| King County Symposium FAQs | |
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| **Eligibility and Authorization** | |
| Is mental health service for children self-referred or need referral from PCP? Need prev. authorization? | For most outpatient services, mental health services for children continue to be self-referred without need for prior authorization (please see KCICN/BH-ASO Behavioral Health Services handout from the KCICN Information Session for more details by service type). |
| What type of authorization is needed for day treatment? If a client is tiered, isn't day treatment part of the treatment package? Or will day treatment be covered differently? | Day Treatment is considered to be a service provided, as clinically indicated, under the BHRD outpatient tier system. If an agency provides Day Treatment per SERI requirements, and determines that a client would benefit from Day Treatment, then a client is eligible for the service under the outpatient tier. This has not changed post integration on January 1, 2019. |
| Access to care: Will we need to complete the KCICN screening tool in addition to the respective tool for each MCO? | The KCICN Risk Stratification Screening Tool is a screening tool to determine payer for client's services. This screening tool only needs to be completed with new clients who do not already have a SMI/SED indicator in the Extended Client Look-up System (ECLS). Agencies do not need to complete the respective tools for each MCO for BHRD-covered services as that authorization process was delegated to King County. |
| What is a "non-SMI" client? | A non-SMI (or non-SED) client is an individual who potentially needs behavioral health services, but generally falls in the mild to moderate category. At this time, KCICN--at the request of the governing committees which included providers--did not contract with MCOs for the mild to moderate population. Some agencies have individual contracts with the MCOs for this population and would be able to serve them. In most cases, individuals who do not meet SMI/SED would need to be referred to other providers (often Primary Care) who can serve this population. This may change in the future. |
| How long does someone have to be incarcerated to suspend coverage? | A client's Medicaid is suspended after 30 days of incarceration. |
| If KC has 5-14 days to approve/give an authorization, how can we ensure the first on-going appointment is within 7 days? | This timeline is for SUD residential services, not Outpatient programs.<br><br>King County outpatient tiers do not stop a client from going into the KCIT system. While King County and providers have historically called this process an authorization, it is more of a "registration" of an individual to the KCIT system. As these registrations, provided needed information has been submitted to the KCIT system, do not get denied, agencies should move forward with serving the client.<br><br>3B tiers are authorized automatically to 3A tier levels and are adjusted to 3B tier if the justification for tier level is approved. As such, agencies should move forward with seeing the client within required timeframes. |

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| Who enters SMI data into ECLS? How is this managed for new clients and charges? | Agencies, King County, and MCOs (through a data exchange with King County) can enter a client's SMI/SED information into ECLS. For new clients, the agency enrolling the client will be responsible for confirming or entering a client's SMI/SED status. |
| Although no authorization is required for non-intensive MHOP services, registration and notification is required. What does that mean / look like? | The registration includes entering basic client information and demographics into KCIT's system in the same way it has been input prior to January 1, 2019. (Please refer to the ISAC Dictionary for more information.) |
| Will the MCO plans pay for psychiatric residential treatment for youth for eating disorders or other psychiatric conditions if these services are medically necessary? | MCOs have delegated this service to King County. King County has historically authorized these services prior to January 1, 2019 and will continue to do so. |
| Eligibility = ECLS primary source – Pl secondary. Is there a reason these would not match? Why? | BHRD negotiated with the MCOs and determined using MCO data as a primary source eliminated a risk of agencies serving clients and not getting paid. However, if a client has Medicaid in Provider One and is not showing in ECLS as having Medicaid/MCO assignment, please contact BHRD so we can discuss with plans. This may be a data error, but it is one that would need to be resolved to guarantee funding. |
| Can a patient that meets SMI / SED criteria be served at an agency or provider who is not part of KCICN but is contracted with the MCO if that is the patient's choice? | Please refer to MCO Scenario Worksheet (not yet available at time of KCICN Information Session on 1/18/19) and/or call BHRD to confirm ability to serve clients. In most cases, King County agencies would be able to continue serving clients if clients choose to remain with the King County agency, but call BHRD to confirm. |
