

Guidance 12 Behavioral Health Network (BNet) Guidelines and Requirements

Contract Reference: *Sections A-1.1 and C-1.2.3*
Authority: *S. 409.8135, F.S., Chapter 65E-11, F.A.C.*
Frequency: *Ongoing*
Due Date: *Ongoing*

A. Summary

The Managing Entity shall:

1. Designate a Behavioral Health Network (BNet) Coordinator on staff to coordinate with
 - a. Contracted Community Based Care Lead Agencies and their Behavioral Health Liaisons (Liaison)
 - b. Network Service Providers providing BNet services,
 - c. Other Managing Entity BNet Coordinators, and
 - d. The BNet statewide coordinator at Office of Substance Abuse and Mental Health (SAMH) Headquarters;
2. Ensure BNet Service Providers comply with the eligibility criteria for BNet enrollment;
3. Ensure BNet Service Providers comply with the set protocols outlined for BNet enrollment; and
4. Develop and implement a policy for providers related to BNet protocols.

B. Background

Fulfilling the requirements of section 409.8135, F.S., BNet is a statewide network of behavioral health service providers who serve Medicaid ineligible children ages 5 to 19 years of age with severe mental health or substance use disorders who are determined eligible for the Title XXI of the United States Public Health Services Act, KidCare program. It is aimed at treating the entire spectrum of behavioral health disorders and provides both children and their parents with intense behavioral health planning and treatment services for the duration of the child's enrollment. The needs of the child are the primary focus for treatment. BNet Service Providers address these needs through:

1. In-home and outpatient individual and family counseling;
2. In-home and outpatient targeted case management;
3. Psychiatry services and medication management including direct access to the network service provider's pharmacy with no co-payments; and
4. Advocacy and provision for wrap-around services to meet each child's social, educational, nutritional, and physical activity needs.

C. BNet Funding and Network Service Provider Payment Policy

The fund source for the BNet program is the Florida Legislature's annual appropriation to support the projected enrollment, as adopted by the KidCare Social Services Estimating Conference. The appropriation is at least 70

percent federal Title XXI funds, with the balance state general revenue funds. There is no other source of funds directly related to the provision of BNet services. The Department allocates the BNet budget to the Regions on an annual basis, but the funds are drawn down on a monthly basis through billing by the Department of Health to the Agency for Health Care Administration for the count of BNet enrollees in each area of the state during the month billed. The document supporting the official count and identification of currently active clients is the final enrollment roster distributed to the Managing Entity and its BNet Service Providers each month by SAMH Headquarters staff. Only those clients listed on the final roster with an enrollment status code of "Y" are eligible to represent a capitation payment. However, the BNet Service Provider is not required to bill for every client reflecting enrolled status ("Y") on the final roster. In making payment to its BNet Service Provider, the Managing Entity must ensure that the number of clients for which payment is billed by the provider does not exceed the total number of clients represented to be in enrolled ("Y") status on the final roster and does not include payment for any client reflecting a status other than enrolled.

The capitation payment methodology is based on a statewide average cost of care, which must be validated periodically. Such validation requires linking the capitation payments made to BNet Service Providers to those providers' actual cost of the care provided. Accordingly, the Managing Entity shall require its BNet Service Providers to submit annually by September 1, a Statement of Program Cost report briefly summarizing the revenue and expenditures experienced in the contract year ending the prior June 30, in which the BNet Service Provider received capitation payment to provide BNet services. The report shall be forwarded to the statewide BNet Coordinator and shall contain the following elements in a format to be determined by the Managing Entity:

1. Name of the BNet Service Provider;
2. Period the report covers;
3. Total of capitation payments received by the BNet Service Provider;
4. Total cost of BNet services provided;
5. Cost of administration experienced in providing those services; and
6. Signature and title of the official attesting to the veracity of the report.

D. Policy Development and Implementation

1. The Managing Entity shall develop and implement a written policy to outline key procedures related to BNet and the enrollment of children who are not eligible for Medicaid. While each Managing Entity will be responsible for their own layout of the policy, the following key elements shall be included:
 - a. Designation of BNet Coordinator;
 - b. Form review;
 - c. Payment review;
 - d. Compliance reviews; and
 - e. Technical assistance.
2. The Managing Entity will designate a coordinator to oversee BNet compliance and enrollment completed by providers. The coordinator will be responsible for ensuring a child is still eligible and enrolled prior to the approval of invoices. Additionally, the Managing Entity shall develop and implement procedures to ensure forms and tracking information are properly completed prior to any final submissions.
3. To ensure providers are in compliance with the protocols listed below, the Managing Entity shall complete intermittent reviews of information submitted as well as process reviews. In addition, the Managing Entity should provide technical assistance to providers with questions relating to eligibility, enrollment, disenrollment, and other BNet areas.

