Division of Public and Behavioral Health
Substance Abuse Prevention and Treatment Agency (SAPTA)
Subcommittee on Utilization Management

MINUTES
DATE: August 8, 2017
TIME: 9:00 a.m.
CONFERENCE: 888-363-4735, Access Code 3818294
NOTE: This is a teleconference only.

BOARD MEMBERS PRESENT
Mark Disselkoen, Chair
Tammra Pearce, Bristlecone
Lana Robards, New Frontier
Ester Quilici, Vitality Unlimited
Angela Mangum, WestCare
David Robeck, Bridge Counseling

BOARD MEMBERS ABSENT
Kendra Furlong, SAPTA

OTHERS PRESENT
Kathy Paxton, WestCare
Lea Cartwright, Nevada Psychiatric Association
Pauline Salla, Humboldt County Juvenile Services
Kim Moore, HELP of Southern Nevada
Allison Martinez, WestCare
Diaz Dixon, Step 2
Tammy Clark, Odyssey House
Christina Zidow, Odyssey House
Amanda Swenson, WestCare

SAPTA/STATE STAFF PRESENT
Raul Martinez
Joan Waldock

1. Welcome and Introductions:

Mr. Disselkoen opened the meeting and noted there was a quorum present.

2. Public Comment

Ms. Quilici asked that the minutes reflect the appreciation and thanks of the Subcommittee for Mr. Lovgren's contribution to this and other subcommittees and noted that they all wished him well.

3. Review Policies and Protocols Related to the Utilization Management Process and Make Recommendations to the SAPTA Advisory Board

Mr. Disselkoen presented a summary of the history of the subcommittee and of the utilization management (UM) process. He stated that the goal of this subcommittee was to create a residential treatment services utilization management process. The reasons for starting with residential services were many.

- There was a unique payment from SATPA related to residential services since Medicaid did not pay for them in most cases, although the institution for mental disease (IMD) rules provided some flexibility.
- There was an enhanced rate for residential treatment services through SAPTA that would use some sort of UM process.
- It was important, from an administrative perspective, that SAPTA was as consistent as possible with Medicaid and health maintenance organizations (HMOs) reimbursements.

He reported that this came down from the Substance Abuse and Mental Health Services Administration (SAMHSA) relating to management of block grant dollars. It was Mr. Disselkoen's understanding that the change was not due to mismanagement in the past, but reflected a desire to create a process that was parallel, but with more flexibility than what existed for Medicaid or HMOs.

Mr. Disselkoen stated that many people worked on the policy with him, including DuAne Young and Kendra Furlong. He also received feedback from Kyle Devine and Dr. Stephanie Woodard. The process was put together, trainings were done, and attempts were made to present it to the SAPTA Advisory Board. The Subcommittee was created because there were enough questions and concerns from the provider/public pool that it was time to come to a consensus on the policy to be able to move forward. He stated he would only be able to give a status report regarding the UM process to the Board at the next meeting. He expected there would be questions that needed to be answered before this group could come up with firm recommendations to improve the policy.

He pointed out that the policy mentioned a "utilization manager." He explained that may not be the right title for him as he worked with Ms. Furlong and Dr. Woodard. He stated it was less a position and more of an activity that oversaw the process, providing quality assurance. Another concern he mentioned was that many did not feel the World Health Organization Disability Assessment Schedule (WHODAS) 2.0 assessment was necessary. He stated that he and Ms. Furlong agreed that the assessment was probably overkill when looking at what agencies do currently with Medicaid and HMOs, adding another layer of bureaucracy. Another concern he mentioned was the 14 days for initial approval for residential treatment according to American Society of Addiction Medicine (ASAM) 3.5. He pointed out that he and Ms. Furlong agreed that should be 21 days, up to 14 days for ASAM 3.1, and up to 7 for 3.5. He noted that when they were discussing how many days should be allowed in the initial approval, they decided on 7 and 14 because that was somewhat consistent with data from the past, but added that would be a burden for providers and for SAPTA. He looked at statistics from the National

Health Information Center (NHIC) to back up his information to support the change to 21 days as average length of stay. He recommended that they increase the days for initial approval.

He stated there had been a concern that documentation submission for services and approvals would not receive a definitive "here and now" approval. He commented that typically, one talked with a live person, gave the needed information, and received approval. One reason the live person phone approval was not part of this policy was because it would be very costly to carry out. He mentioned that the state of Idaho hired an HMO to manage all its block grant dollars, but the percentage of dollars going to administer that was significant.

