Parent Initiated Treatment/Admission Practices Stakeholder Breakout Group

August 24, 2018 Meeting

1:00 PM - 3:00 PM

PIT WORKGROUP HB2779	
(1) The Department of Social and Health Services must convene an advisory group of stakeholders to review the parent-initiated treatment process authorized by chapter 71.34 RCW.25. The advisory group must develop recommendations regarding: (a) The age of consent for the behavioral health treatment of a minor (b) Options for parental involvement in youth treatment decisions (c) Information communicated to families and providers about the parent-initiated treatment process (d) The definition of medical necessity for emergency mental health services and options for parental involvement in those determinations. (2) The advisory group established in this section must review the effectiveness of serving commercially sexually exploited children using parent initiated treatment, involuntary treatment, or other treatment services delivered pursuant to chapter 71.344 RCW. (3) By December 1, 2018, the department of social and health services must report the findings and recommendations of the advisory group to the children's mental health work group established in section 2 of this act.	
(1) Welcome	**Lead: Lonnie Johns-Brown**
• Introduction of participants	**Attendees:** Lonnie Johns-Brown, Meg Jones, Karen Kelly, Mary Clogston, , Lisa Daniels, Kathy Brewer, Brad Forbes, Melanie Smith, Jim Theofelis, Peggy Dolane, Natalia Koss Vallejo **On the Phone:** Robert Hilt, Kalen Roy, Shannon Simmons, Laurie Lippold **HCA Staff:** Diana Cockrell, Mandy Huber, Lois Williams, David Johnson, Paul Davis
(2) Review of survey results	**Lead: Lonnie Johns-Brown**
• Review and discussion of survey results	Lonnie introduced Meg Jones with the Association of Washington Healthcare Plans (AWHP) to discuss survey responses. A stakeholder asked for clarification about who AWHP represents. The AWHP representative said that several insurance plans are represented by AWHP including, but not limited to, Aetna, Amerigroup, Children's Health Plan of Washington (CHPW), Coordinated Care of Washington (CCW), Kaiser WA, and Kaiser HP NW, which are most of the private insurance plans in Washington. This discussion will not include Medicaid, Medicare, other public plans, or self-insurers.

	However, some of the above plans do cover Medicaid. AWHP stated they are invested and interested in the health of Washington citizens. A review of the questions the group sent to her was conducted and sent out to AWHP providers. A review of AWHP provider responses follows: **1.) What do you use for determining the standard of care for inpatient mental health treatment? (Examples: Milliman, CareWeb)** A question was asked about national oversight of the plans. Medicaid is the national standard. The agencies all use nationally recognized and evidence-based treatment guidelines to assess medical necessity. Centers for Disease Control and Prevention (CDC) also reviews the criteria. The clinical expertise of local practicing physicians is also used. Standards are based on scientific documentation and peer review. It was reiterated several times that most insurance companies post their guidelines on-line on the carrier's website. A lot of carriers are moving to the model of adding patient pages to view reasons for approval/denial. It was suggested that it might be helpful to have more information from the CDC as to the criteria they use. **2.) Are there diagnoses/circumstances that have different time frames? If so, what are they and why?** Plans look at two levels; acute and non-urgent. Assessment must occur within 24 hours of admit. Plans need to sign off on the diagnosis and treatment plan. There is a need to ensure the patient is in the right setting and has the treatment plan to provide the right treatment. In Washington, the biggest challenge is "finding beds" and ensuring that if someone needs to be moved to another facility, there will be a bed for them. Concurrent review takes place once the patient is in the facility and moving through the treatment process. The concurrent review looks at how the patient is doing, are they moving forward, backwards, or is static. The review determines if services need to be adjusted or is the patient ready for discharge planning. A question was asked about the percentage of patients who are denied at the 24-hour timeline (how many times is there no alignment between the plan and providers?). That information is not available for this discussion but