E. ADMINISTRATIVE PROTOCOL

The information below is intended to supplement the provisions of Chapter 65E-11, F.A.C., outlining administrative protocols specific to BNet. The Screening and Eligibility Tracking Form, the Reverification and Request for Disenrollment Form, and the Statement of Understanding are found in **Template 6 – BNet Participant Forms**. The Alternative Services and Medications Report forms are found in **Template 7 – BNet Alternative Services Forms**.

Step I: Initial Contact with the Child

1. The KidCare program currently accepts applications for enrollment in KidCare continuously throughout the year. Upon initial contact with the child, the Behavioral Health Liaison (Liaison) must determine whether the family has previously submitted an application for KidCare enrollment, and if so, within the past 120 days. If a current application is not on file with KidCare, the Liaison will assist the family in completing an application or reactivating a previously filed application. Concurrent with completing the application, the Liaison should administer the screening portion of the Behavioral Health Network Screening and Eligibility Tracking Form (Form), and also complete the Statement of Understanding form.
2. If the initial contact is made at a time when enrollment for KidCare is closed for any reason, the Form should indicate that the child is not eligible for enrollment in BNet as KidCare enrollment is currently closed. The Liaison should inform the parents regarding the restrictions on enrollment and advise them to apply when enrollment reopens. Even in periods of closed enrollment, the family should submit the application form to KidCare, where it will be forwarded to the Department of Children and Families, Office of Economic Self-Sufficiency and screened for Medicaid eligibility. The BNet provider shall provide Care Coordination to try to connect the family to another resource in instances when the child has unmet behavioral health needs.
3. If the parent advises that the child is already enrolled in KidCare, the Liaison proceeds to **Step II: Screening** to determine whether an assessment is warranted.

Step II: Screening

1. The Liaison must use the current version of the Form.
2. If the child receives a positive screen indicating meeting treatability criteria for BNet services, the Liaison completes Part I of the Form and proceeds to **Step III: Complete Assessment**.
3. If the child receives a negative screen indicating they are not eligible for BNet services, the Liaison completes only Part I of the Form, and submits the Form to the Managing Entity, with a copy to the Children's Medical Services (CMS) area office. Reference to CMS area offices or local offices should be read to also include offices of any entity contracted by CMS to manage the provision of medical services to enrollees of the CMS Plan on a statewide or regional basis. The SAMH Managing Entity forwards a copy of the Form to the BNet coordinator at SAMH Headquarters. The Managing Entity may approve the Liaison to submit some or all enrollment-related forms addressed in this Administrative Protocol directly to SAMH Headquarters with a copy to the Managing Entity. Such license is intended to hasten the transfer of enrollment-related information and does not diminish the Managing Entity's role as the approving entity.
4. If the Liaison is processing a referral on a child previously screened by the Liaison or another Provider, the Liaison reviews the previous screening results to determine whether the screen was negative or positive. If positive, the Liaison proceeds to **Step III: Complete Assessment**.
5. If the previous screen was negative, the Liaison conducts the screen again. If the new screen is positive, the Liaison proceeds to **Step III: Complete Assessment**. If the new screen is negative, the Liaison completes only Part I of the Form and submits the Form to the Managing Entity, with a copy to the CMS area office. The Managing Entity forwards a copy to the BNet coordinator at SAMH Headquarters.

Step III: Complete Assessment

1. Following a positive screen, the Liaison conducts, or arranges delivery of, a complete assessment, which may include one or more of the following steps:
 - a. Verification of previous screening results;
 - b. Face-to-face interview with the child's family;
 - c. Completion or review of additional assessments as needed (if an assessment has not been completed within the past six months, a new assessment must be completed); and
 - d. Resolution of any conflicting results.
2. If the results of the child's assessment are positive, the Liaison completes Part II of the Form and proceeds to **Step IV: Final Behavioral Health Network Determination**.
3. If the results of the child's assessment are negative for BNet clinical eligibility, the Liaison completes Part II of the Form and submits the Form to the Managing Entity, with a copy to the CMS area office.
4. The Managing Entity forwards a copy of the Form to SAMH Headquarters.

Step IV: Final Behavioral Health Network Determination

1. Following a positive assessment, the Liaison forwards the completed Behavioral Health Network Screening and Eligibility Tracking Form to the Managing Entity BNet Coordinator, along with a recommendation regarding acceptance of the child for BNet enrollment.
2. The Managing Entity receives the completed Form and reviews the material to determine whether it agrees with the Liaison's recommendation regarding the child. If the Liaison's recommendation is to accept the child for BNet services and the Managing Entity agrees, the Managing Entity approves the child's Form and notifies the Liaison and the BNet coordinator at SAMH Headquarters. The Liaison sends an information copy to the area CMS office.
3. The BNet coordinator at SAMH Headquarters officially notifies CMS Headquarters.
4. If the Managing Entity disagrees with the Liaison's recommendation regarding a child's qualification for BNet enrollment, it must convene a multi-disciplinary team to review the case. The team's decision is binding.
5. If the Liaison's recommendation is to accept the child into BNet and the Managing Entity concurs, but no capacity is currently available, the child is enrolled in the CMS Plan-, designated behavioral health eligible, and provided all medically necessary services, both physical and behavioral, through CMS Plan resources pending the availability of BNet capacity. Rescreening is not required prior to enrollment in BNet for a child on the waiting list unless it has been six months since the child's last assessment.

