Frequently Asked Questions for the Medicaid MCO Management of Acute-Psychiatric Care Changes effective 10/1/18

Admissions

1. Do Screening Centers have to obtain prior authorization before an individual is admitted?

   For Medicaid MCO members admitted as an emergency or urgent admission, prior authorization is not required prior to admission. The admitting hospital must contact MCO for Prior authorization within 24 hours of admission.

2. If a Medicaid patient in the ER is determined in need of psychiatric admission and there is a delay, will the MCO be responsible for covering the extended ER stay?

   If admitted to the same hospital, the MCO will combine the ER and inpatient stays into one admission. If the admission is to a different provider, the MCO can cover the Medicaid member up to 48 hours if under observation.

3. Are MCOs responsible for an admission when a patient is unable to establish they are covered by Medicaid on admission and the coverage is determined several days later?

   Yes, the MCO is responsible to cover the admission if the patient is in the MCO and meets medical necessity criteria.

4. If a patient is admitted to a psychiatric inpatient setting and begins withdrawal requiring withdrawal management, will both admissions be covered?

   Withdrawal management in a psychiatric hospital does not necessitate a separate admission.

5. Will the MCOs be able to admit Medicaid members to private psychiatric hospitals?

   Yes, under the "In Lieu of Service" (ILOS) clause of the Managed Care Rule, MCOS can admit individuals to private psychiatric hospitals (IMDs) in lieu of admission into a general care hospital. This pertains to the entire Medicaid population eligible for inpatient hospitalization.

In-patient psychiatric

6. Do all of the MCOs use the same medical necessity criteria?

Each MCO has the right to utilize any nationally recognized medical necessity criteria. The use of the criteria will be documented in the contract. For acute medical detoxification, the MCOs are required to use the American Society of Addiction Medicine (ASAM) criteria.

7. How will the MCO's manage the patient that has both a medical and psychiatric issue during the same admission?

   Within the same hospital, the admissions may be combined. If the medical facility does not provide psychiatric care, the patient may be transferred to another facility for a separate admission. Both the inpatient medical and psychiatric admissions are the responsibility of the MCO effective 10/1/18.

8. If a patient is involuntarily committed and the judge orders continued stay despite the treating psychiatrist's recommendations to discharge, will the stay be covered by the MCO?

   The MCO is required to cover the stay as long as the judge's order is in effect.

9. Will the MCOs cover psychiatric inpatient stays at a less than acute level of care when medically necessary?

   Yes, MCOs will review for medical necessity and use non-acute/administrative guidelines if a member no longer meets acute level of care and the reason for the delay in discharge is beyond the control of the individual, their family or the hospital.

Discharge Planning

10. If a patient is admitted to a psychiatric unit and is no longer meeting an acute level of care but cannot be safely discharged, i.e. homeless, awaiting guardianship determination, will the MCO cover the stay?

    When the individual no longer meets medical necessity at an acute level, the MCO will review for payment using the administrative rate. The administrative rate is appropriate when a discharge is not safe and a delay in discharge is beyond the control of the discharging facility.

11. If a patient is admitted to a psychiatric unit and their group home or family refuse to take

the individual back, will the MCO cover this admission?

Each situation is unique and the MCO will work with the hospital to find additional support for the family or an alternative discharge option. An administrative payment may or may not be appropriate depending on the rationale for the delay and what the facility did to ameliorate the situation.

12. Will the MCO's pay the daily fee for service to a DD group home to hold a bed for a patient whose inpatient stay exceeds 14 days?

    No.

13. If a patient is admitted to a psychiatric unit and is determined to need nursing home level of care upon discharge, will the MCO be responsible for coverage of the days patient is stable but waiting for admission?

    Yes, it is the MCOs responsibility to cover consistent with NJAC 10:52-1.9 - Administrative days nursing facility level of care.

14. If an individual is refused acceptance at a State or County hospital, will the MCOs cover the inpatient admission until case resolution?

    If the patient is involuntary, the plans will cover the inpatient admission until the patient is discharged, transferred or legal status changes. If the patient is voluntary, the MCO will review for medical necessity and use non-acute/administrative guidelines if member no longer meets acute level of care.

15. If a patient is discharged with a recommendation for Involuntary Outpatient Commitment (IOC), will the MCO pay for IOC?

    MCOs are only responsible for IOC services for MLTSS, FIDE-SNP or DDD recipients.

16. What is the MCO's responsibility for ensuring an outpatient appointment within 7 days for all discharged patients?

    It is the responsibility of the MCO to work with the hospital discharge planners to ensure follow-up with an outpatient BH provider has been arranged. For the DDD,

MLTSS and FIDE-SNP member, the MCO is responsible for the payment and follow up of the psychiatric outpatient appointment.

Transportation

17. Will the MCO be responsible for ambulance transport if a client requires involuntary inpatient psychiatric care at another facility?

    Yes

18. If a patient is being transferred from a STCF or other acute care inpatient setting to a State/county hospital, is a pre-certification required for the ambulance?

    Yes, transportation is the responsibility of the MCO and will require pre-certification.

