DBT Informational Webinar – Q&A Responses

July 2024

Question 1: What should agency leadership plan for and commit to, in terms of the caseload for DBT therapists and the overall capacity of the DBT program?

Answer: *OBH's goal is to establish, with this second DBT training cohort,* ***five (5) solid and sustainable DBT teams*** *that can each provide a comprehensive DBT program in their communities. To achieve that goal, we ask that applicant teams:*

- *Include* ***4-6 licensed clinicians****, committed to full participation in and completion of the DBT training program to achieve OBH-approved DBT qualification.*

- *Of the 4-6 licensed clinicians on the team, 2 must be independently-licensed LMHPs (for example LCSW, LPC, LMFT), while additional team members may be provisionally-licensed practitioners employed in the agency setting under board-approved supervision (LMSW, PLPC, PLMFT).*

- *Each of the DBT team clinicians must commit and have agency leadership support to carry an initial caseload of DBT training cases immediately following the initial DBT didactic training. Starting with training cases as soon as possible after the didactic training, is critical to learning the DBT model. An* ***initial caseload of at least 3 DBT cases*** *starting after the didactic training, can provide the ability to truly learn and practice the DBT model, while providing some balance with the ability to provide "treatment as usual" services to other agency clients. Delivery of DBT to only 1-2 clients may not provide sufficient practice to learn the model at the same pace as other training participants. Clinicians and agencies can also consider having clinicians serve more than 3 initial DBT training cases, if the agency determines to support the clinician(s) to devote a higher proportion of clinician time to the DBT program.*

- *Following year 1 of DBT training, we expect that trained DBT clinicians can and should increase their DBT caseload; additional experience with the DBT model should allow for an increase in the DBT caseload, and agency establishment of the DBT program should allow for sufficient outreach and referral pathways, such that the DBT team should be experiencing an increase in demand and can expand the numbers of clients served in DBT. DBT clinicians and agencies should plan for this increase in DBT program capacity. This may look different ways in different agencies and communities; some DBT clinicians/agencies may commit DBT clinicians to "full time" DBT with caseloads of 14-18 DBT clients per clinician, while other DBT clinicians/agencies may maintain partial caseloads of 4-6 DBT clients per clinician, while those clinicians deliver other services alongside DBT.*

Question 2: Does more than one therapist from and agency have to participate or can one therapist participate? Can solo practitioners combine to create a team? Can solo practitioners combine with therapists at a Child Advocacy Center 501(c) to form a team?

Answer: *This training opportunity is designed for teams that will be able to deliver a comprehensive DBT program to fidelity, and delivery of comprehensive DBT to fidelity requires a team. If your agency is not providing a full team, several agencies can work together to create a team of clinicians who agree to commit to the training requirements and the delivery of the DBT. The agencies and clinical team need to work out referrals, assessments, caseload, how out-of-session crises are managed, who manages out-of-session crises/coaching, and who has clinical responsibility for shared clients. Agencies also need to work through EHR systems, billing, and communication with MCOs. If you are in private practice, you can choose to develop a team of clinicians across agencies or solo practices who are willing to commit to both the training and the delivery of DBT. It may also be possible for solo practitioners and 501(c) clinicians to create a DBT team, but this will be dependent on multiple factors, the most relevant of those being the imperative that the intervention is delivered to Medicaid clients. The same details that were outlined when combined-agency DBT teams apply to teams that are developed by solo practitioners. In addition, regardless of the origin of the team's members, it is critical that all parties agree to commit to all components of this initiative— the full training, the delivery of DBT, and the consultation.*

Question 3: We have difficulty getting our clients, who are primarily domestic violence survivors, to participate in any type of group, however, these skills would be beneficial to them. Can you provide the skills training portion individually in addition to the weekly therapy?

Answer: *A large percentage of clients initially do not want to sign up for group skills, however, we have found that they can be talked into trying it. It is more effective to try to only do this in a group setting, and not only do it on an individual level. You may want to administer the skills training on an individual level initially, but it is best to ultimately transition to a group setting as it is more sustainable for managing DBT within your organization.*

A large percentage of clients initially do not want to sign up for skills group, however, DBT offers a lot of commitment strategies to support a client participating in the full treatment model. You may have to administer skills training on an individual level initially (for specific programmatic reasons), but it is best to ultimately transition to a group setting as it is more sustainable for managing DBT within your organization.

