Medi-Cal Healthier California For All
Behavioral Health Workgroup

Right Place, Right Care:
screening, assessment, prior authorization, medical necessity, and documentation

January 29, 2020

Agenda:
Right place, right care

10:00 – 10:15	Welcome and Introductions
10:15 – 12:00	Proposed Changes: Lower Levels of Care
12:00 – 12:45	Break for Lunch
12:45 – 2:00	Proposed Changes: No Wrong Door
2:00 -- 3:00	Proposed Changes: Higher Levels of Care
3:00 – 3:15	Public Comment
3:15 – 3:30	Closing Comments

Meeting Objectives

Objectives of this workgroup meeting:

- Ensure DHCS is on the right track with updates to screening, assessment, prior authorization, and medical necessity (documentation requirements to be discussed on January 30)
- Provide detailed feedback and recommendations

Proposed Changes for Lower Levels of Care

Definitions

Term	Definition
Medical necessity	≥21: a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. (W & I Code §14059.5(a).) <21: a service is "medically necessary" or a "medical necessity" if the service is necessary to correct or ameliorate mental illnesses and conditions (42 U.S.C. Section 1396d(r)(5); W & I Code § 14059.5(b)(1).)
Screening	Brief triage tool to help beneficiaries get into the right delivery system for treatment
Clinical assessments	Evidence-based, validated tools to determine a beneficiary's diagnosis and treatment needs to help guide treatment and level of care decisions, e.g., ASAM criteria (assessment)
Prior authorization criteria	Criteria reviewed in advance of the service used by payers to determine whether services are medically necessary and will be reimbursed (includes concurrent authorization, reviewed at same time as service)
Outcomes tools	Tools to track outcomes over time, measuring effectiveness of a service

Screening (triage)	Screening tool: understand MH needs, symptoms, and/or diagnoses. If substance use, is SUD treatment needed? ASAM criteria (screen)

Where should beneficiary start treatment (scope and intensity of services needed)?

Right place: delivery system	Needs can be met by MCP services? MCP delivery system	Need more intensive or broader scope of services? MHP	SUD? Connect to SUD services

What is the diagnosis and what treatment is needed?

Right care: Assessment and treatment	MH: evidence-based assessments and treatments SUD: ASAM criteria (assessment)

Is a higher level of care needed?

Prior authorization	**Lower level of care?** MH & SUD: No PA SUD: ASAM (assessment) by 30 days	**Higher level of care?** MH: prior auth process SUD: ASAM (assessment)

How should providers document?

Documentation	Problem list: diagnoses and active needs Progress notes: goals, plans, services

Proposed MH Outpatient Policy Changes

- ***Universal MH screening tool*** for beneficiaries ***not yet in care*** to determine best place to start care (MCP or MHP delivery system)
- A beneficiary can receive all MH services (MCP and MHP benefits) ***prior to the provider determining a diagnosis.***
- A beneficiary can receive MH services by a MH provider ***even in the presence of an SUD*** (moving away from "primary diagnosis")
- ***Clarify medical necessity for <21*** given the protections of EPSDT:
  MH services in the MCP and MHP benefit are medically necessary if needed to correct or ameliorate a condition, or for normal individual development, whether or not they are in the State Plan.
- ***Clarify medical necessity for adults:***
  SMH services are medically necessary if MH needs are beyond what can be provided in the MCP MH benefit and services are provided in accordance with the State Plan or waiver (changing current focus on eligible diagnoses and service criteria)

Proposed statewide MH screening tools (<21 and ≥21):

- ***Designed for non-licensed staff*** (e.g. hotlines, intake staff) to determine the best place for a beneficiary to start care: MCP or MHP delivery system
- ***Clinical staff would not be required to use the tool*** – they are trained to determine MH needs, diagnoses, and appropriate services.
- The tool would ***identify beneficiary's BH needs, symptoms, and/or diagnoses***:
  - Can those needs be met by the relatively narrow group of services covered by MCPs? (defined as care for people with milder or moderate impairment)?
  - Or does the beneficiary need more intensive services, or a broader scope of services, than are offered by the MCP?
  - Is there substance use? If yes, add ASAM criteria (screen).

