

5-000 THE BEHAVIORAL HEALTH BENEFITS PACKAGE

5-001 INTRODUCTION: 482 NAC 5-000 sets forth the responsibilities of the Behavioral Health Managed Care Organization (behavioral health plan) in delivering the Behavioral Health Benefits Package to the managed care client. While the provider is responsible for providing services to the client, the behavioral health plan, as the contracting entity with Medicaid, assumes primary administrative and operational responsibility for the development and implementation of the managed care requirements. In developing its program for the delivery of the Behavioral Health Benefits Package, the behavioral health plan shall incorporate the information contained in this Title, as well as 471 NAC, which defines in detail the minimum service provisions required for behavioral health services under Nebraska Medicaid.

5-002 BEHAVIORAL HEALTH MANAGED CARE PLAN: Medicaid managed care delivers the Behavioral Health Benefits Package to Medicaid clients through a Prepaid Inpatient Health Plan (PIHP). The following provisions describe the behavioral health plan's responsibilities in Managed Care.

5-002.01 General Requirements: The Behavioral Health Managed Care Plan (behavioral health plan) is responsible for establishing a statewide system of behavioral health services. The behavioral health plan is required to comply with, but is not limited to, the following general requirements:

1. Credential only providers enrolled in Nebraska Medicaid;
2. Provide a full array of services along a continuum of care in accordance with 471 NAC 20, 32, and 35 including active treatment;
3. Provide access to behavioral health services and necessary referrals 24 hours per day, 7 days per week;
4. Provide a client handbook, a comprehensive list of providers, and other informational materials about the Behavioral Health Benefits Package to the clients enrolled with the behavioral health plan. The plan is prohibited from performing any direct solicitation to individual Medicaid clients. Any general marketing to Medicaid clients must be approved by Medicaid prior to implementation and shall comply with the 482-000-9 marketing guidelines.
5. Comply with Medicaid's continuous Quality Assurance/Quality Improvement activities, provide behavioral health services meeting Medicaid's quality standards, and comply with all requests for reports and data to ensure that QA/QI performance measures are met (See 482 NAC 6);
6. Coordinate activities with Medicaid, other managed care contractors, and other providers for services, as appropriate, to meet the needs of the client, and ensure systems are in place to promote well-managed patient care;

7. Maintain, at all times, an appropriate certificate of authority to operate issued by the Nebraska Department of Insurance;
8. Prohibit discrimination against behavioral health providers based upon licensing;
9. Prohibit hiring, employing, contracting with or otherwise conducting business with individuals or entities barred from participation in Medicaid or Medicare;
10. Allow clients with chronic or severe conditions or experience-sensitive conditions, e.g., HIV-AIDS, to go directly to a qualified provider within the behavioral health plan's network;
11. Report all fraud and abuse information to Medicaid in a timely manner; and
12. Make available 24-hour, 7 days per week access by telephone to a live voice (an employee of the plan or an answering service) so that referrals can be made for non-emergency services or so information can be given about accessing services or how to handle medical problems during non-off ice hours.

5-003 BEHAVIORAL HEALTH BENEFITS PACKAGE GENERAL PROVISIONS: All services provided under managed care must meet the requirements of 471 NAC unless specifically waived by Medicaid. The provider and behavioral health plan shall apply the same guidelines for determining coverage of services for the managed care client as Medicaid applies for other Medicaid clients. Actual provision of a service included in the Behavioral Health Benefits Package must be based on whether the service could have been covered under Nebraska Medicaid on a fee-for-service basis under Title 471 NAC.

All services in the Behavioral Health Benefits Package must be provided or approved by the behavioral health plan.

