



# Accessing Emergent Behavioral Health Services and Treatment

*Mental Health Parity and Screening Policies for  
Medicaid Beneficiaries*

Kansas Department for Aging and Disability Services  
Behavioral Health Services Commission  
10/07/2015

How We Got Here and Why The Change

# MENTAL HEALTH PARITY

# MHPAEA Summary

- **The Mental Health Parity Act of 1996 (MHPA)** provided that large group health plans cannot impose annual or lifetime dollar limits on mental health benefits that are less favorable than any such limits imposed on medical/surgical benefits
- **The Paul Wellstone & Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)**
  - Extends the parity requirements to SUD
  - Requires a general equivalence in the way MH/SUD and medical/surgical benefits are treated with respect to
    - annual and lifetime dollar limits
    - financial requirements
    - treatment limitations
  - MHPAEA does NOT require large group health plans or health insurance issuers to cover MH/SUD benefits
  - Requirements apply only to large group health plans and health insurance issuers that choose to include MH/SUD benefits in their benefit packages

# MHPAEA Summary

- Applies to Medicaid non-managed care plans
- Children's Health Insurance Program (CHIP)
- Medicaid managed care programs
- 2010 the Affordable Care Act expanded application of MHPAEA to Medicaid non-managed care Alternative Benefit plan benefits
- November 2013: Final regulation implementing MHPAEA
- Regulation distinguished between quantitative and non-quantitative treatment limitations
  - Quantitative: visit limits, day limits
  - Non-quantitative: pre-authorizations

# MHPAEA's Requirements

- Financial requirements that are applied to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements that are applied to substantially all medical/surgical benefits. The statute defines “predominant” as the most common or frequent of such type of limitation or requirements
- There are no separate cost sharing requirements that apply only to mental health or substance use disorder benefits
- Treatment limitations that are applied to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations that are applied to substantially all medical/surgical benefits

# MHPAEA's Requirements

- There are no separate treatment limitations that apply only to mental health or substance use disorder benefits
- The criteria for medical necessity determinations with respect to mental health or substance use disorder benefits are made available to any current or potential participant, beneficiary, or contracting provider upon request (including reasons for denial)
- If a plan or coverage provides out-of-network coverage for medical/surgical benefits, it provides out-of-network coverage for mental health or substance use disorder benefits

# Concerns Relating To Mental Health Parity

- KMAP policy requiring completion of an acute hospital screen conducted by a qualified mental health professional (QMHP) in order for a hospital to receive Medicaid reimbursement for treatment
  - Tying a screen to payment reimbursement is not in compliance
  - State response: KMAP will be updated to reflect preadmission screens are no longer required in order to receive Medicaid reimbursement
- Requiring a screen by a Community Mental Health Center (CMHC) QMHP
  - Screening/prior authorization is a non-quantitative limitation
  - Hospitals can/should determine medical necessity
  - State response: received technical assistance from CMS regarding screening policies and processes, ultimately leading to new policies

Effective 10/12/2015 12:00 AM (CT)

# MEDICAID POLICIES FOR ADULTS

# Voluntary Admissions To A Community Hospital With An Inpatient Psychiatric Unit:

- Pre-admission screening (billed using T1023) is no longer required as one of the criteria for payment of an inpatient stay
- Medical staff assess and determine medical necessity for admission
- Hospital notifies MCO of admission and follows MCO utilization management policies and procedures
- The MCOs will apply their own criteria for payment of the stay based on medical necessity

# Admissions To A State Psychiatric Hospital

- KSA 39-1602 gives statutory authority to CMHCs to assess individuals for potential state psychiatric hospitalization
  - CMHCs will continue to assess individuals to determine whether a person, under either voluntary or involuntary procedures, can be evaluated or treated, or can be both evaluated and treated, in the community or should be referred to the appropriate state psychiatric hospital
- KAR 30-31-10 states in part that CMHCs shall provide, when necessary or requested and necessary, assessment of individuals in their catchment area to determine if a person needs admission to a state psychiatric hospital
- CMHCs will continue to use the KDADS approved instrument as part of assessment and documentation, including the disposition and signature by the QMHP
- State General Funds (SGF) will be used to reimburse CMHCs for responding to requests for an assessment and referral to a state psychiatric hospital