Key changes:

- Decrease focus on "SMH covered diagnoses" since the same diagnoses can be covered in both MCP and MHP networks.
- Define beneficiary needs and which services match the needs.

Proposed SUD Outpatient Policy Changes: **Screening and Entry into Care**

- ***Current policy, proposed to be applied consistently statewide:***
  - ***ASAM criteria (screen)*** used to quickly identify beneficiary needs and facilitate entry into services (can be done by non-licensed staff).
  - ***Neither prior authorization nor the ASAM criteria (assessment)*** should be required prior to lower levels of care.
  - ***Provider-completed screenings*** should be accepted by the county; counties should not mandate re-screening be done by county staff.
- A beneficiary may receive outpatient SUD services ***prior to receiving a diagnosis*** (unspecified diagnosis is okay)
- ***Clarify medical necessity for <21*** given protections of EPSDT:
  Services are medically necessary if needed to correct or ameliorate a condition, or are necessary for normal individual development, whether or not they are in the State Plan.
- ***Clarify medical necessity for adults:***
  Services are medically necessary if provided in accordance with the State Plan/waiver (the services are included benefits), and the level of care is determined based on ASAM criteria (screen) to start treatment and ASAM criteria (assessment) for ongoing treatment.

Proposed SUD Outpatient Policy Changes: **Assessments and Ongoing Care**

- ***Current policy, proposed to be applied consistently statewide:***
  - ASAM criteria (assessment) done ***within 72 hours*** for residential care; ***within 30 days*** for outpatient services
  - ***Provider-completed assessments*** should be accepted; counties should not mandate re-assessments by county staff.
  - ***Repeat ASAM criteria (assessments)*** should not be required more often than every 6 months for outpatient services and every 12 months for NTPs
- A beneficiary can receive SUD services by a MH provider ***even in the presence of a MH condition*** (moving away from "primary diagnosis") as long as the provider is contracted with the plan to provide such services.
- ASAM criteria (assessment) ***may be completed by non-licensed staff*** if using a on-line, validated tool. (Customized or adapted ASAM criteria assessments would still require licensed clinical oversight).
- ***Addendums to indicate changing conditions*** are sufficient (rather than repeating the entire assessment).

Case examples: screening tool and treatment before diagnosis

Screening tool: *A patient with poorly controlled bipolar disorder moves to California and calls the BH line on his MCP insurance card. He explains that he frequently loses jobs and was recently homeless. After a brief screen, he is connected by the MCP to the MHP due to need for more intensive psychiatry management and rehabilitative services.*

Treatment before diagnosis: *A patient tells her PCP she is hearing voices. The PCP does a warm hand-off to a clinical psychologist within the MCP network, who then sees the patient twice to assess her needs (screening tool not needed since she is being evaluated by a licensed clinician). Since the patient's evolving needs are greater than can be managed by the MCP mental health benefit, the psychologist connects the patient to the MHP for SMH services. The county schedules the patient for a clinician visit without completing a screening tool (since her need for specialty MH was already identified by a licensed clinician). After three visits, the county psychiatrist diagnoses schizophrenia. The MCP pays for the initial psychologist visits done within the MCP delivery system and the MHP covers pre- and post-diagnostic treatment done within the MHP delivery system.*

Case examples: ASAM criteria and comorbid conditions.

ASAM criteria (assessment) prior to higher level of care*: An adult is arrested for methamphetamine possession; the collaborative court requests residential treatment. An ASAM assessment determines the client doesn't need this level of care, but does meet criteria for intensive outpatient. One month into treatment, the client's condition changes, and an ASAM assessment addendum determines he now meets criteria for residential treatment. The client is admitted into a residential facility.*

Comorbid MH and SUD in an adolescent: *A mother calls the county BH hotline because her teenager is "out of control." The staff interviews the teenager and identifies both MH symptoms (anxious, feels worthless, trouble sleeping) and possible SUD (admits to daily THC use). While the MH symptoms could be treated by the MCP, the possibility of an SUD leads to a referral to the county, since the county could manage both conditions. The teenager is seen by a MH provider and additional SUD services are coordinated by a case manager. The provider bills MH billing codes for MH symptoms ("ameliorating a condition"), and does not worry that neither the presence of an SUD nor the absence of a definitive MH diagnosis will lead to disallowances.*

Workgroup Discussion

For both adults and children:

- Which tools could be used or adapted for statewide use?
- What are best practices to determine what, if any, MH services a beneficiary needs?
- Should ACE scores be included in the tool and factored into decision-making?

