0:0:0.0 --> 0:0:24.830
SOUCY Cassandra * DCBS
Brooke is out of the office, so I am going to be leading us through hopefully our final Rulemaking Advisory Committee for all of the work that we've done on House Bill 3046. So maybe that's a good sign that I get to bookend our time with this, these rules.

0:0:26.260 --> 0:0:33.30
SOUCY Cassandra * DCBS
What we'll do today, and we have the agenda up above, is do a walk-through of the final rule review.

0:0:33.450 --> 0:0:39.990
SOUCY Cassandra * DCBS
Are there any brief comments we can definitely take those during that time?

0:0:41.310 --> 0:0:51.150
SOUCY Cassandra * DCBS
I will just note and I'll say this again at the end, this is not the final time for public comment or comments about the rules. This is just part of the rulemaking process and then once we actually launch into the formal rulemaking process, we will hold a public hearing, which will include a public comment period as well, so.

0:1:5.210 --> 0:1:32.890
SOUCY Cassandra * DCBS
It it's not the final time to get any last minute statements or things, but I think we've done some really great work over several months now and so hopefully that that will go move quickly. We will spend some time talking about the statement of need and fiscal impact, in particular two pieces, the impact on small businesses and then also the racial equity impact. And I'll provide more information once we get to that point.

0:1:35.600 --> 0:1:50.380
SOUCY Cassandra * DCBS
We also have a presentation today from Ken Minkoff on level of care placement implementation. So we'll get through some of our rules stuff and then we'll hear that presentation. And then finally, at the end, we'll close with some public comments.

0:1:51.380 --> 0:1:53.310
SOUCY Cassandra * DCBS
And hopefully that will be, we'll wrap up our time with House Bill 3046 and kick off the official rulemaking process, which will continue until the end of the year. Through that formal process.

0:2:12.840 --> 0:2:27.20
SOUCY Cassandra * DCBS
To start, just want give an opportunity. We sent out a comment letter from Moda. If Dan, if you want to provide any additional comments or let the letter speak for itself, I'll turn it over to you.

0:2:28.440 --> 0:2:57.640
Dan Thoma
Thanks. Yeah, just real quickly the I was trying to track with my letter in the rules and it's kind of

challenging because the number the numbering in the sections has changed, but the first part of the letter was really just cleaning up around the N equals and QTLS. The second part of the letter was in response to HealthNet's letter. And I thought that most of the questions that they had didn't really need additional clarification.

0:2:58.130 --> 0:3:3.900
Dan Thoma
I did recommend an additional clarifying sentence in section 12.

0:3:5.360 --> 0:3:10.50
Dan Thoma
And because of the numbering kept changing around, I think it ended up.

0:3:11.150 --> 0:3:15.270
Dan Thoma

It was bumped to 11 but should be bumped back to 12.

0:3:16.530 --> 0:3:24.980
Dan Thoma
Because it's related to the billing codes and restrictions on billing codes and ended up in one of the other sections.

0:3:28.950 --> 0:3:39.140
SOUCY Cassandra * DCBS
Great. Thanks Dan for that. And I think that's a good segway to launch into our discussion about the final rule draft.

0:3:40.260 --> 0:3:46.890
SOUCY Cassandra * DCBS
The first three sections, so 836-053-0012 There are no changes. The same goes for -1403 and 1404 and there are some changes that were made between the last draft that you saw in this draft to -1405 and I'll pause and let Karen get to -1405. It's the section with a lot of red, not this one, but the next one.

0:4:13.220 --> 0:4:13.580
WINKEL Karen J * DCBS
OK.

0:4:14.290 --> 0:4:15.480
SOUCY Cassandra * DCBS
In this section.

0:4:16.510 --> 0:4:26.140
SOUCY Cassandra * DCBS
To talk through some of the changes like you like, Dan, you mentioned we did rearrange some of the language so first.

0:4:26.300 --> 0:4:41.430
SOUCY Cassandra * DCBS

I'm and not sub one we added included but not limited to prescription drugs and this is just to match the language that is in the statute. As we've discussed before and in terms of making those the same.

0:4:42.220 --> 0:4:53.170
SOUCY Cassandra * DCBS
We also removed language on predominant and substantially so from that sub one, but it is included in 1C.

0:4:53.860 --> 0:4:55.240
SOUCY Cassandra * DCBS
Hopefully that makes sense.

0:4:57.0 --> 0:5:2.750
SOUCY Cassandra * DCBS
Included in those subsections. So from A through F we moved.

0:5:3.150 --> 0:5:17.740
SOUCY Cassandra * DCBS
Sub four there. All of those sections have been slightly reworded so that they are more clear and that they better align with statute or state law and also the federal parity requirements.

0:5:18.950 --> 0:5:25.150
SOUCY Cassandra * DCBS
So in that you won't find the sub four. That was pretty expansive, but all the numbering has been adjusted accordingly.

0:5:29.700 --> 0:5:36.480
SOUCY Cassandra * DCBS
And I'll pause there and see if there are any comments, questions or concerns, and I'll try my best to answer questions.

0:5:37.720 --> 0:5:41.820
SOUCY Cassandra * DCBS
And if not, we will take them back to the team to discuss.

0:5:51.900 --> 0:5:54.130
SOUCY Cassandra * DCBS
Alright, I'm not hearing anything.

0:5:57.790 --> 0:5:58.680
SOUCY Cassandra * DCBS
The last.

0:6:10.430 --> 0:6:21.90
SOUCY Cassandra * DCBS
If you do think of any changes, please send those to us as soon as possible. If there are any comments or questions or things that we should consider before we sort of finalize this draft, like I said.

0:6:22.340 --> 0:6:31.650
SOUCY Cassandra * DCBS
This is not the final time to provide any comments. There will be a formal public comment period where you can provide additional comments to us.

0:6:33.680 --> 0:6:37.50
SOUCY Cassandra * DCBS
I'll pause here, see if there's anything for us to talk through.

0:6:41.590 --> 0:6:45.660
WINKEL Karen J * DCBS
I'm sorry. This is Karen. Which rule are we on?

0:6:48.420 --> 0:6:50.150
SOUCY Cassandra * DCBS
Oh, just all of them.

0:6:51.470 --> 0:6:51.930
WINKEL Karen J * DCBS
Gotcha.

0:6:46.370 --> 0:6:52.40
SOUCY Cassandra * DCBS
We're just on all of it. It is just general. I've just opened it up. Generally, if there are any final comments on our final draft for.

0:6:56.940 --> 0:6:57.350
WINKEL Karen J * DCBS
OK.

0:6:58.230 --> 0:6:58.940
SOUCY Cassandra * DCBS
The rules.

0:7:0.210 --> 0:7:0.570
WINKEL Karen J * DCBS
Alright.

0:7:8.240 --> 0:7:12.470
SOUCY Cassandra * DCBS
All right, I'm not hearing any comments. Oh Melissa.

0:7:14.70 --> 0:7:21.780
Melissa Todd (OIMHP) (Guest)
I just had one question. I think I think I understand this, but all the way in the part on network adequacy at the very end.

0:7:22.840 --> 0:7:51.870
Melissa Todd (OIMHP) (Guest)

836-053-0320 so because this wasn't in before and I just saw on 2A that bit about how the use of telemedicine or telehealth or other technology may be used to meet network access standards. And the way I'm reading this it this is this section applies to like everyone medical and behavioral health. But I just remember we had a discussion, it's higher up, it's up near the top.

0:7:53.750 --> 0:7:57.420
Melissa Todd (OIMHP) (Guest)
Actually it's like 2A.

0:7:56.980 --> 0:7:58.40
SOUCY Cassandra * DCBS
Yeah, it's right there.

0:8:16.820 --> 0:8:17.110
WINKEL Karen J * DCBS
Yeah.

0:7:58.720 --> 0:8:19.810
Melissa Todd (OIMHP) (Guest)
Just that we had discussed last time about at least as behavioral health network adequacy goes that my recollection is that we weren't using telehealth to network adequacy. So that was a question that one of my colleagues had.

