Policy and Design Workgroup
Meeting Synopsis – 051723a
May 8, 2023

A. Outstanding Action Items

1. Future changes to SERI Coding and Crisis Facilities

   How will commercial carriers be informed on an ongoing basis, about billing changes related to Behavioral Health Crisis Services; e.g., SERI changes, changes in list of Crisis Facilities, etc.?

   Decision:

   Commercial Carriers will sign up for HCA's list service pertaining to SERI changes. SERI changes will include any/all changes to the BH Codes for Crisis Services spreadsheet.

   - ***Teresa will*** provide a link to this list serve
   - ***Bill and Teresa will*** determine how best to indicate on the BH Codes for Crisis Services spreadsheet the relevant date of last change for a service, i.e., so that a carrier can refer to the appropriate version of the SERI document.

B. New Considerations

1. Brainstorming: Moving Forward with Commercial Coverage for Mobile Crisis Response

   Background: Emergent Findings

   a. Fee-for-Service Billing & Reimbursement

      i. For 3 BH-ASOs, 837P and 835 processing is ***within reach*** of current IT & Operations capabilities

         3 BH-ASOs (11 counties – 57% pop.) have IT systems and operational processes that can / could support 837P-claims as the service reporting and billing method and 835s as the method to process Remittance Advice. 2 of these BH-ASOs anticipate that the timeframe of January 1, 2024 may be too aggressive to have these capabilities in place. King County would like to maintain momentum and implement as soon as possible, with a continued goal of January 1, 2024.

      ii. For 5 BH-ASOs, 837P and 835 processing is ***outside of*** current IT & Operations capabilities

5 BH-ASOs (28 counties – 43% pop.) have IT systems and operational processes that either can't support 837P & 835 processing or would need resources to make the necessary enhancements.

There does not appear to be a business case for investing resources and time to increase system capacity to support fee-for-service billing and remittance advice processing.

- The number of anticipated commercial carrier members receiving Mobile Crisis Services, and the associate revenue, is not likely to cover the costs of IT system and operations upgrades.
- There is uncertainty / concern about whether General Fund dollars can be used to make investments in IT systems and processes in order to support fee-for-service billing with commercial carriers.

b. Eligibility-Benefits Determination Technology Solution Alternatives

i. 4 possible technology solution alternatives were identified in the Technology Workgroup. Compelling reasons were made for eliminating 2 of them.

ii. For one of the remaining alternatives "IT System and Workflow upgrades", resources would be required to upgrade BH-ASO / Agency IT systems to exchange 270-271 Eligibility transactions and to enhance staffing for new automated and manual eligibility determination workflows. There is concern that the amount of commercial reimbursement will not cover the cost of the resources.

iii. The other remaining alternative, "Centralized clearinghouse", calls for a centralized "application(s)" that likely will not be available until late 2024 at the earliest and there will be significant costs to build/deploy and maintain.

Concept: Providers & BH-ASOs would interact with a "central application portal" that will send their query to all carriers. Each carrier will reply to the query and the "central application portal" will compile all results and present them to the submitter.

Issues/concerns that were raised and still need to be addressed before this solution approach is discarded, refined or recommended are:

- ***Key Design Questions***:
  - Is a master patient index required?
  - Will there a common interface standard be used / updated in lockstep by all carriers or will the central service build/maintain and interface with each carrier?
- ***Solution Vendor***: Is there a vendor that has already implemented the required capabilities or do some/all of the capabilities need to be built/assembled?
- ***Timeframe and Costs***: Earliest implementation timeframe likely 12-18 months. Cost to build/deploy are guess-estimated between $500,000 - $1,500,000 if capabilities have to be built assembled. Annual operating costs

are guess-estimated to be in the same ballpark. These do not include time/cost for commercial carriers to implement and maintain on their side.

- ***Funding***: Who/how will fund the centralized application build, deploy/ support?
- ***Precedent***: Will building a custom solution for this business scenario set a precedent for creating a custom solution for other business scenarios?
- ***Bottom Line***: Will the value provided by this solution approach outweigh the costs of building and operating it?

Discussion:

a. The Emergent Findings, outlined above, were discussed and clarified, with ***Precedent*** and ***Bottom Line*** added to the Technology Solution Approach Findings.

b. Fee-for-Service Billing

i. There was consensus that a phased approach for implementing fee-for-service billing across the BH-ASO regions would be viable, depending upon:

- Network Access requirements (AADR) that will need to be met by commercial carriers in counties were implementation is delayed beyond January 1, 2024.

  Action Item: OIC

- The availability of an acceptable technology solution for determining eligibility and benefits. BH-ASOs will be asked to confirmed whether or not they can implement fee-for-service billing with the current capabilities for determining eligibility and benefits.