	can be looked into. Also, can the group learn more about the definition of urgent? Seattle Children's Hospital stakeholder commented that there is not usually a lot of denials at the 24-hour timeline because they are screening for appropriate care. However, this is not the same experience with Medicaid. A parent stakeholder stated that insurance companies will deny after an inpatient stay and asked if anything can be done about that? The experience with some plans is they will look at authorizations after discharge and deny an entire stay, ex. Regence is one plan that will do this. The stakeholder also commented that independent reviews are helpful in getting the company to pay claims. 3.) **Do you use a benefit manager to determine such admissions?** Plans do contract with benefit managers to look at medical necessity but most plans don't use them for youth services. **4.) What criteria do you OR your benefit manager, use for continued stay review?** Same criteria and standards as outlined in question 1. **5.) Do you require prior authorization prior to a patient being admitted?** Plans do not have long wait times for prior authorizations for non-urgent admissions. It usually takes between one to five days, depending on the condition or diagnosis. Other times are standardized because it is not urgent. Admission can also be affected by the number of available beds. A stakeholder asked about bed shortages with non-urgent authorizations. Will companies find a bed out of network? It varies, depending on the region that member is trying to find services in. If the Health Plan (HP) didn't contract with all available providers, then the Office of Insurance Commissioner (OIC) ensures that they cover and reach network agreements. There is a need to show good cause as to why there is no access to these beds. The practice varies carrier by carrier. That said, if a member needs services, AWHP wants them to have them.

	How quickly can a denial be appealed? Must companies comply with state and federal guidelines? For non-urgent, it would depend on the company and their agreements. If not able to reach a network agreement, they can ask patients to wait for a bed. **6. What is the time frame from request to being admitted?** Admission can also be affected by number of available beds. A stakeholder asked about bed shortages with non-urgent authorizations. Will companies find a bed out of network? It varies, depending on the region that member is trying to find services in. If the HP) didn't contract with all available providers, then the Office of Insurance Commissioner (OIC) ensures that they cover and reach network agreements. There is a need to show good cause as to why there is no access to these beds. Practice varies carrier by carrier. That said, if a member needs services, AWHP wants them to have them. **7. a. Is there a standard minimum length of stay for inpatient mental health treatment?** Each patient is looked at independently for how long they need to be in the facility and receive services. **b. How is total length of stay determined?** Each patient is looked at independently for how long they need to be in the facility and receive services. **c. Is there a maximum inpatient authorization?** A stakeholder asked if there is a financial cap on services. There is no cap. Quality matters. For out of state (which would be out of network) there would be prior authorization in general, but if there is an urgent situation while out of state, 24-hour authorization is needed. Need to ensure it's the right care and look at costs so there is no abuse. **8.) What differences, if any, are there in your admissions and review practices when the Inpatient treatment comes about via PIT?** A stakeholder commented that there is no difference with carriers, but the exception is Behavioral Health Organizations (BHOs).

	5 Minute Break **9.) a. What is the process for determining post-inpatient treatment release?** **b. What post-inpatient treatment options do you approve?** **c. What criteria are used to determine what will be approved?** Decisions around post-inpatient treatment release are based on a clear post-discharge plan. There are 7-day and 30-day reviews required. The National Committee for Quality Assurance (NCQA) reviews. Standards are set as to best practices. What percentage of providers meet the review deadlines? Not meeting the deadlines can affect their credentials and accreditation is required for many of the carriers. What happens in areas of the state where there are few providers? The standards are the minimal requirements and they need to meet them all. Quality matters to the insurance carriers. What happens when patients don't qualify after admission if they are out of network? They have to pay out of pocket. The leg looked at requiring paying for admissions tests or letting them stay for a while, but the insurance companies don't want these uncontrolled costs. Mental health (MH) is the same as other types of medical care. Often the companies are trying to limit access by requiring prior authorization for overdone, or controversial procedures. The plans for MH treatment have come a long way. OIC has a new federal grant regarding prior authorization need. Most complaints are about the day-to-day need for treatment authorizations, not the emergency ones. There is a lot of work by commercial carriers for prescribing controls. The data is shared with them when they are not within guidelines. Payments can be contracted differently, such as Value-based (if the provider meets measures then they get bonuses). They are constantly working with insurers to develop more quality programs. A stakeholder asked if the more talented providers who don't want to join networks are being pursued. There are a lot more options for the providers, they are finding their own groups. As the cost of care goes up, there is less negotiation room. The number of providers are going down while the population is going up. There are a lot of providers not going into networks because of less hassle and more profit elsewhere. Some carriers have a star rating system for providers, this can be upsetting to the providers, but improves care. There are still complaints about being turned down because the patients are stable, which is not the process for physical health treatments. OIC does not want to see these types of denials.

