

### Shared Values and Goals

- ❖ We see each client and their situation as unique and believe the best care involves individualized discharge planning and a flexible, collaborative approach
- ❖ We work to identify and minimize barriers to discharge from acute care
- ❖ We support efficient processes for hospital Utilization Review (UR) staff
- ❖ We work toward consistency within and across Behavioral Health Systems of care
- ❖ We collaboratively manage the system of care and help clients to the least restrictive setting as soon as they are ready
- ❖ We engage and activate community resources/ providers
- ❖ Behavioral Health Plan (BHP) Utilization Management (UM) staff integrate UM and Care Coordination functions and incorporate discharge planning
- ❖ We work to ensure each client has a mental health follow up appointment within 7 days

### All Admission Criteria Must be Met per the Health Share Pathways Regional Practice Guidelines

- Client must have or be suspected of having a covered primary mental health disorder covered by the Oregon Health Plan that is the cause of the signs and symptoms that make consideration of hospitalization necessary
- The client must be medically stable and medical causes have been ruled out as the source of the mental or behavioral symptoms
- Less restrictive levels of care must have been explored, including increasing the intensity of outpatient treatment, and demonstrated to be less likely to be effective, more intrusive, unavailable or too dangerous
- Admission cannot be strictly for the purpose of temporary housing or due to homelessness
- For individuals presenting with intoxication due to alcohol, sobering must occur and the individual must be **re-assessed\*** prior to approval for an inpatient stay.
- For other substances, if the individual meets the criteria for “a clear and reasonable inference of danger to self or others”, admission will be approved. \*\*

\* Re-assessment is considered complete when adequate time has lapsed from when the individual arrived intoxicated to the ED and verified by a UA, BAL or self-report and the clinical presentation remains the same after the individual is considered sober in the clinical judgment of medical personnel. A 2<sup>nd</sup> UA or BAL is not required by the BHP UM staff.

\*\* Criteria related to individuals presenting with Co-occurring symptoms

### At least one of the following is present:

- A clear and reasonable inference of danger to self or others\*\*
- Dangerous assaultive or other uncontrolled behavior, including extensive damage to property, not due to substance abuse

- Inability to provide for basic needs, safety and welfare
- Acute deterioration in mental health functioning causing exacerbation of other medical conditions
- The need for regulation of psychotropic medication that cannot be safely done without 24-medical supervision

**Notification and Pre-authorization Procedures**

The **requirement** for Preauthorization for inpatient admission is also seen as an opportunity to mobilize community resources and look at a least restrictive, clinically appropriate environment for Health Share members. Notification of admission to hospital does not constitute prior authorization and payment approval.

**1. Preauthorization Process**

Before a patient is admitted, Hospital staff contact the assigned Health Share Behavioral Health Plan and provide current, legible clinical information in written format (typed, printed, etc.)

- When written clinical is not available, BHP’s may accept verbal clinical depending on the thoroughness or quality of the information presented. BHP's will verify with the hospital that the information is documented in the patient’s hospital record by receiving a copy of the documentation, before end of business day, either by fax, secure email or direct electronic health record access (e.g. Epic). Verbal review is considered provisional and written documentation should be submitted to support the verbal report.

The following grid identifies contact information for each Behavioral Health Plan.

	Clackamas County	Multnomah County	Washington County
Preauthorization – Business Hours	Phone:503-742-5331; Fax:503-742-5335  BHP UM staff are available M-F 8a–5p; follow-up within two hours of receiving the information to conduct UR if no one is available at the time of contact.	Member Services 503-988-5887  Available 24 hours per day, 7 days a week	Washington County Member Services at 503-291-1155 to request preauthorization. Clinical review will be provided. Available 24 hours per day, 7 days per week.

Preauthorization – After Hours	Phone: 503-742-5331; Fax: 503-742-5335  After hours, weekends, and holidays: Notification by phone and fax of clinical information required.  BHP UM staff follow up the next business day.	Member Services 503-988-5887  Available 24 hours per day, 7 days a week	Washington County Member Services at 503-291-1155 to request preauthorization. Clinical review will be provided. Available 24 hours per day, 7 days per week.
Continued Stay Contacts	Phone: 503-742-5331; Fax: 503-742-5355 Monday through Friday	Member Services 503-988-5887 Monday through Friday	Adults and Children: P: 503-846-3168 F: 503-846-3147

**2. Eligibility is not determined until after admission**

Once the hospital determines an admitted client is a Health Share member, they contact the appropriate BHP for authorization. If client is still on the unit, BHP UM staff will confirm eligibility and review clinical for approval on that same day. If approved, authorization will be retroactive to the day of admission. If client has already discharged, BHP UM staff will make a determination within 10 business day after receiving the clinical documentation.

