is the "**payer of last resort.**" All other sources must first be utilized before LCDAC funds are considered. Other sources may include Medical Assistance or Medicaid, Veteran's administration, insurance coverage, and private pay.

There is no residency requirement for any level of care for LCDAC funding.

### A. LCDAC Funding

Medical Assistance (MA), also known as Medicaid, eligibility should be verified during the client's first visit and should be monitored during each subsequent session. Clients who do not have active MA must immediately apply for MA. While waiting for MA eligibility determination, clients are eligible for LCDAC funding and will have an LCDAC liability completed. Please see Lancaster LCDAC's *Liability Determination Policy* for more information. Clients who do not apply for MA or comply with MA regulations will not be considered Lancaster LCDAC funded clients. The provider can scholarship the treatment or ask the client to resume counseling when he/she applies for MA benefits.

The client liability process and forms were developed by the Department of Drug and Alcohol Programs (DDAP) and LCDAC. Providers must adhere to all the liability

requirements as described in the DDAP Fiscal Manual and DDAP Website.

***1. Liability Determination***

The liability is the amount the client must pay the treatment provider for services. The liability is based on a sliding fee scale. The more a client makes, the more the client will contribute to his or her treatment. If two family members are in treatment at the same time, a separate liability is assessed for each family member. Client liabilities will be collected by the facility which conducts the treatment. All client liabilities will be subtracted from the LCDAC cost, whether collected or not by the facility providing the treatment. The LCDAC then pays the provider the remaining amount owed the provider, as per the contracted rate.

No liability is needed for a level of care assessment or withdrawal management services. All other levels of care require a liability. After the completion of the level of care assessment and placement determination episode ***BUT BEFORE*** the first treatment appointment; OR at the end of the withdrawal management service episode, the client will meet with a contracted treatment provider employee who has been trained by LCDAC to complete liability determinations.

With the client, the contracted treatment provider will complete the Client Liability Form to ascertain the appropriate liability amount the client will be paying for the services. All income should be verified by the provider via a client's supporting documentation (that is: W2 forms, pay stubs, Social Security Disability Income statement, bank statements, etc.).

To be considered valid, the liability must show the amount the client will be required to pay towards his or her treatment and the form ***must be*** signed and dated by the client. Completion of the liability form does not guarantee that the client will receive LCDAC funding.

The liability form and supporting documentation (copies of the supporting documents are acceptable) are placed in the client file and will be reviewed during the LCDAC provider monitoring site visit. Failure to sign the liability or provide supporting documentation for verification of income renders the client liable for the full cost of service. Providers who do not have income documentation on site will be required to reimburse the LCDAC for LCDAC paid services that occurred without income verification.

LCDAC payment is payment in full for LCDAC funded clients.
The provider cannot charge the client for any amount above the LCDAC liability. If LCDAC payment is not involved, the provider can charge the published rate.

***2. Liability Effective Dates***

Clients who are awaiting a determination of eligibility from MA will receive a LCDAC liability effective for a maximum of 60 days. If the client does not

obtain an MA determination within the sixty (60) day limit, the provider can request an extension. These will be reviewed on a case-by-case basis. The client must have applied promptly and complied fully with the MA process to be considered for an extension.

To continue to be eligible for LCDAC funding after the initial 60-day liability has expired, a valid MA rejection form is required. The rejection must be for a legitimate reason, not for a missed appointment, loss of paperwork, or failure to comply with MA procedures. Only one (1) 60-day liability is allowed for a client.

Once a valid MA rejection letter is received, the initial 60-day liability can be extended to be effective for one year. Client liabilities that are effective for one year must be recalculated on an annual basis, using the date of the original liability as the anniversary date. The outpatient provider is responsible for monitoring the client liability and for working with the client to renew the liability one month prior to the anniversary date.

Client liabilities should also be recalculated if the client's income increases or decreases by more than 10%.

### *3. Liability Minimums, Maximums and Abatements*

All LCDAC funded clients are required to have a minimum liability. For clients in outpatient level of care, intensive outpatient level of care, or partial hospitalization level of care, the minimum liability is 10% per session.

For clients in inpatient treatment, the minimum liability is $2/day. The SUD bundled methadone treatment services funded by LCDAC have a minimum liability amount of 10%. Maximum liability amounts are determined by a client’s income and are listed on LCDAC Liability Tables. Liability Tables may be located on the LCDAC website, or a request can be made to the LCDAC Fiscal Department.

Clients who have a liability amount that is above the minimum may request to have their liability lowered or abated. However, no liability can be made lower than the minimums that have been identified above. (Exceptions to this rule MAY be considered, on a case-by-case basis, for clients aged 17 and under. Please contact the Lancaster LCDAC Fiscal Office for further information.)

To request an abatement, the client and his therapist shall complete the Request for Liability Reduction and the Liability Appeal Monthly Budget forms in their entirety and submit it to the LCDAC Fiscal Officer. Once reviewed by LCDAC, the final liability determination shall be sent to the provider.

### B. Other Sources of Client Funding – Active MA

For clients with active Medical Assistance (MA), treatment funding will be provided through MA/HealthChoices. No charges for treatment will be made to the LCDAC, unless MA funding is later denied.