F. Reverification of BNet Eligibility

1. The BNet Service Provider must re-verify enrolled clients for continued clinical eligibility no less frequently than every six (6) months. The six-month time period begins for each client with the date of assessment indicated on the enrollment Screening and Eligibility Tracking Form or the last, subsequent reverification on file. This includes clients who were on the waiting list prior to enrollment.
2. Criteria for continued enrollment in BNet are a qualifying mental health or substance use diagnosis and a CGAS score of 50 or less, or a comparable score from a subsequently adopted successor instrument approved by the Department. The provider may retain for up to an additional two-month period a client whose

CGAS score exceeds 50, but who is considered unlikely to maintain that level of progress, after which the client must be reassessed. The provider must disenroll the client if the subsequent score is greater than 50. A score of 50 or lower re-qualifies the client for subsequent reverification at six-month intervals.

3. The provider uses the Reverification and Request for Disenrollment Form to capture the results of a reverification assessment. The provider:
 - a. completes the first two sections to identify the BNet Service Provider and the client;
 - b. checks the Reverification box in the first section;
 - c. populates the primary diagnosis and CGAS score blocks; and
 - d. provides a secondary diagnosis, if known.
4. The Liaison initials the form and enters the date of the reverification. The provider follows the same distribution protocol as specified above under **Enrollment Step II: Screening**, paragraph 3, to report reverifications.

G. Disenrollment Processing

1. BNet recognizes two categories of disenrollment: those related to loss of clinical eligibility, and those related to loss of Title XXI coverage. All disenrollments reflecting the loss of clinical eligibility require submittal of a disenrollment form by the Liaison and exclude a client from participating in BNet unless reenrolled in the program. This type of disenrollment applies to the following:
 - a. client's CGAS score exceeds 50;
 - b. client completed treatment;
 - c. primary diagnosis is changed to one not covered;
 - d. client or client's parent or guardian declines services or is noncompliant with services; or
 - e. client is admitted to residential treatment exceeding 30 days.
2. The following disenrollments relate to loss of Title XXI coverage and require submittal of a disenrollment form:
 - a. client moves out of state;
 - b. client is incarcerated; or
 - c. client obtains insurance coverage other than Medicaid.
3. The following administrative actions also terminate a client, but do not require submittal of a disenrollment form, as CMS provides the information directly to BNet in monthly data files:
 - a. client turns 19 years of age;
 - b. client is determined Medicaid eligible;
 - c. parent or guardian fails to pay monthly premium;
 - d. parent or guardian fails to complete renewal; or
 - e. parent or guardian requests cancellation of client's enrollment in the CMS Plan.
4. The BNet Service Provider will use the Reverification and Request for Disenrollment Form to request disenrollment of a client by:
 - a. completing the top section identifying the BNet Service Provider,
 - b. checking the Request for Disenrollment check box,
 - c. completing the second section identifying the client, and

- d. completing Part II – Assessment – Request for Disenrollment, indicating the reason for disenrollment. Part I does not require completion.

5. If the reason is that the child has other insurance coverage other than Medicaid, the provider should briefly include information that will help identify the other insurance. If either residential treatment or incarceration is indicated, the provider should include the additional information requested on the form. If the reason is that the child no longer meets BNet criteria, the provider must check the most pertinent one of the listed choices or specify "other" and elaborate briefly in the space provided. The Liaison will initial and date the form. Submittal of disenrollment forms follows the same path as enrollments and reverifications, as detailed above under Enrollment Step II: Screening, paragraph 3.

H. BNet Alternative Services Reporting

BNet Service Providers providing services that are not reportable to the SAMH Data Warehouse report those services on the BNet Alternative Services and Medications Forms C1 and C2. The C1 form is used to obtain Managing Entity approval to use the proposed alternative service, and to report the provision of alternative services. The record of approved alternative services is retained by the Managing Entity to support the use of those alternative services reported by the provider. The C2 form is used to report medications provided. Both forms are submitted to the Managing Entity monthly and are also copied to the statewide BNet Coordinator for entry into an Access database. In lieu of the Managing Entity submitting such Protected Health Information (PHI) to the SAMH regional office, the Managing Entity may submit a monthly attestation summarizing the PHI documentation received from its BNet Service Provider(s). The attestation shall include the following:

1. Name of each document received from the BNet Service Provider(s);
2. Date each document was received by the Managing Entity;
3. Date submitted to the BNet Coordinator (if applicable);
4. Evidence of Managing Entity approval of alternative services provided by the BNet Service Provider;
5. Managing Entity staff responsible for reviewing the submitted documentation; and
6. Name and dated signature of person submitting the attestation.