**3. Delayed Admission**

When authorization has been given but the member has not been admitted within 8 hours of the determination, an ED psychiatric reassessment or update should be provided in clinical note form and signed by a hospital staff member such as MD, Psych Nurse Practitioner or other licensed mental health professional employed in that capacity. If more than 8 hours has transpired past the authorization determination without any reassessment given to BH UM, then the authorization is null and void and a new request will need to be submitted.

**4. Incorrect enrollment at time of admission**

In situations where a member is incorrectly enrolled in a BHP at the time of the inpatient admission hospitals will need to work with multiple Behavioral Health Plan partners for UM and Coordination of Care. Per the state enrollment rule, enrollment changes cannot be made during the inpatient stay, therefore the assigned BHP will be responsible for the UR and payment during the stay. The assigned BHP will notify the receiving BHP who will be responsible for discharging planning including determination of appropriate levels of care.

The hospital will be responsible for assisting the member in contacting Health Share of Oregon to request reassignment to home BHP, which facilitates appropriate discharge planning. Also, the assigned BHP will be responsible for submitting an HSO-Enrollment Change Form and will include the receiving BHP in the email request to Health Share of Oregon.

#### 5. Administrative Denials Process and Timelines

Pre-authorization is **required** by all three Behavioral Health Plans for mental health inpatient admission. A Notice of Denial of Payment may be issued if no pre-authorization is obtained, and the day(s) leading up to the admit notification from the hospital to the BHP are not paid. Exception to this process: Out of Area Hospitals with an address that is outside a 50 mile radius from the Portland Metropolitan area.

#### 6. MD to MD communication on admission and continued stay criteria

##### Qualifications for a MD to MD Consult

##### All Must Apply:

- The member is still admitted to the acute care unit
- The member is not set to discharge the day of the MD to MD request.
- If a complete request is received before the member discharges, then the MD to MD determination is completed.
- The denial determination was based on medical necessity and is not an administrative denial.
- New clinical information is provided in writing.
- The new clinical information was received within one business day from the time of verbal denial notification.

##### MD to MD Process:

- BHP UM Staff make Utilization Management decision per Regional UM Protocol
- For Denial of Admission or Continued Stay criteria, the hospital UR is notified verbally, and a Notice of Denial of Payment is faxed to the hospital. If the attending MD at the hospital disagrees with the decision, the hospital can submit new information in writing, in which to support admission or continued stay. This can include an updated progress note, email or some other means of written communication as deemed appropriate by the hospital. The hospital has one business day to submit new information once they receive verbal notification of the denial from the BHP.
- The BHP MD reviews information within two business days of receipt

- If the BHP MD overturns the denial, the BHP UM staff will notify the hospital, the BHP MD will provide a written response and the authorization will be updated to reflect the change in decision.
- In the event that the BHP MD overturns a denial, authorized days will include the day of original denial through the date of BHP decision to overturn. This process does not take place of the Appeal process but allows for an attending MD to present information about a complicated case while under her/his care

#### Declined MD to MD Consults:

- If the request does not meet the above criteria or the BHP Staff determines the request does not demonstrate a good faith effort due to no new clinical information or lack of acuity demonstrated in the received clinical information, the request may be declined for processing. The BHP UM staff will notify the requester verbally that the MD to MD request has been declined and that the Appeals process can be followed.

#### Criteria for Continued Stay:

Despite reasonable therapeutic efforts, clinical evidence indicates at least *two* of the following:

- The persistence of problems that resulted in the admission to a degree that continues to meet admission criteria.
- The emergence of additional problems that meet admission criteria.
- A severe reaction to medication or the need for further monitoring and adjustment of dosage that requires 24 hour medical supervision.
- Daily progress notes document that the client's mental health problem(s) are responding to or are likely to respond to the current treatment plan.
- Evidence of active discharge planning in collaboration with UR coordinator and BHP UM staff.
- Evidence of active treatment including modification of treatment plan where progress is limited.
- No less restrictive level of care that would meet the client's and public's need for safety is accessible.
- The client's continued care is not for the primary purpose of temporary housing or due to homelessness.