| Does a clinician need to check eligibility for care coordination service in between appointments? | If a service is billable, then the contract requires eligibility be checked prior to delivery of services. Agencies need to self-determine how to manage this requirement and the risk associated with not checking eligibility. |
| Will eligibility checks be requried before phone services as well as every in person (F to F) service and will these begin 1-1-19? | If a service is billable, then the contract requires eligibility be checked prior to delivery of services. Agencies need to self-determine how to manage this requirement and the risk associated with not checking eligibility. |
| If you check eligibility for a current client before providing a routine service and it shows they are no longer eligible what do we do? Do we deny service on that day? | Agencies need to self-determine how to manage this requirement and the risk associated with not checking eligibility. This would be the same issue prior to January 1, 2019 as it is post January 1, 2019. |
| Are eligibility checks required for patients who dose DAILY? | If a service is billable, then the contract requires eligibility be checked prior to delivery of services. Agencies need to self-determine how to manage this requirement and the risk associated with not checking eligibility. |
| **KCICN Population** | |
| If a member moves across county lines can they keep their BH provider? If so, how long? | Please refer to MCO Scenario Worksheet (not yet available at time of KCICN Information Session on 1/18/19) and/or call BHRD to confirm ability to serve clients. In most cases, King County agencies would be able to continue serving clients if clients choose to remain with the King County agency, but call BHRD to confirm. |

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| If a client living in Pierce (or other FIMC region that has Medicaid) comes to us an meets SMI or SED criteria, can we get paid for them in the KCICN system? What would the process look like? | Please refer to MCO Scenario Worksheet (not yet available at time of KCICN Information Session on 1/18/19) and/or call BHRD to confirm ability to serve clients. In most cases, King County agencies would be able to continue serving clients if clients choose to remain with the King County agency, but call BHRD to confirm. |
| If a person enters outpatient SUD in King County and moves 3 blocks and now lives in Pierce County, but still wants to couplets OP at their KC agency, can they or will Pierce County of the plan require them to transfer agencies? | Please refer to MCO Scenario Worksheet (not yet available at time of KCICN Information Session on 1/18/19) and/or call BHRD to confirm ability to serve clients. In most cases, King County agencies would be able to continue serving clients if clients choose to remain with the King County agency, but call BHRD to confirm. |
| Will we still be able to see clients registered in different regions? | Please refer to MCO Scenario Worksheet (not yet available at time of KCICN Information Session on 1/18/19) and/or call BHRD to confirm ability to serve clients. In most cases, King County agencies would be able to continue serving clients if clients choose to remain with the King County agency, but call BHRD to confirm. |
| Pt is completing home detention (ankle bracelet?) and is being monitored. Who is responsible? KC had denied responsible stating pt. is incarcerated. | If a client is in the community, Medicaid will cover the care of the client, and therefore, KCICN will cover Behavioral Health care. If agencies have case-specific questions, please contact BHRD. |
| If a provider did not contract with the ICN, how are these services authorized and billed? | Please refer to MCO Scenario Worksheet (not yet available at time of KCICN Information Session on 1/18/19) and/or call BHRD to confirm ability to serve clients. In most cases, King County agencies would be able to continue serving clients if clients choose to remain with the King County agency, but call BHRD to confirm. |
| If a patient is enrolled with a KCICN agency and wants to transfer to a provider that is directly contracted with a MCO – Is this okay? Does the new provider have to do something to inform KCICN to cancel the tier? | Please refer to MCO Scenario Worksheet (not yet available at time of KCICN Information Session on 1/18/19) and/or call BHRD to confirm ability to serve clients. In most cases, King County agencies would be able to continue serving clients if clients choose to remain with the King County agency, but call BHRD to confirm. |
| Will KCICN-covered SMI patients be transparent in P1? Most primary care settings do not have ECLS access? | No. KCICN enrollment will not be visible in Provider One. Primary Care providers may be able to access ECLS. If there is an individual need, please contact BHRD to discuss. |
| How is medical necessity measured for 0-3 year olds? SED standards don't apply well to this age group. | Agencies should use DC-03. |
