February 8, 2021

Via Email: shaina.zurlin@dhcs.ca.gov
Attention: Dr. Shaina Zurlin
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California Department of Health Care Services
1501 Capitol Avenue, MS 4000
Sacramento, CA 95899-7413

Subject: CBHDA Comments – Concurrent Review and Authorization of Inpatient Psychiatric Services

Dear Dr. Zurlin:

Thank you, and your colleagues at DHCS and Aurrera Health Group, for the opportunity to provide timely written feedback on several topics related to concurrent review and authorization of inpatient psychiatric services. Over the past year, CBHDA has provided several sets of informal written comments and redlined documents intended to help inform DHCS' development of secondary implementation guidance for concurrent review. As the joint CBHDA/CHA workgroup process concludes, we are sending this letter to share key concerns and recommendations that we hope DHCS will consider as you move forward with policy development. Below, we address three topics where DHCS has requested additional feedback (physician certification, beneficiary notifications, and communication best practices). We close by highlighting additional topics where we would appreciate further discussion between CBHDA and DHCS.

Physician certification, initial authorization, and continued stay requests

It is CBHDA's understanding that federal regulations specific to utilization controls for psychiatric hospitals that receive Medicaid funds require a treating physician to certify the need for an inpatient psychiatric service upon admission.[1] These federal utilization control requirements would appear to remain in effect regardless of other procedures that a state or Medicaid managed care plan may adopt to authorize Medicaid payments for psychiatric services. We defer to DHCS to verify this interpretation of federal regulations and to determine how the Department, as the single state Medicaid agency, will monitor and enforce hospital compliance with physician certification requirements. If DHCS decides that hospitals should provide evidence of physician certification to MHPs during the concurrent review process, MHPs have no objection to receiving and monitoring that evidence of certification.

However, CBHDA has also provided DHCS with written feedback on the minimum necessary clinical information that we recommend hospitals communicate to MHPs *alongside any attestation of physician certification*. Critically, as Medi-Cal managed care plans MHPs have an obligation to establish medical necessity for each day of inpatient psychiatric care that is authorized and reimbursed with Medi-Cal dollars.[2] As we stated in our letter to Dr. Kelly Pfeifer on May 19, 2020 and in subsequent comments to DHCS, we do *not* believe that an attestation from a physician that merely indicates the provider has certified an inpatient admission as specified in federal regulation is sufficient to establish medical necessity

[1] 42 CFR § 456.160
[2] 9 CCR 1820.205. See also 2017-2022 MHP Boilerplate Contract, Exhibit A, Attachment 2 "Scope of Services" (1)(B & C) and Exhibit A, Attachment 6 "Utilization Management Program (2)(E) (specific to authorization of emergency psychiatric services).

for an inpatient psychiatric stay. The responsible MHP must also receive sufficient information about the beneficiary's clinical condition to verify that Medi-Cal medical necessity criteria have been met. The need for the hospital to communicate basic clinical information to the MHP is not limited to admission, or to each federally required renewal of physician certification thereafter. Timely communication of appropriate clinical information is needed for an MHP to authorize each day of an inpatient stay.

Please see our submissions to DHCS and Aurrera dated November 27, 2020 (initial authorization) and January 21, 2021 (continued stay requests) for detailed recommendations outlining the minimum necessary clinical information that MHPs should review to validate medical necessity. In summary:

- **Initial authorization requests from hospitals must include baseline clinical information to establish medical necessity.** CBHDA recommends that within one working day[3] of an inpatient psychiatric admission, a hospital should provide an MHP with clinical information included in the medical evaluation[4] and initial plan of care,[5] as defined in federal regulation. If the hospital observes all requirements related to initial physician certification as specified in 42 CFR, Sections 456.160, 156.170, and 256.180, the minimum necessary information to be communicated to the MHP should align with what is required of the physician at the time of admission. As such, this information should be available for review by the MHP within one business day. Even if a hospital were not observing federal physician certification requirements per se, the informational elements MHPs would like to receive at this time should be completed by the hospital shortly after admission as a matter of standard clinical practice. By requesting only information that is typically collected during the hospital admission process and already required for utilization review, MHPs intend to keep the initial authorization process feasible, standardized, and streamlined for hospitals.
- **MHPs will authorize an initial 48-hour period *only if* clinical information is communicated as detailed in our written proposal to DHCS on November 27, 2020.** MHPs are willing to endorse a standard best practice of authorizing a minimum of 48 hours at the beginning of each inpatient stay (with the option to authorize a longer period) ***only if*** hospitals communicate sufficient clinical information to establish medical necessity. Although the proposal for all MHPs to provide 48-hour authorizations upon admission has been discussed with the full CBHDA/CHA workgroup, DHCS has not yet weighed in to confirm the type of clinical information hospitals will be expected to provide to MHPs to support initial authorization requests. Workgroup members have been asked to agree to a recommendation that all MHPs provide initial 48-hour authorizations without assurance that hospitals will share sufficient clinical information to establish medical necessity. We want to be very clear that for MHPs, an initial 48-hour authorization must be conditioned upon receipt of clinical information needed to establish medical necessity. Again, attestation of physician certification could be part of this exchange, but that attestation would be insufficient in the absence of communication about the beneficiary's clinical condition.
- **CBHDA has provided detailed recommendations on the information needed to establish medical necessity for continued stay requests following these initial authorizations.** In our January 2021 comments to DHCS, CBHDA confirmed our support for a proposed list of clinical information that should be communicated by hospitals as part of continued stay authorization requests. We also offered detailed definitions and