#### UM/ Continued Stay Review Procedures

1. Hospital UR will fax updated clinical information in legible written format to BHP UR unless BHP UR has access to Epic.
2. Once clinical information has been received and reviewed, BHP UM staff will contact hospital UR staff via phone. If no additional information is needed, the BHP UM staff will determine the number of days for authorization of continued stay and the date of the next review. The number of days between clinical reviews will be individualized based on the situation.
3. BHP UM staff will take responsibility for communicating with hospital UR staff regarding authorization for continued stay and communicating with hospital social worker for discharge planning as appropriate. The hospital UR staff is responsible for providing clinical on the day of review.

### Medical Unit Transfers

When a client transfers to a medical care unit and remains there past midnight, it is the responsibility of the hospital to notify the appropriate BHP UM staff. It is considered that the patient is receiving their primary treatment on a medical unit at that point and the approved authorization for psychiatric inpatient episode of care will be ended as of midnight.

Should the client need to return to psychiatric acute care following the medical stay, prior authorization will need to be reobtained.

When a client transfers to a medical service and returns to psychiatric acute care within the same business day, the authorization is not ended and a prior authorization is not required before continuing the current psychiatric episode of care.

### Referrals to Long Term Care (LTC) - Adults

When county staff determines that an individual is appropriate for LTC, the hospital staff will submit a referral packet within three business days of notification. For Medicaid clients, if approved for LTC, the state picks up payment for acute care from the date they received the referral.

#### **Determination for Admission to LTC per OAR 309-091-0000:**

State hospital level of care is determined appropriate when the individual's condition or symptoms have not improved in an acute care setting despite having received

comprehensive psychiatric and medical assessment, treatment and/or community services typical for a psychiatric illness or psychiatric emergency.

**Prior to referral for admission to a state hospital, the individual should have received:**

- a. A comprehensive medical assessment to identify conditions that may be causing, contributing to, or exacerbating the mental illness;
- b. Services from an appropriate medical professional for the treatment and stabilization of any medical or surgical conditions that may be contributing to or exacerbating the mental illness and
- c. Treatment in an acute setting within the parameters of the most recent version of the American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders.

**In addition there must be evidence of additional treatment and services having been attempted, including:**

- a. Use of evidence-based or promising psychosocial interventions which were delivered in relevant, culturally-competent, strength-based, person-centered and trauma-informed manners, which adequately treated the assessed and/or expressed needs of the individual. When requested by the individual, treatments should include members of the individual's family, support network and /or peers;
- b. Documentation of ongoing review and discussion of options for discharge to non hospital levels of care and
- c. Documentation of services and supports attempted by the responsible party to divert admission and establish treatment and recovery in a non-hospital setting.

**Exclusion Criteria and Exceptions:**

State hospitals are intended to provide recovery-oriented intervention for individuals experiencing symptoms related to a severe, persistent and disabling mental illness.

**Admissions must not be based upon a primary diagnosis of the following related conditions:**

- a. An acute or existing medical or surgical condition which requires primary placement in a medical setting and which cannot be safely or adequately treated within a state hospital facility;
- b. Delirium;
- c. Pervasive Developmental Disorder;
- d. Intellectual Developmental Disorder;
- e. Substance Use or Substance Abuse Disorder or
- f. Personality Disorder

### Holds and 14 Day Diversions:

Involuntary Commitment Program (ICP) staff have different roles than BHP UM staff with regard to assessing clients for continued stay.

- The role of the ICP staff is to determine whether the clients meets the legal criteria for dangerousness and makes a recommendation for a hearing or not.
- The role of the BHP UM staff is to conduct utilization review based on medical necessity criteria, regardless of the ICP determination.
- Payment by Health Share is not guaranteed when the BHP UR staff determines the client does not meet medically necessity but the ICP staff is recommending a hearing.
  - BHP UM staff do work closely with ICP staff and make every effort to coordinate and communicate continued stay and discharge planning. ICP staff will communicate with BHP UM staff when they are no longer recommending a hearing or a hold is dropped.