If a client enters treatment with an active MA card, the liability form will not be completed. It is expected MA funding will be utilized for treatment whenever possible.

LCDAC contracted treatment facilities must acquire an MA approval and accept MA clients. If a facility loses its MA approval, the LCDAC will not pay for the MA clients' treatment services. With the MA Health Choices project, this includes having and keeping a contract with the managed care organization.

LCDAC may cancel the contract if the facility is not MA approved for funding. MA approved treatment programs must maintain the MA approval for the length of the LCDAC contract.

**LCDAC and its staff do not interpret MA regulations or policies for itself or any of the treatment providers. It is the sole responsibility of the treatment provider to know and understand the MA policies, procedures, and regulations of providing services and for billing/reimbursement.**

### C. Other Sources of Client Funding - VA

DDAP identifies Veterans who use substances as a priority population. LCDAC and its contracted providers are required to address the needs of veterans as follows:

1. Conduct screening and level of care assessment (LoCA) services.
2. Utilize the most current ASAM Criteria.to determine the appropriate level of care.
3. Make a referral to the identified treatment level of care.
    - i **LCDAC cannot deny funding to a veteran based on eligibility for VA benefits or because of the recommended level of care.**
    - ii **LCDAC must offer the recommended LoC to the veteran regardless of the funding source.**
4. Provide the full continuum of treatment services to veterans.
5. Provide additional case management services as appropriate.
6. If the facility operated by the U.S. Department of Veterans Affairs (VA) is determined to be the most appropriate facility to provide treatment for the veteran,
    - i LCDAC or the contracted provider must directly connect the individual to the admitting provider and
    - ii LCDAC or the contracted provider must confirm that the veteran was admitted as planned.

iii It is not acceptable to only provide contact information for treatment to the Veteran.
iv The warm-handoff approach is required (see policy regarding how to execute a true warm-handoff).
v LCDAC may continue to provide Case Management Services while the veteran is in the VA facility.

### D. Other Sources of Client Funding - Insurance and HMO

LCDAC funding is the payment of last resort. If a client has insurance, the treatment provider will aggressively seek payment from the insurance company prior to requesting funding from LCDAC.

For LCDAC to consider assisting the client in paying for SUD treatment when the client is covered by an insurance policy or HMO, an insurance rejection letter should be obtained. The following information must be identified on the "rejection letter" from the insurance/HMO:

1. The name of the insurance company/HMO, the address, and phone number should be clearly on the letter.
2. The signature of the person making the decision and the phone number to reach this person should be identified. The name should be clearly printed or readable.
3. A summary of the client's SUD benefits as specified in the client's HMO/insurance policy should be given.
4. A summary of the SUD treatment services already provided to the client in this benefit year.
5. A statement that pertains to the client's ability to convert benefits from one modality to another.

This rejection letter from the insurance company must be placed in the client record and may be reviewed by LCDAC during monitoring site visits.
Questions or issues regarding this matter may be directed to the LCDAC Fiscal Department.

## V. Emergent Screening

Providers will implement the SUD emergent screening protocol as described in the most currentt DDAP Case Management and Clinical Services (CMCS) Manual. All screenings conducted on LCDAC funded clients will be submitted to LCDAC via any client information system required by DDAP.

## VI. Outpatient Assessment and Placement Determination Episode/Client Intake

The contracted treatment provider will meet with the publicly funded client to provide an

assessment and placement determination episode (previously referred to as the Level of Care (LoC) assessment). During the assessment and placement determination episode, a LoC assessment tool (such as the DDAP Treatment Assignment Protocol Assessment: TAPA) will be completed. The purpose of the assessment is to evaluate an individual's strengths, resources, preferences, limitations, problems, and needs. Moreover, the assessment determines an individual's priorities for treatment. The assessment and placement determination episode are a face-to-face* (*unless an alternative option has been approved) interview to ascertain the treatment and treatment-related needs of the individual based on the degree and severity of substance use and the treatment and treatment-related needs of the individual based on the six dimensions of The ASAM Criteria, 2013.

**All** clients must be offered an appointment to complete the assessment and placement determination episode within seven (7) days of the date of initial client contact. If an appointment cannot be offered by the treatment program within the seven (7) day requirement, the client will be given a referral to another facility. Documentation of the date the appointment was offered to the individual MUST be recorded in the provider records.

To complete the assessment and placement determination episode in its entirety within the 7-day requirement, the provider ***may*** need to schedule the appointment for more than the traditional 45-minute session to complete the following required documents in their entirety:

1. Approved LoC assessment tool (such as: Treatment Assignment Protocol Assessment).
2. A communicable disease screening as well as referral services for:
    a. Tuberculosis (TB)
    b. Hepatitis C
    c. Human Immunodeficiency Virus (HIV)
3. Problem Gambling Screening and Referral
4. Coordination of services (that is: Case Management Service Plan/Recovery Plan)
5. Placement determination using the most recent version of the ASAM criteria; and
6. Entry into the most current DDAP data system (that is: Web Infrastructure for Treatment Services (WITS).