[3] Federal regulations for Medicaid hospital utilization controls at 42 CFR § 456.125 state that utilization review of each hospital admission for Medicaid beneficiaries must occur within "one working day" of the admission or of the individual's application for Medicaid coverage. We do not see an alternate timeframe for admission review proposed in federal regulations specific to psychiatric hospitals (42 CFR § 456.150 - 456.245). Consequently, we suggest that one working day should be the interval that a hospital has to submit clinical information for MHP review, and the subsequent interval an MHP has to review and make an authorization decision. Our understanding is that "business day" is typically defined in law to mean any day other than a Saturday, Sunday, or federal or state holiday. For clarity, we suggest DHCS avoid using "24 hours" unless 24 hours is specified in state or federal law (as it is in CA HSC § 1367.01(h)(3), which states that a health plan must notify treating providers within 24 hours of any modification, delay or denial of covered services authorized via concurrent review).

[4] 42 CFR § 456.170

[5] 42 CFR § 456.180

descriptions for each informational element, consistent with the multi-dimensional approach to documenting inpatient clinical indicators that had been discussed at length by the joint workgroup. We continue to recommend that *discharge planning information be added to the list of required components for continued stay communications*. The hospital and treating provider are already obligated to conduct discharge planning activities specified in California state law,[6] and these activities are reimbursed as part of hospitals' daily rates. The MHP has a clear interest in ensuring that beneficiaries experience appropriate transitions of care and typically partners with the hospital to support the discharge planning process and aid with problem resolution for particularly complex cases. CBHDA views discharge planning as an explicit mandate for hospitals that will frequently be implemented through bi-directional communication and collaboration with the MHP. We respectfully request that DHCS communicate this in any forthcoming guidance on concurrent review.

Beneficiary notifications and appeals

CBHDA has previously discussed several recommendations related to beneficiary notifications with DHCS staff and Aurrera consultants. We also provided some relevant feedback in our January 2021 mark-up of the continued stay request document. We would summarize our key recommendations as follows:

- **Beneficiary Notice of Action templates should include language to clarify that even if an inpatient stay is modified or denied, the Medi-Cal beneficiary is not responsible for any costs.** This recommendation for new NOA language may be out of scope for DHCS guidance that is specific to concurrent review requirements and procedures, but we wanted to promote this as a best practice for beneficiary informing.
- **California code that references the need for a treating provider to agree to a care plan before inpatient services are discontinued should be carefully interpreted in the context of concurrent review of psychiatric services.** DHCS, Aurrera, and CBHDA recently discussed implementation of the following language from California Health and Safety Code (emphasis added):
    - *. . . In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.*[7]

  CBHDA would suggest that this statutory language was almost certainly not drafted with an intent to establish specific expectations for implementing transitions from acute inpatient psychiatric days to administrative days. In context, this section of statute applies more broadly to managed care plan authorization of all Medi-Cal services, including concurrent review of all inpatient services. Further, we are unable to locate a more specific definition of "care plan" in the Health and Safety Code. CBHDA's interpretation is that this language was likely intended to prevent unplanned discharge – i.e., "discontinuation" of hospital care before a provider and beneficiary can engage in appropriate discharge or transition planning. In this context, "care plan" likely refers to a plan for discharge and transition of care, which hospitals are already obligated to develop per CA HSC § 1262 and 1262.5. We want to reiterate that in the case of a transition to Administrative days, the client does not face unplanned discharge or discontinuation of stabilizing services like medication. Consequently, we recommend that DHCS look carefully at how this language has been interpreted and operationalized elsewhere in Medi-Cal, for non-psychiatric, general acute hospital medical inpatient stays. We recommend DHCS decline to issue guidance that would establish additional procedural requirements for a transition to Administrative days, or guidance that would encourage hospitals to use this code section to justify requests that the MHP continue to pay an acute day rate after the client's clinical condition has stabilized and an acute day rate is no longer indicated.

