

Frequently Asked Questions on SB 58 Implementation

Authorizations and Claims

1. Can you provide clarification on how strict/closely will the MCOs follow the TRR guidelines?
The MCOs are required to follow the current DSHS Resiliency and Recovery Utilization Management (RRUMG). The individual's Level of Care will be determined by the ANSA/CANS. The MCO will be required to pay for all services allowed in the level of care service package. The MCOs have different outcome measures than has been required by DSHS in the past.
2. How long can a MCO take to authorize services?
The Uniform Managed Care Manual states the MCO has up to 3 business days to issue coverage determinations after the receipt of request for authorization of services. The MCO must respond within 1 business day for concurrent hospitalization decisions and within 1 hour for post-stabilization or life-threatening conditions, except that for Emergency Medical Conditions and Emergency Behavioral Health Conditions, the MCO must not require prior authorization.
3. Will the TRR serve as the authorization for counseling in LOC 2 or will providers be required to do additional authorizations?
No. HHSC has instructed MCOs that the current DSHS utilization management guidelines Texas Resilience and Recovery (RRUMG) service packages may include counseling, pharmacological management and other Medicaid covered mental health services and the authorization is for the entire service package.
4. How will providers send authorizations to MCOs (fax machines, email, other)?
HHSC has created a service request form that is included in Section 15.2 of the UMCM. LMHAs/Provider entities will need to negotiate that with each MCO on how that information is transmitted to the MCO. HHSC expects that MCOs offer as many options as possible and work in good faith with the LMHAs to develop a process that works for both entities.
5. For counseling services, currently MCOs require an authorization for these services, with the possibility of completing an authorization for the ANSA/CANS through the MCO – will MCOs still require counseling authorizations or combine into one as the TRR does?
HHSC has told the MCOs that the RRUMG service packages may include counseling, pharmacological management and other Medicaid covered mental health services and so the authorization is for the entire service package and only one form. Providers must complete the MH Rehab and TCM Services Request Form and submit to MCO, as required by the MCO.

6. Describe requirements of the first 90 day transitions for authorizations? How will this be done if they do not have access to CMBHS?

DSHS is providing HHSC will all the current authorizations by August 26th, 2014 and HHSC will supply to the MCOs. Previously approved client service packages will be grandfathered in for the purpose of continuity of care and reauthorization will not be required during the transfer from fee-for-service to managed care. After the first 90 days, notification and authorization requirements will be determined by the MCO and the provider. The MCO must accept the ANSA and CANS as long as it is valid under the DSHS Resiliency and Recovery Utilization Management (RRUMG) guidelines.

7. How will CMBHS be used in the authorization process?

DSHS and HHSC have agreed that providers will continue to enter the LOC-R and the LOC-A in CMBHS at this time for Medicaid managed care members. The MCO is responsible for determining requirements for authorizations for consumers that are enrolled in Medicaid managed care.

8. Can an MCO require prior authorization for crisis services?

Crisis Intervention services are considered emergency behavioral health services and do not require prior authorization but providers must follow current RRUMG.

9. What are the allowable authorization limits to be used by the MCO for MH Rehab and MH TCM?

The health plans must follow TRR and TMPPM and are not allowed to set additional prior authorization limits. There are no hard limits under TRR. There are limits for MH Rehab/MH TCM in the TMPPM as follows:

- i. TCM – 32 units (8 Hours) per calendar day*
- ii. Day Programs –G0177 may be reimbursed for up to 6 units (4.5 to 6 hours) per calendar day, in any combination, for clients who are 18 years of age or older.*
- iii. Medications Training and Support – H0034 may be reimbursed for up to 8 units (2 hours) per calendar day in any combination.*
- iv. Crisis Services – H2011 may be reimbursed for up to 96 units (24 hours) per calendar day in any combination.*
- v. Skills Training- H2014 may be reimbursed for up to 16 units (4 hours) per calendar day in any combination.*
- vi. Psychosocial Rehabilitation – H 2017 for nonemergency services may be reimbursed for up to 16 units (4 hours) per calendar day in any combination for clients age 18 and older. Emergency services may be for up to 96 units (24 hours) per calendar day in any combination.*

10. Will the MCOs be required to process multiple claims for the same service to the same member on the same day for MH Rehab and MH TCM?

Yes. HHSC instructed the plans on July 25, 2014, that they must be able to process multiple claims for multiple services on the same day, just as TMHP does today. The

MCO should lift the duplicate edit if necessary to be able to process multiple claims on the same day. Providers should not roll up the services into one claim line.

11. If the MCO and Center agree that the Service Request Form is not necessary, can they agree not to send it in on every member and to have it available upon request?

No. The MCO will need the Service Request Form in order to process Medicaid Fair Hearing letters as directed by HHSC. Without the form, the MCO will not have the required information.

12. MCOs are requiring Centers to bill Medicare and private insurance first for these services and be denied, before billing Medicaid. However, Medicaid is the only program that covers MH Rehab and MH TCM. They are Medicaid specific benefits. Will HHSC direct the plans that providers do not have to bill Medicare and private insurance first for these services?