The assessor, ***not the client***, must complete the LoC assessment tool. The LoC assessment tool **MUST** be completed in the first appointment with the individual, this appointment **MUST** be ***face-to-face**** (*unless an alternative option has been approved), AND all the aforementioned documents **MUST** be completed in their entirety. Based on the information gathered and processed through the ASAM Placement Summary Sheet, the appropriate level of care will be determined. If the client remains with the contracted provider where the assessment and placement determination episode was conducted, an intake appointment will need to transpire/be scheduled. ***Contracted providers who complete the assessment and placement determination episode must maintain neutrality when referring individuals into a specific level of care, a specific facility, or provider.***

REMEMBER, the assessment and placement determination episode are to be completed within the seven (7) day requirement. If either the seven-day timeframe or the completion of the assessment in one session cannot be met, the person who conducted the assessment and placement determination **must** document the reason in the individual's record.

The information gathered during the assessment and placement determination episode determines the most appropriate level of care. The first appointment following the completion of the assessment and placement determination episode is considered the intake appointment (for billing purposes an “Individual” appointment). During the intake appointment the following LCDAC documents are to be completed:

- the Grievance and Appeal form
- the Request for Client Services (as appropriate for residential or inpatient placements)
- the appropriate LCDAC release(s) of information
- the Liability forms**; and
- all other documents that the LCDAC may identify.

**Client liability forms are calculated ONLY IF treatment is being recommended in accordance with the outcome of the assessment and placement determination episode. A liability is not relevant for any individual in which treatment is NOT being recommended. The LCDAC Client liability forms will be completed following the completion of the assessment and placement determination episode AND **BEFORE** the first scheduled treatment appointment.

BE ADVISED: The aforementioned documents are LCDAC specific. Additional documents per licensing regulations or other regulatory entities may also be required. MOREOVER, it is required that any/all line items on any/all forms/documents MUST reflect that they were reviewed. Therefore, for those items that are not applicable and/or relevant, a mark (that is: NA; /; 0; X) is to be used. There are to be NO blank lines/items/areas remaining on any form/document.

The provider will use the most recent version of the American Society of Addiction Medicine (ASAM) Criteria for all adults and adolescents when determining the appropriate level of care for any client who requires and receives funding for substance use disorder treatment from the LCDAC. The most current ASAM Placement Summary Sheet shall be completed for the admission into treatment, continued stay reviews during treatment, and discharge status from the treatment episode. How to conduct an admission, continued stay, and discharge is outlined in The ASAM Criteria with supplemental instructions provided by DDAP. Providers must obtain training on the use of The ASAM Criteria from approved DDAP trainers and document their training with the LCDAC.

The Case Management Service Plan/Recovery Plan must be completed as part of the assessment and placement determination episode and updated no less than every 60 days through an individual’s time in treatment. This coordinated service approach is a collaborative process which includes engagement, evaluation of needs, establishing linkages, arranging access to services, ensuing enrollment in the appropriate healthcare coverage, advocacy, monitoring, and other activities to address the individual’s treatment-related needs throughout their course of treatment. Collaborating on the Case Management Service Plan/Recovery Plan includes communication, information sharing, and occurs regularly between the case manager, contracted treatment provider, and the individual receiving services.

This organized coordinated approach for the identified treatment & non treatment related needs ensures individuals with complex, multiple problems receive the individualized services

they need in a timely and appropriate manner. This process is intended to promote self-sufficiency and empower the individual to assume responsibility for his /her recovery.

Clients who will benefit from extra support can be offered a referral to Recovery Support Specialists (RSS) or a SUD Case Manager. Regardless of whether a referral for RSS or CM has been made, the counselor will document non-treatment needs on the Case Management Service Plan/Recovery Plan in the Web Infrastructure for Treatment Services (WITS). To address identified needs, the counselor will refer clients to the necessary agencies and services.

Clients cannot be required to participate in additional activities with a RSS, CM, or Resource Coordinator (RC) to be eligible to receive a specific level of care or type of service. Additionally, the LCDAC will not require a specific population to participate in these additional activities, to receive treatment.

## VII. Client Services Management

Many of the outpatient providers will be given funding to hire one or more SUD Case Managers and or Recovery Support Specialists (RSS). Details of these positions and responsibilities are identified in the *LCDAC Case Management Expansion Plan*.

1. All Contractors shall cooperate with the LCDAC case managers in their activities on behalf of publically funded clients. This shall include:

    a. adherence to all LCDAC policies and procedures
    b. utilization of all required forms as may be issued by LCDAC
    c. obtaining all required releases from clients/prospective clients; and
    d. allowing case managers who are providing case management services with a place on-site to meet with the clients as may be necessary.

2. Contractors shall assist clients in obtaining all benefits for which they are eligible or due to them and which may assist them in accessing necessary intervention and treatment services. This includes but is not limited to private insurance, Medicaid, and Veterans Administration benefits.

3. Contractors shall supply treatment clients or potential clients with approved grievance and appeal procedures.

4. Treatment contractors shall communicate with case managers, with appropriate releases, at times of continuing care reviews, discharge and at occurrence of any significant event, including potential AMAs, family crisis, etc. for the purpose of assisting the case manager in their advocacy, support and coaching activities designed to link the client with necessary support/ancillary services and/or to keep the client in treatment.