0:8:28.480 --> 0:8:34.930
SOUCY Cassandra * DCBS
Yes. So this is specific to and just like the general network adequacy reporting that we do get.

0:8:36.530 --> 0:8:38.760
SOUCY Cassandra * DCBS
I do know that we will be.

0:8:39.460 --> 0:9:5.140
SOUCY Cassandra * DCBS
Introducing an LC that will address more network adequacy problems. So I think we can sort of address that when we kind of do our network adequacy overhaul. It is a good point thinking, Melissa, for bringing that up and we'll make sure to make note of that as we're continuing the network adequacy conversation, which I'm sure many of you will also be a part of as that kicks off.

0:9:5.830 --> 0:9:6.330
SOUCY Cassandra * DCBS
Gary.

0:9:7.880 --> 0:9:27.850
Gary Holliday (PacificSource) (Guest)
Hey, good question. In regards to that same rule under 2E, if we adopt the clarification of the underlying, the gay, lesbian, bisexual, do we then have to go up under subsection two and change the date from March 31st 2020 to 2023 because we're now modifying the rule?

0:9:32.740 --> 0:9:37.280
SOUCY Cassandra * DCBS
That's a good question. We'll take that back to our team to talk through.

0:9:38.110 --> 0:9:38.610
Gary Holliday (PacificSource) (Guest)
Thank you.

0:9:38.550 --> 0:9:41.360
SOUCY Cassandra * DCBS
I think it's because it's an annual report.

0:9:42.730 --> 0:9:45.390
SOUCY Cassandra * DCBS
We'll, make sure that we dot our I's and cross our T's on that that front.

0:9:49.0 --> 0:9:50.0
Gary Holliday (PacificSource) (Guest)
Thank you.

0:9:56.940 --> 0:10:0.730
SOUCY Cassandra * DCBS
Any other comments about the final draft rule?

0:10:2.220 --> 0:10:9.710
kminkov
So Hi there. Since I'm your guest speaker, I don't know if I'm allowed to comment, but I have a comment so, but I'll take my turn.

0:10:14.170 --> 0:10:17.680
SOUCY Cassandra * DCBS
Please if you have a comment, feel free to jump in.

0:10:17.150 --> 0:10:27.20
kminkov
So one of the things I, I mean I don't know the scope of the law that you're creating the rule for. But one of them is there are a couple of issues that often.

0:10:28.200 --> 0:10:32.90
kminkov
To me, are opportunities and the parity discussion that may not be looked at.

0:10:33.370 --> 0:11:3.80
kminkov
One of them, I mean that have to do with equivalency of benefits for people with behavioral health needs to common benefits for people with medical need and one of them is Home Care Services and making sure that access to Home Care Services for people with behavioral health diagnosis who may be home bound by virtue of their behavioral health diagnosis or need intensive in home care have equivalent benefit and access to the right kind of services with the right service mix.

0:11:46.480 --> 0:11:56.930
SOUCY Cassandra * DCBS
Thank you for those comments. I think some of that is addressed in the statute, but we will take note of that. Thank you.

0:12:0.470 --> 0:12:3.200
SOUCY Cassandra * DCBS
All right. Any anything else on the rule?

0:12:7.640 --> 0:12:19.200
SOUCY Cassandra * DCBS
Again, like I said, you'll have an opportunity to provide a formal public comment during the public hearing when we get to that point in the room. The formal rulemaking process, so.

0:12:20.880 --> 0:12:30.910
SOUCY Cassandra * DCBS
Keep that in mind if other things pop up between now and when we have our public hearing, which I think will be in October, if I've remembering the timeline correctly.

0:12:32.600 --> 0:12:42.70
SOUCY Cassandra * DCBS
So there is some time to stew on this language and see if there's any other changes or suggestions you would like to provide to the division.

0:12:44.230 --> 0:12:56.710
SOUCY Cassandra * DCBS
OK, moving on to our what is referred to as a SNFI which is the Statement of Need and Fiscal Impact.

0:12:58.220 --> 0:13:10.220
SOUCY Cassandra * DCBS
This is required piece of our rulemaking process and important for us to get. This is partially why we're all meeting today is to get the RAC feedback on.

0:13:10.740 --> 0:13:18.530
SOUCY Cassandra * DCBS
Impacts to small businesses and then also the racial equity impact in having a conversation about that.

0:13:21.0 --> 0:13:29.170
SOUCY Cassandra * DCBS
Before we sort of get into this, I know that we've got some people who are new to the rulemaking process, so the statement of need and fiscal impact.

0:13:29.630 --> 0:13:44.340
SOUCY Cassandra * DCBS
Is really supposed to address the proposed rule language. So what we are changing from current rule, since that's what our rules have done, are changing from one rule to the next.

0:13:47.590 --> 0:14:13.440
SOUCY Cassandra * DCBS

We'll start with small business cost. Some of the things that we would love to get feedback is from you all is any identification of small businesses that could be subject to the proposed rule, things that come to mind are in, in terms of this would be potentially mental health practitioners who are so low practice as a small business.

0:14:14.40 --> 0:14:16.730
SOUCY Cassandra * DCBS
And any kind of cost that you think might come up related to the proposed rule, which most of these requirements are on insurers, but if there are aspects of this that in your professional or subject matter expert opinion that we should be aware of, I think that would be helpful for us to hear from you all.

0:14:51.140 --> 0:15:10.990
SOUCY Cassandra * DCBS
Alright, I'm not hearing anything. If something does come to mind in terms of the small business impact, you can feel free to e-mail myself, Lisa, and Brooke and we'll make sure to get that included in our SNFI. And we'll also do some work on it ourselves. Gary.

0:15:12.310 --> 0:15:29.670
Gary Holliday (PacificSource) (Guest)
Hey, Cassie, just clarifying in looking at small business and the impact since this rule is now going to require you know, the level of care placement criteria being more transparent, is that going to put in these burden on those nonprofit professional associations, you know that develop their placement card? I'm trying to understand if it impacts them or they already have it in place and there is no more impact.

0:15:38.940 --> 0:16:2.190
SOUCY Cassandra * DCBS
That is a good question, Gary. I think that's something that we will consider, I think and just to give everyone some context, generally, DFR does talk about some of the general fiscal impacts, even if it is not specific to a small business. So usually we'll put a line in there that there will likely be administrative costs incurred by an insurance company.

0:16:2.750 --> 0:16:12.540
SOUCY Cassandra * DCBS
Gary. My sort of guess is that a lot of those nonprofits are not wouldn't qualify necessarily as a small business under the Administrative Procedures Act. But if we are aware that any would be, that would be super helpful for us to know if any of you know off the top of your heads. Like I said, we will be diving into this and getting more information as we finalize all of all of those pieces for rulemaking purposes.

0:16:38.400 --> 0:16:38.700
Gary Holliday (PacificSource) (Guest)
Thank you.

0:16:45.770 --> 0:16:50.0
SOUCY Cassandra * DCBS
OK, I'm not hearing anything else on the small business front.

0:16:51.160 --> 0:17:4.860
SOUCY Cassandra * DCBS
We'll move on to the racial equity impact statement. This is a new piece to rulemaking, so if you've been involved in some of our rulemakings thus far, you've probably heard about this. If not, this is a new component.

0:17:6.160 --> 0:17:22.430
SOUCY Cassandra * DCBS
House Bill 2993, which passed in 2021, requires agencies to include a statement identifying how the adoption of the rule will affect racial equity in the state, and this is required on all rulemaking. So you get to look, this will be part of our, you know, rulemaking process going forward for all types of rules, not just this one.

0:17:33.770 --> 0:17:37.480
SOUCY Cassandra * DCBS
And part of this is thinking about what racial groups will likely be most concerned or affected by the issues that are addressed in the rules?

