

The background of the slide is a light gray gradient with several realistic water droplets of various sizes scattered across it. The droplets have highlights and shadows, giving them a three-dimensional appearance.

# CONCURRENT REVIEW AND AUTHORIZATION, INPATIENT

IN 19-026 AUTHORIZATION OF SPECIALTY MENTAL HEALTH SERVICES

IMPLEMENTATION BY 3 COUNTIES: SAN DIEGO, ALAMEDA, SHASTA

# AUTHORITIES

- Centers for Medicare and Medicaid Services (CMS) Final Rule (42 CFR §438.210)
- CMS Parity Rule (81. Fed. Reg. 18390)
- DHCS Parity Compliance Plan (October 2, 2017)
- MHSUDS Information Notice (IN) 19-026: Authorization of Specialty Mental Health Services (May 31, 2019)

# LEARNING OBJECTIVES

- Understand background and policy requirement for County Mental Health Plans (MHP) to conduct concurrent review and authorization for psychiatric inpatient hospital and psychiatric health facility (PHF) services.
- Be able to define concurrent review and authorization and implement in your county.
- Describe how three (3) counties implemented and operationalized concurrent review and authorization of psychiatric inpatient hospital and PHF services.
- Identify three (3) positive aspects of implementing concurrent review and authorization.
- Identify three (3) challenges of implementing concurrent review and authorization.

# BACKGROUND AND POLICY

- On May 6, 2016, CMS published the Managed Care Final Rule (Final Rule) aimed at aligning the Medicaid Managed Care regulations with the requirements for other major sources of coverage.
- The Final Rule stipulates requirements for coverage and authorization that became effective July 1, 2017 (42 CFR §438.210).
- On March 30, 2016, CMS issued the Parity Rule to strengthen access to mental health and substance use disorder services for Medicaid beneficiaries. It aligned certain protections required of commercial health plans under the Mental Health Parity and Addition Equity Act of 2008 to the Medicaid program.
- On October 2, 2017, DHCS submitted its Parity Compliance Plan, which identified inconsistencies in the application of standards and policies for authorization of both inpatient and outpatient services by MHPs and Medi-Cal Managed Care Plans (MCPs).
- On May 31, 2019, the MHSUDS IN 19-026 was issued, which indicates the policy of concurrent review and authorization for psychiatric inpatient hospital and PHF services. DHCS will formally promulgate the regulations by July 1, 2022, as required by statute.

# CONCURRENT REVIEW AND AUTHORIZATION

## DEFINITIONS:

- **CONCURRENT REVIEW:** clinical review to make medical necessity determinations while a beneficiary is actively receiving treatment.
- **AUTHORIZATION:** approval of both service and payment based on medical necessity.



## SAN DIEGO IMPLEMENTATION



- Optum San Diego Public Sector has been contracted as the Administrative Services Organization for the County of San Diego Behavioral Health Services for the last 23 years.
- We facilitate the inpatient concurrent review process as well as other authorization and administrative functions.
- We have utilized documentation review for our inpatient concurrent review process since 2012.

# SAN DIEGO WORKFLOW

- Hospital may initiate contact with Optum to provide admission notification, and/or request concurrent review and authorization for inpatient psychiatric services, 24 hours a day, 7 days a week.
- The review begins when the hospital calls Optum to request concurrent review and faxes over relevant documentation.
- The concurrent review process includes a review of the documentation to determine if medical necessity is met.
- Clinical information is reviewed by licensed clinicians and determinations are made based on Medi-Cal Medical Necessity Criteria for Psychiatric Inpatient Hospital Services (Title 9, CCR, §1820.205 and §1820.220).

# SAN DIEGO WORKFLOW- CONTINUED

- If medical necessity is met, the clinician will authorize and provide notification to the hospital.
- If medical necessity is not met, the clinician will consult with the medical director for determination. All potential denials or modifications are reviewed and determined by the medical director.
- If denied, the clinician will notify the facility verbally, and in writing, within 1 hour of the determination. The appropriate NOABD notification is faxed to the facility, as well as mailed to the beneficiary, within 2 business days.
- An expedited review (informal process) of the denial may be requested by the hospital physician.
- Clinical staff enter all relevant information pertaining to medical necessity and the authorization determination in the county's electronic health record.