5-004 SERVICES IN THE BEHAVIORAL HEALTH BENEFITS PACKAGE

1. Crisis Stabilization Services (see 471 NAC 20 and 32)
 - a. Crisis Assessment;
 - b. Sub-acute Hospital - Adults age 19 & over;
2. Acute Inpatient Hospital (see 471 NAC 20 and 32);
3. Residential Services (see 471 NAC 20 and 32)
 - a. Psychiatric Residential Treatment Facility (PRTF) - Children under age 19
 - b. Therapeutic Group Home (ThGH) - Children under age 19;
 - c. Professional Resource Family Care (PRFC) - Children under age 19;
 - d. Dual Disorder Residential - Adults age 19 & over;
 - e. Intermediate Residential for substance abuse - Adults age 19 & over;
 - f. Short-Term Residential - Adults age 19 & over;
 - g. Halfway House - Adults age 19 & over;
 - h. Therapeutic Community for substance abuse only - Adults age 19 & over;
 - i. Community Support for substance abuse - Adults age 19 & over;

4. Outpatient Assessment and Treatment (see 471 NAC 20 and 32):
 - a. Partial Hospitalization;
 - b. Day Treatment-Children under age 19;
 - c. Day Treatment for mental health-Adults age 19 & over;
 - d. Intensive Outpatient for mental health-Children under age 19;
 - e. Intensive Outpatient for substance abuse;
 - f. Medication Management;
 - g. Outpatient (Individual, Family, Group);
 - h. Injectable Psychotropic Medications;
 - i. Substance use disorder Assessment;
 - j. Psychological Evaluation and Testing;
 - k. Initial Diagnostic Interviews;
 - l. Home-based Multi-Systemic Therapy - Children under age 19;
 - m. Biopsychosocial Assessment and Addendum;
 - n. Sex Offender Risk Assessment - Children under age 19;
 - o. Community Treatment Aide (CTA) - Children under age 19;
 - p. Client Assistant Program (CAP);
 - q. Comprehensive Child and Adolescent Assessment (CCAA) - Children under age 19;
 - r. Comprehensive Child and Adolescent Assessment Addendum - Children under age 19;
 - s. Conferences with family or other responsible persons - Children under age 19;
 - t. Hospital Observation Room Services (23:59);
 - u. Social Detox - Adults age 19 & over;
 - v. Electroconvulsive Therapy (ECT) - Adults age 19 & over;
 - w. Crisis Outpatient Services - Adults age 19 & over;
 - x. Ambulatory Detoxification - Adults age 19 & over;
 - y. Psychiatric nursing (in home) - Adults age 19 & over;

5. Medicaid Rehabilitation Option (MRO) (see 471 NAC 35):
 - a. Psychiatric Residential Rehabilitation;
 - b. Secure Residential Rehabilitation;
 - c. Assertive Community Treatment (ACT) and Alternative ACT (Alt. ACT);
 - d. Community Support (MH);
 - e. Day Rehabilitation; and

6. Support Services:
 - a. Interpreter Services for behavioral health services;
 - b. Telehealth Transmission.

The services above represent covered services under Medicaid. The behavioral health plan is responsible for working with Medicaid to ensure the client has access to all services when medically necessary. The behavioral health plan must also ensure that the services provided to the client are accessible (in terms of timeliness, amount, duration, and scope) as those services provided to the non-managed care client.

The behavioral health plan shall provide the above services in amount, duration and scope defined by Medicaid in 471 NAC. The behavioral health plan can place appropriate limits on the above services based on medical necessity or utilization control. The behavioral health plan shall also ensure that the services provided to the client are as accessible (in terms of timeliness, amount, duration and scope) as those services provided to the non-enrolled Medicaid client.

The behavioral health plan is allowed to provide medically necessary services to the clients that are in addition to those covered under Medicaid. The behavioral health plan is also allowed to provide substitute health services when the behavioral health plan has determined it to be more cost effective than the covered service and the health status of the client is expected to improve or stabilize. If additional or substitute health services are provided, the total payment to the behavioral health plan will not be adjusted but will remain within the certified rates agreed upon in any resulting contract and approved by Centers for Medicaid and Medicare Services.

5-005 SERVICES FOR EMERGENCY MEDICAL CONDITIONS: Prior approval by the client's behavioral health plan is not required for receipt of behavioral health emergency services.

5-005.01 Emergency Services Provided to Managed Care Clients: The behavioral health plan must cover and pay for behavioral health emergency services regardless of whether the provider that furnishes the services participates in the behavioral health plan network.