0:17:46.830 --> 0:17:53.860
SOUCY Cassandra * DCBS
Is there any data that we should have to help determine those racial equity impacts? Are there any adverse impacts that we should be thinking about in terms of this rulemaking?

0:18:2.190 --> 0:18:6.640
SOUCY Cassandra * DCBS
My sense is that rulemaking is beneficial overall for all people across Oregon, but if there are things that we are not thinking about, we would love to hear that now or that we should be potentially thinking about, especially in terms of how this could impact different communities, communities of color across Oregon.

0:18:25.290 --> 0:18:30.780
SOUCY Cassandra * DCBS
Any thoughts or information with regard to the racial equity impact?

0:18:41.450 --> 0:18:53.880
SOUCY Cassandra * DCBS
OK, I'm not hearing anything that's jumping out, so we'll continue that work and make sure if anything does come up, not just on the racial equity side, but on the small business impact.

0:18:55.50 --> 0:19:7.320
SOUCY Cassandra * DCBS
Feel free to e-mail those of us at DFR so that we can make sure that that gets included in the SNFI which will be submitted with all of the rulemaking documents. Once they are all finalized.

0:19:11.100 --> 0:19:14.700
SOUCY Cassandra * DCBS
And with that, we are we are moving quickly through the agenda.

0:19:16.480 --> 0:19:21.510
SOUCY Cassandra * DCBS
We are now at the part of our agenda for the level of care placement implementation presentation from Ken.

0:19:30.250 --> 0:19:34.100
SOUCY Cassandra * DCBS
I will pass it over to you to present your information.

0:19:35.320 --> 0:19:37.430
kminkov
Alright, thank you so much.

0:19:39.170 --> 0:19:40.720
kminkov
I have some slides.

0:19:42.220 --> 0:19:54.750
kminkov
But I wanted to how many people do we have altogether like 20? Some odds. 30 people. We have a little over 30. OK, so that's a fairly large size audience.

0:19:56.730 --> 0:20:4.940
kminkov
And I wanted to and how much time do we have on the agenda for this piece of the discussion, so I can plan accordingly. Cassandra.

0:20:5.620 --> 0:20:13.740
SOUCY Cassandra * DCBS
We have about 30 minutes we are ahead of schedule. So there's some buffer time, but I would just plan for 30 minutes.

0:20:12.280 --> 0:20:27.220
kminkov
30 minutes. OK, great. And one of the things that I wanted to know, I had spoken to Brooke about this ahead of time and then to Garner. But I wanted to get a sense from you, maybe on behalf of the group or others.

0:20:36.120 --> 0:20:47.740
kminkov
The professional society derived level of care criteria for the purpose of the transparency and whoever just spoke was referencing.

0:20:48.800 --> 0:20:50.670
kminkov
What I don't know is what people do or do not know about the Locust family of tools, which is one of the sense of level of care instruments that is being referenced and has been, you know, implemented to a certain extent in California over the past year or almost two years now.

0:21:12.440 --> 0:21:24.730
kminkov
So and I wanted to kind of match my presentation to our people, clue full and they have some sophisticated questions or people pretty ignorant, don't know what the Locust is. Never saw one.

0:21:26.810 --> 0:21:34.800
kminkov
So anyway, just help me understand what would be most helpful for you in this presentation before I just start talking, because once I talk, I talk.

0:21:36.60 --> 0:22:5.330
SOUCY Cassandra * DCBS
So I would say that we have a spectrum of folks who are represented on the Rulemaking Advisory Committee. We've got a lot of folks who are very familiar with Locust and have utilized it in their professional roles. And we also have folks like myself. I've never used Locust, but I do know something about it, because I've learned about it through this rulemaking process. And so I think you've got people who are familiar with it and are familiar with the language around Locust and CAL Locust.

0:22:11.510 --> 0:22:34.520
kminkov
OK, so from where you sit, what do you think would be the kinds of what would what would be most helpful for me to do and I'll respond accordingly as and I'm asking you in particular not only because you're running the meeting, but because you identified yourself as someone who knows something about it but not a whole lot and you've never used it so.

0:22:36.330 --> 0:22:38.280
SOUCY Cassandra * DCBS
I think presenting based on the information that you discussed with Brooke and Bennett, I think that is a good way to move forward in terms of the presentation today, not to sideways it with my own lack of knowledge and what not, but.

0:22:56.340 --> 0:22:58.450
SOUCY Cassandra * DCBS
Dan, you have a your hand raised.

0:23:1.240 --> 0:23:5.360
Dan Thoma
Yeah, thanks. So Dr Minkoff and thank you for coming here and meeting with us. I was one of the ones who lobbied to have you here today in.

0:23:11.190 --> 0:23:26.590
Dan Thoma
What I'm hoping for is lessons learned from the California implementation. What went well, what went poorly as insurers and providers, what do we need to know in order to make this implementation as successful as possible.

0:23:32.100 --> 0:23:40.90
kminkov
OK, so alright. So I'm going to ignore my slide set then Dan.

0:23:41.700 --> 0:23:52.270
kminkov
And I'll just give a little bit of an overview of what's particularly relevant for that question. And then you guys can take it where you want to go, OK.

0:23:52.340 --> 0:24:3.350
kminkov
OK, so Hi everybody, I'm Ken Minkoff. I'm a community psychiatrist. I'm on the board of the American Association for Community Psychiatry, which is the author of the Locust Tool and the coauthor with the American Academy of Child and Adolescent Psychiatry of the latest version of the child's tool in the Locust family of tools, which is called the CAL Locust, Cassie for the moment because it's a merger of two nearly identical tools which had kind of diverged. And then there's an early childhood tool that belongs to a cap, which is called the EXE CSI.

0:24:39.210 --> 0:24:44.550
kminkov
And they're all similar in construction. They have similar purposes, just targeted to different age groups.

0:24:45.470 --> 0:24:54.880
kminkov
And we've been working with California since and with insurers in California.

0:24:55.960 --> 0:25:16.390
kminkov
Since just before the official implementation date of Senate Bill 855, which is the legislation in California that your legislation was partly modeled on, and that implementation date was January of 2021, so we've been doing this for nearly two years.

0:25:18.50 --> 0:25:34.50
kminkov
And that's good news for you because we've gotten a lot better about how to support both the payers and other interested parties in this process. But I think it is helpful to be a little bit cognizant of things you want to think about in the implementation process.

0:25:41.740 --> 0:25:53.400
kminkov
And you know and the opportunity that you may have in the moment to affect that and in my conversation with Brooke.

0:25:54.40 --> 0:25:55.760
kminkov
It wasn't, you know, she was you know, indicating that the thing you do as a rulemaking committee is circumscribed, as Cassandra was indicating by the requirements of the state rulemaking process, such as they are.

0:26:14.70 --> 0:26:32.440
kminkov
You don't have a lot of room to meander into other areas, but to the extent that you, you know, have reach into other areas that may be relevant to the implementation and go beyond just simply what you put into the rulemaking process. There are things to think about, so.

0:26:33.850 --> 0:26:51.840
kminkov
One of the rationale for the law is several fold as you know and California and I'm assuming in Oregon, which is and it's not so much it has some in relationship to a parity concept.

0:26:53.270 --> 0:27:25.820
kminkov
But the piece that has to do with using these criteria are more about the issue of having objectivity and transparency in the way that insurers utilize their behavioral health utilization management criteria to make decisions about what we, even though our tool is called level of care utilization system, what we like to call service intensity assessment and determination.

0:27:27.590 --> 0:27:30.780
kminkov
For people with behavioral health needs both initially and as they move through a continuum of care.

0:27:37.330 --> 0:27:56.800
kminkov
And the framework for so and the goal is to have this be an objective process so that there is an understanding by payers, providers, families, people up at the state high level regulatory level.

0:27:58.120 --> 0:28:14.90
kminkov
About how these decisions are being made, since they have important impact on everything from the experience of individuals and families in service to the allocation of resources at a high level.