# SAN DIEGO-REIMBURSEMENT PROCESSING

- Final confirmation and approval of reimbursement occurs when the Treatment Authorization Request (TAR) is received from the hospital.
- Optum records receipt of the TARs, reconciles against what was authorized in the electronic health record, completes the required fields, and once completed, submits to the Medi-Cal Fiscal Intermediary.

## ALAMEDA COUNTY IMPLEMENTATION

- Alameda County Behavioral Health Utilization Management Program (ACBH UM) is the designated program to receive admission notification and conduct concurrent review and authorization for acute psychiatric hospital and psychiatric health facility services.
- Concurrent review has been done for a Short Doyle/Medi-Cal Inpatient Hospital for over 23 years. Effective 2015, review has been completed through remote access of the hospital electronic health record.
- For many years, concurrent telephonic review has been done for a few contracted Fee-for-Service (FFS) Inpatient Hospitals.
- In 2017 concurrent review was made available to all FFS Inpatient Hospitals.

# ALAMEDA COUNTY: ADMISSION NOTIFICATION AND CONCURRENT REVIEW SCHEDULING

- Within 24 hours of admission, the admitting facility notifies ACBH UM.
- Concurrent review methodology is determined and scheduled between admitting facility and ACBH UM.
  - ACBH UM gives provider flexibility to choose either concurrent review via documentation review or telephonic.
- Concurrent review frequency is determined by staffing ability and clinical need. Frequency ranges from daily Mon-Fri to 2 days/week.

# ALAMEDA COUNTY: CONCURRENT REVIEW

## MEDICAL NECESSITY CRITERIA:

All admission service dates are independently reviewed to make medical necessity authorization determinations in accordance with Medi-Cal Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services (Title 9, CCR, §1820.205 and §1820.220).

## TWO-LEVEL CLINICAL REVIEW:

- Initial review by a licensed clinician.
- Any admission day(s) that are found questionable, are forwarded to a UM physician for an independent secondary review for final authorization determination of the questionable day(s).

# ALAMEDA COUNTY IMPLEMENTATION WORKFLOW: WHERE WE ARE NOW

## HYBRID AUTHORIZATION PROCESS:

- **CONCURRENT REVIEW AND AUTHORIZATION:** Service dates determined to meet Medi-Cal medical necessity criteria by a licensed clinician are concurrently authorized for reimbursement.
- **CONCURRENT REVIEW AND POST-DISCHARGE AUTHORIZATION:** Service dates found questionable by a licensed clinician are pended for post-discharge independent review by a physician for final authorization determinations.
  - Consultative renderings of questionable day(s) by licensed clinicians are provided concurrently to acute facility providers, who may request/initiate physician-to-physician consultation.

# ALAMEDA COUNTY: ADMINISTRATIVE REIMBURSEMENT PROCESSING

- The Treatment Authorization Request (TAR 18-3), is the Medi-Cal reimbursement request form.
- Post-discharge, the acute facility provider submits the TAR to ACBH UM.
- ACBH UM, upon receipt of the TAR completes the below administrative actions to enable the acute facility provider to receive reimbursement.
  - Authorization determination notations on the TAR.
  - Submission of the TAR to the Medi-Cal Fiscal Intermediary (FI).
  - Completion of both provider and beneficiary notifications., the latter is applicable only if there are adverse benefit determinations (i.e. NOABD-Payment Denial).

# ALAMEDA COUNTY: WHERE WE HOPE TO BE AND NEXT STEPS

## WHERE WE HOPE TO BE:

- Revise hybrid authorization process to a full concurrent authorization process.
- Increase and streamline physician-to-physician consultation option.
- Add an informal provider appeal option, prior to formal provider appeal process.

## NEXT STEPS AND CHALLENGES:

- Increase physician coverage and access. Challenge of physician recruitment to public sector and small pool of physicians with administrative experience/interest.
- Challenge of shifting from post-service/discharge payment denial to service denial/termination, which can lead into beneficiary expedited appeal requests and aid paid pending.