| When and in what circumstances, does KCICN refer to us (providers)? Can patients continue to self-refer to us directly? | Individuals can continue to self-refer. Additionally, King County, MCOs and Providers established an Algorithm to assign clients to agencies when an MCO is referring a new client to the KCICN system. This workflow is still being established. More information will be available in the near future. |
| For SUD providers, do we have the option to bill MCOs for clients who are not within SO1 or SO2 care rates. | No. All SUD services are contracted through KCICN. |
| What will be the KCICN screening to for infants and young children under 6 years of age? Many of the "domains" of eligibility criteria are not appropriate for young children. | Agencies should use DC-03. |

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| **Critical Incidents** | |
| If someone has a suspended tier and experiences an EO, does that get reported to the managed care plan? Or KC? 365 days post-care – E.O.: Extraordinary Occurrence. | Extraordinary Occurrences (EO) no longer exist post January 1, 2019. Now they are called Critical Incidents. Critical Incidents get reported to Managed Care Organizations if a client receives Medicaid-funded services under the KCICN. They get reported to King County if the client receives non-Medicaid-funded services, state- or federal- grant funded services, or locally funded services such as MIDD. The BHRD Provider Manual has more details on format and Critical Incidents in general.<br><br>Agencies do not need to report Critical Incidents in the 365 days after a client is exited. This is no longer a requirement. |
| Critical Incident – For Outpatient – Is the 24 hour from Friday to Saturday or Friday to Monday? Are weekends and holidays excluded from the 24 hour time frame? | The 24 hour requirement is from time and date that the agency finds out about a Critical Incident (not necessarily 24 hours from the actual incident), and is considered 1 business day. |
| Clarification around EOR reporting – Slide stated that timeline is not going to change but verbally ad in next slide it stated it must be reported in one business day. This is a change from current practice. | As a reminder, Extraordinary Occurrences (EO) no longer exist. They have been replaced with Critical Incidents. The standard for reporting is 24 hours (1 business day) from the time when agencies find out about the incident. |
| How are critical Incidents defined? | Please refer to the BHRD Provider Manual for more information and contact BHRD staff if there are additional questions. |
| For critical incidents are those submitted online or by fax? If online, is it a secure system? | Please refer to the BHRD Provider Manual for more information and contact BHRD staff if there are additional questions. |
| **Grievances** | |
| If an agency resolves a grievance internally with a consumer, do we still repot it to the MCO? Or only repot if it cannot be resolved? | If a grievance is resolved at a lower level (such as at the agency or through partnership with BHRD), AND client does not wish to file a grievance, then it does not need to be reported to the MCO. As a reminder, only the client can file a grievance. |
| **American Indian/Native Alaskan** | |
| How can we identify a native client when verifying coverage in Provider One? | Provider 1 has not changed. Agencies will verify AI/NA status in the same way they did prior to January 1, 2019. The HealthCare Authority (HCA) is aware that it would be helpful if Provider One had this information visible, but has not made any changes to Provider One yet. |
| **Outpatient Services** | |
| When a patient presents in the ED and needs psych hospitalization, will the outpatient provider still need to see the patient in the ED to confirm decision to hospitalize? | Yes. The outpatient provider, as the clinician with the most knowledge of the client's case, will still need to assess client's need for psychiatric hospitalization to assist hospital and Designated Crisis Responders' decision to involuntarily detain an individual. |
| Beg. 1/1/19 – Will clients be able to have both MAT & SUD TX services at the same time? | At this time, the MAT tier was priced to include SUD Outpatient Services. Clients cannot receive SUD Outpatient Services from one agency while receiving MAT services as the agency providing MAT services also receives the funding for the outpatient services without approval of an exception request through BHRD. This may change in 2019, but is unchanged as of this FAQ. |

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| Will there be any changes to the outpatient benefit tiers or authorization system? | As of the beginning of January 2019, there are no changes to the benefit tiers or authorization system. However, the KCICN governance committees are currently working on a tier redesign that better meets the needs of the network and the goals of integration. This new tier design will likely go into place in 2019. |