MCOs may not require providers to submit a Medicare or private insurance denial for services that are never covered and/or paid by Medicare or private insurance, including Targeted Case Management and Rehabilitative Services that will be carved-in effective September 1, 2014. For dual eligible individuals, providers will not bill MCOs, as services for these individuals will be billed through TMHP as done before the 9/1/14 carve-in.

13. A MCO wanted use the Service Request Form as notification only and NOT consider the service request for to be a prior authorization process. However, they are reading TRR (see the quoted language below) and feel that means they have to prior authorize. *“authorizations at the LOC level and medical necessity determinations at the LOC level is requested prior to service delivery.”* HHSC has clarified with the MCOs that this authorization statement in TRR does not apply in managed care. This will be captured on the transition log for the MCOs and in the FAQs shared with MCOs and LMHAs.

14. We are seeking a better understanding of the following billing practices for group practices using CMS 1500:

Box 31 usually identifies the physician who rendered the service. Does the State currently accept the Group practice name (i.e. ABC Clinic) instead? (Transition Log Reference #79)

Yes the state currently accepts the Group Practice name in Box 31

15. Typically the rendering in the CMS 1500 24 I/J is the person who actually touched the member. If a supervising BH provider submits their information in the place of a non-licensed provider for the new BH services, how will we know who rendered the service? Historically we have needed to know the actual rendering provider because payment amount is based on level of licensure. For these services, is the reimbursement the same regardless of level of licensure (or no license)? (Transition Log Reference # 148)

For mental health rehab and mental health targeted case management the MCO may not require the name of a rendering provider on claims submitted to the MCO if that provider is not a type that enrolls in Medicaid (CSSPs, Peer Providers, Family Partners, and some QMHPs). A rendering provider number is only required if the individual delivering the service is licensed and has a Medicaid provider number.

16. For behavioral health carve-in, what will be the requirements concerning behavioral health for pre-authorizations on existing members. Will HHSC require a transition period for honoring new authorizations? Will the health plans need to perform re-assessments after a time certain for existing members? When will HHSC provide the current authorizations for this program? (Transition Log Reference #163)

All acute care service authorizations must be honored for up to 90 days per the managed care contracts, including the new behavioral health services being added for 9/1/14. To determine when reassessments for Mental Health Targeted Case Management (TCM) and Mental Health Rehabilitation services must be completed, please refer to the Resiliency and Recovery Utilization Management Guidelines (RRUMG) in Chapter 15.1 of the UMCM. HHSC will provide the MCOs MH TCM and MH Rehab service authorization data no later than August 26th, 2014.

17. Related to Targeted Case Management: Please confirm all modifiers listed for the service must be included on the claim (excluding HZ). For example, a claim for routine case management for a child would be represented by T1017 TF HA. (Transition Log Reference #170)

Yes, all modifiers appropriate for the particular service/person must be included on the claim.

18. Related to Targeted Case Management: Is specific positionality required for the modifiers or can they appear in any order on a claim? (Transition Log Reference Number 172)

HHSC does not require a specific order of the modifiers on a claim for this particular service.

19. Related to Targeted Case Management: We have been unable to locate all of the procedure code/modifier combinations on the TMHP fee schedule. Please clarify which fee schedules contain the rates for these combinations. (Transition Log Reference Number 173)

HHSC provided this information to the MCOs on 4/4/14 through Michelle Zook.

20. We understand that the requirement is that we are able to accept electronic claims through our health plan web portal. To be more specific, our MCO can accept facility claims in 5010 837I format either singly or in batch format and that all costs associated with such functionality shall

be borne by our MCO. (Transition Log Reference Number 184)

Is this understanding correct?

Correct.

21. HHSC indicated LMHAs are contracted with TMHP as facilities but also indicated they may be provider groups. For provider groups, the MCOs are required to include a rendering provider ID on the encounter submitted to TMHP. Will TMHP be changing the edits in their system so our encounters can be accepted without a rendering provider ID? (Transition Log Reference # 229)

LMHAs are enrolled in Medicaid as a facility type Multi-specialty clinic. Per the UMCC Section 8.2.7.3 the MCO must maintain a qualified Network of entities, such as Local Mental Health Authorities (LMHAs) and multi-specialty groups that employ providers of these services. As per the UMCM Chapter 15.1, the MCO may not require the name of a performing provider on claims submitted to the MCO if that provider is not a type that enrolls in Medicaid. TMHP will accept an encounter without the rendering provider for groups so for encounters where a non-licensed, non-Medicaid enrolled provider renders the service they will not be required to put their rendering provider information on the claim.

