

## **9. MENTAL HEALTH AND CHEMICAL DEPENDENCE SERVICES**

### **Overview**

This chapter describes how mental health and chemical dependence services are provided under the authority of The Partnership Plan.

### **Identification of Mental Health and Chemical Dependence Needs**

In accordance with the requirements outlined in the model contract, all MCOs must have satisfactory methods for identifying enrollees requiring mental health and chemical dependence services. The contract requires MCOs to conduct a health screening to assess for any special health needs that the member may have. See Appendix 12.3b for a State DOH template of the health screening form. The Department requires that the plans adopt practice guidelines consistent with current standards of care as recommended by the American Academy of Pediatrics, the U.S. Task Force on Preventive Care, the New York State Child/Teen Health Plan, New York State Prenatal Care Standards for Managed Care Plans, the US DHHS Center for Substance Abuse Treatment, and the AIDS Institute Clinical Standards for Adult, Adolescent, and Pediatric Care. In addition, plans must have policies and procedures to ensure that members receive follow-up services from appropriate providers based on the findings of their assessment.

All MCOs must have policies and procedures to ensure that network and mental health providers appropriately evaluate the patient's treatment needs. MCOs must also have policies and procedures in place to ensure that members who have been evaluated and determined in need of treatment actually receive referrals to appropriate providers. As a part of the C/THP program, MCOs are also required to ensure that network providers appropriately screen children for behavioral and developmental problems and to make referrals for follow-up care and treatment as needed.

The State requires all MCOs to submit encounter data for mental health and chemical dependence services included in the managed care benefit package.

The State Department of Health Division of Managed Care and Program Evaluation has developed a protocol to evaluate the provision of behavioral health care services for managed care enrollees. A description of these initiatives is included as Appendix 9.1 to this document.

### **Mental Health Services**

All recipients, except those in the SSI or SSI-related categories, who enroll in an MCO, must obtain needed mental health services through their MCO. MCOs must permit all enrollees to self-refer to a network provider for an initial evaluation of a mental health problem without going through their primary care provider. MCOs must also make available to their enrollees a complete listing of the behavioral health care providers in their network.

MCOs must provide their non-SSI enrollees with all medically necessary covered mental health treatment in the least restrictive, clinically appropriate setting. SSI recipients are enrolled in

MCOs for a health only benefit.

The capitated mental health benefit package includes up to 20 outpatient visits and 30 inpatient days (combined with chemical dependency). Once a total MCO benefit of 20 outpatient visits or 30 inpatient days<sup>1</sup> is reached, the State reimburses plans for their reimbursable costs of providing services through a stop loss mechanism.

Under the stop loss program, the MCO manages, coordinates and pays for mental health outpatient visits and inpatient hospital days for patients who exceed their 20 outpatient visits or 30 inpatient days<sup>1</sup> benefit. The MCO bills the NYS Medicaid Program for these services at the contracted fee schedule via the State's stop loss program.

Specialized services, including Intensive Psychiatric Rehabilitation Treatment (IPRT), Continuing Day Treatment (CDT) for Adults and Day Treatment for Children, SED Clinic Services for Children, Intensive Case Management, Supportive Case Management (ICM/SCM), Home and Community Based Services for SED Children, Partial Hospitalization, Assertive Community Treatment (ACT), Personalized Recovery Oriented Services (PROS), Rehabilitation Services in licensed community residences, and Family Based Treatment are not covered by the managed care plans. These services are accessed through fee-for-service Medicaid

For additional information about covered and non-covered services, please refer to Appendix K of the MMC/FHPlus contract. The model contract may be found at [www.nyhealth.health\\_care/providers/index.htm](http://www.nyhealth.health_care/providers/index.htm).

### *Mandatory Enrollment*

In mandatory counties, Non-SSI individuals who meet the definition of Serious and Persistent Mental Illness (SPMI) or Serious Emotional Disturbed (SED) may be eligible for an exemption from enrollment, but may voluntarily enroll for the same comprehensive benefits. SSI individuals who meet this definition will be enrolled in MCOs for a "health only" benefit. Mandatory enrollment for SSI individuals began in NYC in January 2005 and will be phased in across the State.