5. For placement decisions, all agencies will be required to collaborate with other agencies serving the client in the placement and ongoing treatment decisions.

a. When placement and/or continuing care decisions involve a client in the juvenile or adult criminal justice system and/or the Children and Youth Social Services Agency (CYA), the agency will triage with the agency caseworker or officer as part of the clinical decision-making process. This will include initiating any necessary client release forms. It will also include cooperating with CYA and/or Juvenile Probation in carrying out the tenants of the state and federal laws of the Adoption and Safe Families Act.

b. When placement or continuing care decisions involve a senior also involved with a caseworker at the Area Agency on Aging (AAA), the agency will obtain the necessary releases and triage with the AAA caseworker.

c. When placement or continuing care decisions involve a client with a diagnosed co-occurring mental illness and/or intellectual disability, the agency will obtain the necessary release and triage with the mental health clinician, intellectual disability caseworker and/or case manager, in placement and on-going treatment decisions.

## VIII. Initial Assessment Reimbursement

The outpatient provider may bill the LCDAC a maximum of three (3) hours, or $228.00 for the assessment and placement determination episode. As outlined in section ***VI. Outpatient Assessment and Placement Determination Episode/Client Intake,*** the assessment and placement determination episode must be completed using an approved LoC assessment tool with the ASAM Summary Sheet indicating the placement determination. The assessment with placement determination and intake must be completed within seven (7) days of the date of the initial client contact. If this timeframe cannot be met, the reason must be documented in the client file. This requirement will be reviewed during the LCDAC monitoring site visit.

The LCDAC contracts its assessment and placement determination functions to the outpatient providers in Lancaster LCDAC. The following components MUST be included as part of the assessment and placement determination episode:

1. Approved LoC assessment tool (such as: Treatment Assignment Protocol Assessment).
2. A communicable disease screening as well as referral services for:
    a. Tuberculosis (TB)
    b. Hepatitis C
    c. Human Immunodeficiency Virus (HIV)
3. Problem Gambling Screening and Referral
4. Coordination of services (that is: Case Management Service Plan/Recovery Plan)
5. Placement determination using the most recent version of the ASAM criteria; and
6. Entry into the most current DDAP data system (that is: Web Infrastructure for Treatment Services (WITS).

The assessment and placement determination episode must be completed in its entirety in one (1) session prior to referring an individual to the appropriate level of care, except when the individual needs withdrawal management. All assessments must include all the components listed above and must be completed in WITS. This requirement will be reviewed during the LCDAC monitoring of the treatment provider.

The assessment and placement determination episode can occur outside of the outpatient facility if the client cannot physically get to the outpatient facility. Examples include clients that are in a psychiatric unit or a local hospital. The client must have a Lancaster County address. Assessments can only occur in a location within the Lancaster LCDAC borders, UNLESS ***written verification (that is: letter; email; etc.) is obtained from an LCDAC staff member AND is retained in the client file for verification upon request***. All assessment requirements and reimbursement rates are the same for the mobile assessment and placement determination episodes. An outpatient clinic cannot use more that 20% of its contract cap on mobile assessments. The billing code for the mobile assessment and placement determination episode is 003002.8.

**Only qualified individuals who have completed all required and applicable DDAP-approved case management core trainings within 365 days of hire, are able to independently perform the assessment and placement determination episodes as well as provide case coordination services to the LCDAC funded individual. For those staff members who have been assigned to execute the case management responsibilities, yet have not completed the required trainings, supervisor signatures must be found on all documents until said required trainings have been secured. Failure to adhere to these requirements may result in forfeiture of LCDAC payment.**

## IX. Outpatient, Intensive Outpatient, and Partial Hospitalization Level of Care Reimbursements

- Hours of operation and the fee schedule MUST be posted in a common area.

- ADULTS

Per the ASAM criteria alignment, outpatient level of care services is defined as regularly scheduled treatment sessions of fewer than nine (9) contact hours per week. The outpatient therapist is reimbursed by the LCDAC at $72.00 per face-to-face* (*unless an alternative option has been approved) individual clinical hour and $32.00 per hour for group therapy.

Per the ASAM criteria alignment, intensive outpatient treatment (IOP) services are defined as regularly scheduled treatment sessions at least three (3) days per week, for at least nine (9) hours, but no more than nineteen (19) hours per week.

The intensive outpatient therapist is reimbursed by the LCDAC at $72.00 per face-to-face* (*unless an alternative option has been approved) individual clinical hour and $32.00 per hour for group therapy.

Per the ASAM criteria alignment, partial hospitalization services are defined as 20 or more hours of clinically intensive programming per week. Partial services that take place in a

community-based/non-residential clinic will be reimbursed by the LCDAC at $64.00 per face-to-face* (*unless an alternative option has been approved) individual clinical hour and $24.00 per hour for group therapy.

To align with the Medical Assistance regulations regarding maximum group size, whenever an LCDAC client is participating in group therapy, no more than ten (10) clients may participate in the group, regardless of the other funding streams supporting the other clients in the group.

