Washington State Health Care Authority

Washington State Department of Social & Health Services

Transforming lives

Monthly Tribal Meeting

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Agenda

9:00 AM	Welcome, Blessing, Introductions
9:10 AM	Medical Necessity (DBHR)
10:00 AM	Other issues: -Intergenerational Trauma as a Risk Factor (DBHR) -Update: BHO Ombuds Development of Training (DBHR)
10:30 AM	Workgroups: Statewide BHO-Tribal Convening and AIHC Biennial Health Summit (DBHR and HCA)
11:00 AM	Workgroup: Mental Health Carve-Out Planning (DBHR and HCA)
11:30 AM	Upcoming Consultation: BHO and MCO Contracts and Indian Addenda
Noon	Closing

WELCOME, BLESSING, INTRODUCTIONS

MEDICAL NECESSITY

Medical Necessity

- This presentation is in response to an item on the tribal issues grid (#10).

Tribal Concern	Tribal Request	State Comment/Response
BHOs are requiring new assessments for their medical necessity and authorization determinations.	Tribal Request: Require BHOs to accept tribal MH and tribal SUD assessments with full faith and credit.	(1) For an individual to receive Medicaid MH or SUD services through a BHO, the BHO is required to determine that there is *current* medical necessity for the requested service. In making this determination the clinician conducting the assessment should use all other information available, including assessments conducted by other providers. At a minimum, the BHO has to verify that at the point in time services are requested, medical necessity for the treatment is present. (2) For SUD assessments, BHOs accept medical necessity based on ASAM criteria. (3) Tribes are attested or licensed, so their assessments should be viewed equally with non-Tribal provider assessments.

Why Document Medical Necessity?

- It is good care.
  - Provides for care continuity.
  - Keeps clinician on track—it provides a map.
- Documentation is required by payers:
  - Medicaid
  - Medicare
  - Other Insurance
- Medical Record is Legal Document
  - Protects Clinician

Medical Necessity—Guidelines for Charting

- Good rule: Never write something in the chart you do not want your client to read.
- Use a Person Centered Approach
  - Chart reflects a real partnership between practitioner and patient
  - It is more than respect.
  - It improves outcomes.

Medical Necessity

- Requires that all services/interventions be directed at a medical problem/diagnosis and be necessary in order that the service can be billed
- A claims based model that requires that each service/encounter, on a stand alone basis, reflects the necessity for that treatment intervention

Medical Necessity

- The service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction.
- There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable.

Medical Necessity

- This course of treatment may include mere observation, or where appropriate, no treatment at all.
- Bottom line: the treatment interventions must help the person get better, or at the very least, prevent a worsening of the person's health

Tests for Medical Necessity

- There must be a diagnosis: ICD 10
- The services ordered are considered reasonable and effective for the diagnosis
  - Directed at or relate to the symptoms of that diagnosis
  - Will make the symptoms or persons functioning get better or at least, not get worse
- The ordered services are covered under that person's benefit package (State Plan Services)

Medical Necessity—Reviewing a Chart

- Is there a diagnosis? Is there adequate documentation?
  - Clinical Rationale for diagnosis
- Is there a meaningful assessment of current functioning?
- Are treatment interventions identified?
  - Are they lined to the assessment?
  - Is there reasonable likelihood for improvement?

Medical Necessity—Reviewing a Chart

- Is there a Treatment or Care Plan?
  - Does the plan identify intervention types (services)
  - Is the plan signed by the practitioner and patient?
  - Is the plan geared towards the patient's level of functioning and diagnosis?
  - Is there indication that the patient participated in plan development?
- Does each encounter note document the intervention, the need for the interventions, and the outcome?