For children and youth:

- What are the best ways to ensure all high-risk kids (including foster youth) have streamlined access to specialty MH care? Is presumptive (automatic) eligibility needed if the screening process is quick, simple and streamlined?

For adults:

- We are proposing to shift the definition of “mild-moderate” to “understanding needs and matching them to services.” How would this work in practice?
- Is an initial ASAM criteria (assessment) within 30 days reasonable for outpatient services?
- Should DHCS limit the frequency of required ASAM re-assessments (no more frequent than every year)?
- How do we avoid a ping-pong effect (e.g., an MHP refuses a referral from an MCP psychologist)?

No Wrong Door

No wrong door proposal

DHCS is NOT proposing to change:

- Which specific MH services are covered by MCPs
- Rates paid to MCPs for MH services
- Expectations of MCPs and MHPs to contract and pay providers, consistent with obligations under their DHCS contracts

Problems we are trying to address:

- Low penetration rates for MH services
- Disrupted continuity of care for beneficiaries whose functional impairment changes or with “moderate” conditions/impairments
- “Ping-ponging” between systems

Proposed change: No wrong door for children

MCPs, MHPs and Counties (for SUD) are each responsible for children's behavioral health services under EPSDT.

MH and SUD services:

Start care wherever beneficiary shows up for treatment.

If beneficiary needs a different level of care, the delivery system treating the patient is responsible to assess the beneficiaries needs (no standard screening tool required when a client sees a provider) and then care-coordinate into the other system.

Services are medically necessary if needed to correct or ameliorate MH or SUD conditions, including symptoms, whether or not in the State Plan.

Non-duplicative services are reimbursable in both delivery systems simultaneously – do not disrupt continuity relationships.

Proposed change: No wrong door for adults*

MH and SUD services:

Start care wherever beneficiary shows up for treatment.

If beneficiary needs a different level of care, the delivery system treating the patient is responsible to assess the beneficiaries needs (no standard screening tool required when a client sees a provider) and then care-coordinate into the other system.

Services are medically necessary if provided in accordance with the State Plan or waiver.

Non-duplicative services are reimbursable in both delivery systems simultaneously – do not disrupt continuity relationships

***Not part of original DHCS proposal; currently under consideration.**

Case studies: no wrong door

Services in two systems, youth:

The mother of a 16-year-old calls the BH line on her insurance card because her daughter suffers from erratic moods affecting school attendance. She is referred to an MCP psychologist and starts weekly therapy. She gets worse: stops going to school, refusing to leave the house other than for therapy visits, and starts reporting delusions and hallucinations. The therapist refers her to the MHP, where she receives coordinated specialty care, family support services, and case management, and she is encouraged to continue her trusted relationship with her MCP network psychologist. Over time, it is discovered that the psychotic episode was due to experimental substance use; the teen stops using substances, and the psychosis resolves. She stabilizes, no longer needs county services, and continues to see the MCP psychologist when needed.

The county covers the services from the MHP-contracted providers, and the MCP covers her initial and ongoing psychology visits with the MCP-contracted provider.

Case studies: no wrong door

Services in two systems, adults:

An adult talks to non-licensed staff on the crisis line, reporting depressed mood, trouble sleeping, but no psychosis, delusions, nor suicidal thoughts. The staff conducts a standardized screen, determines that his needs can be met with MCP services, and connects him to the MCP BH intake line. He is seen three times for weekly therapy before he admits that he drinks a fifth of whisky every night. The therapist helps him get into SUD treatment, and continues see him for counseling. The MCP pays for the counseling visits and the county SUD plan pays for SUD treatment.