A client cannot receive services at two different LCDAC contracted programs at the same time. LCDAC will only pay for sessions that take place in the contracted provider's DDAP licensed office, except for substance use disorder mobile assessments. Any exception to the therapy location policy must be discussed with and approved in writing by the LCDAC and adhere to DDAP licensing requirements.

Providers affiliated with a residential facility cannot refer clients to the "sister" residential facility, unless clinically justified (i.e., family involvement, medical considerations, etc.) and a written authorization is provided by the LCDAC. For those providers licensed to provide various level of care services, written procedures indicating evidence-of-neutrality is upheld must be made available upon request.

The provider is responsible for documenting all individual and group counseling sessions with clinical notes to verify services. Billing that is not verified by individual and group notes in the client file during the monitoring verification process will be deemed reimbursable to the LCDAC within thirty (30) days.

The outpatient, intensive outpatient, and partial hospitalization programs may purchase and distribute Narcan kits, also known as Naloxone kits, for any Lancaster County resident legally permitted to receive such medication. All current state and federal laws and protocol must be followed when distributing these kits. The program will receive reimbursement for these kits, up to a maximum of $100 per kit. This reimbursement is included in the contract cap for the agency.

The outpatient, intensive outpatient, and partial hospitalization contract caps will specify the total maximum amount of LCDAC funding for the fiscal year, (July 1 to June 30). Providers are responsible for monitoring these contract caps and notifying the LCDAC when nearing the cap. All reimbursement to the outpatient programs, including payment for treatment, training, (up to a maximum of 25 hours per counselor, per fiscal year), consultation, Narcan kits, etc. are included in the cap.

- FAMILY MEMBERS

The outpatient and/or intensive outpatient and/or partial hospitalization level of care providers may provide a maximum of five (5) hours of counseling and education for family members and significant others, without the client being present for these sessions. A special fiscal code (003014.0) is used for these sessions on the LCDAC invoice. Reimbursement for this service is $72 per hour, for a maximum of $360.00.

- ADOLESCENT

For those outpatient, intensive outpatient, and partial hospitalization therapists that are **pre-approved in writing** by LCDAC, the therapist is reimbursed by the LCDAC at $76.00 per face-to-face* (*unless an alternative option has been approved) individual clinical hour, and $32.00 per hour for group therapy, for adolescent outpatient counseling.

To receive pre-approval from LCDAC for the special adolescent reimbursement rate, the therapist must have a Masters' degree or above in counseling or human services, and must submit the following information to LCDAC, via e-mail:

a. Therapist's resume.
b. How often is the therapist supervised each week?
c. Who provides the direct supervision of the therapist? What are the supervisor's credentials?
d. What evidence-based modalities of treatment will be used in the therapy sessions? How is fidelity maintained using these evidence-based therapies?
e. Identify any special certifications or licenses of the therapist.
f. Describe the clinical training and education that the therapist will receive each year.
g. Identify any experience the therapist has in working with clients under the age of 18.

If LCDAC approves the therapist in writing for the enhanced reimbursement rate, the outpatient clinic can invoice LCDAC using these enhanced rates, when this therapist provides therapy to any client under the age of 18.

- ADDENDUM

The residential rehabilitation programs negotiate the per-diem rate when contracting with the LCDAC. The residential programs are responsible for some case management functions, such as client advocacy, treatment plans, referral to other services, and aftercare services. There are no caps placed on residential programs since the written authorization controls the LCDAC dollar.

If the residential facility is asked to provide additional case management services, beyond the normal workload of the residential case manager, the residential facility can request written authorization from LCDAC, for case management services reimbursement at $36.00 per hour.

## X. Outpatient, Intensive Outpatient, and Partial Hospitalization Authorization

- ADMISSION

No written or verbal authorization for outpatient services, IOP, or partial is required. All outpatient, intensive outpatient, and partial facilities have contract caps to control LCDAC funding. Providers are responsible for monitoring these caps throughout the year. The LCDAC is not financially responsible for outpatient, intensive outpatient, or partial programs that exceed their yearly LCDAC caps. All reimbursement to the outpatient, intensive outpatient, and partial

programs, including payment for treatment, training, consultation, etc. are included in the cap.

LCDAC shall have the right to unilaterally modify caps throughout the year. Caps can be increased or decreased, depending upon LCDAC review of available funds and program utilization. This is accomplished through a change in the contract, signed by both LCDAC and facility director.

- REQUEST FOR EXTENSION OF FUNDING AUTHORIZATION

**Outpatient Services**

- Initial Outpatient treatment funding authorizations are active/occur for up to six (6) months.
- Treatment beyond the six (6) month period requires the request for an extension of funding, which is as follows:
  - An updated ASAM Placement Summary Sheet comprised of a Level of Service and Risk Rating must be completed **AND** entered into PA WITS.
  - Additionally, the outpatient provider is responsible for completing a ***Continued Stay Request Form***.
  - The ***Continued Stay Request Form*** includes a section to detail the individual's progress and an estimated length of treatment extension.
  - The completed ***Continued Stay Request Form*** **AND** a copy of the current client liability form must be emailed to DrugAlcohol@co.lancaster.pa.us.
- The LCDAC CM Supervisor is responsible for approving or denying the request; ensuring that funds are available for the requested extension.
- The LCDAC CM Supervisor will email an approval or denial to the treatment provider making the request.
  - If the request is denied, the LCDAC CM Supervisor will follow up the email alert with a discussion of level of care/recovery support service transfer options with the provider.