0:28:19.20 --> 0:28:34.890
kminkov
Because your law, in California the law applies only in the commercial marketplace, both direct insurance products and managed care products. And in Oregon, how much does it extend? I forget into the OHA and the Medicaid world. The CCOs and all those kind of good things.

0:28:43.240 --> 0:28:57.520
SOUCY Cassandra * DCBS
I believe that the law does extend the CCOs. Uh, the group that you have here today is mostly focused on the commercial side. And I know that there are likely separate conversations happening on the CC side.

0:28:58.130 --> 0:29:28.60
kminkov
OK so but given that the implementation so and that in my view, that's a very good thing that you're looking at. You know you're not carving out one marketplace as having a different set of rules than the

other because on the ground in real systems, people show up with all kinds of mixtures of product all the time. And so and the implementation issues that I'm going to raise are actually stronger because they are going to be held more broadly.

0:29:28.720 --> 0:29:29.430
kminkov
So in developing the tool the way the tool is set-up for those of you who may be completely unfamiliar with it, we approach service intensity assessment for shorthand, what level of care does a person need?

0:29:45.550 --> 0:30:11.980
kminkov
As a dimension of assessment that's ancillary to their diagnosis or their symptoms of the moment. So you can have schizophrenia and you can need any kind of intervention for your schizophrenia, ranging from a routine outpatient visit to an acute hospitalization, depending on a whole bunch of variables that go well beyond the diagnosis.

0:30:12.750 --> 0:30:35.300
kminkov
And in fact, apply those same variables apply no matter what your diagnosis is. You can have a set of symptoms like suicidal ideation, and you can be treated at any level of care from routine outpatient, all the way up to inpatient, depending on a whole bunch of variables that relate to that particular symptom.

0:30:36.220 --> 0:30:41.180
kminkov
And so there's some science behind this that's actually been around for quite a while. Because these tools were first developed and thought about in the 90s. But have not necessarily infiltrated.

0:30:53.20 --> 0:31:12.970
kminkov
And actually, they're more infiltrated into the insurance industry per se. Then they are actually into the way clinicians are fundamentally trained and into the core products and regulatory requirements of state behavioral health systems, including Medicaid.

0:31:14.40 --> 0:31:25.970
kminkov
So to advance this idea that these determinations are not an issue of whether insurers or saving money or not any more than diagnosis are that they're based on objective.

0:31:27.820 --> 0:31:46.950
kminkov
Criteria that are measurable to a certain extent, not that there is not some subjectivity involved and everybody can understand how these decisions are made and how the nature of the decisions translates into the service intensity required is really what the tools bring to the table.

0:31:48.110 --> 0:31:51.880
kminkov
And it's, you know, it's far from a perfect science.

0:31:53.140 --> 0:32:22.270
kminkov
The both the locust tools which govern mental health world services, including people with co-occurring substance needs and intellectual disability needs who may be in the mental health care continuum and the ASAM criteria which are very similar in construct and govern how service of service intensity determinations are made in the world of substance use disorder treatment, which also includes people with co-occurring mental health conditions and physical conditions and.

0:32:22.570 --> 0:32:34.250
kminkov
And intellectual developmental conditions and brain injuries and they're very similar and they the way the tool is intended to be used.

0:32:35.810 --> 0:32:52.150
kminkov
Automatically starts to challenge the usual design of the system on a couple of different levels. So first of all, you know when we design the tool, we were thinking that this is a tool that is used by clinical staff.

0:32:52.890 --> 0:33:8.660
kminkov
It's not a highly complicated tool. It's not like you have to have, you know, an independent licensed practitioner to use it. Any level of staff can be talked to. Use that. If there are people doing crisis work or you know, whatever they can be taught to use the tool.

0:33:10.400 --> 0:33:40.330
kminkov
But the point is that it was intended, and similarly, you know folks who work inside insurance companies if they're provided adequate information, they can apply the tool to the clinical information that receive. Ideally, when an insurance company or a payer who's not an insurance company is applying the tool to service intensity determinations, the information they're receiving from the provider or where, you know, wherever they're getting that information.

0:33:40.910 --> 0:33:45.650
kminkov
Is, you know, utilizing the same assessment process so.

0:33:47.90 --> 0:34:19.860
kminkov
You know, so that providers would use the locus, the utilization management people would use the locus, everybody would be using the right tool and they could have discussions about you know, how they chose different anchor points in the tool. But the framework would be part of it just like, you know, when you when you're a provider seeking a service for somebody you, you give them the diagnosis using established diagnostic criteria doesn't mean you may not, you know be off base or people may disagree, but everybody's using a common framework for diagnosing.

0:34:21.20 --> 0:34:35.420
kminkov
The same way you use a common framework for making service intensity assessments and the assessments are multidimensional. They're related to 6 dimensions, risk of harm functionality, comorbidity, you know, engagement and treatment, evidence of what happened in the past treatment history and you know, strengths and supports in the environment essentially.

0:34:53.200 --> 0:35:21.270
kminkov
And each one of those is scored along. You know you got a score based on defined anchor points that allow you to rate from one to five. And then there's the scoring algorithm that's mostly adding it all up, but has some other rules in it that generate a service level that in the Locust ranges from zero to 6 and rear zero is just kind of a basic like, you're out in the world and you get, you know, accessed at every baskets.

0:35:24.680 --> 0:35:55.530
kminkov
Level one is kind of a maintenance level. Level 2 is active outpatient treatment, Level 3 is a more intensive outpatient treatment level 4 is a medically managed, highly intensive outpatient treatment like assertive community treatment or a partial hospital program. Level 5 is some kind of a medically monitored residential environment for you know for active treatment, not housing. And Level 6 is essentially equivalent to inpatient. So that's the layout.

0:35:56.890 --> 0:36:1.970
kminkov
So implementation issue number one is that as much as possible.

0:36:3.360 --> 0:36:12.610
kminkov
We would recommend that in the process of doing the implementation that there's a mechanism not just to train.

0:36:13.550 --> 0:36:19.290
kminkov
The insurers, because that's built into the law and that they have to get trained at their expense.

0:36:20.230 --> 0:36:40.700
kminkov
But also to have a mechanism as a state for helping to train all providers that may be needing to utilize this approach to service intensity determination, so that everybody's on the same page, ideally not at their own expense.

0:36:41.900 --> 0:36:48.750
kminkov
Now the way that so I'm going to talk a little bit about this in California and what we recommended and what has not happened.

0:36:50.190 --> 0:36:58.220
kminkov
So that you have an opportunity to think about it differently, you may or may not. But anyway, so the way the California law is written.

0:36:58.820 --> 0:37:7.890
kminkov
All insurers are responsible for providing information about the tool to their providers.

0:37:9.150 --> 0:37:17.460
kminkov
And there's a variety of guidelines for how they're supposed to do it that are more or less aligned with basic insurance standards.

0:37:19.980 --> 0:37:21.220
kminkov
However.

0:37:21.950 --> 0:37:24.0
kminkov
If you think about how the commercial market.

0:37:24.100 --> 0:37:28.350
kminkov
I'm operates and most of you will resonate with this.

0:37:29.790 --> 0:37:36.230
kminkov
Most people who do business in the commercial market may have, you know, relationships with 20 different insurers.

0:37:36.890 --> 0:38:2.140
kminkov
And having each insured have its own way of informing providers about how the tool works is duplicative, inefficient and confusing. So what we suggested to the state of California, the division of Managed Healthcare which operate, you know, governs their MCO's and the division of insurance which governs commercial plans, because California knows how to make everything more complicated than it needs to be.

0:38:3.990 --> 0:38:22.510
kminkov
Was that all the plans and the state should get together and create a training approach that and fund it with our help that all people who were providers who needed it could get, you know, as an asynchronous training kind of thing.

0:38:24.310 --> 0:38:52.980
kminkov
And they have never done that. They nodded, and they kind of implied that a state agencies, it wasn't

their job. And you as rulemakers, you know, it's not your job either. So it becomes nobody's job, and then nobody does it. And then the insurances are competing with each other. So they couldn't sit in the same room and. But so in terms of Dan's question, one of the things that I would think of right at the beginning is how do we create an accessible minimal cost or no cost state coordinated training approach.