| For local funded services only – Who do not require a diagnosis – How do we send encounters? From a trauma informed care it seems harmful to require this. | As of January 1, 2019, currently encounters would require a diagnosis, but this is currently being worked on by KCIT. The intent is that this requirement is changed in the KCIT system so that encounters for locally-funded services that do not require a diagnosis will not require a diagnosis on encounters. |
| How does outpatient treatment on demand factor into appointment standards (on timeliness)? | Outpatient Treatment on Demand (OTOD) is based on an incentive system. If agencies are able to meet the criteria OTOD, and see clients quicker than basic timeliness standards, they receive incentives. If agencies do not, they still must meet timeliness standards established by CMS. |
| With the money for crisis services going directly from the HCA to King County how will this effect: | |
| 1. The current crisis system | By creating a Behavioral Health Administrative Services Organization (BH-ASO), King County will continue to receive all funding for crisis services. This has allowed King County, with the inclusion of local dollars, to maintain our existing crisis system. |
| 2. How KCICN providers get paid for providing crisis services to their client | Since King County, through creating the BH-ASO, has continued to receive funding for crisis services, the methods for paying KCICN and BH-ASO providers for crisis services remain unchanged. |
| 3. Will this no longer be a requirement for KCICN Providers? | This question is unclear. If the question is whether KCICN providers will continue to need to serve their clients in crisis, the answer is yes. The funding for clients who experiencing crisis has been built into the outpatient tiers. While King County has contracted with Crisis Connections to provide after hours crisis support, it is expected that outpatient providers will continue to work with clients who are in their care and experiencing crisis. |
| In the ED: Does the current requirement to have the assigned MH provider conduct a face to face or consult prior to a medical authorities for IP how to replace by the crisis connection diversion phone call? | These two requirements are separate requirements. It is still King County's expectation that Assigned Mental Health Outpatient Providers will continue to provide face-to-face consults prior to the Designated Crisis Responders (DCRs) making a decision whether to involuntarily detain a client. If a hospital is able to negotiate a diversion opportunity through Crisis Connections, then this has potentially eliminated a need to have the MH Outpatient Provider conduct a face-to-face consult with the client. Either requirement could lead to a client not needing to be involuntarily detained as a lower-level of care has met the client's need. As these two requirements can affect each other, and are often required in a short time frame, it is likely that both will happen. |

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| Crisis services – Will provider organizations still be responsible for ED evaluations after hours, weekend for their Medicaid clients? | Yes, agencies will still be responsible for ED evaluations. This is because the outpatient agency is the provider with the most information on clients behavioral health history and most able to assess client's needs for hospitalization. |
| Does the KCICN screening tool replace the locus? Can we discontinue the locus or 1-1-19? | The KCICN screening tool does not replace the Locus. The KCICN Risk Stratification Screening Tool is meant to be used to identify payer (whether a client falls within the population served by KCICN or by providers contracted for mild to moderate services directly with the MCOs). The Locus includes an actual assessment of clients' current status and need for services. The two complete different functions. |
| What will clinical audits (if any) look like in 2019? | The 2019 clinical audit plan is currently under development. |
| Does each chart need the ICN screening tool or is documentation that it was completed sufficient or both? | The KCICN Risk Stratification Screening Tool is meant to be completed for new clients. At this time, BHRD is not requiring that this information be submitted to BHRD. An agency must self-determine how to document that the Screening Tool has been completed. It is likely BHRD will audit for this requirement in the next year. |
| How will services for spenddown clients be managed? Will there still be non-Medicaid funding through KC to cover these? Can we still apply the tier rate to the spenddown? | Clients will continue to have their benefits suspended during spend-down. In MH cases, agencies can determine priority to their assigned MIDD funding for non-Medicaid benefits. MIDD funding for non-Medicaid SUD tiers goes through an application process at the county.<br><br>Determination of whether the tier rate can be applied to the spenddown is determined by DCHS. At this time, BHRD is not aware of any changes to that system. |
| Will case management and care coordination get funded in 2019? | Case Management and Care Coordination are among the services included in the outpatient tier and should be administered when clinically indicated. |