**IOP/Partial Hospitalization Services**

- Initial IOP/Partial treatment funding authorizations are active/occur for up to ten (10) weeks.
- Treatment beyond the ten (10) week period requires the request for an extension for funding, which is comprised of the following:
  - An updated ASAM Placement Summary Sheet comprised of a Level of Service and Risk Rating must be completed AND entered into PA WITS.
  - Additionally, the outpatient provider is responsible for completing a Continued Stay Request Form.
  - The ***Continued Stay Request Form*** includes a section to detail the individual's progress and an estimated length of treatment extension.
  - The completed ***Continued Stay Request Form*** **AND** a copy of the current client liability form must be emailed to DrugAlcohol@co.lancaster.pa.us.
- The LCDAC CM Supervisor is responsible for approving or denying the request; ensuring that funds are available for the requested extension.
- The LCDAC CM Supervisor will email an approval or denial to the treatment provider making the request.

- If the request is denied, the LCDAC Case Manager will follow up the email alert with a discussion of level of care/recovery support service transfer options with the provider.

## XI. Residential and Inpatient Authorizations

For the outpatient level of care services (that is: outpatient; intensive outpatient; partial hospitalization) as well as withdrawal management services at the 3.7 level of care, NO PREAUTHORIZATION from LCDAC is required.

LCDAC requires ***PREAUTHORIZATION*** for the following levels of care:

- 3.1 Clinically Managed Low-Intensity Residential Halfway House
- 3.5 Clinically Managed Medium-Intensity Residential Services (Adolescent)
- 3.5 Clinically Managed High-Intensity Residential Services (Adult)
- 3.7 Medically Monitored Intensive Inpatient Services (Adult)
- 3.7 Medically Monitored High-Intensity Inpatient Services (Adolescent)
- 4 Medically Managed Intensive Inpatient Services

When the level of care assessment indicates a residential or inpatient level of care, LCDAC requires a *REQUEST FOR CLIENT SERVICES* packet to be utilized to request funding for the above-mentioned levels of care. The *REQUEST FOR CLIENT SERVICES* packet shall be completed by the provider requesting funding approval and must be emailed to DrugAlcohol@co.lancaster.pa.us within 5 (five) business days of admission. If an interim period exists between funding determination and/or securing placement, the client is eligible to receive outpatient level of care services.

LCDAC requires a *REQUEST FOR CLIENT SERVICES* packet for residential services at the time withdrawal management is requested, as residential services require preauthorization.

The provider shall email the REQUEST FOR CLIENT SERVICES packet to DrugAlcohol@co.lancaster.pa.us to request funding. If an individual is being referred to another facility, the current provider is responsible for securing LCDAC funding prior to admission to the accepting facility and is required to forward such approval to the accepting facility.

Providers must email a completed *Request for Client Services* two-page form with a completed updated ASAM Summary Placement Sheet if this status changes. Once received by the Case Management Unit, a response shall be emailed within 5 (five) business days to the requester. Verbal communication shall not constitute authorization. The approved *REQUEST FOR CLIENT SERVICES* email sent from LCDAC Case Management Until shall be retained by the provider and be made available upon request. Failure to produce an approved *REQUEST FOR CLIENT SERVICES* email may result in denial of funding.

The placement of the client into a residential program will be made by the LCDAC. The client will be given at least two (2) choices of residential programs. The LCDAC Case Manager will contact the "*chosen*" residential program to establish a start date and inform the facility of the approval of funds by the LCDAC fiscal unit. The LCDAC Case Manager will then call the

referring provider to confirm approval. This confirmation phone call must be documented by the treatment facility (date of call, time, LCDAC staff name, etc.). The Case Manager making the referral will make arrangements with the rehab/inpatient program to accept the client and schedule an intake date and transportation (if transportation services are available via the program).

If more time than initially approved is warranted, the provider may submit further requests for funding authorization in an email directed to the assigned LCDAC Case Manager with a CC to the LCDAC Case Manager Supervisor.

The residential rehabilitation programs will not be capped through their contracts, since written authorization is necessary from the LCDAC Office before a client is placed. LCDAC will not be financially responsible for residential rehabilitation programs who admit a LCDAC client without prior written authorization from LCDAC.

## XII. Invoicing

To be reimbursed for services for LCDAC clients, providers will submit the *Service Rendered Reports/Invoices* and corresponding admission forms to LCDAC. For residential programs, only clients for whom an authorization has been issued should be included on the invoice.

Invoices must be submitted within two (2) months the date the service was provided. If the invoice is submitted after the two (2) month deadline, LCDAC will have the option of not paying the provider for the service that was rendered.