0:39:3.750 --> 0:39:7.890
kminkov
So then all providers can have access to the training that they need.

0:39:9.270 --> 0:39:21.720
kminkov
OK, so everybody's learning at the same time, the insurers will have to, you know, they have to train their staff and they have to do it at their own expense. But is there a provision for training the provider? So that's 1.

0:39:24.430 --> 0:39:27.140
kminkov
The second thing that we learned in California is that the insurers.

0:39:38.20 --> 0:39:47.80
kminkov
You know well, first of all, I mean, this is no surprise and we were just in the commercial more so even now two years in. The commercial plans have been in extremely different stages of adoption.

0:39:56.660 --> 0:40:5.290
kminkov
So some of them were first to the table before the law was even implemented. Wanting to get everybody trained and we're very eager to work with us to make sure they did it right.

0:40:7.900 --> 0:40:13.150
kminkov
There are some in the middle that got everybody trained and then insisted on using the tool improperly.

0:40:14.30 --> 0:40:17.160
kminkov
And we're very upset that they couldn't use it improperly.

0:40:19.840 --> 0:40:25.700
kminkov
There are probably 1/3 to 1/2 of all the insurers who are still not using it.

0:40:27.370 --> 0:40:32.480
kminkov
And for some of them, it's weird because they're using the tools and other parts in other states.

0:40:33.180 --> 0:40:38.270
kminkov

But they're digging in their heels and saying to California you have no right to make us through this, and we're not going to do it. So you should anticipate that.

0:40:43.730 --> 0:40:57.370
kminkov
To some extent, I think some of these places approach it as a matter of principle that you can't be directing them to do these things, even if they want to. We may want to, but we won't do it because you're making us.

0:40:58.860 --> 0:41:9.760
kminkov
The other thing that we learned, though, and this is real important because it was something we learned as we went, and it's not an easy thing to grasp.

0:41:12.120 --> 0:41:16.50
kminkov
You know, most of the insurers have they have, some of them have their own criteria.

0:41:20.340 --> 0:41:29.770
kminkov
Some of them, you know, many of them have varying adoptions of MCG or you know the.

0:41:31.650 --> 0:41:32.580
kminkov
Much of a pallet.

0:41:33.80 --> 0:41:35.440
kminkov
But the other one InterQual.

0:41:40.180 --> 0:41:45.550
kminkov
And there are aspects of those tools that the Locust tools do not do.

0:41:47.350 --> 0:42:17.600
kminkov
OK, so for example Locust is totally about service intensity determination. It will not help you decide whether to authorize ECT or Neuropsych testing or TMS or whatever. And you know we felt and it was very important to inform the state that using locust for what it's intended to do doesn't mean you can never use MCG when there are things that MCG does that Locust.

0:42:17.690 --> 0:42:26.390
kminkov
Doesn't do so that was an important message. But the other thing that came up pretty quickly is that there's a different workflow.

0:42:27.510 --> 0:42:41.640
kminkov

For how the MCG and InterQual tools operate and it's built into the idea that our tool is a tool for independent service and objective service intensity assessment.

0:42:42.690 --> 0:43:1.770
kminkov
And their tools are utilization management tools. So I'm going to try to explain this and some of you may know this already, but it makes a difference in the workflow in the way that the current tools operate like MCG and InterQual. It starts with a request for a level of care.

0:43:2.900 --> 0:43:11.490
kminkov
And the whole workflow is based on the request. The request may come from a provider, Hi, so and so showed up at my residential program and I'm calling for authorization and I'm requesting level of care which level care that I happen to deliver.

0:43:21.440 --> 0:43:33.470
kminkov
And then the whole thing works from that request and then they take the request, they gather the clinical information, they match it to the MCG thing which tells them whether or not it's matched to that request and then it says yes or no.

0:43:40.740 --> 0:43:46.460
kminkov
And it may, depending on how they have set it up, give them alternatives or not.

0:43:47.480 --> 0:44:0.340
kminkov
But both, mostly the process is a utilization management, yes or no request you know you we yes or no answer to the request and then they do a similar version of that for continuing care.

0:44:2.200 --> 0:44:9.750
kminkov
The way the Locust works is different, the Locust says as part of your assessment of this person to begin with.

0:44:10.650 --> 0:44:15.780
kminkov
You use the Locust to make an assessment of service intensity.

0:44:16.440 --> 0:44:20.290
kminkov
And then you ask for what the Locust recommends.

0:44:22.380 --> 0:44:43.150
kminkov
OK. So that's a different workflow. It means that it starts with the, not with the request, but with the assessment. And so when you dig into this with the insurers, we found that a lot of the details of implementation go beyond just training and using the tool.

0:44:43.990 --> 0:45:13.640
kminkov
But we needed to provide consultation to them to help them adapt, using the tool into their workflow, their decision processes, their decision trees, their internal reviews, they're supervision processes and so on. When we set-up our trainings with the insurers, we always included an expectation that they would have at least one or two consultation meetings to help them address these questions.

0:45:21.820 --> 0:45:28.530
kminkov
But that piece is the understanding that simply learning how to use the tool is sufficient to ensure successful implementation.

0:45:34.990 --> 0:45:54.340
kminkov
Is A is and it isn't, you know to say. How were they actually implementing this and is it in their workflows and decision trees and is this something that they're accountable for sharing with us and for getting help if they're, you know, if there's an issue or even getting help proactively because we know there's going to be an issue.

0:45:55.600 --> 0:46:9.450
kminkov
That's another question that is worth you thinking about as you go into this. The other is another issue that is very important is how the Locust informs benefit design.

0:46:10.760 --> 0:46:14.750
kminkov
So a very common example is.

0:46:16.250 --> 0:46:31.910
kminkov
I mean in in the ideal sense, one of the advantages of statewide adoption of the Locust is not just for the purpose of making decisions with the services you have, but for illustrating where there are recommended services that are not available.

0:46:33.820 --> 0:47:5.740
kminkov
So one of the things in your implementation is, well, that's not going to happen unless you're collecting data about mismatch and it's not going to affect the insurers unless there's some guidance about what they should do when there is a mismatch. So. And one thing we learned about insurers is, you know, it's one thing when they're using the tool in the right spirit and those that do, you know, they can figure this out. But those that are doing it only because you're making them.

0:47:51.980 --> 0:48:20.980
kminkov
And this is why the public sector piece of this is so important. They have they have schizophrenia, they have a substance use disorder. They're homeless, they're in and out of the ER, you know, and but they're not immediately at risk and they're not committable. And if you offer them a residential

treatment, they wouldn't take it. And the recommended treatment for them is, would, you know, normally when you kind of add up all the characteristics would be under locus, a level 4.

0:48:21.880 --> 0:48:27.540
kminkov
For intensity, for treating their schizophrenia and their co-occurring disorders, which essentially is an assertive community treatment.

0:48:28.860 --> 0:48:47.330
kminkov
And let's say this person is 20. Let's say they're not even on meditate. They're 24 years old and they're still covered on their parents commercial plan, and they're living out in the streets. I know you would never have problems like this in Oregon. I mean, rumors have it, there are a lot of these people in Portland, but I don't believe them. I'm sure it's not true, but anyway.

0:48:49.150 --> 0:49:5.450
kminkov
And they say, well, level four, yeah, we have level 4 in our commercial plan. It's partial hospital. Can the person go to 20 hours of groups a week and the person can't go to 20 hours. A group in five years because they're not going to go to groups. And they said, well, we don't have an acting benefit.

0:49:7.520 --> 0:49:8.520
kminkov
So what did they do?

0:49:9.330 --> 0:49:11.770
kminkov
They offer partial which the person won't accept.

