Parent Initiated Treatment/Admission Practices Stakeholder Breakout Workgroup

September 11, 2018 Meeting

8:00 AM - 10:00 AM

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/Introductions	**Facilitator: Lonnie Johns-Brown**
• Introduction of participants and review of meeting goals	**Attendees:** Lonnie Johns-Brown, David Johnson, Danielle Cannon, Lisa Daniels, Kathy Brewer, Avreayl Jacobson, Kevin Black **On the Phone:** Kalen Roy, Mary Clogston, Melanie Smith **HCA Staff:** Diana Cockrell, Mandy Huber, LaRessa Fourre, Lois Williams, Paul Davis, Gary Hanson, Blake Ellison, Colette Jones, Amanda Lewis
(2) Presentation by HCA on PIT Admission Practices	**Facilitator: Lonnie Johns-Brown**
• HCA Presentation and discussion on Admission Practices per MCOs and BHOs	**Questions of presenters** David Johnson with DBHR went through the Insurance Survey questions in regards to BHOs. He reviewed federal requirements and Washington state requirements and the Washington Administrative Code (WACs).

	For the document titled "Insurer Survey Questions" David formulated the responses to questions listed from the insurer survey questions, rules, and BHO contracts. Managed care entities are required to abide by 42 CFR 438. They must have written policies for behavioral health care. 1) **What do you use for determining the standard of care for inpatient mental health treatment? (Examples: Milliman, CareWeb, ASAM, etc.)** *Per the Prepaid Inpatient Health Plan (PIHP) contract, BHOs must maintain and follow written policies and procedures for authorization of behavioral health services including: 6.2.5. Criteria for Authorization of Routine and Inpatient care at a community psychiatric hospital.* *The criteria used may vary by BHO but are likely to rely on tools such as the Milliman Care Guidelines, Locus/Calocus, etc.* 2) **Are there diagnoses/circumstances that have different time frames? If so, what are they and why?** *Diagnoses do not trigger different timeframes, but specific circumstances do.* *Emergency services and post-stabilization services follow the time frames of 42 CFR 438.114:* • *Authorization is not required to render emergency related stabilizing care to the point of stabilization for discharge or transfer.* • *Post-stabilization services require response from the BHO for services within 1 hour of provider request. And the Provider can assume authorization if the plan does not respond within the hour up until the point that contact is made.*

	Non-emergency inpatient services/planned admission follow the requirements of 42 CFR 438.210: • *For inpatient services the PIHP contracts require authorization decisions to be made as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.* Lonnie confirmed the statement "Services within 1 hour of provider request" is guided by CFR. Emergency services do not require prior authorization. Post-care requires authorization within an hour. Further care requires expedited decision making (within 72 hours). A stakeholder asked how Children's Long Term Inpatient (CLIP) is impacted or plays a role in this. David informed that CLIP is outside of the BHO contracts. CLIP referrals are reviewed for medical necessity by the regional CLIP committee and then the application and documents go to the CLIP Administration for review. Lonnie said she would like to know the timeframes for CLIP and what are the guidelines. A CLIP bed would be considered a non-emergency psychiatric bed. It was asked why eating disorders are monitored differently. A stakeholder lead explained that 72-hour admissions are for medical necessity due to danger to self or others, or gravely disabled. A stakeholder explained that the system wasn't designed, it just grew as mental health treatment needs were brought to the legislature's attention. It was clarified that a youth with an eating disorder might stay in an acute hospital setting for several weeks until medically stable; then be discharged for outpatient (OP) services, usually once their weight is back up to 85 percent, organs are stable, etc. The length of stay is typically longer than an acute care stay. The CLIP Administrator informed that CLIP tries to be a resource across the state for mental health treatment, but the CLIP system was not designed to meet general population and high capacity needs. It was added that the decision isn't about the rationing of a limited resource but the least restrictive type of treatment.

	3) **Do you use a benefit manager to determine such admissions?** *Varies by BHO* Lonnie asked if BHOs use a benefit manager, what BM do they use? Asked clarifying question about "varies by BHO." Do they use the same criteria but just different managers? A stakeholder lead explained her experience with BHOs using different criteria. Lonnie expressed that there is less uniformity within the mental health system. David discussed that the treating physician should be deferred to. David discussed the adverse benefits determination appeal process. 4) **What criteria do you OR your benefit manager, use for continued stay review?** *Varies by BHO* The BHO is responsible for inpatient psychiatric care and crisis stabilization. If there is a limited scope of services, then inpatient care rules apply for emergency care. If emergencies arise, they are responsible for purchasing services out of network, if needed. For example if a youth needs services out of state, they wouldn't be held liable to pay, unless it is an emergency. How does SUD residential play into this? SUD residential providers are contracted with the BHO, MCO, etc. and would bill accordingly. A stakeholder expressed dissatisfaction with the conflicting, confusing terms for treatment, i.e., inpatient is hospitalization, residential is treatment. 5) **Do you require prior authorization prior to a patient being admitted?** *Treatment of unstabilized emergency medical conditions do not require prior authorization. Post-stabilization services require prior-authorization but follow the rules of 42 CFR 422.113(c).* • *1hr BHO response or authorization assumed until the plan makes contact* • *BHOs are obligated to pay for post stabilization services they have not authorized until*