Historically, the provider would only charge the LCDAC for face-to-face client services. It is expected that this in-person, face-to-face service shall prevail. HOWEVER, in the event a provider would like to offer telehealth services, a waiver MUST BE SECURED from LCDAC for each client PRIOR to the rendering of the telehealth services. Failure to secure an approved waiver PRIOR to the rendered telehealth services*, payment for said services may not occur. (*For those providers equipped to provide telehealth services, written policies and procedures MUST exist and MUST be made available upon request).

No charge will be made to the LCDAC if a client cancels an appointment or does not attend a scheduled appointment.

All individual sessions are a **minimum** of a 45 minute time period to be considered one billable "hour". For sessions falling under 45 minutes and over 22 minutes, the provider can bill for a .5 "hour" of service. Group sessions shall follow the aforementioned formulary for individual sessions.

### A. Staffing Requirements

Outpatient providers must submit the names and resumes of each therapist/counselor conducting services and being reimbursed by LCDAC. The credential standards for LCDAC

funded therapists/counselors are in alignment with the most current DDAP licensing regulations.

## XIII. Confidentiality

Confidentiality is one of the cornerstones guiding the treatment of substance use disorders. As such, treatment providers MUST ALWAYS make the required provisions for systems security and protection of all persons currently or formerly screened, assessed, diagnosed, counseled, treated, and rehabilitated for SUD.

All contracted treatment providers will require each staff member, both clinical and administrative, to sign a Confidentiality Statement, agreeing to observe a strict standard of confidentiality. Staff will agree that the knowledge and information of a confidential nature, gained through employment, may not be used, distributed, or discussed outside of the immediate work responsibilities. All state and federal confidentiality laws will be understood and strictly enforced.

## XIV. Client No Show Fees and Other Charges to LCDAC Clients:

For LCDAC funded clients, "*No Show Fees*", or any other charge or fee assessed to a client, cannot exceed a cumulative amount of $60.00, in any fiscal year. Once the client's invoice balance of $60.00 is reached, the facility will discontinue any charge for not showing up for an appointment, or for any other charge to the LCDAC client. ***This $60.00 maximum does NOT include the charge for client liabilities***.

If the "*No Show Fees*" is below $60.00 on July 1, then the facility can once again begin to charge the client for *No-Shows*, up to when the balance owed reaches $60.00 again. Then any further charges for *No-Shows*, or any fee, must be discontinued for the rest of the fiscal year.

This requirement does NOT include any charges or amounts assessed to the client before the client became a funded LCDAC client. For example, it does not include the co-pays, deductibles, *No-Show* Fees, etc., during the time when the client was not an LCDAC funded client; they may have been covered by insurance, private pay, etc.

## XV. Client Data and Forms

Contracted treatment providers must submit all DDAP required client data via any client information system determined by DDAP. The contracted treatment provider will also need to submit the ***LCDAC Admission Form***, Client Liability form (when required), and ***LCDAC Discharge*** form via email to the Lancaster LCDAC whenever a client enters or leaves a facility.

The ***LCDAC Admission form*** and Client Liability Form (when required) must be submitted to LCDAC within five (5) workdays of the initial assessment/admission to treatment. The ***LCDAC Discharge Form*** must be submitted within five (5) workdays of the client's discharge. Failure to submit this information will delay LCDAC payment.

LCDAC funded clients referred to residential treatment programs should be discharged

from the outpatient facility using the ***LCDAC Discharge form***. When the client returns to the outpatient program, a new outpatient ***LCDAC Admission form*** is developed and submitted via email to LCDAC. Residential programs will submit a copy of the ***LCDAC Admission*** and Client Liability form (when required) via email.

## XVI. Medication Assisted Treatment

Services for opioid dependent clients may be provided through Methadone maintenance or Suboxone/Buprenorphine treatment programs. Policies and procedures for this modality of treatment will follow the same protocol as residential treatment, such as ASAM level of care, pre-authorizations, case management services, etc.

LCDAC clients served in an Opioid Treatment Program (OTP) (previously known as Methadone Maintenance Treatment Programs) must meet or talk with a LCDAC case manager at time frames determined by the case manager, for a request for funding extension review and re-evaluation of the client's financial status.

## XVII. LCDAC Meeting Requirements

All LCDAC contracted treatment providers are required/mandated to meet with the LCDAC a minimal of three (3) times each year, for the purpose of information dissemination, problem solving and networking. The time and place of the meetings will be at the discretion of the LCDAC.

It is strongly encouraged that ALL LCDAC contracted providers disseminate the information gleaned during the LCDAC Provider meetings during their regularly staff meetings.

At the discretion of and/or needed by LCDAC, attendance at additional specialized provider meetings may be required.

## XVIII. Monitoring

LCDAC will conduct a minimum of one (1) annual monitoring site visit at each LCDAC contracted facility. Client files will be reviewed, and contract compliance checks will be conducted. Out-of-county programs may also be reviewed at the sole discretion of the LCDAC. Additional site visits may also be conducted for any contracted treatment programs for client record reviews and contract compliance. A written report will be developed by the LCDAC and submitted to the treatment facility. As needed, the facility will be required to respond in writing with a corrective action plan.