5-006 PHYSICAL HEALTH COORDINATION ISSUES: The following rules apply when coordination of services is required between the physical health plan responsible for the Basic Benefits Package and the behavioral health plan responsible for the Behavioral Health Benefits Package, as addressed by the Medicaid in regulations governing both components of managed care. In situations where the client isn't participating in both components of managed care, the associated service is coordinated with Nebraska Medicaid on a fee-for-service basis.

5-006.01 Emergency and Post Stabilization Services for Behavioral Health Services: Behavioral Health Emergency and post stabilization services provided to a managed care client are the responsibility of the client's behavioral health plan.

The behavioral health plan is no longer responsible for the service at the time that an attending emergency physician or the provider actually treating the client initiates an evaluation and/or treatment of the client and determines that the services are medical. Coverage for services from that point forward must be obtained from the physical health plan.

5-006.02 Admissions for 24-Hour Observation: When a managed care client is admitted to an acute care facility as an outpatient for 24-hour observation for purposes of a behavioral health diagnosis, the behavioral health plan is responsible for payment of the observation stay. Authorization for the admission must be obtained from the behavioral health plan.

The behavioral health plan is no longer responsible for the service at the time that an attending emergency physician or the provider actually treating the client initiates an evaluation and/or treatment of the client and determines that the client does not have a behavioral health diagnosis. Coverage for services from that point forward must be obtained from the physical health plan.

5-006.03 Chemical Detoxification Services: Coverage for chemical detoxification hospital admissions must be obtained from the physical health plan, if the client is participating in the physical health component of managed care.

5-006.04 History and Physical (H&P) Exams for Inpatient Admissions for Behavioral Health Services: The H&P completed for an inpatient admission for behavioral health services is the responsibility of the physical health plan. The physician completing the H&P must obtain authorization from the physical health plan.

Inpatient behavioral health services provided to clients participating in the behavioral health component of managed care in a freestanding or hospital-based Psychiatric Residential Treatment Facility (PRTF) or Therapeutic Group Home (ThGH) are the responsibility of the behavioral health plan. H&Ps provided to managed care clients for these allowable services are responsibility of the physical health plan.

5-006.05 Ambulance Services for Managed Care Clients Receiving Behavioral Health Treatment Services: Emergency medical transportation, regardless of diagnosis or condition, is the responsibility of the physical health plan.

5-006.06 Injections Associated with Behavioral Health Services: Injections of psychotropic drugs in an outpatient setting are the responsibility of the client's behavioral health plan.

5-006.07 Lab, X-Ray and Anesthesiology Associated with Behavioral Health Services: Lab, x-ray, and anesthesiology services associated with behavioral health services such as ECT or CCAA, authorized by the behavioral health plan, are the responsibility of the physical health plan if the client is participating in the physical health component of managed care.

5-007 FEDERALLY QUALIFIED HEALTH CENTERS (FQHC): If behavioral health services are provided by the FQHC, the behavioral health plan shall contract with the FQHC or otherwise arrange for the provision of FQHC services.

5-008 PAYMENT FOR SERVICES: Payment of services provided to the behavioral health plan shall be a capitated payment. Medicaid pays a monthly capitation fee to the behavioral health plan for each enrolled client for each month of Managed Care enrollment. The monthly capitation fee includes payment for all services in the Behavioral Health Benefits Package.

The capitation payment rates are actuarially determined and are based on eligibility category and age. Medicaid shall adjust rates, and complete all necessary contract amendments, when it is determined appropriate, based on any program changes, or in instances where an error or omission in the calculation of the rates has been identified.

Payment to the MH/SA plan is payment in full for all services included in the Behavioral Health Benefits Package. No additional payment may be requested of Medicaid or the client.

5-008.01 Recoupments/Reconciliation: Medicaid shall not normally recoup payments from the behavioral health plan. However, in situations where payments are made incorrectly, Medicaid shall work with the behavioral health plan to identify the discrepancy and shall recoup/reconcile such payments.

5-009 BILLING THE CLIENT: The behavioral health plan may not bill a client for a Medicaid coverable service, regardless of the circumstances.

A provider of service may only bill the client pursuant to 471 NAC.