ASAM Alignment Frequently Asked Questions (FAQ)

1. What is the ASAM Alignment and what does it mean for my organization?
    a. The ASAM Alignment process was initiated by DDAP and OMHSAS to ensure that all providers are utilizing ASAM in every aspect of their treatment delivery. This begins at the assessment phase where concerns, issues, and problems are identified. These issues are then addressed in the treatment planning phase, and progress is monitored and addressed in both group and individual sessions. The progress notes will reflect the progress or lack of progress on the identified issues and will be considered in the continuing stay review. Finally, these same issues will be addressed in the discharge planning stage of treatment. The idea that a common thread creates a continuum throughout treatment is at the center of the alignment process. Alignment also includes therapy milieus, provision of Medication Assisted Treatment, staff credentialing and training, and co-occurring capability. Please use this link to view DDAP's information and guidance on alignment.

2. What is the due date for the alignment process?
    a. All programs were expected to begin alignment with a goal date of July 2021. However, DDAP and the BHMCOs are working with providers through July 2022 to assist with their alignment. Of course, Magellan will continue to work with providers on alignment well after July 2022.

3. What will happen if my organization does not align with ASAM?
    a. The ASAM Alignment is directly connected to the 1115 Waiver, which was approved by the Center for Medicare and Medicaid Services. The approval allows Pennsylvania to continue to receive federal money for large Substance Use Disorder (SUD) residential and hospital treatment facilities. Under this waiver, and in order to

continue receiving this funding, Pennsylvania is required to improve access to and delivery of ***all*** SUD treatment, which includes: **New provider standards and patient placement criteria consistent with ASAM, which is the latest national evidence-based guidelines.** If providers are unable to demonstrate an alignment with ASAM, they will not be eligible for funding.

4. How will we know if we meet the ASAM requirements for the services of organization offers?
    a. DDAP and OMHSAS have engaged a private contractor to develop an ASAM Alignment Review tool for each level of care. There will be a pilot test of the 3.5 review tool in late June. Discussion of the tool and the pilot test is on the agenda for DDAP's ASAM TA meeting in August. Here is the link to view previous meetings and to register for upcoming sessions.

5. Do we need a DDAP license for every aligned level of care we provide?
    a. Yes, each level of care provided must be licensed by DDAP for that level of care in order to be a contracted provider with Magellan.

6. Are all DDAP licensed facilities required to be Co-occurring capable?
    a. All providers receiving funding for providing treatment services under agreements with Single County Authorities and/or Managed Care Organization must be providing services that are co-occurring capable or actively working towards co-occurring capability.

7. What is the difference between co-occurring capable and co-occurring enhanced?
    a. "Co-occurring enhanced services placed their primary focus on the integration of services for mental and substance use disorders in their staffing, services, and program contents such that both

unstable addiction and mental health issues can be adequately addressed by the program" (ASAM p.417). DHS and DDAP will be publishing an updated bulletin explaining specific programmatic and licensing requirements necessary for a program to be identified as co-occurring enhanced in the near future.

8. What does it mean to be a 3.5 Enhanced and 3.7 Enhanced provider?
    a. The additional MH license from DHS is required in the XYZ package when the provider is asking for a higher co-occurring enhanced rate.

9. Does ASAM differentiate between long-term and short-term residential care?
    a. DDAP no longer distinguishes between short-term and long-term care. All programs are expected to provide client-driven care that will result in different lengths of stay for each client/member. The providers' scheduled programmatic approach to care will not be accepted as an approach to treatment.

10. Do AA/NA meetings count towards "daily clinical service" hours?
    a. Alcoholics Anonymous and Narcotics Anonymous or other self-help and mutual-help groups are not clinical services. Definition of skilled treatment services clearly states that attendance at self-help or mutual-help meetings such as AA or NA, volunteer activities, homework assignments involving watching videos, journaling, and workbooks do not represent skilled treatment services for the purpose of daily clinical service hours for each level of care. Reference: ASAM p. 429.

11. Are chores considered part of the daily clinical service?
    a. Daily clinical services entail a formal service offered by a staff member employed by the agency to people receiving services at the agency. Daily clinical services require a progress note that relates back to the treatment plan. Direct or indirect observation or supervision of activities of daily living, or ADLs, are not considered a clinical service. Chores themselves are not a clinical service, as the staff member employed by the agency is not offering a formal service during the completion of chores. While the actual time performing the chore is not a clinical service under ASAM, any work done by the client at the project, including chores, must be included on the treatment plan. (709.63(a)(9), 709.53(a)(12), 709.83(a)(12).

12. Who can facilitate group sessions and where can I find information on the current staffing regulations that align with ASAM?
    a. All clinical staff should either be licensed clinicians or have their certification from the PA Certification Board **or** be working toward their state licensure or certification, if they were hired after July 1, 2021. Clinical responsibilities can be found on the State regulation site at this link.

13. What kind of programming is required on weekends and holidays?
    a. Programming and therapy are required every day of the week, including weekends and holidays. If a member does not require therapy on weekends or on a holiday, their level of care need should be re-evaluated.

14. Can we provide telehealth group facilitation for our residents?
    a. Telehealth is a complement to the services provided. The telehealth therapist should be their own staff (not referred out) to ensure the members are receiving that level of care within that facility. If the facility is providing telehealth, the onsite client client-to-counselor

still needs to be maintained. See this link to the OMHSAS Telehealth bulletin.

15. Will the codes for 3.5 Enhanced and 3.7 Enhanced change and if so, will we still be able to use the old codes for billing?
    a. Effective July 1, 2022, the H0018 and H0018HH Billing codes are no longer available for use. The replacement codes are H2036 and H2036HH. This change is state-wide and not specific to Magellan, nor is it Magellan-initiated.

If you have any questions, please contact us at this email address: ASAMAlignmentInquiries@magellanhealth.com