[6] HSC § 1262 and 1262.5

[7] HSC § 1367.01(h)(3)

- **Clarify that the MHP has one working day to review an authorization request and make a determination, followed by an additional 24 hours to provide written notice to the treating provider.** MHP review, provider notification, and beneficiary notice are separate, sequential events that may occur over two consecutive 24 hour periods (or 2 business days, as described on p. 2 of this letter). Neither CA HSC § 1367.01(h)(3) nor DHCS Information Notice 19-026 appear to provide definitive timelines for hospitals to submit timely clinical information to MHPs, or for MHPs to complete review of hospital information. Instead, these authorities specify timelines for MHPs to notify treating providers and beneficiaries.[8] We recommend DHCS clarify all relevant timelines and citations in any subsequent guidance to MHPs and hospitals.
- **Identify options for hospitals or providers to appeal an MHP determination and clarify that formal or informal appeals from a provider are separate and distinct from the beneficiary's right to appeal.** In joint workgroup dialogue, we have heard some confusion about the distinction between provider and beneficiary appeal rights. MHPs are obligated to retain a physician for purposes of consultation and dispute resolution.[9] As a best practice, some MHPs have established an "informal appeal" process whereby a hospital may request a secondary physician review of an MHP's denial before the beneficiary receives a Notice of Action, but this approach is not required. Existing processes for SMH provider appeals are outlined in WIC 14684.1; DMH Letter 03-07; Title 9 CCR § 1850.315 and Title 9 CCR § 1850.320. Will the MHP provider appeal pathways included in Title 9 still apply to denial or modification of inpatient psychiatric benefits after concurrent review is implemented? If so, we recommend DHCS explicitly refer to these provider appeal options in guidance on concurrent review, and clearly distinguish between timelines and expectations for provider and beneficiary appeals.

Communication Best Practices

In general, best practices for communication between hospitals and MHPs during concurrent review include flexibility on the part of both partners, a focus on real time issue resolution, and collaborative, bi-directional conversations and information sharing about patient care needs and authorization and payment decisions. Several MHPs have been highly successful in implementing concurrent review practices with their local hospitals that exemplify these principles. As a result, only very rarely result do these MHPs experience sustained disagreement with a hospital over medical necessity. These MHPs, including but not limited to joint workgroup members from Los Angeles, Alameda, and Shasta counties, continue to be willing to share their strategies for effective implementation of concurrent review and to serve as resources to other CBHDA members, hospitals, and DHCS.

CBHDA's key recommendation for any guidance DHCS may choose to issue describing best practices for concurrent review communications is as follows:

- **Hospitals and MHPs may share clinical information required for concurrent review through any medium that is feasible for both partners, including telephone, secure transmission of electronic documents, remote review of electronic health records, or use of dedicated software tools.** The vast majority of MHPs will choose to offer phone-based review or, as necessary, request that documents containing standard clinical information be shared through a straightforward method like secure email. MHPs typically establish these mediums for communication in dialogue with their local hospitals, and often offer the hospital a choice among multiple procedures and modes of communication. For contracted hospitals, these expectations can be negotiated in contract terms. For non-contracted hospitals, MHPs typically provide a simple letter describing their concurrent review process and appropriate points of contact. This approach is working in many counties. Retaining some degree of flexibility is important so that both hospitals and MHPs may accommodate their ideal business practices and staffing patterns to the extent possible. The goal of any

[8] In addition, we find the language in HSC § 1367.01(h)(3) to be less than clear about the expected timeline for notifying the treating provider vs. the beneficiary when authorizations are conducted via concurrent review. As such, our January 2021 comments to DHCS also included a recommendation that when an MHP notifies the hospital/treating provider of a modification or denial within 24 hours of making a determination, they could also send the beneficiary's written notice in care of the hospital at that time.
[9] HSC § 1371.4(a)

forthcoming concurrent review guidance focused on communication best practices should be to improve efficiency and reduce variation. In the experience of MHPs that conduct concurrent review, it is not realistic nor desirable for either MHPs or hospitals to imagine that all variation in local processes can be eliminated.

We also note that several MHPs have developed useful informational materials for hospitals that could be adopted as templates by other MHPs and hospitals. For example, Los Angeles County MHP has a simple checklist that outlines where clinical information needed for MHP review is likely located in the clinical record, so that hospital staff other than the treating providers can help communicate information to MHP reviewers. Shasta County MHP, in partnership with its contractor Beacon Health Options, maintains a straightforward list of the informational elements that the MHP reviewer will request each time a hospital calls with an authorization request. CBHDA and counties are happy to provide further sample documents or other information about best practices that are working right now for counties and hospitals. We also expect that these types of implementation tools can be updated based on any additional guidance released by DHCS. MHPs remain open and interested in being active partners in developing statewide collaborative trainings, tools and implementation guides with DHCS and hospitals.