22. Our MCO met with LMHAs and in discussion of crisis intervention and billing for those services, the LMHAs indicated that now bill with a non-specific diagnosis code of 799. As this is a non-specific diagnosis code our claims system will deny this code for a more specific code. We understand from the LMHAs that this has not been an issue when billing traditional Medicaid. Our concerns are (a) if we submit an encounter to HHSC with the diagnosis code, will HHSC accept the encounter?; (b) is it HHSC's expectation that MCOs allow billing outside standard billing requirements by these providers?; (c) can HHSC provide written assurance that we will not be later penalized if we make this exception? (Transition Log Reference # 237)

The MCO must authorize Mental Health Rehabilitative Services and Targeted Case Management in accordance with UMCM Chapter 15. As described in the UMCM, from September 1, 2014, to August 31, 2015, the MCO must authorize Mental Health Rehabilitative Services and Targeted Case Management using the DSHS Resiliency and Recovery Utilization Management Guidelines (RRUMG). In the current RRUMG a mental health diagnosis is not required for admission to Level of Care- 0 which is crisis services only. The provider should use the non-specific diagnosis code 799. All other Levels of Care require a mental health diagnosis which is detailed in the RRUMG.

23. Eligibility for these programs is clearly defined in HHSC's presentation, however, specific Diagnoses that are covered is not identified. Will these be defined? (Transition Log Reference #240)

The MCO must authorize Mental Health Rehabilitative Services and Targeted Case Management in accordance with UMCM Chapter 15. As described in the UMCM, from September 1, 2014, to August 31, 2015, the MCO must authorize Mental Health Rehabilitative Services and Targeted Case Management using the DSHS Resiliency and Recovery Utilization Management Guidelines (RRUMG). Within the RRUMG the diagnosis required for each level of care is described. For children it is based more on the Severity & Complexity of Symptoms along with a mental health diagnosis.

24. What specific encounter data requirements are there for these types of provider claims (CSSPs, Peer Providers, Family Partners, and some QMHPs)? We are concerned that if these providers bill on a CMS-1500, then they are required to be enrolled with Texas Medicaid as per 837P Encounter requirements or else the encounters will reject at TMHP. The rendering (performing) provider's NPI is required per 837P Encounter requirements. Please confirm. (Transition Log Reference #273)

MCOs will process the credentialing and claims in the same way TMHP does it today: at the agency level.

25. Behavioral Health Respite Care will be covered as part of the PSR/ TCM service array, however the Respite Code S5151 is not listed within the PSR/ TCM services codes that were provided. In addition, our understanding is that there is not a separate FFS rate for Respite Care and that LMHAs currently use General Revenue funds to cover Respite Care.

- a. Will LMHAs work through the MCOs for authorization and billing of Respite Care?
- b. If so, what code will be used for Respite Care and will it follow standard Encounter requirements?
- c. If not, will the LMHAs still have to Encounter for Respite Care? (Transition Log Reference #292)

As per the contract the MCO must cover Mental Health Rehabilitative Services and Targeted Case Management in accordance with UMCM Chapter 15. As described in the UMCM, from September 1, 2014, to August 31, 2015, the MCO must cover Mental Health Rehabilitative Services and Targeted Case Management using the DSHS Resiliency and Recovery Utilization Management Guidelines (RRUMG). In accordance with UMCM Chapter 15, the MCO is not responsible for providing any services listed in the RRUMG that are not Covered Services. Respite is not a covered service.

26. The form does not address standard therapeutic vs High Needs therapeutic within a care package. For example: LOC-2 ; Level of Care 2 Estimated Utilization Per Month; Standard Therapeutic 3.25 hours per month and High Need Therapeutic-5.5 per month. Question: Does the form need to reflect this or are we to simply authorize the High Need Level? (Transition Log Reference #313)

If the MCO is going to require an authorization process, HHSC requires the MCOs to authorize at the highest level of service, up to the maximum allowed number of units allowed under the TMPPM.

27. Will the MCO still be able to require authorizations for inpatient hospitalizations and/or observation stays despite an authorization for TCM/MH Rehab services? (Transition Log Reference #321)

Inpatient hospitalization services as defined by the UM guidelines require a separate pre-authorization process, consistent with MCO procedures. Observational stays are not considered inpatient hospitalization stays and MCOs should follow UM guidelines related to these services. Observational stays are referenced under crisis services of the UM guidelines.

28. Please clarify if the MH Targeted CM and Rehab Services Request Form will be amended to remove the references to CANS/ANSA scores, as it is our understanding that a score is not produced upon completion of the assessment, but rather a level of care. (Transition Log Reference #327)

You are correct, the Request Form will be revised to remove the CANS / ANSA scores. So that HHSC can ensure all feedback and modifications are included in this form, the next revision will be sent to plans at a later date, likely post-9/1/14. This will minimize confusion and ensure multiple iterations of the form will not be distributed.

29. We also request that future revisions to the MH Targeted CM and Rehab Services Request Form include expansion of the text field utilized to provide the rationale of deviation from the recommended level of care. Alternately, include instructions to direct the provider to submit an additional page, if necessary, to adequately document the rationale. (Transition Log Reference #328)

HHSC has distributed the word version of this document to as part of the agenda for the 8/1/14 Carve-in Meeting (sent 8/1/14). In the PDF version of the form currently online (located here: <http://www.hhsc.state.tx.us/medicaid/managed-care/UMCM/Chp15/15-2.pdf>), text entered that populates several lines automatically generates a scroll bar that allows the editor to submit additional information.