	○ *A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;* ○ *(ii) A plan physician assumes responsibility for the enrollee's care through transfer;* ○ *A BHO representative and the treating physician reach an agreement concerning the enrollee's care; or* ○ *(iv) The enrollee is discharged.* *Non-emergency/Planned admissions follow the rules of 42 CFR 438.210 which permits the PIHP to place appropriate limits on a service. Prior authorization may be required.* A question was asked about process for Substance Use Disorder Inpatient (SUD IP) residential treatment. A stakeholder explained there were changes as treatment moved to MCOs from BHOs over the last two years. A stakeholder lead shared a couple of examples of how inpatient psychiatric care interacts with SUD treatment. Most SUD inpatient providers are paid through medical patient detox. The hospitals work to get youth into a residential setting that treats SUD. The American Society of Addiction Medicine (ASAM) is the federal medical program that has been used for 25 years by payers to determine medical necessity. Clinicians also use ASAM criteria during the assessment process. ASAM criteria is used to submit claims to BHOs and determine level of care. Colette shared information pertaining to Early and Periodic Screening Diagnostic and Treatment (EPSDT), the federal Medicaid rule that applies to any client under age 21 and requires Medicaid payers - BHOs and MCOs - to cover any service that is medically necessary to attain or maintain function. Under EPSDT, states must cover a broad array of preventive and treatment services. There has been a lot of recent education around EPSDT. Helpful in discharge planning, which is much the same for MCOs as with BHOs. Anything that is medically necessary for the child must be equally effective and cost effective.

	6) **What is the time frame from request to being admitted?** *Emergency inpatient services do not require prior approval.* *BHOs have up to 1hr to approve post-stabilization services related to an emergency.* *Non/Emergency / Planned admissions follow the timelines present in 42 CFR 438.210* A stakeholder asked where parents can take their youth who need SUD treatment. Do they take them to OP, IP hospital? Peggy questioned the waiting period between inpatient treatment and referral to ongoing treatment. LaRessa explained that CLIP is for mental health. Substance use is separate unless it is co-occurring. Co-occurring treatment is determined by what the primary problem/diagnosis is. Lonnie referred back to David's document and question 3. Lonnie stated she would like to know which BHOs use a benefit manager, and what company they use. There is great variation across BHOs in determining criteria and authorization. Lonnie says there should be standard tools. Kathy says there are some basic, common starting points. But the response from a BHO, even with the same documentation and authorization request, could vary in terms of authorization of care. Common issue is that a BHO would state the condition is "baseline," meaning that one's symptoms and condition is unlikely to improve with the level of care being requested. The baselines can affect denials. Example, youth with autism are less likely to get authorization because it is a baseline diagnosis. David said denials should not be the basis of diagnosis after the fact, but based on what is presenting. This gives more power to the physician to determine an emergency. Patty questioned whether prudent layperson is different than an individual making a clinical judgement. Yes, a prudent layperson can be anyone who voices their opinion about the need for care for another individual. Peggy feels the system needs to accept that children are different from adults and that we need to include special education as an entry way to treatment.

7) **a. Is there a standard minimum length of stay for inpatient mental health treatment?**

No.

b. How is total length of stay determined?

Should be determined by the treating physician in consultation with the plan. Any denial must be reviewed by the plan's medical director.

c. Is there a maximum inpatient authorization?

No

Are benefit managers determining the length of stay? Benefit managers are allowed by the plans. The determination varies and so does the criteria used. Lonnie asked which benefit managers are being used. Kathy said in reality, there is variation for approvals. There are different evaluation tools being used. David went to question 5 about prior authorization for admittance. No plans require authorization for stabilization. BHOs will usually cover and also post-care after stabilization. Non-emergency situations can follow different rules which allow limits on treatment. Planned admissions need prior authorization, also based on standard (five day) and urgent (72 hours) response times. Total length of stay should be determined by the physician. There are caps on the amount of benefits. David said there were no differences with PIT.
Lonnie stated for our next meeting she would like to outline and identify any gaps.

