Frequently Asked Questions on SB 58 Implementation

HHSC Responses as of July 29, 2014

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 one-page draft request for services form. LMHAs/Provider entities will need to negotiate that with each MCO on how that information is transmitted to the MCO. If the MCO requires notification or authorization, the one-page form is the required form. However, how that information is transmitted can vary by plan.

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 15, 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 a 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, the 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 when a change in the LOC occurs. 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 provider do not have to bill Medicare and private insurance first for these services? 

MCOs are federally required to ensure they are the payor of last resort. It is common practice for proof of a third party denial to be provided for all services and providers. The MCOs may request a denial from Medicare or private insurance before adjudicating or authorizing a Medicaid claim for these services. HHSC will not direct the plans to change this process.

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.

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.)

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.

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 and HHSC does not get involved in that process.

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 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 E (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. Providers do not initiate the Medicaid Fair Hearing process or issue Medicaid Fair Hearing letters to Medicaid MCO members. HHSC will work with DSHS on this issue to provide clarity to providers and plans.

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.

**DSHS Requirements**

1. Consumers will be removed from LMHA’s GR and target numbers; will these be removed from our contract?

   DSHS will be responsible for adjusting your current contract targets but all Medicaid managed care clients should not be part of your contract of targets with DSHS effective 9-1-14. HHSC staff has reached out to our HHSC leadership to have discussions with DSHS about this.

2. 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.

3. 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.
4. Will the LMHAs be held to the wraparound measurement for the MCO?

*No 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.*