# SHASTA COUNTY – A FEW PARTICULARS



- Two local hospital ERs, staffed by Shasta County clinical staff almost 24 hours a day.
- Provide 5150 crisis evaluation, safety planning, and case management.
- The Transition, Admission, and Discharge (TAD) Team place all individuals admitted for inpatient psychiatric care.
- Admin Days – The TAD Team places individuals into non-acute treatment facilities who are receiving inpatient services, are conserved, and no longer meet criteria for acute care.



# SHASTA COUNTY- OVERVIEW

- Contracted with Beacon Health Options of California (Beacon) to provide Concurrent Review and Authorization beginning on March 1, 2019.
- Provide concurrent review to Shasta County Medi-Cal beneficiaries, including when the beneficiary falls into the IMD exclusion.
- Facilities are responsible to coordinate authorizations with other insurers for individuals placed by Shasta County that have another county's insurance, private insurance, or Medicare.

## SHASTA COUNTY— OVERVIEW CONT.

- Beacon has licensed clinical and MD staff available 24/7/365
- Process is telephonic – facility documentation can be requested if deemed necessary.
- Authorizations are prospective.
- Authorization of Administrative Days – process is complicated and requires support from Shasta County UM staff.
- Shasta County claims UR/QA at 75% of contract cost + enhanced State General Fund (SGF) (Prop 30) claiming.

# SHASTA COUNTY– WORKFLOW

- The facility calls the Beacon 24-hour toll-free number to request authorization within 24 hours of admission.
- A Beacon licensed clinician is assigned to the beneficiary for that episode of inpatient care.
- The clinician is responsible for gathering the clinical information, coordinating clinical calls, recording the information in Beacon's health record, making authorization decisions, consulting up the chain when medical necessity criteria is in question, etc.
- Beacon provides verbal authorization within 24 hours of receiving the clinical information and sends an authorization letter to the facility/provider and the beneficiary within two days.

## SHASTA COUNTY– WORKFLOW CONT.

- The Beacon clinician has ongoing, in-depth conversations with the facility throughout the beneficiary's stay to review information including: beneficiary's current presentation, diagnosis, treatment and response, use of best practice guidelines, discharge planning, care coordination, etc.
- Facilities are encouraged to provide information directly from their medical record.
- Beacon has various levels of decision-making for authorizations; licensed clinicians are the first line and decisions are also made by UM managers, through team consultation, and MD review.
- All adverse determinations are made by an MD.
- Peer to peer (MD) consultation is offered in the case of possible denial and also for consultation regarding medical necessity for length of stay and treatment guidelines.

# SHASTA COUNTY— NOABD AND APPEALS

- If an authorization request is denied or modified, Beacon:
  - Informs the facility/provider verbally and then faxes the NOABD to the facility/provider.
  - Faxes the beneficiary notice to the facility to be provided to the beneficiary while they are still receiving inpatient services.
- Appeals are handled by Shasta County UM/QA.

# SHASTA COUNTY– ADMINISTRATIVE DAYS

- Different processes for conserved vs non-conserved beneficiaries.
  - Conserved Beneficiaries:
    - Shasta County TAD Team conducts the placement activities for beneficiaries that are conserved.
    - Facilities are automatically authorized by Beacon for seven days at a time. This is Shasta County's commitment to pay the facility and does not guarantee Shasta County's ability to bill Medi-Cal for the days.
  - Non-conserved Beneficiaries:
    - Facility is responsible for conducting and documenting placement activities.
    - Authorizations are supported by communication and collaboration between Shasta County, Beacon, and the facility.

# SHASTA COUNTY– IMPLEMENTATION

- Notified facilities prior to implementation, included detailed information on how to engage in the process; not all facilities participating yet but it increases all the time.
- Began working with two local PHFs and local hospital about six months before implementation.
- Shasta County UM staff available for consultation, problem-solving, training, troubleshooting, etc. for facilities, Beacon, and Shasta County staff.

# SHASTA COUNTY– UM TAR AND INVOICE PROCESSING

- The TAR is submitted by hospitals along with the psychiatric evaluation, discharge summary and plan, and the history and physical.
- The TAR is completed by the county using the information from the discharge summary and submitted to the FI.
- UM staff verify authorized days and days billed and whether required documentation exists to bill Medi-Cal for any admin days.