8) **What differences, if any, are there in your admissions and review practices when the inpatient treatment comes about via PIT?**

No difference

	9) ***a*****. What is the process for determining post-inpatient treatment release?** *Consultation between plan and hospital* **b. What post-inpatient treatment options do you approve?** *The range of services covered by the 18 State Plan Modalities provided by BHOs: Document attached.* **c. What criteria are used to determine what will be approved?** *Guidelines developed by the BHO for rehabilitative services.* Post treatment is determined by plan and hospital. The range of services are covered by the 18 state plan modalities provided by BHO. Is there equity across the state? Post stabilization services favor those who live in urban cities, and not necessarily those who don't have access to treatment at an agency. There is a need to strive for equity across the state and recognizing that there are still differences and inequities for those who live in rural and urban settings. Emergency Medical Treatment and Active Labor Act (EMTALA) requires following the emergency medical condition requirements. Under EMTALA, if an individual goes to an emergency department, the child or youth must be treated, either there, or by transfer to another to another facility able to provide care, who accepts Medicaid. If one cannot receive authorization, the provider none the less may have the responsibility/obligation to pay, or to transfer the individual to a facility if there is space available. They still need to have the beds available. There need to be places for youth to get needed services. Mental health moved from the Medicaid medical rules to the rehabilitation rules. The difficulty is applying a medical model to the rehabilitation program. There are different value systems in the program. Needs patient complaint, but don't see many. **10) What do you see as role in terms of quality and oversight of PIT treatment providers?** *Depends on the contractual relationship of the provider. Limited for services furnished*

	under the HCA Medicaid Core Provider Agreement, greater for those with a direct contract relationship. Collette Jones, from the Health Care Authority (HCA), also spoke from the "Insurer Survey Questions" document and specified differences for the integrated managed care (IMC) regions. By January, most of the state will be integrated and mental health and general health will no longer be separated, but be under one payer. The change started in April of 2016 and it is getting smoother as integration rolls out. Collette gave some historical context to how we came to be a bifurcated state at this current moment. Southwest Washington and North Central regions are now integrated. Pierce, King, North Sound, Greater Columbia, and Chelan will integrate in January 2019. In 2020, the remaining three regions (Thurston/Mason, Salish, and Great Rivers) will integrate. In 2020, Washington will no longer be a bifurcated system. Payment is moving into one contract, paying one contractor to pay for medical and behavioral health care. There are early warning systems in place to identify areas of concern. The legislature required a statewide program for foster care, which went to Coordinated Care Washington (CCW). In January 2019, CCW will have the mental health and substance use treatment contract for foster care for the entire state. It will also include children who were adopted out of the system (adoption support) and alumni of the system who aged out and will be covered up to age 26. Patty asked who picked CCW for foster care and how does that include personal choice? Colette explained that DCYF, HCA, and CMS had conversations in regards to this question. It was determined that one strong contractor was needed for the foster care population. DCYF has chosen that children in foster care will be in this single managed care plan. The option chosen is a voluntary managed care program, meaning you can opt into (or out of) this program. Fee for Service (FFS) is the other option, however, another managed care plan cannot be chosen. CCW offers the same benefits to those who have opted in and/or opted out into FFS. The difference is that CCW is required to provide coordination and FFS is not. Question about network adequacy for FFS. Colette explained this continues to be looked at and worked on to ensure network adequacy. There is the foster care contract, and then there are integrated managed care contracts. The rest of the population is region by region. Federal rules require that there must be a choice. It was taken into

	consideration that plans may have vulnerabilities and struggles, so for long-term planning, it seemed best to have three plans in each region. Each MCO had to demonstrate a sufficient network for medical and behavioral health to be awarded in the regions in which they bid for. King County will have all five plans. The regions have been changing because counties have asked to move. Does FFS have a network? This is something that is monitored closely. Most benefits are carved into the managed care systems, and some benefits are still out. For example, dental. The dentist can be billed directly to HCA, and the primary care visits are billed to your managed care plan. None of the plans require authorization for emergency and post stabilization services, but do require concurrent, or ongoing stay authorizations. Managed care entities are very familiar with working with hospitals. Early Periodic Screening Diagnosis and Treatment (EPSDT) – equally effective and cost effective. When reviewing all of this, looking at it from a parity standpoint. Attached: ASAM Criteria http://www.naadac.org/assets/1959/meelee_asam_criteria.pdf 18 state plan modalities-pdf
Next Steps	**Lonnie Johns-Brown**
	Lonnie stated the group has gathered a lot of information, we've heard from parents, Kevin, and Kathy's perspective. Goal of next meeting is to specifically identify gaps. Folks can send their questions this week. Admission Practices Breakout Group will need to get out the information and then meet again to identify gaps and resolutions. Lonnie will send out next steps and questions generated with a timeframe. Hailey will get date for the next meeting sent out. Meeting minutes may not be out this week, but Lonnie will email. ASAM and eighteen state plan modalities will be attached to the meeting minutes. Meeting adjourned at 11 AM.
End Meeting	**Lonnie Johns-Brown**

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