0:49:13.230 --> 0:49:29.40
kminkov
OK, so you know you want guidance language, you don't necessarily want them to try to put the person in residential, which they won't accept, although for some people that may be the appropriate intervention. So they should, they don't have one level of care that matches. They should go up.

0:49:31.140 --> 0:49:51.490
kminkov
But the other is that they should develop the individualize, you know, single benefit capacity so that people actually get what they need. And it's the very least you want them to track when the stuff that's recommended is not available so that you can gather data at the state level, not the rulemaking people but the data gathering people.

0:49:52.650 --> 0:50:14.900
kminkov
To determine whether or not you know, there are recommendations that emerge about changes and benefit that then come under, you know, insurance, law or insurance regulations or whatever. And the same thing applies in Medicaid. I mean Medicaid benefit package is going to be much greater, but how

that supplied by different Co is also going to be, you know, its own individualized adventure. So you have to pay attention to this as well.

So I covered a lot of ground. There's one more thing I wanted to say. Because came up in the rulemaking process, which has to do with all the insurers are required to do IRR interrater reliability for the scoring. And you know, our recommendation is that they're responsible for their IRR processes. They do this with other tools and we have, you know, we have guidance for it.

0:50:45.690 --> 0:50:46.340
kminkov
But.

0:50:48.260 --> 0:50:52.700
kminkov
You know, in the rulemaking process, you need to keep in mind.

0:50:54.410 --> 0:50:56.600
kminkov
That there's a balance in achieving IRR.

0:51:1.350 --> 0:51:4.200
kminkov
If you want really high IRR scores.

0:51:5.310 --> 0:51:10.300
kminkov
You have to get IRR cases that could be scored correctly.

0:51:11.120 --> 0:51:13.500
kminkov
By a machine, essentially.

0:51:14.770 --> 0:51:16.780
kminkov
Because they essentially give you the answers.

0:51:18.50 --> 0:51:40.900
kminkov
So really high our score sound good, but they're not necessarily the best thing from a quality improvement perspective because they buy us the insurers against actually using the IRR process for learning because the price you pay for people getting something wrong is too high.

0:51:41.630 --> 0:52:11.680
kminkov
So that's something we've been struggling with in California. We went this, the level they wanted was 90%, which is very high on the IR department and you know we can do that. But we realized that in order to do that, you know it was like giving them Mickey Mouse questions that didn't really help them. So that's OK if that's what you want. But you know on the other hand, you know, really do this so that it becomes an annual skill based.

0:52:11.760 --> 0:52:23.60
kminkov
Learning exercise that really everybody is encouraged to do for the purpose of learning you. You don't want to have it be so rigid that you know nobody can take a risk.

0:52:24.440 --> 0:52:28.730
kminkov
In dealing with their folks. So anyway, that was another piece, so I'll stop.

0:52:31.80 --> 0:52:35.650
kminkov
Is that helpful, Dan, was that kind of along the line what you're hoping for?

0:52:38.110 --> 0:52:41.710
Dan Thoma
Yeah, very helpful to me. I hope others have also found it helpful.

0:52:43.410 --> 0:53:1.600
Dan Thoma
I mean, I think I think we've got a lot of work to do as, as I've said before to, you know, to make sure we roll this out in a way that improves the system of care rather than just kind of throws a wrench in into the works. And I appreciated your comments on IRR too. When we do, I interrater reliability here at Moda.

0:53:2.780 --> 0:53:16.970
Dan Thoma
We tend to get fairly low scores because we deliberately pick cases. That's really sort of fall right along the line, and it's a great it's a great generator of discussion, but it doesn't make you look great next necessarily, if somebody external was looking at it.

0:53:18.50 --> 0:53:28.410
kminkov
Yeah, thanks for understanding that. It's not everybody gets that at all. So and you don't want to write a rule that says your IRR can be terrible and you don't have to do anything about it, so.

0:53:29.570 --> 0:53:55.820
kminkov
But paying attention to the opportunity to go as far as you can in the rulemaking process to create proactive expectations of participating in quality improvement activities around their service intensity assessments, both individually company by company and there are Oregon Health Plan or CEO's as well as well as developing.

0:53:56.440 --> 0:54:1.140
kminkov
Anything that you can implement that becomes the official.

0:54:1.220 --> 0:54:24.500
kminkov

Old continuing service intensity oversight Quality Improvement Committee, where there's expectation of representation from the insurances of different types. You know, public, private, different kinds of Medicaid and Medicare plans providers. You know people would lived experience the state.

0:54:25.270 --> 0:54:37.220
kminkov
And everybody's sitting there gathering the data and managing the process with the expectation that you're going to need continuous improvement. That would be an important structure to have in place.

0:54:37.540 --> 0:54:46.540
kminkov
Yeah. And I know it probably wasn't envisioned in the legislation, but to the extent that you can build something like that in.

0:54:49.370 --> 0:55:9.130
kminkov
You know, you would anticipate that for this to go well, you would want to venue that was charged with that responsibility and with some expectation that everybody was coming in for the right reason. Not that you're going to nitpick the insurer. So they don't want to show up, but that it actually is a collaborative learning process.

0:55:10.270 --> 0:55:17.180
kminkov
You know those insurers that use these tools really do like them when they go about it for the right reason. They find it helpful.

0:55:18.800 --> 0:55:23.310
kminkov
But not everybody comes to it. And in that spirit, so you want to build that where you can't?

0:55:33.500 --> 0:55:38.190
SOUCY Cassandra * DCBS
Thank you for all that information. I know I learned some things and I took some notes.

0:55:39.650 --> 0:55:44.210
SOUCY Cassandra * DCBS
You know, I think part of what the division does, our division regulates the commercial market. I think we want to continue having an open conversation even when the rules are finalized about any issues that do come up.

0:55:58.540 --> 0:56:14.870
SOUCY Cassandra * DCBS
I think I've mentioned this before in this rulemaking advisory committee, and if not, we have regular touch bases with our all of the insurers to talk about issues and are happy to hear from providers when there are issues as well. And so I think.

0:56:16.270 --> 0:56:18.760
SOUCY Cassandra * DCBS

There's a real desire to see this go as smooth as possible and also having some connected points with our colleagues at OHA who will be engaged in this work as well. On the Co side.

0:56:29.670 --> 0:57:2.890
kminkov
Like well, and as the double ACP and speaking on behalf of a cap, our partners, and I'm pretty sure ASAM feels the same way. We want to be helpful to you, you know. And so I mean getting these tools out. I mean, we developed these tools like 20ish years ago almost 25. And so we've always been wanting people to use them and now that they're finally being used, we want people to use them, get the advantage of and use them right. And we know they're not perfect. So we're always thinking about how to improve what we're doing and so forth. So we want to be a helpful partner.

0:57:4.190 --> 0:57:16.860
kminkov
And personally, as someone who most of my career is consulting to large state and county systems around people with complex needs, not just in the utilization management space but all over some of you know.

0:57:18.720 --> 0:57:29.520
kminkov
You know, I understand how hard it is for state systems to do stuff like this. So you really need to kind of, you know, like be willing to, like, ask for help.

0:57:31.760 --> 0:57:58.340
kminkov
The other thing that you'll find, and you may have found this already, is that some of the insurers will try to set this up like it's adversarial, you know, like oh you said we could get everything for free and we have to pay for training and they won't let us use the tool without licensing it and using technology. And that's all true.

0:57:59.70 --> 0:58:30.680
kminkov
And the reason for that is we found that giving people free copies of the tool meant that they would deconstruct it and do whatever they wanted with it. And we had no quality control. So we insist that people use approved software algorithms that we can verify, and we have a number of different platforms through our software partner, which is Deerfield, and they do have to pay for this. OK. It's not, it's very cheap compared to other things they do. But you would think that they were being asked to, you know.

0:58:30.750 --> 0:58:57.210
kminkov
Like their whole profit margin is going to suddenly go away because they're having to do this. So you know, I mean, we want them to, you know, be good partners in this and we will help you to negotiate with them if they come to you saying that something or other is just impossible. We're always looking for ways of facilitating this within the bounds of if they're going to use the tool, we want them to use it properly.