30. Regarding the service request form Chapter 15.2, we notice the Child/Adolescent section does not contain all levels e.g., 1.1, 1.2, 2.2, 2.3, 2.4. Shouldn't these be listed as options for requesting authorizations?

These levels of care are relevant to the past UM guidelines, Texas Resilience and Recovery and are not related to the current UM guidelines.

31. Regarding ANSA/CANS submissions- It is our understanding that Non LMHA providers do not have access to the CMBHS system as contracting has not been completed. What date is targeted

for contracting to be completed and those providers to have access to the Columbus system? If after 9/1 is there a mitigation plan put into place to allow for those providers to submit assessments?

Non-LMHA providers will have the ability to access the CMBHS system beginning September 1, 2014. However, any non-LMHAs will require training on using the CMBHS system and DSHS will work individually with each provider for initial system set-up. Although technically each provider will have access to the CMBHS system, new providers must undergo training to utilize it effectively. DSHS is in the final stages of including the user agreement and instructions for accessing the CMBHS system on their website. HHSC will send this information to the health plans as soon as it becomes available. HHSC will share this information as soon as it becomes available from DSHS.

For providers who assume services for individuals who have been previously assessed by an LMHA, MCOs will honor the assessment for up to 90 days as communicated through previous guidance.

32. Regarding DX7999/V7109 for H2011- Where can we find the documented mandate requiring MCOs to process and pay the H2011 code with this DX?

This information is included in the Texas Resilience and Recovery Utilization Management Guidelines. A diagnosis code of 799.9 notates an unknown diagnosis. HHSC expects MCOs consider this diagnosis a billable medical code that can be used to specify a diagnosis on a reimbursement claim. According to the UM guidelines, no diagnosis code is needed for crisis services.

33. Regarding Multiple Claims for procedure codes- Where can we find the documented mandate requiring MCOs to accept and pay for multiple claims even if they appear to be a duplicate?

HHSC has provided guidance to MCOs that they must accommodate multiple claims during the same day for behavioral health services. Each MCO has provided to HHSC a "work-around" which allows services of this type to be paid rather than denied. Additionally, the work around proposed was not a solution where the Provider was required to "roll-up" units of service for the same day to allow the claim to adjudicate to paid status. HHSC expects the work-around ensure the claims paid are valid instances of unique services that indeed occur at different times during the same day.

34. Our MCO will be asking that the service request forms be faxed to us by the LMHA and will return the faxed approval to them. In order to do that they need our FAX number and we will need

their FAX number. May we put our fax numbers and include a blank for their FAX number? This is how our current BH prior authorization and CCR requests are handled. If so we can include a copy of the form including these numbers in the Provider letters we will be sending out.

LMHAs have been provided a grid that includes all contact information and SRF submittal instructions for MCOs. HHSC is requiring that providers and MCOs use an unmodified version of the SRF as included in the Uniform Managed Care Manual Chapter 15.2. However, MCOs may offer providers a form that includes additional information such as fax numbers necessary for submittal. HHSC will allow providers to use versions of the form that include minor modifications (fax number, MCO name, MCO contact information, etc.), but providers are not required to do so. MCOs may not remove or modify any fields on the SRF.

35. Please describe the process for billing dually eligible individuals receiving Mental Health Rehabilitative Services and Targeted Case Management.

All dual eligible individuals will have Medicaid acute care services paid through TMHP, just as LMHAs do prior to 9/1. The wraparound Claims for services such as Mental Health Rehabilitation Services and Targeted Case Management that are not covered by Medicare will be paid through FFS as they are paid today.

36. LOC – 9 is not specifically outlined in the Texas Resilience and Recovery Utilization Management Guidelines

How will we determine the CORE/Adjunct Services that will be provided in this LOC (Targeted CM, Skills Training, Medication Training & Support, etc.?).

Level of Care 9 will be generated by the CMBHS system (after a provider enters in ANSA information) if the consumer assessed does not have a diagnosis of bipolar disorder, major depression or schizophrenia. Under these circumstances, CMBHS will generate LOC-9. If an LOC-9 is generated by the system, a provider will always request a different level of care based on clinical assessment. So in summary, there are no Core or adjunct services that will be provided or requested under this level of care. HHSC is aware this level of care is listed on the Service Request and Authorization form and will be removing this in future iterations of the form.

37. It was our understanding that if a previously approved client service package was due for reassessment during the 90 day transition period, the LMHAs would complete that reassessment. Is HHSC stating that this will not be the case during the 90 day transition period?

You are correct—if services are due for reassessment during the 90-day transition period, that reassessment is required for continued services.

38. The response to this question still indicates that MCOs will receive service authorization data no later than August 15th 2014. On the call on Friday 08/15/2014 HHSC indicated this information would not be available until the week of 08/25/2014. Which is the correct date?

This information has now been provided to the MCOs. HHSC has sent a crosswalk that includes additional detail related to the provider entity.

39. Does response provided regarding positionality of modifiers on claims also apply to the submission of encounters by the MCOs?

No, there is no positionality of modifiers requirements for encounters sent to HHSC. However, MCOs may have positionality of modifiers requirements for providers.