The definition of SPMI and SED is:

Adults eighteen (18) and older who are diagnosed as seriously and persistently mentally ill, and children through seventeen (17) years of age who are diagnosed as seriously emotionally disturbed qualify for a mental health exemption if they have utilized the following services during the twelve month period prior to scheduled enrollment:

- Ten (10) or more encounters, including visits to a mental health clinic, psychiatrist or psychologist and inpatient hospital days relating to a psychiatric diagnosis ; or

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<sup>1</sup> The inpatient limit is for any combination of mental health and/or chemical dependence services.

- One (1) or more specialty mental health visits (i.e., psychiatric rehabilitation treatment program; day treatment; continuing day treatment; comprehensive case management; partial hospitalization; rehabilitation services provided to residents of OMH licensed community residences and family-based treatment and mental health clinics for seriously emotionally disturbed children).

As counties are approved to begin mandatory enrollment, enrollment materials are distributed to potential enrollees that include information about exemptions and how to apply for one.

### **Persons with Chemical Dependency Problems**

Medicaid Managed Care enrollees access outpatient chemical dependency services through the Medicaid fee-for-service program. All persons requiring inpatient treatment for chemical dependency problems who are enrolled in an MCO must access such care through the MCO. MCOs must permit all enrollees to self-refer to a network provider for an initial chemical dependence assessment and evaluation for inpatient detoxification, inpatient rehabilitation or outpatient detoxification services without going through their primary care provider.

MCOs must provide all medically necessary treatment in the least restrictive, clinically appropriate setting. Once a total MCO benefit of 30 inpatient days (combined with mental health inpatient) for medically necessary and clinically appropriate Medicaid reimbursable inpatient chemical dependence rehabilitation and treatment<sup>2</sup> is reached the State will reimburse plans for their reimbursable costs of providing services through a stop loss mechanism.

There are no day limitations on inpatient detoxification when medically necessary (i.e., complicated DRGs) in an acute hospital setting. The Behavioral Health Stop Loss does not apply to inpatient detoxification services or medically supervised outpatient or inpatient withdrawal services.

Under the stop loss program, the MCO will manage, coordinate and pay for inpatient chemical dependence rehabilitation or treatment days for patients who exceed their 30 day inpatient benefit. The MCO will bill NYS Medicaid Program for these services at the contracted fee schedule via the State's stop loss program.

Welfare Reform related chemical dependency services requirements are met regardless of whether the required services are provided as part of the Medicaid managed care capitated benefit package or reimbursed outside the benefit package. As of October 1, 2004, MCOs shall designate a Welfare Reform liaison who shall work with the LDSS or its designee to ensure that enrollees receive timely access to assessments and services specified in the Medicaid managed care contract and ensure completion of reports containing medical documentation required by the LDSS.

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<sup>2</sup> The inpatient limit is for any combination of mental health and/or chemical dependence services.

## **Coordination of Service Delivery Between MCO providers and Out of Network Providers**

Individuals who are enrolled in an MCO for “health only” services and individuals with serious mental health issues who are receiving behavioral health services that have been carved out of the capitated benefit package (Non-Covered services) will receive behavioral health care services from out of network providers. In each case, MCOs are expected to cooperate with these out-of-network providers to the extent reasonable, practical, and possible in ensuring that recipients receive care in a coordinated fashion. The State recognizes that individuals receiving care outside of the managed care plan may not always be forthcoming with their in-plan providers about the nature and extent of the treatment they are undergoing. All MCO enrollees will be encouraged to permit exchange of clinical information.

## **9. MENTAL HEALTH AND ALCOHOL AND CHEMICAL DEPENDENCE SERVICES IN FAMILY HEALTH PLUS**

Under FHPlus, these services are subject to a combined benefit limit of 30 inpatient days/60 outpatient visits per calendar year with no stop loss, extended benefit program, or fee-for-service wrap around provision. There is no distinction for persons with SPMI or SED. Enrollment in HIV SNPs (and mental health SNPs should they be reauthorized) is precluded until such time as one or more SNPs applies and is approved by the State and CMS to offer the FHPlus benefit package. FHPlus enrollees are not subject to welfare reform related chemical dependency requirements.