0:59:6.570 --> 0:59:16.540
SOUCY Cassandra * DCBS
All right. Thank you. Any other questions or comments about implementation in California or issues that?

0:59:18.40 --> 0:59:22.10
SOUCY Cassandra * DCBS
In that experience, I see Gary, your hand is raised.

0:59:22.850 --> 0:59:37.510
Gary Holliday (PacificSource) (Guest)
Ken, could you clarify or, excuse me, I'm Gary Holiday. I'm with PacificSource health plans and health attorney here in Oregon. Can you can you help me understand what not only is it the train itself, but what is it that's preventing some of the providers from using this tool?

0:59:38.160 --> 0:59:39.30
kminkov
Providers.

0:59:39.740 --> 0:59:48.200
Gary Holliday (PacificSource) (Guest)
The psychologist. Psychiatrist. Cause you said, you know, training costs are one thing. Is there something else that may be preventing it or is it just the cost of training them on it?

0:59:48.340 --> 0:59:51.870
kminkov
Well, it so there's two different things. It's sort of how to have access to it.

0:59:55.380 --> 0:59:57.800
kminkov
So one of the things is.

0:59:59.320 --> 1:0:4.440
kminkov
It's the ideal thing for the tool is if it's embedded in an electronic health record.

1:0:9.910 --> 1:0:12.260
kminkov
You know of the agency that you're working in?

1:0:13.320 --> 1:0:19.500
kminkov
And what some places have done which we recommend is.

1:0:20.940 --> 1:0:30.750
kminkov
So then the question becomes, how do you get it in the health, in the health record and how do you do that in a way that doesn't reflect cost to the provider because?

1:0:31.890 --> 1:0:41.300
kminkov
So one of the things that we're busy negotiating with is ways of getting it into the electronic health record platforms for providers.

1:2:1.150 --> 1:2:32.190
kminkov
But you know, if the provider is going to do that, that's great. Like, I'm making a referral to PacificSource and when I go on the PacificSource platform, I can enter the client information into the platform and a locust pops up or the appropriate tool for what I'm asking for. And I can fill it out because I'm already trained. And then that information goes right to Pacific source and then they can use it in California. We found only a minority of the of the payers. We're interested in doing that.

1:2:32.590 --> 1:2:35.320
kminkov
And there was no requirement that they did. That was a cool thing.

1:2:36.780 --> 1:2:54.580
kminkov
And then there's no real provision for training. So basically, if the provider hasn't gotten training from somewhere else, then they're left kind of just reading the instructions on the tool and trying to figure it out. And that's not ideal. So the advantage you know.

1:2:56.240 --> 1:3:18.590
kminkov
Providing access to more universal training is, first of all, I don't want the insurers to have to each insurer develop their own training. That's very inefficient. As I said, it's much easier if there's one standard training for everybody in Oregon. They all get it. There can be one that's adapted for UM people and one for clinicians. But we, you know, we have those things that are pretty much available.

1:3:19.600 --> 1:3:21.370
kminkov
And then you make it available for folks.

1:3:50.430 --> 1:3:50.920
Gary Holliday (PacificSource) (Guest)
Great.

1:3:22.830 --> 1:3:51.280
kminkov
Collectively, you know, so nobody is, you know, it's not like 6 insurers have to pay for trainings for the same people, right. And then everybody can get a training. And then if people, you know, don't have it in their own, they can access it on your platform. And there it is. It's right there. It's just part of what you, you know, the same platform that you're, staff use. It's just something that you make available to providers, you know, and you give them the right codes to go in and use it, you know, and like that.

1:3:52.190 --> 1:3:52.750
kminkov
That makes sense.

1:3:53.90 --> 1:3:54.530
Gary Holliday (PacificSource) (Guest)
Yes, thank you very much.

1:3:58.820 --> 1:4:6.880
kminkov
But like I mean, Gary, I mean your meta point is this kind of stuff, Gary just illustrated the exact kind of question.

1:4:7.820 --> 1:4:29.930
kminkov
Question that we will get from insurers that nobody likes thinks about when the laws being written and you're developing rules, it's like, let's be practical and try to figure out how to make this available to folks at a, you know, at a reasonable cost at the level of scale you want. And we want to do it in a way that's helpful.

1:4:33.830 --> 1:4:39.280
kminkov
But you know, we're not in a position to just give it all away either, so, right.

1:4:41.270 --> 1:4:41.740
kminkov
Dan.

1:4:45.770 --> 1:4:47.570
kminkov
How about we get a bill?

1:4:44.720 --> 1:4:48.960
Dan Thoma
Oh can we go with Bill first?

1:4:50.360 --> 1:5:16.730
Bill Bouska
Oh, thanks. I was involved in implementation of the caucus and then the EXE a couple years after that here in Oregon. Good 15 years ago. And one of the dynamics that we discovered, and I think it's even true even more true now, is especially when you get a higher score that points to some sort of inpatient or residential level of care suggestion that for some people that means.

1:5:17.70 --> 1:5:49.20
Bill Bouska
You know my kid or my patients or this person scored of five. So that means they go into residential and they're for some people. They're. So there's this concreteness about the score. And even though you could arrange an array of services that matches that intensity of need, somebody could still say Nope,

they scored a five. If they go here. And that was a difficult dynamic. I worked at the state at that time for us to get around, especially for people who thought placement was a very important thing. But.

1:5:49.130 --> 1:6:1.550
Bill Bouska
The reason I bring it up is because that is a real dynamic. People get really concrete on the score, but also our bed capacity and availability of those services is very, very, very, very tight and really difficult to get into. So how do you, you know, suggest we get around sort of that concreteness of the score and the ability to really wrap services and create an intensive program around so.

1:6:13.480 --> 1:6:27.920
kminkov
So Bill, that's a brilliant question. And I think actually there are folks on the ACAP side who actually spent a lot of time thinking about that issue. I know because I've had these conversations just around this issue. So this is not unfamiliar.

1:6:29.250 --> 1:6:48.140
kminkov
And one of the things I would also suggest just parenthetically is that you guys may reach out, I'm not sure who the right person in Oregon would be, but there's a team of folks in Arizona that has been using the Cal Locus, Cassie and their system for quite some time.

1:6:49.430 --> 1:6:56.380
kminkov
And very successfully. And they've negotiated a lot of these issues, you know, at that level already.

1:6:57.900 --> 1:7:4.810
kminkov
And so it might be helpful just to compare notes. So one of the things is in the latest update of the tool.

1:7:7.300 --> 1:7:12.290
kminkov
The language of the instructions has tried to make it clear.

1:7:15.310 --> 1:7:24.300
kminkov
That there are opportunities for helping the person be in the right match service.

1:7:25.690 --> 1:7:43.250
kminkov
So that level 5 is essentially a residential level, but especially for kids, it's much easier to do with kids that you can create equivalent service packages that provide that often more effectively in a home based environment.

1:7:44.670 --> 1:7:46.880
kminkov
OK, so you can write that language.

1:7:49.500 --> 1:8:5.70
kminkov
There is a dilemma cause I've been looked at this from both sides. OK, so on one level you have people saying I don't care what it says. I want my kid in placement and it says he meets criteria for placement. So place him.

1:8:5.910 --> 1:8:31.330
kminkov
And you're saying it's going to be better for him. You know, if he's this way or that way and you know, and then you get into can I force the family to take him if they don't want him and blah, blah, blah. So you want language that helps you to negotiate those disputes because the locus won't give you a clear answer for that. And the flip side of it is.

1:8:32.210 --> 1:8:38.540
kminkov
That payers will often use the flexibility in the tools.

1:8:39.300 --> 1:8:43.890
kminkov
To create alternatives that are actually not equivalent.

1:8:45.660 --> 1:8:55.710
kminkov
And so they'll say, well, it says that we can offer alternatives to residential, provided that there an equivalent level of care through the provision of wrap around service.