40. How will HHSC know that an encounter submitted by an MCO is for services provided by a non-licensed provider and therefore the encounter should not be rejected by HHSC?

HHSC will not reject encounters submitted where the rendering provider is a non-licensed provider and therefore no rendering provider information is included in the 24J box of the CMS 1500 form.

41. HHSC's response did not respond to the concern regarding the submission of encounters by an MCO with this diagnosis code. Historically encounters submitted with "dump codes" have not been accepted and the MCOs have had resubmit the encounter with a more specific diagnosis code. Please address this issue.

799.99 is a valid DSM-IV code. MCOs that submit this code on encounters related to Crisis services where the member is newly presenting for services will not be required to re-submit with another DSM-IV diagnosis.

42. Please clarify that the use by LMHAs of diagnosis code 799.9 is only acceptable for crisis services. Or is HHSC allowing the use of 799.99 for other services beyond crisis services?

This code is only applicable for crisis services, and diagnosis codes are needed for all other levels of care.

43. If the MCO has a concern regarding the validity of the services being billed as "unique services", can the MCO deny these services and request additional documentation from the LMHA?

If this question is related LMHAs billing multiple services within the same day, HHSC has provided direction to MCOs to accommodate a solution for this that does not include denying claims or “rolling up” claims into a single submission in order to adjudicate. As previously directed, HHSC expects that a process is established that ensures the MCOs are able to handle multiple claims submitted within the same day. HHSC is not allowing a modifier to be used.

44. A question was raised during the call with HHSC Friday (8/8) regarding code J1265 (injectable). The code is currently listed on the TMHP fee schedule however it is not referenced in the TRR UM guidelines.

This is a covered service outside of the behavioral health carve-in. This is not part of the array of any new behavioral health services.

45. Some providers are listed as "numbers" vs. an actual provider name on the MCO report for SB58 services. Could the state please provide the provide name to the MCO?

The provider name crosswalk was provided to the MCOs on Thursday, August 28th from Leslie Gibson. Please contact allen.pittman@hhsc.state.tx.us if you would like this file resent to your MCO.

46. An MCO is stating that it will only authorize services back one day from the date they receive the SRF. They will not pay for services before that date. It was our understanding that plans would be authorizing back to the assessment date so that we could provide services as soon as the individual presented and was assessed. Please clarify.

LMHAs are required to submit the SRF to the MCO within 5 business days of the assessment and MCOs must authorize back to the assessment date that is listed on the SRF. If an LMHA does not submit the SRF within 5 business days of the assessment, the LMHA is financially at risk for services occurring more than 5 days before the SRF was submitted if the MCO denies the services. This timeline accommodates multiple processes that some LMHAs must complete to derive a Level of Care (LOC). MCOs are authorized to increase the timeline to more than 5 business days, but are not authorized to mandate a shorter timeline for submitting the SRF after assessment. If an MCO requires authorization for deviation of services from one LOC to another, LMHAs are financially at-risk for any services provided within the new level of care before authorization from the MCO.

47. Per the State/Encounter directive, PSR/TCM services are to be billed under their group ID. According to CMS regulations, we cannot “direct” an OON provider on how to bill.
- For OON MHMR’s, can we enforce this rule and deny their claims if they bill under the individual clinician?

HHSC is investigating the answer to this question and will provide a response soon.

48. Per the State directive, we are not to deny MHMR PSR/TCM claims when billing for duplicate services on the same day.

- Does this exception include the OON MHMR’s as well?
- If so, is there a list of TIN’s to identify all of the OON MHMR’s in order operationalize this? We are at risk of denying OON MHMR claims without being able to identify them.

HHSC is investigating the answer to this question and will provide a response soon.

49. Please clarify the section in the TMPPM that expresses some mental health professionals are paid “...70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085.”

Although the TMPPM does not specifically exclude the SB 58 services of mental health rehabilitation and mental health targeted case management from the 70% guidance, this language does not apply to services carved in under SB 58. The 70% stipulation is not included in the "note codes" of the fee schedule and was not discussed during any of the presentations of the roll-out and therefore does not apply to SB 58 services.

Credentialing

1. What are the MCO requirements for credentialing related to non-licensed staff?

The MCO must credential Provider organizations, and any licensed Network Providers providing services through one of these entities, in accordance with the Contract but not the non-licensed providers. The MCO is prohibited from establishing additional supervisory protocols beyond the HHSC contract and manual.

The MCO will not individually credential Providers of Mental Health Rehabilitative Services and Targeted Case Management who are not licensed providers types enrolled in Medicaid, such as a Peer Provider (PP), Family Partner (FP), Community Services Specialist (CSSP), and Qualified Mental Health Professional for Community Services (QMHP-CS) if the QMHP is not also a Licensed Practitioner of the Healing Arts (LPHA.)