# SHASTA COUNTY– IMPLEMENTATION CHALLENGES

- Everyone had to learn and make adjustments.
  - Shasta County staff – TAD Team had an important role that involved an increase in their workload. Complete the Inpatient Psychiatric Placement Notice for all beneficiaries placed and email to Beacon.
  - PHFs – completely new process that they had no experience with, lack of resources to engage, and discomfort with the UM process (oversight of their care in real-time).
  - Beacon staff had to learn a new language, different regulations, some of which were quite different than they were used to and the learning has to be pushed out to weekend, afterhours, and new staff.
  - Authorization of admin days!!

# SHASTA COUNTY— IMPLEMENTATION SOLUTIONS - PHFs

- Shasta County and Beacon worked closely with the PHFs to ease their concerns.
  - Allowed retrospective review if there were glitches and the concurrent review process was not successful.
  - Problem-solved staffing issues – the PHFs have implemented various solutions:
    - Management-level staff until it was up and running more smoothly then moved to nurses .
    - Medical assistant/UR staff.
    - Discussions about resources and the need for solutions to be part of the larger conversation with the state and counties.
    - Created dedicated phone lines with confidential voicemail for exchange of information between Beacon and PHF.
  - Less worry and fewer issues as PHF staff became more experienced with the process.

# SHASTA COUNTY– STRENGTHS

- Hospital familiarity with the process.
- Beacon relationships with hospital UR departments.
- Increased care coordination and oversight.
- Contracting with a Quality Improvement Organization (QIO) – Like entity allows for 75% claiming + enhanced SGF (Prop 30) claiming. Beacon is designated a QIO-Like entity by CMS.
- Beacon accreditation, infrastructure, and robust P&Ps; Beacon has processes in place already to meet requirements such as interrater reliability and evaluation of UM practices.
- Joint Quality of Care processes.

# SHASTA COUNTY– DECISION TO CONTRACT FOR PROVISION OF CONCURRENT REVIEW

- Assessed resources, costs, and risks.
- Resources:
  - Lack of required staff – licensed clinical staff and MD availability.
  - Lack of staff with required experience, training, and expertise in inpatient care.
  - No accepted clear guidelines for operationalizing medical necessity for continued stay services.
- Costs:
  - Estimated cost of acquiring, training and retaining clinical and MD staff.
  - 24 hour availability.
  - Cost of creating the infrastructure and processes such as monitoring interrater reliability, objectivity in clinical decision making, and creation or adoption of level of care guidelines.

# SHASTA COUNTY– DECISION TO CONTRACT FOR PROVISION OF CONCURRENT REVIEW

- Risk Assessment:
  - Change from retrospective review by authorizing payment for services already received to providing concurrent review and utilization management by authorizing services and payment concurrently with the provision of services; involves the possible denial of services prior to the beneficiary receiving the services.
  - Process too burdensome for facilities might result in fewer inpatient beds.
- Shasta County made the determination that contracting with Beacon allowed us to appropriately and positively address the questions of risk, resources and costs.

# FEEDBACK OF BENEFITS OF CONCURRENT REVIEW

## BENEFICIARY, PROVIDER, AND COUNTY BENEFITS:

- Increase care coordination opportunities, and more specifically County involvement/support with beneficiary aftercare and disposition planning.
- Increase County monitoring of service utilization, to ensure the beneficiary is being treated in the least restrictive treatment setting and allows for identification of potential quality of care issues in real time.
- Timely beneficiary notification of adverse benefit determinations, which enables beneficiaries to initiate appeal rights while still in treatment.
- Timely provider notification of service/reimbursement determinations.
- Establish collaborative working relationships.

# FEEDBACK ON CHALLENGES OF CONCURRENT REVIEW

- Staffing:
  - Will require additional licensed clinicians and physicians to provide timely responses.
  - Administrative staffing to assist with processing of notices and TARS.
  - Clinical and administrative staffing for appeals, including expedited appeal processing.
- More challenging for PHFs to implement due to lack of staffing resources and unfamiliarity with concurrent review.

# LESSONS LEARNED

- Ongoing collaboration with hospitals, pre- and post-implementation is critical.
- For San Diego & Alameda: Verbal concurrent review was not as efficient as documentation review and does not align with regulation requiring written documentation.
- Alameda: If flexibility is provided in concurrent review methodology (i.e. documentation review vs. telephonic), it is important to stay with one review methodology from admission through discharge.