### Coordination and Discharge Planning

1. BHP UM staff will determine whether the client is connected to a community mental health provider. If they are connected to a provider, BHP UM staff will notify the provider on the 1<sup>st</sup> business day after admission. This will be done via secure email to a pre-established contact for each program. The emailed form will include the following information:
  - a. Client name
  - b. Medicaid ID
  - c. Date of Admit
  - d. Hospital contact information
  - e. Admission reason
2. BHP UM Staff will inform the Hospital of any existing community mental health provider to which the client is connected.
3. Community mental health providers are expected to make contact with the hospital social worker within one business day following notification. The hospital social worker should contact community mental health provider directly if they do not hear from them by the end of the first business day.
4. When UM staff finds that an adult client is not connected to a provider they will refer to ITT on the 1<sup>st</sup> business day following admission. ITT will contact the inpatient unit in every case to assess the need for intervention.
5. UM staff will oversee care coordination and discharge planning. UM staff will ensure that the following occur, though the person responsible may include others such as providers, hospital social workers or other system case managers:

- a. The community mental health provider has been notified and has contacted the hospital or client.
  - b. The client is in the right level of care, and if not, is referred to the recommended level.
  - c. If no provider, ITT has made contact with hospital and client.
  - d. Barriers to discharge are examined and collaboratively addressed.
  - e. If client is affiliated with a provider the next appointment has been scheduled within 7 days of anticipated discharge.
  - f. A psychiatric services appointment is scheduled AND there is a plan to ensure adequate medication supply until the appointment.
6. When Choice Model or Wraparound Care Coordinators are involved, they may take the lead in discharge planning and coordination with the hospital social worker. It is the expectation that community providers are also engaged throughout the stay and involved in the discharge plan for enrolled clients.
  7. When a member presents with a co-occurring condition (mental health and Substance use), the UM staff will coordinate with the County A&D Coordinator to identify necessary treatment and resources for the substance use disorder.
  8. Care Conferences/Multi-disciplinary team meetings should be held in any of the following scenarios when deemed appropriate in order to better coordinate discharge planning:
    - a. Discharge placement is not identified
    - b. There is disagreement among the clinical team about the course of care
    - c. Greater than three admits in the last 6 months
    - d. Disagreement about discharge planning with guardian(s) or treatment provider
    - e. Other systems are involved such as DD, Child Welfare, etc.

The UM staff and hospital staff will coordinate scheduling and invitations for care conferences. This should be done as soon as one of the above issues are identified and should allow for team members to participate in person or via telephone. Participants may include but are not limited to: client, family, inpatient LMP, outpatient LMP, outpatient mental health provider, guardian, DD case manager, child welfare case worker, Choice Model or WRAP Facilitator, UM staff, hospital social worker.

### Discharge Procedures

Hospitals will inform BHP UM of planned discharge date during concurrent review, and will notify of actual discharge date same business day as the discharge.

At point of discharge, no later than next business day, and in line with meeting the 7 day follow up appointment requirement, BHP UM staff will *ensure* that a secure email is sent to the outpatient provider with the following information:

- a. Client Name, Medicaid ID, and Date of Discharge
- b. Discharge Medications and dosages, any pertinent available lab results and recommended level of care at discharge should be obtained by current provider or be receiving provider and sent by the discharging hospital *A full discharge summary summarizing hospital course and treatment recommendations should be made available to the community mental health provider within 7 days of discharge from the hospital.*
- c. Please note, even for a member with a denied payment or dual coverage, the BHP is still responsible for the 7 day post hospital follow up appointment. As a result, the hospital will notify the UM staff of the member's discharge regardless of payment status.

### Institution for Mental Diseases (IMDs)

Health Share will abide by, and authorize according to OAR rules for IMDs as noted in OAR 410-141-3160.

#### **OAR 410-141-3160**

##### **Integration and Care Coordination**

(21) A CCO may cover and reimburse inpatient psychiatric services, but not including substance use disorder treatment, at an Institution for Mental Diseases (IMD), as defined in 42 CFR 435.1010. (See OAR 410-141-3000 for the definition of an IMD.) The state may make a monthly capitation payment to a CCO using Medicaid capitated funds for inpatient psychiatric services for an alternative service or setting, incorporating all the following requirements as defined in 42 CFR 438.6(e):

- (a) For members aged 21-64;
- (b) As inpatient psychiatric services for a short-term stay of no more than 15 days during the period of the monthly capitation payment;
- (c) The provision of inpatient psychiatric services in an IMD shall meet the requirements for in lieu of services as defined in 42 CFR 438.6(e)(2)(i) through (iii):
  - (A) The alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the state plan;
  - (B) The CCO must offer the option to access the state plan services and may not require a member to use the IMD as an alternative service or setting;
  - (C) The approved in lieu of services are authorized and identified in the CCO contract and may be offered to members at the CCO's option.