2. Regarding some of the new types of BH providers, our MCO understands the HHSC position is that the MCO will process the credentialing and claims in the same way TMHP does it today—at the agency level. We have been asked to confirm that in accordance with this direction, the MCO does not need to require the rendering clinician information in any box on the claim form. (Transition Log Reference #76)

As any paper or electronic claim adjudicated by the MCO must be submitted to HHSC as an encounter, MCOs should ensure that all data elements required on the applicable 837 transaction is required for original claim submissions. In general, MCOs should utilize existing claim adjudication and encounter submission requirements to adjudicate claims and submit encounters for BH services. However, for mental health rehab and mental health targeted case management the MCO may not require the name of a rendering provider on claims submitted to the MCO if that provider is not a type that enrolls in Medicaid (CSSPs, Peer Providers, Family Partners, and some QMHPs).

3. UMCM 15.1 states: The MCO must credential Provider entities, and any licensed Network Providers providing services through one of these entities, in accordance with the Contract.

NCQA and the TMPPM do not require credentialing of individuals within a facility. This includes hospitals, as well as ambulatory behavioral healthcare facilities. This statement is telling us that the employees within the LMHA, like Licensed Social Workers, and Psychologists, will require credentialing? Please clarify.

HHSC will update this to read that the UMCM Chapter 15.1 will be updated to reflect that the MCOs must credential Provider entities, in accordance with the Contract and the TMPPM. HHSC will remove the requirement that MCOs must credential “any licensed Network Providers providing services through one of these entities.”

Covered Services

1. Has there been discussion of MCOs considering allowing Peers to provide Rehab services?
As per the current Texas Medicaid state plan, Peers and family supports can provide MH Rehab in FFS and managed care.
2. Would MCOs consider allowing Peers to provide Case Management?
*TCM are outlined in our Medicaid state plan and are the same in FFS and managed care. If a peer meets the criteria they should be able to provide TCM.
A qualified provider of mental health targeted case management must:*

Demonstrate competency in the work performed; and Possess a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or Be a Registered Nurse (RN)

3. Are MCOs acknowledging the difference between Intensive Case Management and Routine Case Management?

Yes, they are required to do so.

4. Has there been any discussion of MCOs allowing CM and Rehab to be done through tele-video?

The current Medicaid telemedicine rules apply.

5. Is TCOOMI funded rehabilitation and targeted case management included in the carve-in?

The MCO is not responsible for providing Criminal Justice Agency funded procedure codes with modifier HZ because these services are excluded from the capitation.

6. Proposed contract and UMCC language changes state that the MCO Service Coordinator will develop the service plan as part of targeted case management. Is the intent of this language to prohibit the Local Mental Health Authority (LMHA) from providing the development of the service plan? If so, are the MCOs allowed to contract LMHA services to assist in this process under the oversight of the MCO Service Coordinator and utilization management process? (Transition Log Reference #98)

The draft language was changed please reference 8.2.7.3 Mental Health Rehabilitative Services and Targeted Case in the UMCC. The new language does not prohibit the LMHAs from developing the service plan. LMHAs and other providers will be able to provide targeted case management services which include development of the service plan and mental health rehab services with the authorization of the MCO.

7. Regarding Employment Assistance (EA):

We understand this is currently a benefit for *STAR+PLUS Waiver (SPW)* waiver members and for those with targeted case management – will we get data on members joining our plans already receiving services? (Transition Log Reference #95)

EA is a new service to the SPW. It is not associated with targeted case management. It is possible that an MCO may enroll an individual into the SPW who has been receiving EA through an Intellectual and Development Disability (IDD) service and would need to get a signed consent to request documentation related to EA.

8. We know the BH services of Targeted Case Management and Mental Health Rehab apply to STAR and STAR+PLUS, but does it also apply to CHIP? Are these services outlined or identified in the CHIP Evidence of Coverage (EOC), and if not will they be? (Transition Log Reference #194)

SB 58 does not require MH rehab services or targeted case management be provided under the CHIP program. However, certain mental health services are required to be provided by CHIP MCOs today as outlined in the CHIP EOC.

9. For the employment benefit referenced in the behavioral health carve-in (rehab services), will the benefit mirror what will be provided in the STAR+PLUS waiver, or will this be a stand-alone benefit specific to this population and this program? It appears the benefit is more limited than what is provided under the STAR+PLUS waiver. (Transition Log Reference #215)

Employment related services that provide training and supports that are not job specific and have as their focus the development of skills to reduce or overcome the symptoms of mental illness that interfere with the individual's ability to make vocational choices, attain or retain employment can be provided under Skills Training and Development. These services should not be confused with Employment Assistance or Supported Employment allowed under the HCBS STAR+PLUS Waiver.