Additional requests and recommendations

In conclusion, we would like to highlight a few issues that CBHDA hopes to address in direct dialogue with DHCS:

- **Potential mechanisms for recoupment and enforcement if inpatient days are pre-authorized but medical necessity is never established:** Under existing and proposed DHCS guidance, an MHP may choose to pre-authorize multiple inpatient days. Alternately, the MHP may review clinical information and provide authorization every twenty-four hours for one day at a time. MHPs and hospitals agree that offering multi-day authorizations is more efficient for both partners and allows for the natural progression of patient care. As such, MHPs will likely continue to offer multi-day authorizations. But at present, there is little recourse for an MHP if it pre-authorizes multiple inpatient days and the hospital subsequently fails to share clinical information needed to establish medical necessity. We recognize that in the vast majority of cases, hospitals will communicate appropriately. But in those cases where this communication fails, the MHP currently has no viable way to retract payment authorization, recoup payment for unsubstantiated days,[10] or decline to utilize the services of that hospital. CBHDA would like to have a focused discussion with DHCS about potential future options for MHPs to establish mechanisms for recoupment, decline to contract with underperforming hospitals (despite contracting requirements currently outlined in 9 CCR § 1810.430), or perhaps refer a hospital for corrective action or oversight performed by DHCS.
- **DHCS audit and review practices:** During the joint workgroup process, DHCS has stated that the Department will abide by MHP determinations of medical necessity; DHCS will not establish audit practices that "second-guess" MHP decision-making and disallow payment for inpatient stays authorized by the MHP. CBHDA strongly supports this proposed approach. Fear of DHCS disallowances during MHP chart review, as well as disallowances experienced directly by public hospitals when they are audited by DHCS, have helped to produce existing, problematic practices of overly prescriptive documentation. CBHDA requests that DHCS issue guidance for MHPs that clarifies how documentation of inpatient medical necessity will (and will not) be reviewed by DHCS.
- **Changes to documentation requirements for administrative days:** As discussed with DHCS and Aurrera, CBHDA members and hospitals share a desire to simplify and streamline the documentation that is currently required to authorize payment for administrative days. Title 9 regulations lay out existing requirements,[11] so we assume these regulations would have to be revised before any substantive change can be implemented. Is DHCS in fact open to revising Title 9 to allow hospitals and MHPs to adopt new requirements for administrative day documentation? If so, CBHDA can provide an alternative proposal.

[10] Please note that due to the use of the TAR process and 3rd party fiscal intermediary, MHPs currently do not make direct payments to hospitals and this complicates efforts to establish recoupment procedures.

[11] 9 CCR § 1820.220 (i)(5)(b) and 9 CCR § 1820.230 (d)(2)(B)

During the joint workgroup process, several other topics were identified as “parking lot” items because they are not strictly related to procedures for concurrent review. DHCS has requested input on parking lot items that should be prioritized for further discussion. CBHDA believes the issues addressed in this letter overlap with some parking lot items. In near-term discussions with DHCS, we hope to prioritize the three topics directly above. In considering other parking lot issues, we agree that there is work that can be done related to county-of-responsibility, but we do not view this as necessitating sustained engagement between hospitals, MHPs, and DHCS. CBHDA reiterates that MHPs are committed to working collectively to develop consistent protocols for communication when a hospital seeks authorization from the county that appears in the MEDS database, but in fact the beneficiary resides in another county. We recognize that consistent practices among MHPs are needed to ensure hospitals can engage the appropriate MHP(s) for authorizations and for discharge planning. CBHDA also suggests that several parking lot topics do not need to be prioritized for further formal discussion between DHCS, counties and hospitals because they would be more appropriately addressed through dialogue between individual hospitals and MHPs. These include contracts, rates, and costs, including rates paid for administrative days.

CBHDA appreciates the time and effort that DHCS staff and Aurrera consultants have put into managing the joint workgroup process, and we thank you for the opportunity to provide this additional written feedback. As we have communicated to DHCS, we feel that the workgroup has provided valuable input to inform additional guidance on concurrent review. We hope DHCS will act to resolve outstanding policy questions in areas such as the appropriate application of federal utilization control regulations, and then use the workgroup’s recommendations to develop updated implementation guidance or perhaps even a toolkit for best practices. CBHDA is committed to continued conversation with DHCS and hospitals on concurrent review, and we are also happy to provide further written feedback at any point.

Thank you again for your time and your consideration of our comments.

Sincerely,

Paula Wilhelm
Director of Policy

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