  Action Item: BH-ASOs

ii. For BH-ASOs with a system that needs to be enhanced/upgraded in order to do Fee-for-Service billing, can General Fund dollars be used by BH-ASOs to expand the capabilities of their systems and processes to fee-for-service bill the commercial carriers.

Action Item: HCA

iii. Can BH-ASOs use non-Medicaid funding to cover member cost share that is not paid by the commercial carriers, regardless of income?

Action Item: HCA

c. Eligibility-Benefits Determination Technology Solution Alternative

i. IT System and Workflow upgrades

Action Item: Bill will talk with BH-ASOs to better understand their current System and Workflow Capabilities

ii. The "Centralized Clearinghouse" alternative is likely to be fundamentally different than existing clearinghouses. Where most clearinghouses target a request/information to a specific commercial carrier, this approach calls for the request to be sent to all commercial carriers.

Given the varied definitions and understandings of clearinghouses across the healthcare community, a set of questions will be sent to providers and BH-ASOs to understand if/how they use clearinghouses.

Action Item: Bill & Stephanie will get a better sense of what clearinghouse offer.

Some/not all clearinghouses send eligibility requests to commercial carriers. With only a few exceptions, these requests are targeted at a single carrier specified by the submitter. It appears that a few clearinghouses may have the capability to send a request to multiple health plan ("scattershot") but this is prohibitively expensive to be done as a standard practice.

iii. From commercial carrier's perspective, the current infrastructure for eligibility-benefit's determination appears to work for medical and behavioral health providers. From the community behavioral health system (Mobile Crisis Response) perspective, the business/operations needs of the agency providers are different than private sector behavioral health provider, and the current infrastructure does not satisfy their needs. (i.e., the workflow of private sector behavioral health providers is fundamentally different than the workflow of a BH-ASO's network of agencies/providers.)

iv. Currently the eligibility-benefits determination technology requirements to support HB1688 and the technology requirements to support HB1477 are being evaluated in two separate processes. There may be benefits of understanding the similarities and differences across the two sets of requirements.

v. The considerations raised in this discussion will be brought forward to the discussions by the Technology Workgroup.

2. Parameters for payment of post-stabilization services

Background:

Problem Statement:

Health plans are trying to define the parameters in their systems to identify those services that constitute post-stabilization and to determine the end-point for these services. This challenge of identifying parameters applies similarly to Medical services, Surgical services as well Behavioral Health services. In all three cases, the

Federal guidance seems to be insufficient to prevent various interpretations. As such, various interpretations can occur across carriers and if providers and carriers have different interpretations of the scope of applicable services and the end date for a patient's course of treatment, the patient could potentially be balanced billed. Clarifying and reaching a common understanding of the parameters would reduce the likelihood of a member being pulled into a payment dispute between provider and carrier.

Proposed Next Step

Convene a subgroup of representatives from crisis facilities and commercial carriers. The intent is to walk through a variety of examples of typical behavioral health events and the associated course of treatment. The objective is to determine if common parameters for post-stabilization services and end points across events present themselves. If so, the Policy & Design Workgroup would consider identifying them as consensus recommendations.

Discussion:

a. There was consensus agreement on the Problem Statement and the Proposed Next Step.

b. To be meaningful, the scope of the effort would include:

   i. Arriving at a common understanding/interpretation of the legislated definition of post-stabilization services

   ii. Defining a common language / terminology pertaining to post-stabilization services, e.g., "peer bridgers".

   iii. Defining when post-stabilization "begins" (i.e., what are the emergency trigger points) and "ends"

   iv. Determining the spectrum of services that can be considered post-stabilization services and confirming the appropriate SERI codes

   v. Determining the locations in which post-stabilization services could be provided.

c. Involvement of representative from Mobile Crisis Response providers through providers from all crisis facilities would be beneficial.

d. There is a question whether this activity falls within the scope of the Policy & Design Workgroup. The current scope is limited to business/operational issues. This scope may be legislative, regulatory and clinical.

3. Potential Denial Reasons

a. Invalid/incorrect primary or secondary modifiers

Action Item: Teresa-Bill will confirm modifiers in SERI spreadsheet

b. Missing Attending Physician Last Name

Action Item: Chris will confirm that this is a possible reason given DOH certification levels for SERI services and that there will rarely be an attending physician

c. Inappropriate practitioner credentials reported for service

Action Item: Teresa-Bill will confirm DOH licensure for SERI services in SERI spreadsheet

d. Procedure code bill type inconsistent with place of service.

This current SERI spreadsheet should correctly reflect these relationships.

e. Date of Service subsequent to termination of coverage

There may be a needed provider workflow step to obtain appropriate state funding for this encounter.

C. Next Meeting: May 31th. 9:30-11:30