# CMHCs Roles

- Continue providing crisis responsiveness and triage in the community when necessary or when requested and necessary
  - Basic, Intermediate, and Advance Crisis Interventions
  - Mobile crisis services
  - Peer Support crisis services (if available)
  - This includes assessment and referral to a state psychiatric hospital
- When requested, assist community hospitals with diversions and linking individuals to the right level of care, services in the community
- Provide hospital liaison services and assist with discharge planning to those admitted

Effective 10/12/2015 12:00 AM (CT)

# MEDICAID POLICIES FOR CHILDREN & YOUTH



# Voluntary Admissions To A Community Hospital With An Inpatient Psychiatric Unit:

- Pre-admission screening (billed using T1023) is no longer required as one of the criteria for payment of an inpatient stay
- Medical staff assess and determine medical necessity for admission
- Hospital notifies MCO of admission and follows MCO utilization management policies and procedures
- The MCOs will apply their own criteria for payment of the stay based on medical necessity
- This policy also applies to free-standing Private Psychiatric Hospitals

# Admissions To A State Hospital Alternative (SHA) Facility For Children

- SHAs will follow same policy as adult state psychiatric hospitals
- CMHCs will continue to be the gatekeeper – providing assessment and evaluation to determine whether the child/youth can be treated in the community or referral to SHA as appropriate
- SGF will be used to reimburse CMHCs for this service

# Admissions To A Psychiatric Residential Treatment Facility

- PRTF admissions are not considered emergent, therefore pre-authorization is required
- The MCO shall facilitate consultation with representation from the responsible CMHC, the parents (as appropriate) or caregivers (including child welfare contractor or juvenile services case manager, if applicable), other persons knowledgeable about the child or adolescent, and the child or adolescent as appropriate
- If prior authorization is granted, MCO utilization management process will begin upon admission
- The frequency of MCO utilization management reviews shall be based on the individual needs of the member and be reflected in the member's Plan of Care

# Changes In Level of Care

- Pre-admission screening and prior authorizations are not required for emergent admissions
- Prior authorization is required for PRTF treatment
- Movement between levels of care other than a state hospital alternative can occur without pre-admission screening and will be coordinated by the MCO and with input from other responsible parties (see next slide for scenarios).

# Changes In Level of Care

## Scenario: PRTF to Acute

- If the youth is in a PRTF and an emergent event occurs, the receiving hospital will assess and admit if it is medically necessary
- The hospital follows MCO UM policies (notifies MCO member was admitted and so forth) and utilization management begins immediately
- The MCO will apply their own criteria for payment of stay based on medical necessity
- When the youth is stabilized, the MCO will give prior authorization to return to the PRTF if still medically necessary for that level of treatment

# Changes In Level of Care

## Scenario: Acute to PRTF

- If the youth is in an acute setting and PRTF level of care is being considered in lieu of returning to the community, contact the MCO and request consultation.
- The MCO will facilitate a conference involving all responsible parties and assess whether the youth can be treated in the community or if PRTF is appropriate
- If PRTF is appropriate, the MCO will give prior authorization and utilization management will begin upon admission

# CMHCs Roles

- Continue providing crisis responsiveness and triage in the community when necessary or when requested and necessary
  - Basic, Intermediate, and Advance Crisis Interventions
  - Mobile crisis services
  - This includes assessment and referral to a state hospital alternative for children and to PRTFs
- Upon request, assist with diversions and linking children and families to the right level of care, services in the community
- Provide hospital/PRTF liaison services and assist with discharge planning to those admitted

From Our Providers

# FREQUENTLY ASKED QUESTIONS



# FAQ From Community Hospitals

- **Do we need to gain prior authorization from an MCO before admitting someone into the hospital?** *No, not for emergent situations. Except in those circumstances as expressed under EMTALA, the hospital must comply with the utilization management policies and processes of the MCO to which the member is enrolled. The MCOs will apply their own criteria for payment of the stay based on medical necessity. Providers are required to follow all MCO utilization management policies and procedures. Provider's failure to follow these policies and/or not meet medical necessity can result in a denial of payment or recoupment of payments found that do not meet these requirements. If Medicaid but not assigned to an MCO, admission is subject to post pay review by KFMC.*

- **Our community hospital does not have an inpatient psych unit. If someone presents with a mental health crisis, what then?** *Call Kansas Health Solutions (KHS) hotline at 1-800-466-2222. KHS will contact your local community mental health center and dispatch crisis services. The CMHC can assist by providing a preliminary risk assessment, evaluation, linkage and referral to the appropriate level of treatment.*
- **What about psychiatric observation stays? Is this a billable service?** *Yes. Psychiatric observation beds should be billed using procedure code H2013 and are covered up to two consecutive days. During the observation period the patient must receive:*
  - *A physical examination*
  - *History and psychiatric assessment containing recommendations for ongoing treatment*
  - *An initial nursing assessment*
  - *Nursing progress notes written each shift*
  - *A discharge summary*