Question 4: What are the credential requirements for team members?

Answer: *Of the 4-6 licensed clinicians on the team, 2 must be independently-licensed LMHPs (LCSW, LPC, LMFT), while additional team members may be provisionally-licensed practitioners employed in the agency setting under board-approved supervision (LMSW, PLPC, PLMFT).*

At this time, to receive enhanced reimbursement for the individual therapy component of DBT, you must be a licensed mental health practitioner (LCSW, LPC, LMFT, psychologist, psychiatrist) with an independent/unrestricted license. In addition, of the two clinicians co-leading the DBT skills training group, at least one must be independently licensed.

In addition, the Louisiana Department of Health (LDH) is taking a key step to increase the availability of mental health providers in the state with a plan to expand Medicaid reimbursement eligibility to

provisionally licensed mental health professionals (PLMHPs) while they are seeking full licensure. Before this policy is fully effective, rule changes and a state plan amendment (SPA) are required. The Notice of Intent of the proposed rule has been posted and can be accessed here. LDH expects publication of the final rule on July 20. If approved by the U.S. Centers for Medicare and Medicaid Services, implementation is expected to begin on August 1. Once approved and implemented, provisionally licensed clinicians will also be eligible to submit Medicaid claims for both DBT individual and group psychotherapy. This will include practitioners licensed as any of the following: LMSW, PLPC, or PLMFT.

Question 5: What is the fee for the service?

Answer: *OBH has been given approval from CMS (the federal Medicaid authority) to use temporary federal funding for incentivized payments to DBT providers for delivery of DBT.*

OBH has directed the Medicaid MCOs to reimburse for DBT services using the psychotherapy reimbursement rates in combination with an "add-on" payment, which brings the total rates to the following:

- ***$200.00*** *for 60 minutes of DBT individual therapy, with an expected 60-minute session of DBT individual therapy per client per week, and;*
- ***$177.68*** *per client for DBT group psychotherapy, for an expected 120–150-minute DBT skills training group session per client per week.*

Additional billing guidance can be found here:
https://ldh.la.gov/assets/docs/BehavioralHealth/DBT_ARPA_Provider_Incentives_11_06_2023.pdf

The current, temporary federal funding will expire in 2025, at which point LDH plans to transition to using "standard" Medicaid funds to reimburse for DBT. DBT providers will continue to submit claims in the same way, and should not experience a change when LDH transitions from one funding source to another.

Question 6: In reference to the agency leadership development meeting, does the whole team register, or just the team leadership?

Answer: *The Leadership Meeting is designed for clinical supervisors, program managers, or clinical directors, and the identified DBT team leader to help them make informed decisions regarding how to situate and support a comprehensive DBT program within their organization. At a minimum, we encourage each agency to send the person they intend to have as the DBT team leader as well as the supervisor clinically responsible for the program. If you* ***DID NOT*** *have agency leadership attend this meeting, please contact Helen Best, Co-Founder & President of the Treatment Implementation Collaborative (TIC) to see if this training is a good fit for you and your DBT team. She can be reached either by phone or by email at (206) 251-5134 or hbest@ticllc.org.*

Question 7: Has this ever worked with a team in a school district?

Answer: *Logistically here in Louisiana, school-based Medicaid providers who are employed by an LEA and reimbursed through the School-Based Medicaid Program would not be eligible for this training opportunity.-OBH is seeking provider agencies who are contracted, credentialed, and accept referrals through the Managed Care Organizations. If your agency does contract with MCOs, and if you are interested in your agency integrating within a school district as one (but not the exclusive) location of service delivery, please reach out and we'd be happy to discuss these details.*

Question 8: Can someone who works in community-based services providing Community Psychiatric Supportive Treatment (CPST)/Psychosocial Rehabilitation (PSR) do the DBT training?

Answer: *Agencies that provide CPST and PSR are typically licensed to provide a menu of services including LMHP therapy and medication management. An agency providing a wide menu of services such as these may be well-situated to provide DBT. Please consult the LA Medicaid Specialized Behavioral Health Services Manual description of DBT for detailed requirements for the DBT teams or see Question four (4) for a brief summary on licensing requirements for team members.*

Question 9: Does the Nurse Practitioner (NP) at an agency have to be involved in DBT?

