



Behavioral Health Workgroup

1.29.20 Meeting Summary

The Department of Health Care Services (DHCS) held the second Behavioral Health workgroup meeting focused on medical necessity on January 29, 2020.

The meeting was attended by DHCS staff, [workgroup members](#), and members of the public. Molly Brassil from Harbage Consulting facilitated the meeting and Kelly Pfeifer and Brenda Grealish were the DHCS lead presenters.

This meeting focused on the following topics. A full agenda can be found [here](#).

- An overview of the proposed changes to medical necessity for lower levels of care;
- An overview of proposed no wrong door approach;
- An overview of proposed changes to medical necessity for higher levels of care; and
- Public comment on the above topics.

Discussion Summary

The meeting began with a presentation from DHCS providing an overview of the meeting objectives and the proposed changes to medical necessity criteria for lower levels of care. See slides [here](#) (3-14).

- Below are comments made by multiple workgroup members:
 - Support for streamlining and standardizing screenings and assessments to increase efficiency and reduce client and provider burden
 - Calls to pay for care coordination
 - Support for a single, web-based screening tool, that could be administered by non-licensed staff
 - Call for a communication tool for transitions of care
 - Calls for additional training on the mental health benefit and levels of care for providers
 - Calls to pay for provider consultations
 - Support for the idea of moving towards identifying a patient's needs, symptoms, and/or diagnoses and then providing appropriate services to address their needs

Below are additional comments from workgroup members:

- Consider what can be done to better serve high-risk youth
- Ensure that housing and criminal justice are built into the screening criteria
- A standardized tool could help free up time for providers to do care coordination

Next, DHCS presented an overview of the no wrong door proposal. See slides [here](#) (15-21). The following is a summary of the key themes from the workgroup discussion.

- Below are comments made by multiple workgroup members:
 - Support for the no wrong door proposal
 - Calls to ensure that a patient's choice is honored

- Below are additional comments from workgroup members:
 - Ensure there is time built into the timeline for provider education
 - Clarify that there are no future financial penalties if duplicative services are offered
 - Ensure that primary care relationships are considered
 - Consider how to ensure that the right entities are held responsible for their treating their patients

Next, DHCS presented an overview of the proposed changes for medical necessity for higher levels of care and provided an update on ASAM criteria for residential care. See slides [here](#) (22-26).

- Below are comments made by multiple workgroup members:
 - Support for the proposal for a patient to be able to get services from both a Mental Health Plan and a Managed Care Plan
 - Support for a standardized transition of care tool
 - Support for utilizing follow-up teams

- Below are additional comments from workgroup members:
 - Consider how to serve patients who need crisis stabilization, but may not be most appropriately served in an emergency department
 - There is a need to improve the availability of high-level services for kids with complex issues
 - Consider working on statewide medical screening criteria
 - Consider using crisis stabilization units
 - Look at creating a standard, streamlined medical clearance checklist / process

- Call to figure out how a primary care consult can be more easily done in a psychiatric facility in real time
- Consider individuals who move to a higher level of care and then return to ongoing care when they are stabilized

Next, DHCS walked through the proposed policy changes in the presentation. See slides [here](#) (8-11, 17-18, & 24).

- Proposed Mental Health Outpatient Policy Changes (slide 8)
 - Most workgroup members agree on the following:
 - Utilize a universal mental health screening tool to determine system placement
 - Allow beneficiaries to receive all types of services before diagnosis, as appropriate
 - Allow beneficiaries to receive mental health services by a mental health provider even in the presence of a substance use disorder
 - Clarify medical necessity for beneficiaries under the age of 21 given protections of EPSDT
- Proposed statewide mental health screening tools (slide 9)
 - Most workgroup members agree on the following:
 - Design a statewide mental health screening tool for non-licensed staff to determine the place of care
 - Mixed support among workgroup members on the following:
 - Clinical staff is not required to use the statewide mental health screening tool
 - Tool would be focused on needs, symptoms and/or diagnosis
- Proposed SUD Outpatient Policy Changes: Screening and Entry into Care (slide 10)
 - Most workgroup members agree on the following:
 - Clarify medical necessity for beneficiaries under the age of 21 given protections of EPSDT
 - Clarify medical necessity for adults
 - Mixed support among workgroup members on the following:
 - Counties should not mandate re-screening be done by county staff – particularly focused on the need to do concurrent review for residential treatment

- Proposed SUD Outpatient Policy Changes: Assessments and Ongoing Care (slide 11)
 - Mixed support among workgroup members on the following:
 - Consistently applying current policy statewide
 - Online ASAM diagnostic tool can be used by non-licensed providers (desire for customized county tools to also be used by non-licensed providers)
- Proposed Change: No wrong door for children (slide 17)
 - Most workgroup members agree on the following:
 - Start care wherever beneficiary shows up for treatment
 - Non-duplicative services are reimbursable in both delivery systems simultaneously
- Proposed Change: No wrong door for adults (slide 18)
 - Most workgroup members agree on the following:
 - Start care wherever beneficiary shows up for treatment
 - Non-duplicative services are reimbursable in both delivery systems simultaneously
- Proposed changes: inpatient medical necessity (slide 24)
 - Most workgroup members agree on the following:
 - Re-certification can be done by licensed clinician under physician supervision.
- Finally, members of the public were invited to comment. Below is a summary:
 - Urge the department to consider how to address this cross culturally. There shouldn't be any barriers for beneficiaries and services should wrap around the client. Don't treat this as a series of technology problems, rather culture problems.

Next Steps for DHCS:

The Behavioral Health Workgroup will convene to discuss Behavioral Health Integration and Medical Necessity documentation on January 30, 2020.

A Behavioral Health Stakeholder Advisory Committee will take place on February 12, 2020.