A concern expressed previously by Mr. Lovgren was that "SAPTA client" be clarified. Mr. Disselkoen reported that Mr. Devine took care of that in a way that Mr. Lovgren found very helpful. The final concern referred to Mr. Disselkoen regarded the appeals process for a claim that was denied. He explained that the first step would be a peer-to-peer review completed by another residential facility, which would be more equitable to providers than having someone from SAPTA or the Division make the determination. He added that if the peer-to-peer review did not bring about a determination the provider was pleased with, the review would go to the administrative level to be reviewed by the physician from the Division. He commented that it was hoped that the peer-to-peer review would resolve any concerns. Mr. Disselkoen mentioned that this is a pilot program that would be monitored for kinks and that they would develop methods of working those kinks out. He supposed that the initial review approval would be standard, using the basic information—the Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5) diagnosis, the severity must be significant enough for residential services (3.5, for example), that must be congruent with the ASAM level of service recommendation using the criteria. He noted that Mr. Lovgren had suggested they use the ASAM for utilization management, but the policy he provided appeared to be more complicated than the process Mr. Disselkoen's team put together. There appeared to be things ASAM required that the Nevada did not. He opened the meeting to subcommittee members' comments, questions, and concerns, noting that coming up with recommendations that would be voted on would be unrealistic for the SAPTA Advisory Board on August 9.

Ms. Quilici stated that agencies needed to have their requests answered within the time frames every time. She asked what they are to do when SAPTA people have furloughs, are out sick, are on vacation, or forget to follow through and an agency needed an answer. She said that with detoxification (detox), residential treatment, transitional, and targeted case management, people could be into utilization management up to four times. Mr. Disselkoen replied that the concern about response time based on real variables was something that needed to be taken up at the SAPTA Advisory Board meeting. He stated that there needed to be a way to manage that to ensure quick turnaround and that the Subcommittee needed clarification on how that would be accomplished. Ms. Quilici asked if this was a policy or a process. Mr. Disselkoen replied that it was a policy, and that policies do not have to be approved by the SAPTA Advisory Board, but that they should receive input from the field from those it impacts—members of the board and the Subcommittee.

Ms. Quilici brought up Nevada Administrative Code (NAC) 439.345 that is a policy regarding disciplinary actions. She asserted that it applied and that Mr. Disselkoen had said he was going to consider it. He referred to the draft policy which can be found here, noting there was an incongruence that needed to be checked. She expressed surprise at statements in the policy, such as " . . . most cases are resolved at this level." She wondered how that was known. Mr. Disselkoen stated that was the goal—to resolve differences at the lower level so that appeals did not have to go through a long bureaucratic process. He added that, historically, the percentage of approved services for an individual versus the number of appeals in the managed care system was a low percentage overall.

Ms. Quilici asked if "peer-to-peer" would be defined. Mr. Disselkoen noted he would clarify the term as referring to another certified residential treatment program in the system. Ms. Quilici referred to the section on auditing file protocol and asked what "outside of the traditional monitoring period" meant since SAPTA already had access to the visual health records (VHRs) and could effectively audit at any time. Mr. Disselkoen explained that a contract monitor focused on meeting the requirements of 45 Code of Federal Regulations (CFR) in a block grant, contract requirements, grant assurances, scope of work, and budget information requiring annual audits, which have been completed from a desk. In the future, the audits would be more traditional, with a monitor visiting sites annually. He mentioned that a monitor would be different than certification, which focused on NAC 458. He added that some of that information was reviewed as time went on, but when the monitor was done, a report would be generated that would help the provider from a quality assurance standpoint. He further added that every type of third-party payer or HMO had some sort of auditing process they used periodically. He explained this audit would be used as needed, if there were a concern about over utilization, for instance. He agreed it needed to be more clearly defined.

Ms. Quilici expressed concern about the definition of "medical necessity" and ASAM levels of care required for agencies that have already been vetted by managed care organizations (MCOs), fee-for-service, and SAPTA for levels of care. She said the policy stated those agencies needed to be regulated, yet they already were regulated. She also stated the agencies needed different criteria for MCOs and fee-for-service, as those are all over the map—some vetted an agency and then trusted that if the agency said the admission complied, they allowed the admission. She understood Mr. Disselkoen to have said that this policy was included to meet Medicaid guidelines, but there were a lot of guidelines agencies tried to meet. She asked if there had been some mismanagement by others that resulted in agencies being managed so rigorously with admissions when they already used ASAM, DSM, and indicated severity. She also asked, if agencies used those standard, why they were being managed again for the days. Mr. Disselkoen replied that since Medicaid, MCOs, and fee-for-services did not pay for residential services, SAPTA would be paying for a level of service not covered. SAPTA would be looking at intensity and length of stay for the residential piece of it. He gave the example that just because Medicaid would pay for 2.1 for 6 weeks did not mean that the individual needed to be in a bed for 6 weeks. He pointed out that Medicaid would continue to pay the 2.1 after the person was discharged out of residential care. He added that part of the enhanced residential rate required some sort of utilization management process to guide it. Ms. Quilici argued that the requirements needed to be met whether individuals were admitted at 2.1, 3.1, 3.2, or 3.5. Mr. Disselkoen explained that ASAM had different admission criteria for 2.1 than it did for 3.5, so there was some distinction based on level of service, intensity, and length of stay. Ms. Quilici countered that applying the regulations and requirements was the same. Mr. Disselkoen agreed that he needed to provide a better reason for why there were doing that. He directed the Subcommittee's attention back to NAC 458, which set certification as the minimum standard for receiving state or federal funding.