MCO Contracts

1. What is the Readiness Review requirement related to claims payment?
Each MCO must attest to HHSC that the plan has run test claims from the Center to determine the systems readiness to pay claims. Claims testing must be electronic. MCOs must reach out to any contracted provider and provide opportunities to submit test claims and other documentation. The MCO must also verify it accepts all payable codes and modifiers as outlined in the Texas Medicaid Provider Procedures Manual (TMPPM). The MCO will attest to HHSC that they have completed this process by August 15, 2014.
2. Does HHSC have one contract with all MCOs or does that vary by plan?
There is one uniform managed care contract for STAR, STAR+PLUS and CHIP and then another contract for STAR Health.
3. What rate setting data has been shared with the MCOs?
HHSC has shared the current FFS rates for the MH Rehab and MH TCM with the MCOs but negotiations on the rates is determined between the provider and the MCO.
4. Describe the plan to an appeal process, or how HHCS can be used for unfair practices by the MCOs?
Provider appeals and complaints processes can be found in the managed care contracts in section 8.2.4. and 8.2.4.1. HHSC assigns a health plan manager to each MCO, who can work on provider complaints.
5. What are the requirements for developing a network of providers for MH Rehab and TCM?

The MCO must maintain a qualified Network of entities, such as Local Mental Health Authorities (LMHAs) and multi-specialty groups, who employ providers of MH Rehab Services and Targeted Case Management. Provider entities must attest to the MCO that the organization has the ability to provide, either directly or through sub-contract, Members with the full array of RRUMG services.

6. Do the DSHS TAC rules apply to Medicaid managed care contracts for MCOs or providers?
HHSC legal has determined that the current DSHS TAC rules that govern LMHA's for the provision of mental health services (see below list of rules) only apply to LMHAs when they contract with the department (DSHS) for those services and do not apply when LMHAs contract for services in Medicaid managed care. HHSC legal and DSHS legal will be working together to incorporate some of the TAC rule language that applies to consumer rights and protections into the managed care contracts. This new language would apply to all providers who provide services in Medicaid managed care and not just LMHAs.
 - *Chapter 401, Subchapter G (Rights of Persons Receiving MH Services)*
 - *Chapter 412, Subchapter D (Admission, Continuity, and Treatment)*
 - *Chapter 412, Subchapter G (MH Community Services Standards)*
 - *Chapter 414, Subchapter I (Consent to Treatment with Psychoactive Medications-MH Services)*
 - *Chapter 415, Subchapter A (Prescribing Psychoactive Medications)*
 - *Chapter 415, Subchapter F (Interventions in MH Programs)*
7. Are the MCOs responsible for the Medicaid Fair Hearing Process for its members for all services? The Community Centers are currently responsible for following the Medicaid Fair Hearing Process, including send letters to consumers.
MCOs are responsible for the Medicaid Fair Hearing process for their members and the services provided under their contract to the members. HHSC will be providing MCOs with additional guidance related to the fair hearing process in the near future.
8. Will the MCOs be required to process multiple claims for the same service to the same member on the same day for MH Rehab and MH TCM?
Yes. HHSC instructed the plans on July 25, 2014, that they are only allowed to use the TMHP edits for these services. They must be able to process multiple claims for multiple services on the same day, just as TMHP does today. Providers should not roll up the services into one claim line.
9. When can MCOs expect the list of Significant Traditional Providers (STP)? Or, if there is a list available to the MCO's on a HHSC site? (Transition Log Reference #29)

HHSC provided the Behavioral Health STP's on 01/30/14.
10. BH: Can the MCOs request the assessment be done more often than annually? (Transition Log Reference #205)

The CANS and or ANSA assessment must be completed as per the recommendations outlined in the Resiliency and Recovery UM Guidelines links to the UM Guidelines can be found in the UMCM Chapter 15.1.

11. The logistics of exactly what information/forms and how they will be transferred between the Plan and the Provider needs to be determined. (Transition Log Reference #220)

HHSC continues to work closely with MCOs and LMHAs on what forms and authorizations are necessary for the behavioral health carve-in. HHSC will be polling MCOs on critical data elements necessary for service authorization and claims information.

DSHS Requirements

1. The funding will be moving from DSHS to HHSC, is there already a plan in place between DSHS and HHSC?
Yes GR funding will be transferred from DSHS to HHSC for Medicaid matching funds. Some funds will remain with DSHS to account for the Medicaid matching funds for the FFS population.
2. How will the approvals of authorizations in CMBHS be impacted by the implementation of SB 58?
DSHS and HHSC have agreed that providers will continue to enter the LOC-R and the LOC-A in CMBHS at this time for Medicaid managed care members.
3. Will the LMHAs be held to the wraparound measurement for the MCO?
For consumers that are enrolled in managed care the MCO will not pay for non-Medicaid services. Those services are funded by GR and will not be paid by the MCO.

Other

1. Can we get information on the number of enrollees in the BH carve-in by MCO; by product service delivery area and utilization data associated with the members? (Transition Log Reference #57)
On 01/30/14 HHSC provided mental health rehabilitation services and mental health targeted case management services broken down by service delivery area. HHSC will not be providing this data by MCO.
2. Will we be required to list supportive employment, employment assistant, and targeted case management providers in our provider directory? If required, which data elements will be required, as noted in section A.? Information on Provider Listings, from the UMCM Provider Directory Critical Elements? (Transition Log Reference # 154)

MCO's will not be required to list supportive employment and employment assistant providers in the provider directories. Staff is working to update the UMCM, Ch. 3.1; Provider Directory to require MCOs to designate which providers can provide mental health rehabilitation and mental health targeted case management in the online directories. To provide these services, providers must be able to provide the full array of mental health rehabilitation and mental health targeted case management services. Nothing will change for providers of other BH services.