1:8:56.990 --> 1:9:5.270
kminkov
And then they'll provide something that looks like it might be equivalent, but is actually way less so.

1:9:5.940 --> 1:9:36.0
kminkov
And they'll say, Oh well, you can have volunteers from the Boys Club drop in and they can. That's your daily support system. And then you can have 24 hour access to the hotline and that's your 24 hour support. And, you know, you don't daily medical need is a nurse will come to your house twice a week and you can call her when she's not there and they'll say, you know, it's equivalent. See, we did it. That's level 5.

1:9:36.890 --> 1:9:53.120
kminkov
And so you need to have the ability to look at this from both directions to make sure that if somebody is offering an equivalent to residential that is community based because that's in the tool, that that's allowable.

1:9:54.270 --> 1:9:58.820
kminkov
That there has to be language that ensures the equivalency.

1:9:59.460 --> 1:10:14.770
kminkov
Based on the guidance of the frequency and the intensity and the composition of the service package that's intended to be there, and also that you know there's some mediation and accommodation for choice.

1:10:15.820 --> 1:10:22.60
kminkov
You know, because I mean, obviously forcing people to accept services they don't want for their kids.

1:10:23.20 --> 1:10:28.750
kminkov
May not be a good thing. So while you're busy creating the framework for these rules.

1:10:30.60 --> 1:10:39.490
kminkov
You might think about how to address that in the rule language so that you're looking at that through both sides of the lens.

1:10:40.730 --> 1:10:44.240
kminkov
And the second issue that you know you raised is the thing I mentioned earlier.

1:10:49.560 --> 1:11:3.110
kminkov
Denying access to residential treatment if it's, you know so. So I am fully on board with residential treatment tends not to be the most desirable approach to treating kits.

1:11:4.260 --> 1:11:34.190
kminkov
And you really don't want to do that a lot if you can avoid it. The outcomes, you know, get very institutional focused and transitions back to home are disrupted and so forth and so on. There aren't kids who need that higher level. There are kids who can't be safely managed in a home or in a foster home or in an alternative place where can't receive the services that they need at that level of care without getting an actual residential level of care.

1:11:35.960 --> 1:11:51.650
kminkov
And if you don't have enough and you have an objective way of determining who needs it through some combination of they meet the level 5 criteria and the alternative can't be cobbled together or isn't acceptable, or the family won't participate.

1:11:52.820 --> 1:12:0.790
kminkov
And then you say, but we don't have enough of that level of care. Well, that's important information that you are now trying to move from subjective objective.

1:12:1.960 --> 1:12:7.630
kminkov
So you want your guidance in the implementation to take advantage of the opportunity?

1:12:8.280 --> 1:12:19.210
kminkov
Of moving it away from a simple battle of you want this, but we're not going to pay for it too. We have objective criteria that we can determine. This is a legitimate need.

1:12:20.640 --> 1:12:37.750
kminkov
We have some review process that allows us to determine the difference between simple preference and actually recommended best practice and absolute. I can't do it. I refuse. You can't make me and there's no point in trying.

1:12:38.630 --> 1:12:55.880
kminkov
And the capacity to use this as a way of assessing and bringing to another level. Hey, we discovered that the availability of residential treatment for kids with this behavioral consolation and Oregon is, you know, half of what's needed based on having utilized this tool for a while.

1:12:57.40 --> 1:13:16.790
kminkov
And or maybe that you have more than you need. I just don't know. But you know I think that's a rather long winded answer to a very complicated question, but those are the kinds of things that you know at least from my perspective we are eager to get into the details of figuring out the best way to do it.

1:13:26.670 --> 1:13:34.940
Dan Thoma
Alright, I'll take my turn now. Thank you. So Gary's question prompted a kind of a related follow-up question for me.

1:13:35.40 --> 1:13:57.70
Dan Thoma
So particularly, you know, when we first implement this, but probably for an extended period of time beyond the beginning, we're going to be in a situation where at least some, if not many or most, let's just say for example, residential providers don't have direct access to the tool.

1:13:58.550 --> 1:14:20.390
Dan Thoma
And as an insurer, we are we're going to be using it. Can you speak to how and you know there you've got pretty significant restrictions on like paper use of the tool or access to it. So can you speak to?

1:14:18.440 --> 1:14:33.740
kminkov
So what we did in California and this was written in the law as an insurer in Moda is a is a CCO. Dan, am I right about that or not a Co or sort of a CCO your commercial one.

1:14:29.950 --> 1:14:37.630
Dan Thoma
We're at, we're at commercial, we're at commercial insurer, but we also are participants in a couple of CCOs.

1:14:38.300 --> 1:14:44.610
kminkov
OK. And I'm sure I've heard the name before in, in the public space, so.

1:14:46.670 --> 1:15:2.560
kminkov
So the way that you know, the California law required that the insurers are able to make information about the tools available to anyone in their network, consumers, family members, providers, whatever. So when we license the tools to you guys.

1:15:3.840 --> 1:15:8.790
kminkov
There's a whole packet of stuff that you get that you can share with people.

1:15:9.480 --> 1:15:41.950
kminkov
It's not the same as in training, but they can see the tool. They can see how to fill out the tool. They can see that you know and it's provided in a way that says, you know, don't take this and deconstruct it, stick it in your EHR and say, yes, I have permission to do it electronically and blah, blah, blah blah blah, because that's not it. But yes, you have free access to knowing about the tool and getting all the information about it. And if you want training, then you can come to us and we'll train you. But we would, we don't think that's the most efficient, cost effective way.

1:15:42.910 --> 1:15:44.630
kminkov
You train large numbers of people just to have them just sign up for individual trainings and pay for individual trainings.

1:15:56.410 --> 1:15:56.740
kminkov
Right.

1:15:50.630 --> 1:15:58.640
Dan Thoma
Yeah. So we'll be able to go to providers and say, here's the information that we're going to need based on the materials that you'll be giving to us. Perfect. Thank you.

1:15:58.80 --> 1:16:9.670
kminkov
Yeah, but they can see the tool. They can see instructions on the tool manual. They can whatever you materials you choose to share. That way you can share.

F1:16:12.70 --> 1:16:12.690
kminkov
That's it.

1:16:16.590 --> 1:16:17.110
Dan Thoma
Thank you.

1:16:23.170 --> 1:16:27.40
SOUCY Cassandra * DCBS
Any last questions?

1:16:27.910 --> 1:16:31.880
kminkov
Oh and Dan and the same there's another packet for service users.

1:16:33.810 --> 1:16:34.940
kminkov
There's another little guide for patient I forget what we call it. I don't think we use consumers, but something like service users and families, you know, guide for service users, some families for each of the tools.

1:16:54.860 --> 1:16:57.50
SOUCY Cassandra * DCBS
Thank you for all of this information.

1:16:58.540 --> 1:17:6.590
SOUCY Cassandra * DCBS
I think if any of you have any follow up questions or your teams if they listen to this rulemaking advisory committee.

1:17:8.450 --> 1:17:19.310
SOUCY Cassandra * DCBS
We can certainly help pass that along to Ken and Ken are you open to being a resource if we've got implementation questions that come up awesome.

1:17:16.360 --> 1:17:32.110
kminkov
Oh, absolutely. I mean, I knew. I knew I was sticking my neck into that noose when I volunteered to do this, but we have a team of folks, you know, and the double ACP. And then we have another team for the child tools with the ACAP people.

1:17:33.670 --> 1:17:56.210
kminkov
So you know, and then if you start reaching out, we have a project manager named Stephanie Smith Dillard, who's our main person that we actually hire to take care of a lot of coordinating all these requests. But you haven't met her and you've met me. So, you know, you can contact me and then over time, we'll figure out the flow and get it all.

1:17:57.400 --> 1:18:10.110
kminkov
Well-oiled and we're anticipating you know we we've had a lot of, we've learned a lot and we've had a lot of good positive experiences working with the payers in California.