Children and Adolescents

19. If a child/adolescent is admitted to a psychiatric unit but awaiting placement by DCP&P, will the MCO cover this admission?

    Yes, consistent with DMAHS policy related to coverage of stay when a child is under DCP&P custody, individuals who no longer meet an acute level of care, but are awaiting placement, are eligible for an administrative payment.

20. What will be the relationship between Perform Care and the MCO's?

    The MCO is responsible for all inpatient hospitalizations and any outpatient behavioral health services that are within the contract for MLTSS, FIDE-SNP or DDD recipients. For Waiver services, or those remaining Medicaid individuals under 21, the MCO will work with Perform Care to ensure services are in place prior to discharge.

21. Will the MCO's be responsible for children's intermediate care admissions?

    No. The Children's System of Care (CSOC) will retain responsibility of the children's intermediate inpatient unit (IIU) admissions and will be covered under Medicaid FFS.

Contracts and Claims

22. What is the requirement for the MCO to make timely claims payment?

    In compliance with the Health Information Electronic Data Interchange Act ("HINT") set forth at N.J.A.C. 11:22-1.1, et. seq., the MCOs will process and pay of clean claims within thirty (30) days for electronic submissions and forty (40) days for non-electronic submissions.

23. What methodology will the MCOs use to establish rates for inpatient psychiatric care?

    Rates and any subsequent methodology are determined between the MCO and the contracted entity.

24. Will the MCO's commit to value based contracting with a clear upside for the provider?

    Value based contracting is encouraged by the State but the decision to commit to value based contracting lies with the MCO. Providers should discuss value based contracting with the MCOs during their contract negotiations.

25. Will treatments like ECT, TMS and ketamine for clinically appropriate patients be included in the rates or billed separate and above the rates? Will they require prior authorization?

    Each plan would authorize these services dependent on medical necessity and cover per contracted rates (i.e. DRG).

26. Do the MCO's plan to include physician coverage in the daily rate or separate?

    This varies and should be part of the MCO and provider contractual agreements.

27. Given the short amount of time prior to October 1, 2018, is it likely the MCO's will not have their payment systems in place causing a significant delay in payments?

    No, each MCO has gone, and continues to go through, readiness review including the ability to properly pay claims related to the recent changes in the MCO contract. No issues have been identified or are anticipated.

28. Will the MCO's roll-up the ER charges into the inpatient payment or will the MCO's pay the ER charge separate from the inpatient charge?

    ER charges are "rolled up" into the inpatient stay if the individual is admitted to the same hospital.

29. If my organization is having an issue with claims payment or contracting with a MCO that is not being resolved with the MCO, who do I contact at the State Medicaid office?

    The hospital or community provider can file a complaint with the DMAHS Office of Managed Health Care at MAHS.Provider-Inquiries@dhs.state.nj.us using the following forms:
    Single Case-
    http://www.state.nj.us/humanservices/dmahs/home/Provider_Relations_Inquiry_Request_form-single_case.pdf

    Multiple cases-
    http://www.state.nj.us/humanservices/dmahs/home/mltss_resources.html

    Information about the process can be found at this link:
    http://www.state.nj.us/humanservices/dmahs/home/MPRU_website_information.pdf

30. If a provider is credentialed as a Medicaid provider, is that provider automatically in the MCOs network?

    No, the Medicaid provider must apply to the MCOs and become credentialed to be a part of that MCO's network. However, when not contracted a provider may contract with the MCO under a "single case agreement".

Other

31. How will the MCO's interface with the pharmacy benefit for Medicaid or other primary insurers?

MCOs are responsible for all Medicaid pharmacy benefits. In the event Medicaid is not the primary insurer, the MCO will follow established third party liability standards. If a medication is denied, there is an appeal process in place for each plan and the member may appeal these decisions.

32. What is the MCO's responsibility for high recidivism patients who are denied admission by the MCO?

    Outside of DDD, MLTSS or FIDE-SNP individuals, the MCO has no responsibility for outpatient care for these individuals. The hospitals should work within the FFS system to find outpatient care options and refer the individual appropriately, possibly to the Intensive Case Management Services (ICMS) program in their county.

33. How often will the MCO's require utilization review for an inpatient admission?

    Length of care decisions vary depending on multiple factors including DRG payment versus per diem payment. The appropriate frequency for authorization of care is made on an individual basis.

34. What is the plan for training MCO staff to ensure consistent knowledge, messaging and decision-making?

    NJ FamilyCare has had several working groups with the MCOs to prepare for this expansion of behavioral health services covered by the MCOs. The working groups are in the areas of Networks, Care Coordination and Communications and will continue to meet regularly.

35. How will Diversionary beds be handled?

    Currently the Division of Mental Health and Addiction Services funds beds in private psychiatric hospitals to divert individuals from state psychiatric hospital admissions, often referred to as "Diversionary beds". Meetings are being held between the DHS Division of Medical Assistance and Health Services and the DOH Division of Mental Health and Addiction Services to provide further guidance regarding Medicaid individuals in private facilities that have MCO coverage (see question 13).