3. BH: Can we get a list of the assessment fields captured in the current CMBS system? (Transition Log Reference # 204)

The links to the CANS and ANSA assessment tools that list all the fields can be found in the UMCM Chapter 15.1

4. How will the plan train our staff on the CANS/ANSA? Will the plan contract with us for this task? We understand this to be the MCOs' responsibility and were informed of this by Melissa Rowan/TX Council at last week's Behavioral Health Consortium. (Transition Log Reference #219)

The MCO must ensure during SFY 2015 that Providers of Mental Health Rehabilitative Services and Targeted Case Management use, and are trained and certified to administer, the ANSA and CANS assessment tools to recommend a level of care to MCO.

5. HHSC hasn't published UMCM Chapter 15.1, when will this occur? (Transition Log Reference #239)

Linda Williams sent UMCM Chapter 15.01 MH Targeted CM and MH Rehab Services and 15.2 MH Targeted CM and MH Rehab to MCOs for review on 6/18/14.

6. Does HHSC have any expectations on what information needs to be provided to our Member Hotline staff regarding the carve-in during "training"? (Shouldn't this transition be essentially seamless or invisible to the member?) (Transition Log Reference #242)

HHSC expects MCOs to train member hotline staff on all new 9/1 initiatives. Please refer to resources provided by Monica Thyssen, including the training presentation 05-19-14-Behavioral Health Carve-Update-Mthyssen.pptx

8. The new PST/ TCM Services Request Form (SRF) is a locked version. Could we have an unlocked version that would allow Providers to cut and paste information into a portal-based request function? (Transition Log Reference #293)

Based on feedback from MCOs and LMHAs, the SRF has been revised and updated. Plans will receive this form through the normal contracting notification process and have an

opportunity to provide suggestions. This updated form will replace version 1 of the form in the UMCM Chapter 15.2.

9. UMCM 15.2 Final Template- Could address or Site location be added to the provider information at the bottom of the form?

This information has been added to the Service Request Form.

10. HHSC expressed the Service Request Form had to be updated/amended because it included the ANSA/CANS score. Any chance you could add a line that reads " Reassessment YES / NO And if possible a line that reads "Previous Assessment Date _____

HHSC has amended the Service Request Form to include a field which notes if the data represents a reassessment. Although HHSC did not include a field that reads "Previous Assessment Date," MCOs may direct providers to include that information in the "Purpose of Form" Field.

11. Please clarify if the MH Targeted CM and Rehab Services Request Form will be amended to remove the references to CANS/ANSA scores, as it is our understanding that a score is not produced upon completion of the assessment, but rather a level of care.

This information has been removed from the updated version of the Service Request Form (UMCM 15.2).

Youth Empowerment Services (YES) Waiver

1. Can you please provide guidance on how to handle billing for members enrolled in the YES Waiver?

If the YES Waiver member is enrolled in Medicaid Managed Care, the member will receive all acute care services (including mental health rehabilitation, targeted case management, counseling, psychiatry) through the MCO. Waiver services will continue to be billed by the provider in fee-for-service. Please note that currently, only LMHAs are able to provide services for YES Waiver participants.

2. How should LMHAs complete the Service Request / Authorization Form for YES Waiver members.

YES Waiver participants currently generate a level of care (LOC) that is not included in the TRR guidelines. CMBHS automatically generates LOC-YES, which is equivalent to

Child / Adolescent LOC 4. Providers should request this level of care on the SRF form if CMBHS generates LOC-YES.

3. What is the YES wavier and how does this correlate to the LOCs under the SB58 Service and the Texas Recovery and Resiliency UM Guidelines?

*Please see the response to question #1 and #2 in this section. For more information about Youth Empowerment Services (YES) waiver, please see this weblink:
<http://www.dshs.state.tx.us/mhsa/yes/>*

4. If a YES waiver member receives a LOC other than LOC 4 as the Recommended Level of Care from CMBHS, how does the provider complete the SRF section which states "Please indicate the recommended level of care generated from the CMBHS system."

Providers should include LOC 4 as the recommended level of care generated from the CMBHS system and provider requested level of care for YES members. MCOs should approve LOC 4 for YES waiver participants.

5. In the DSHS process for Fair Hearings, a Center does not change the LOC from a higher to lower LOC for 10-14 days after the determination that a different LOC is appropriate. This is to allow for the Medicaid Fair Hearing letter to be sent and the member time to respond. Will the MCOs allow the current LOC to remain for 14 days before starting the new authorization at the lower level of care?

Based on current contractual requirements, MCOs are required to continue services at least 10-days after the MCO mails the notice. However, providers should reach out to the MCO to discuss the process and any specific requirements by the MCO. Any MCO guidance on this process must be consistent with HHSC contractual requirements.

6. Describe the age range for YES members:

YES members receive YES services through age 18 and will receive a CANS assessment from an LMHA (not an ANSA). MCOs should accept CANS assessments from YES members aged 18.