Answer: *Prescribers such as nurse practitioners or psychiatrists do not need to be part of the identified DBT team at your agency, though it is very helpful. If your agency does employ prescribers, it is in keeping with best practices for them to be informed of the purpose and benefits of the DBT that the agency commits to deliver and to have a basic understanding of the modules that are being taught.*

Question 10: Can the DBT services be implemented through both Telehealth and face-to-face?

Answer: *Yes, you can deliver DBT interventions both in-person and via telehealth.*

Question 11: Has DBT been found to be effective with clients with higher-functioning Autism?

Answer: *Yes, studies do show that DBT can be effective with clients who have autism, especially the skills component of DBT which focuses on teaching new behavior. However, it is important to note that this training will focus on building comprehensive DBT programs and not focus on building a skill-only model. Additionally, other interventions that are autism-specific should still be considered, as they can offer additional assistance to such clients.*

Question 12: With submitting tapes of sessions, will releases be provided for recordings, or should those be developed on an agency level?

Answer: *The agencies will have to develop their own release of information forms according to agency protocols.*

Question 13: How do the videos needed for training comply with HIPAA?

Answer: *There are a few different ways to achieve this, it varies from agency to agency. However, some methods previously have included allowing consultants to access information from the backend of the agency, showing video via a HIPAA-compliant version of Zoom call so information is not being directly transferred to consultants, and using audio in very specific instances.*

Question 14: After the training, will we be certified to deliver DBT?

Answer: *Upon successful completion of this OBH-sponsored DBT training program, the individual practitioner(s) on the team will receive documentation of completion of an OBH-approved DBT qualification, which qualifies the practitioners/team to provide DBT therapy under Louisiana Medicaid.*

The OBH-approved DBT qualification makes the practitioners/team eligible to receive the enhanced reimbursement rate from the Louisiana Medicaid MCOs for delivery of DBT.

DBT Certification comes from the DBT-Linehan Board of Certification (DBT-LBC), and those in LA who already possess this credential/certification will also be eligible to receive the same enhanced reimbursement rate for delivery of DBT interventions. Certification from the DBT-LBC is not necessary to receive the enhanced reimbursement rate within LA Medicaid, but for some clinicians, achieving this certification is attractive. For those wishing to achieve DBT-LBC certification, this training does a nice job of preparing clinicians for the official Linehan Board of Certification process.

Question 15: When is the DBT RFA period and for how long?

Answer: *The DBT RFA period will open on* ***Monday, July 8, 2024,*** *and close on* ***Friday, August 16, 2024.*** *Only complete applications will be considered. Complete applications should include one* ***Agency Agreement*** *per DBT team and* ***Individual Applications*** *for each member of the DBT team.*

Question 16: Will pre-authorization be required for DBT?

Answer: *DBT is an outpatient therapy service; LA Medicaid policy does not mandate prior authorization for outpatient therapy services and MCOs typically do not require prior authorization for outpatient therapy. It is important to note, however, that outpatient psychotherapy typically needs an authorization if more than 20 sessions are needed. Teams will need to be aware of this and will need to seek authorization from the MCO in a timely fashion in order to prevent disruption of the DBT intervention.*

Question 17: How are the case management, coaching and weekly consultation groups billed?

Answer: *The enhanced rate accounts for the additional time dedicated to consultation and coaching. Coaching can be via text or call, should be VERY brief, and is not considered therapy, so is not a service*

that is individually billable. The rates are enhanced for both individual and group therapy. Both rates are significantly higher that standard rates for individual and group psychotherapy.

Question 18: Are services provided during the consultation process billable?

Answer: *Yes, DBT individual and group sessions provided during the time period when clinicians are receiving consultation from trainers are billable. During consultation, the trainers and providers will discuss the active DBT cases in each clinician's caseload and any ongoing training issues.*

Question 19: Is there an opportunity for a larger agency to have more than one DBT team?

Answer: *Yes, agencies that have larger client populations and larger clinician populations are welcome to apply to have more than one DBT team. This may be particularly advantageous for agencies that have multiple clinics in a metropolitan or regional area.*