Ms. Robards verified that the utilization process became utilization policy, that targeted case management would only continue to be established for pilot program participants, and that they were going to remove the WHODAS. She asked if they should remove outpatient services from the policy until SAPTA decided to include outpatient services in utilization management if the Subcommittee decided to recommend the policy. Mr. Disselkoen stated that because of the volume of outpatient care, there would need to be an enhanced process for those services, so he would recommend that. Ms. Robards pointed out that all their discussions had revolved around level 3 and transitional services, with nothing devoted to outpatient services. She added that every month each agency had done its requests for reimbursement (RFRs), each client identified by a unique identification number was processed through the SAPTA reimbursement system, and that each day or unit of service billed to SAPTA under the Substance Abuse Prevention and Treatment Block Grant (SABG) money was being tracked. She recommended that, rather than have something that would overburden residential providers and

SAPTA, if there were individual files that could trigger a red flag, then SAPTA could go to providers to find out what had triggered the alert. She mentioned that agencies were required to reevaluate individuals in residential programs every 14 days. Mr. Disselkoen said he would check to see if there are current mechanisms in place that do that. Ms. Robards pointed out that the agencies have provided these services, have gotten monitors, could have a desktop review, and that SAPTA could pull any file they wanted.

Ms. Pearce stated she was concerned about getting approval for admissions as many clients came in who qualified under the emergency level of care. She said the policy stated that SAPTA needed to be notified by email within 24 hours of admission. She offered a hypothetical situation—if a client came in on Friday, the assessment indicated it was an emergency, and they tried to get ahold of SAPTA but did not reach anyone, the next clause in the policy states a retroactive review would be conducted by the second business day following the weekend. She pointed out that a lot of money for care between Friday admission and SAPTA approval on Tuesday could be lost and that with Medicaid and insurance companies in general, every penny counted, expressing concern about the loss of that kind of money. Her other concern regarded patients whose insurance covered residential treatment but with exorbitant deductibles. She asked if SAPTA would pay those deductibles, or if their position would be that the patients were responsible for the deductibles, resulting in a huge barrier to treatment. Mr. Disselkoen replied that he advocated for SAPTA to make sure that services were paid for. He stated he would get a clear answer from SAPTA on that. Regarding her question about emergency admissions, he replied that 99.9 percent of the time the days would be paid on an appropriate admission. He commented they would strengthen the policy to ease her concerns. Ms. Pearce pointed out that if Bristlecone submitted RFRs that were constantly being denied, there would be a need for serious concerns, but if RFRs were approved on a regular basis, she did not understand the need for audit.

Ms. Mangum stated that Ms. Furlong mentioned that once there was a process in place that everybody semi-agreed on, they would roll it out one treatment level at a time. She wondered if that was accurate. Mr. Disselkoen replied that he would have to verify that it would be added one treatment level at a time. He said that he saw the benefit to adding one level at a time, rather than inundating the system with three levels. Ms. Mangum also asked how the authorization process would connect to the current RFR process. She wondered if there would be a prior authorization number required under the RFR under each level of treatment. Mr. Disselkoen replied that he would find out for her.

Ms. Martinez commented that some of the risk levels for withdrawal management were more for a 3 or 4 risk level. She stated her concern that some of the drug users of stimulants might not reach those levels even while having difficulties with withdrawal. Mr. Disselkoen replied that risk level for withdrawal would be based on ASAM, and that SAPTA would fall back on ASAM and how agencies documented that. He reiterated that ASAM was the UM tool they would use to determine level of care, intensity, and length of stay. Ms. Martinez mentioned that she had hoped for help with the language. She stated she had not rated anyone coming off methamphetamines or cocaine that high, but those levels she saw more in people withdrawing from alcohol or opiates. She asked if certain stimulants users would not need the higher level of care. Mr. Disselkoen reminded the Subcommittee that ASAM was not a mathematical equation and that two plus two did not always equal four, sometimes it equaled three or five. Stimulant users could have moderate severity, dimensions one through five, but if they had poor living environments under dimension six, an agency could justify residential treatment based on just that. He reiterated that it was important to use ASAM as a guiding principle, not as an exact way to determine level of service. He expressed concern since ASAM created an electronic version that can determine level of service based upon the information inputted as he did not think human behavior was that black and white. He pointed out that 9.9 times out of 10, if an agency documented and justified why they chose a level of service, it would not be denied, explaining that medical necessity was UM criteria justifying that the individual met the criteria for a particular level of service. He stated

the Subcommittee would need to meet again and that he would send out the list, in draft form, of recommendations discussed at this meeting that can be further discussed.

Ms. Quilici said she would like to see vague language in the policy defined. As an example, she referred to the statement that agencies were required to submit a synopsis of clinical information for policy requirements. She asked if that meant the two page form they received (found here). He replied that was the synopsis the policy referred to. She pointed out that the policy should then state, "prior authorization form." Mr. Disselkoen explained that Medicaid requested a treatment plan, but he wanted to focus on admission and continued service, letting that speak for itself.

Mr. Robeck stated that there were co-pays of 40 or 60 percent on some of the lower-end insurance plans that should be considered. Mr. Disselkoen replied that he added that to the list of things to get further information about.

4. Public Comment

There was none.

5. Adjourn

The meeting was adjourned at 10:00 a.m.