Medical Necessity—the Thread

- There are documented assessed needs
- Needs lead to specific goals
- There are treatment goals with measurable objectives
- There are specific interventions ordered by the primary practitioner
- Each intervention, is connected to the assessed need, ordered by the treatment plan and documents what occurred and the outcome

Medical Necessity—Intake Assessment

- Diagnosis with clinical rationale: how the diagnostic criteria are present in the person's life
  - Based on presenting problem
  - Data from patient—their story
  - Observation
- Patient functioning
  - Evidence that the diagnosis/patient condition, causes minimally, moderate distress or functional impairment in Life Domains

Medical Necessity-Intake Assessment

- Patient needs are identified
  - Reflect an understanding of unmet needs relating to symptoms and behaviors
  - The patient's desired outcome
  - Recommendation for treatment and level of care.
- Needs can be seen as underlying conditions or causes.
- When unmet, can cause a gap or hole in life.
  - Behaviors related to those needs.
  - If unmet, behavior can escalate

Medical Necessity—Treatment Plan

- Plan should be linked to assessment needs
- Plan should include desired outcomes in patient's words
- Plan should have a clear goal statement
- Plan should include measurable objectives (how will practitioner and patient know when an objective is accomplished)
- Plan should use patient strengths and skills as resources

Medical Necessity—Treatment Plan

- Plan should clearly describe interventions and service types
- Plan should identify staff and staff type
- Plan should address frequency and duration of interventions

Medical Necessity—Progress Notes

- Must be written for each encounter
- Must address the goals and objectives of the treatment plan
- Must document the intervention via the service modalities ordered by the treatment plan
- If different services are needed: plan must be revised

Medical Necessity—Progress Notes

- Notes should reflect:
  - Goal and/or objective
  - Time spent
  - Location
  - Medical necessity (purpose of encounter)
  - What the intervention was
  - Patient response to the intervention
  - Plan for next interaction
  - Optional: homework assignment

Medical Necessity

- As a practitioner:
  - Know the reason for the encounter
  - Have an agenda for the encounter
  - Follow the map
- Makes it easier to document medical necessity for the visit

OTHER ISSUES:

INTERGENERATIONAL TRAUMA AS A RISK FACTOR

UPDATE BHO OMBUDS TRAINING DEVELOPMENT

Intergenerational Trauma as a Risk Factor

- This update is in response to an item on the tribal issues grid (#15).

Tribal Concern	Tribal Request	State Comment/Response
BH treatment of AI/ANs needs to address historical/inter-generational trauma and related disorders.	Include historical trauma in BHO Access to Care Standards and list of Medicaid-covered diagnoses.	State recognizes the critical impact these factors can have on whole person care. Historical/inter-generational trauma is not an ICD 10/DSM 5 diagnosis, but treatment modalities can incorporate these concepts.

BHO Ombuds Training Development

- This update is in response to an item on the tribal issues grid (#19).

Tribal Issues Grid Item #19		
Tribal Concern	Tribal Request	State Comment/Response
Tribes/UIHOs need more appropriate government-to-government mechanism to address disagreements over BHO decisions.	Require BHO to submit to mandatory mediation in the event that tribes and the BHO disagree in regard to (1) an individual's assessment for the provision of crisis services; or (2) the tribal and BHO plan for coordination of crisis services.	For Medicaid services, access standards are identified in the BHO PIHP Contract. Each BHO must follow the federal regulations for managing the grievance process. This includes timeliness of notice of actions, denials, notification of rights, appeals process and access to the Ombuds office in each BHO.

WORKGROUPS: BHO-STATE-TRIBAL MEETING & AIHC BIENNIAL HEALTH SUMMIT

Workgroups:
BHO-State-Tribal Meeting/AIHC Biennial Health Summit

- **Scope: Combine the two workgroups; they have similar issues, topics, and audiences. Provide updates at the MTM.**

- **Target Date for Events:**
  - BHO-State-Tribal Meeting, October 2016
  - AIHC Biennial Health Summit, November 2016

- **Question:** Should we combine the two workgroups?

- **Question:** How often should we meet?

- **Question:** Who will lead facilitation?