Parent Initiated Treatment/Admission Practices Stakeholder Breakout Group

August 24, 2018 Meeting

1:00 PM - 3:00 PM

	10.) What do you see as role in terms of quality and oversight of PIT treatment providers? Did not discuss and review this question
(3) Do any of the questions need additional follow up?	**Lead: Lonnie Johns-Brown**
• Follow up questions discussed	• Possibly getting more information from the CDC as it pertains to standards/oversight in question 1. • What is the percentage of patients who are denied at the 24-hour timeline (how many times is there no alignment between the plan and providers?). • Also, can the group learn more about the definition of urgent?
(4) Identification of Policy/Process Improvements	**Lead: Lonnie Johns-Brown**
• What processes could be improved/addressed through further discussion with health plans • What improvements could be addressed by OIC/HCA rulemaking or process clarification • What improvements need legislation	A question about more tele-services that includes texting therapy from a stakeholder. It is new, but allowed and is an emerging area of care. This will be a great increase in the rural areas. There is a pilot program for telemedicine in three specific areas. Most carriers already do a small amount, mainly as referrals. They are trying to be creative in delivering services, but there are a lot of bugs left to solve. The Legislature and OIC allow it with a qualified provider but have not accepted tele-services as network providers. Is texting f treatment regulated? This would be a question for Department of Health (DOH). OIC reports there is some movement in that direction. OIC further discussed independent review process. OIC would like to get this information into the hands of consumers. They have information on the website but there's a lot to plow through to get to it. OIC is interested in knowing where to house information for everyday people to access. A stakeholder stated there is a referral line. There is also a referral line for physicians that is well used. Can it be tied into the crisis lines? This process is for state-regulated plans not for Medicaid, etc. Right now, questions go to the federal Department of Labor. OIC asked the group to be thinking about options to get information to parents. Terms and processes need to be explained.
(5) Next Steps	**Lead: Lonnie Johns-Brown**
• Discussion and include time frame	Notes to be out to group by Monday or Tuesday, so OIC, Admission Practices lead can get them out.

for completion of identified tasks	Will we be talking to Medicaid also? A stakeholder from Seattle Children's Hospital states that parents need more information about the interpretations. Suggestion to look at emailed questions from OIC Admission Practices lead. The questions are around conduct disorders and medical necessity. A stakeholder asked for more clarification from experience at Seattle Children's Hospital. The parents might have more input. Inpatient and outpatient are affected. Usually you need to commit a crime to get treatment. A stakeholder suggested there needs to be more outpatient options for youth with conduct disorders, which could avoid criminal behaviors and records. Conduct Disorder is not usually diagnosed, because that is a huge "blot" on their record. A Medicaid discussion will be added to the next agenda. Do we use these questions, or are there new questions? Send new questions to Lonnie with OIC. There is a wide variance between the BHOs, why is that? Will they need to be included in the changes that are coming?
(6) Other Business	**Lead: Lonnie Johns-Brown**
Next Meeting	The next meeting is September 11th from 8AM to 10AM.
End Meeting.	