An adult sees an MCP network psychologist for depression for several months. Over time, the depression becomes worse, despite visits with an MCP psychiatrist and several medication adjustments. She attempts suicide, and after 5150 placement, is admitted in acute psychiatric hospital. After discharge, she receives ECT (electroconvulsive therapy), and she improves. Prior to and post-hospitalization, she continues to see the MCP psychologist. While she is briefly managed by an MHP psychiatrist, during the ECT, after stabilization, she re-establishes care with the MCP psychiatrist for ongoing treatment. The MCP pays for all services performed by the psychologist and MCP psychiatrist. The MHP pays for the hospitalization, ECT, and services by the MHP psychiatrist.

Discussion Questions

- How would it work for a beneficiary to receive mental health services simultaneously in the MCP and SMHS delivery system?
- How do we avoid a “ping-pong” effect for beneficiaries between systems?
- Should it work differently for adults and children?
- Should the presence of a co-occurring disorder change whether a person with milder MH needs is referred into the MCP or MHP?
- What difficulties do you expect, and how slowly should this be phased in?

Proposed Changes for Higher Levels of Care

Update on ASAM criteria (assessments) for residential care

Current state

What is currently happening?

- Inconsistent implementation of concurrent review
- Retrospective review auditing documentation compliance
- Frequent disallowances

What is required by federal regulations?

- Physician certification/licensed practitioner recertification
- Concurrent review
- Completion of medical, psychiatric and social evaluations, with written plan of care

Proposed changes: inpatient medical necessity

- Initial physician certification/recertification documents that the beneficiary meets ***admission requirements*** and meets ***criteria for inpatient care*** –fulfilling federal requirements and replacing DHCS inpatient documentation standards. Re-certification can be done by licensed clinician under physician supervision.

  Note: concurrent review for inpatient services is a requirement for MHPs. Physician certification would meet documentation requirements; concurrent review still needs to determine that inpatient care is medically necessary.
  (see Information Notice 19-026)

  Prior authorization is not permitted for outpatient, lower levels of care.

- As part of determining medical necessity for 5150 inpatient psych, medical clearance in an ED is often required, which can lead to long ED lengths of stay without value-add, when beneficiaries have no sign of an acute physical health condition. ***Should this requirement be removed?***

ASAM update: high-risk populations and higher levels of care

Problem:
Current versions of the ASAM criteria may under-estimate the need for residential or higher levels of care for people leaving institutions (e.g., prison) or for people experiencing homelessness.

Solution:
ASAM leaders state they are actively revising the on-line tool to account for the additional risks of homelessness and criminal justice re-entry, and also plan to incorporate the need for MAT.
They state the on-line tool will be immediately updated, and ASAM will release written guidance for counties or providers using written versions of the ASAM criteria.

Discussion Questions

Do these proposals address current challenges with inpatient medical necessity criteria?

Are there different issues for children and adults?

Should the medical clearance requirement for 5150 holds be removed?

What unintended consequences should we plan for, and how to mitigate them?

Future Meeting Planning

Future Medical Necessity Focused Workgroup Meeting Dates:

- **January 30, February 26**

Meeting Deliverables

- Finalize screening tool
- Finalize medical necessity proposal key elements

Workgroup Feedback

- What additional information is needed to inform policy recommendations?

Workgroup Meeting Schedule

Date	*Time*	*Topic(s) / Agenda Items*
Thursday, January 30th	10:00 am to 3:00 pm	BH Integration and Medical Necessity Documentation
Tuesday, February 4th	10:00 am to 3:00 pm	Payment Reform
Wednesday, February 26th	10:00 am to 3:00 pm	Medical Necessity/ BH Integration
Thursday, February 27th	10:00 am to 3:00 pm	Wildcard (tie up loose ends)

Public Comment

Please limit comments to 2 minutes

Closing and Next Steps

Next Behavioral Health Workgroup Meeting: **January 30, 2020** (Integration)

Questions? CalAIM@dhcs.ca.gov