- **Participation:** Via webinar and teleconference

WORKGROUP: MENTAL HEALTH FEE-FOR-SERVICE (FFS) CARVE-OUT

Mental Health FFS Project Plan

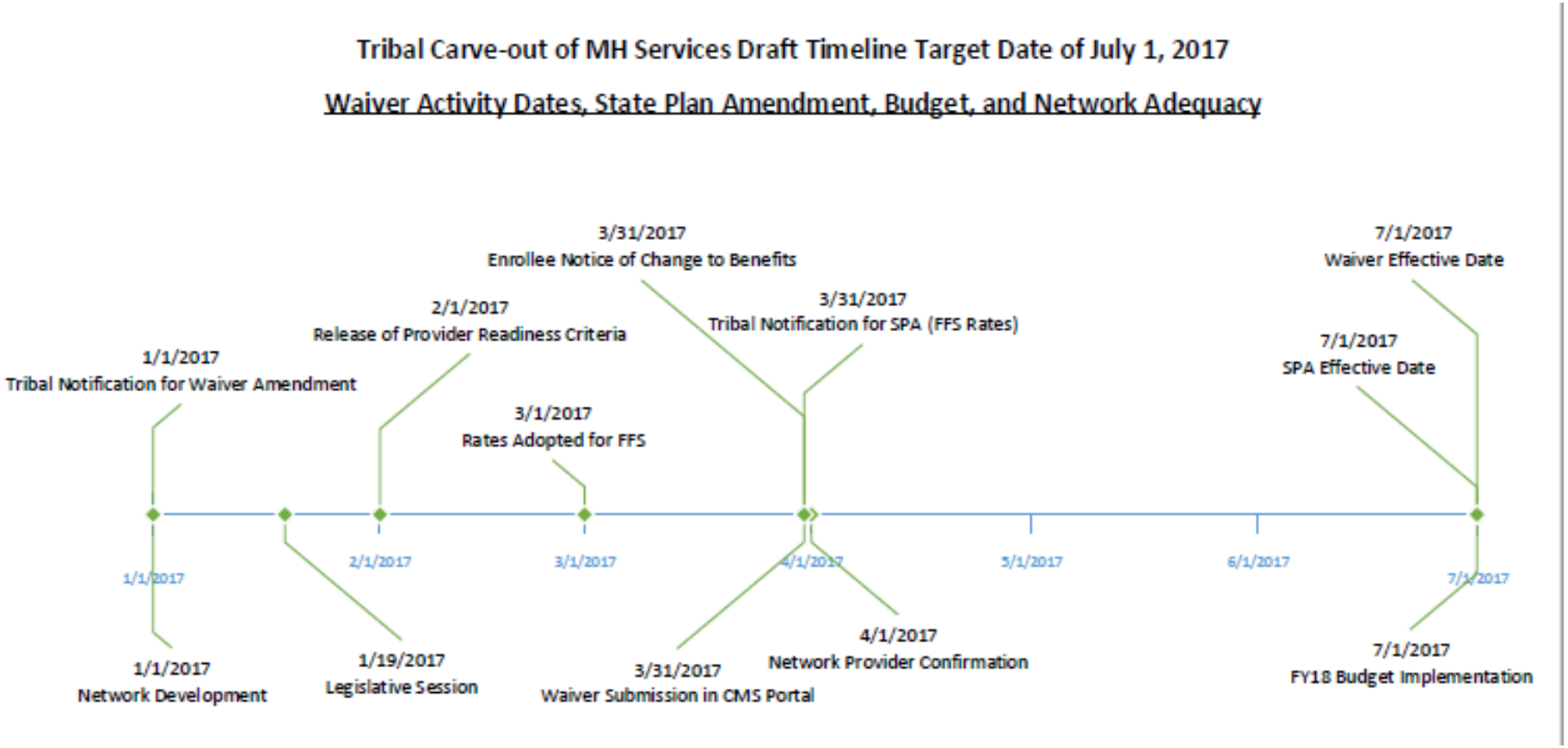
Scope: Agree on implementation date for full carve out and specific language for the waiver renewal submission.

Tasks:

- Create workgroup with tribal, UIHO, HCA, and DBHR representation to meet weekly via webinar/teleconference
- Create timeline with implementation date
- Facilitate Tribal Consultation on waiver renewal language

- Present updates at HCA-BHA Monthly Tribal Meetings
- Potential meeting dates:
  - Every Monday starting August 29th from 11-12 or 2-3. (no meeting on labor day)
  - Every Wednesday starting August 31st from 11-12. (no meeting the week of labor day)

Mental Health FFS Project Plan—DRAFT



Questions?

Issues?

Concerns?

Thank you!

HCA

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