## XVIX. Medical Considerations

Contracted providers will attend to the medical needs and considerations of clients. At minimum, the provider shall have the following in place:

1. Related to HIV
    - Providers must determine whether the individual is at high risk for HIV. Persons who inject drugs are at high risk for HIV. Risk factors for contracting HIV include engaging in unprotected sexual activities and sharing needles. Individuals identified as high risk must be referred to the County's DOH or a DOH partner agency for testing and treatment. The individual's acceptance or rejection of the referral must be documented in the WITS encounter notes as well as in the Miscellaneous Notes in WITS for that LoCA episode.

2. Tuberculosis (TB) related
    - Providers must complete the questions and document the responses to the TB questions by utilizing Miscellaneous Notes. Individuals responding with "yes" to any of the questions are high risk for TB. (See the Interim Policy for referral information). Documentation regarding this scenario with subsequent referrals and outcomes must be captured in the individuals file and in WITS.

3. Hepatitus C related
    - Providers must follow current Department of Health guidelines for ensuring that appropriate individuals are tested for Hepatitis C. Those identified as high risk must be referred to the county or nearby public health clinic for testing and treatment. The individual's acceptance or rejection of the referral must be documented in the WITS encounter notes as well as in the Miscellaneous Notes in WITS for that LoCA episode. At a minimum, the Department of Health indicates that individuals who should be tested include:

4. Reporting of Communicable Diseases.
    - All LCDAC Contracted Providerw within Lancaster County proper shall be required to enter into a qualified service organization agreement (QSOA) with State Department of Health for the purpose of reporting certain communicable and non-communicable diseases. Information pertinent to this requirement is contained in the Policy Bulletin issued on October 22, 2002, by the Department of Health, Bureau of Substance use disorder Programs. Out of LCDAC based licensed and/or project approved Contractors shall be required to enter a QSOA with their local Department of Health or the State Department of Health per the October 22, 2002, DDAP bulletin mentioned above.

5. Urine screens will not be funded by LCDAC.

## XX. Grievance and Appeal

1. Contractors shall inform clients receiving services about their grievance and appeal rights. This will occur during the intake session with the client.

2. Contractors shall adhere to the grievance and appeal procedure issued by LCDAC. Client files will contain a signed Grievance/Appeal form and will be reviewed by LCDAC.

## XXI. Accurate, Complete, and Truthful Information

Providers will conduct ongoing training of staff to comply with LCDAC policies, procedures, and contract requirements to submit accurate, complete, and truthful information to the LCDAC. Providers will establish policies and procedures to ensure that they comply with the LCDAC standards.

Providers are expected to utilize the LCDAC website to ensure that they have the most current information regarding LCDAC procedures, contract amendments, policies, procedures, documents, etc.

## XXII. Annual Data

Providers are encouraged to collect, analyze, and retain client treatment related data as a means to promote quality assurance, treatment improvements and fidelity.

## XXIII. Unusual Incident Reporting (previously listed as: Significant Events)

The provider is to adhere to the most recent DDAP Unusual Incident Reporting directives regarding what to report, how to report, and when to submit an unusual incident report. These directives can be located on the DDAP Website.

ADDITONALLY, ALL PROVIDERS are expected to alert the LCDAC Executive Director in the event ANY contracted provider has a voluntary closure of a site. The following information is expected to be included in the alert to the Executive Director:

a. The definite date of closure
b. The process leading to the closure date
c. A written press press release to provide to the media
d. An identified spokesperson to whom the media shall be directed to contact with questions
e. The necessary information and date when the closure information can be made public; and
f. The date when the staff will be informed of the closure.

## XXIV. Priority Populations

LCDAC with the LCDAC contracted providers shall give preference to treatment to following identified populations **IN THE ORDER** outlined below

1. ***Pregnant women who inject drugs***
2. ***Pregnant women who use substances***
3. ***Persons who inject drugs***
4. ***Overdose survivors***; and
5. ***Veterans***

All individuals in the aforementioned priority populations ***MUST*** have a level of care assessment and placement determination episode ***AND*** **be offered** ***ADMISSION*** into the recommended level of care. If admission into the recommended level of care CANNOT occur; the individual MUST be offered case management services, as well as admission to another level of care.

***There are no LCDAC funding restrictions for admission to treatment for any priority population individual.***

## XXV. Client Records and Quality of Treatment Services

The treatment providers will adhere to the same quality of treatment services and client record keeping for the LCDAC funded client, as the provider performs for Medicaid clients through the PerformCare/HealthChoices contract and PerformCare Provider Manual. Client progress notes must be tied into treatment plans, supervision of counselors must be maintained in the same manner, and quality of counseling must adhere to the PerformCare standards, etc. for the LCDAC clients, as it is provided for the PerformCare clients.

## XXVI. Adherence

The provider is required to adhere to all applicable requirements from the Department of Drug & Alcohol Programs (DDAP)/LCDAC Grant Agreement, as well as DDAP's State Plan, and the Fiscal, Case Management & Clinical Services, Operations, and Prevention Manuals, the information posted on the LCDAC website, and any subsequent revisions, when applicable.