*A physician must admit the patient to an observation bed and discharge him or her at the end of the observation stay.*

- **What if the person presenting is not on Medicaid?** *If the person has private insurance you should follow their policies regarding admissions, medical necessity, notifications, etc., as well as adherence to EMTALA. If the person presenting may need state psychiatric hospitalization, contact KHS at 1-800-466-2222 and request crisis services. KHS will contact the local CMHC and they can assess and make referral to one of the state psychiatric hospitals, if necessary.*
- **Can we still involve the CMHCs with hospital diversions?** *Absolutely. CMHCs can respond to assess and triage, refer, and link individuals to community resources and treatment at the appropriate level. Contact KHS at 1-800-466-2222 to facilitate.*

# FAQ From PRTF Providers

- **Is there a 30-day or 60-day prior authorization period when a Medicaid member is admitted?** *No. If the youth is already enrolled in KanCare at the time he/she is admitted, MCO utilization management begins immediately. The frequency of utilization reviews is dependent on the needs of the youth. By federal regulation, the Plan of Care must be reviewed within every 30 days (see 42 CFR 441.155).*
- **What happens if the youth has never had Kansas Medicaid before so there is no MCO to contact?** *Medical necessity is determined by the PRTF provider (see 42 CFR 441.152 and 441.153).*

- **What about 31 days and the Child in Institution Medicaid application?** *Nothing changes. The PRTF submits application upon admission in anticipation of treatment lasting longer than 30 days. Upon approval, the youth is assigned to an MCO, Medicaid reimbursement is retroactive to day one, and the MCO will begin utilization management from the date of application approval.*
- **Prior to the youth receiving Medicaid benefits under the Child in Institution rule, who determines medical necessity?** *For non-MCO Medicaid youth, medical necessity for admission and continued stays are determined by the PRTF provider in accordance with federal regulations and state standards (see 42 CFR 441.152 and 441.153). Once the youth becomes Medicaid eligible and is assigned to an MCO, the MCO will determine medical necessity from that point forward during utilization management reviews, not retroactively.*
- **How does this policy effect private placement?** *It does not. These are Medicaid policies.*

# FAQ From CMHC Providers

- **What will happen to the screening form? Does this tool go away?** *The screening instrument is still an approved tool to use for gathering information and assessing individuals experiencing a crisis, helping determine the appropriate level of care and services.*
- **T1023 reimbursed CMHCs for providing crisis services, including completion of a screen. How will CMHCs cover the cost for providing crisis services?** *There are 3 billing codes; Crisis Intervention code H2011 (basic), H2011HK (intermediate), H2011 HO (advanced) and may be billed concurrently.*

## H2011 (HO) Advanced Crisis Intervention

Crisis Interventions are symptom reduction, stabilization, and restoration to a previous level of functioning. Activities include a **preliminary assessment of risk** (which may include an assessment of mental status and the need for further evaluation or other mental health services), immediate **crisis resolution** and **de-escalation**, and **referral and linkage** to appropriate community services to avoid more restrictive levels of treatment. This service also includes **contact with the client, family member, or other collateral sources** (e.g. caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to other alternative mental health services at an appropriate level. All activities must occur within the context of a potential or actual psychiatric crisis. Advanced Crisis Intervention **can occur** in a variety of locations, including an **emergency room** or **clinic setting**, in addition to **other community locations** where the individual lives, works, attends school, and/or socializes. Advanced Crisis Intervention may occur when assistance is needed to stabilize a person prior to an emergent admission. This level of intervention includes a clinician utilizing specific treatment interventions such as cognitive behavioral therapeutic techniques that **only a clinician can provide**.

- **The policy definition for H2011 (HO) in part states that this is provided face-to-face. Does the use of tele-video suffice as face-to-face? Yes. The policy is updated to state the following:**

*“Telemedicine: Advanced Crisis Intervention services, billed H2011 HO may be reimbursed when provided via telecommunication technology. When this service is provided via telemedicine, the CMHC QMHP provider must bill the procedure code (CPT code H2011) using the GT modifier and will be reimbursed at the same rate as a face to face service. “*



Open Discussion

Q & A

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