| With regard to transitions of care, is the service provider supposed to document post – discharge services? How can the cost be reimbursed if the case is closed? | Please contact BHRD regarding specific situations. If a client is being seen post-discharge, there may be possibilities to re-open a tier. BHRD staff are happy to consult on specific cases.<br><br>An agency must self-determine how to document services for clients who are no longer enrolled. |
| MCO case management services: When there is already case management services provided by BH clinician, how are the case management services divided with other providers? It is still not clear to me how coordination will take place. | BHRD will be partnering with MCOs to establish "rounds"--times for consultations on client-specific situations. Agencies will be included in these conversations and should be prepared to identify what work they are already doing and how the MCOs can assist with this work. |
| Do members have to agree to MCO care management to receive it? If a patient has been detained and released on a less restrictive order, can they be mandated to participate in care management? | MCOs assign client to care management programs within the MCO based on Utilization Management data. In some cases, client consent is needed (for active programs), in other cases, the care management can be more passive and consent is not always needed. |

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| How many days does an outpatient agency have to provide an appointment following discharge from an Involuntary commitment? (7 days?) | An agency should see a client within 7 days of involuntary commitment. This practice guideline can be more easily achieved if an outpatient provider outreaches the client while they are in the hospital as well and engages with the rest of the clinical team on the discharge planning. |
| What happens to treatment on demand? Are agencies responsible for 24 hr. turn around at request for services? Or is it the 10 day standard? | Outpatient Treatment on Demand (OTOD) is based on an incentive system. If agencies are able to meet the criteria OTOD, and see clients quicker than basic timeliness standards, they receive incentives. If agencies do not, they still must meet timeliness standards established by CMS. |
| **Notification Requirements** | |
| How can we possibly give a 60-day notice for provider terms and adds when we hire someone in under 60 days or have unplanned terminations? | The 60-day notice for provider terminations and additions speaks to required notification timelines for opening or closing new provider offices, locations, or, in some cases, specific services. For clinicians entering and leaving the agency, we are familiar with the timelines for staff leaving and hired and will have expectations of uploading and exiting clinician in the KCIT system in a reasonable timeline. This is most related to making sure clinicians are associated with the correct agency and have correct NPI numbers so that the KCIT system accepts encounters from that clinician. It is also related to knowing when clinicians no longer work in our system as BHRD is responsible to report this information to the MCOs, but the 60-day notice requirement is not for individual clinician changes. |
| How do we provide 60 day advance notice of staffing changes when standard HR practice is 2 weeks' notice for resignations? | The 60-day notice for provider terminations and additions speaks to required notification timelines for opening or closing new provider offices, locations, or, in some cases, specific services. For clinicians entering and leaving the agency, we are familiar with the timelines for staff leaving and hired and will have expectations of uploading and exiting clinician in the KCIT system in a reasonable timeline. This is most related to making sure clinicians are associated with the correct agency and have correct NPI numbers so that the KCIT system accepts encounters from that clinician. It is also related to knowing when clinicians no longer work in our system as BHRD is responsible to report this information to the MCOs, but the 60-day notice requirement is not for individual clinician changes. |

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| 60 days' notice for reporting provider changes: Does this mean that when we hire new clinicians they cannot see clients for 60 days? | The 60-day notice for provider terminations and additions speaks to required notification timelines for opening or closing new provider offices, locations, or, in some cases, specific services. For clinicians entering and leaving the agency, we are familiar with the timelines for staff leaving and hired and will have expectations of uploading and exiting clinician in the KCIT system in a reasonable timeline. This is most related to making sure clinicians are associated with the correct agency and have correct NPI numbers so that the KCIT system accepts encounters from that clinician. It is also related to knowing when clinicians no longer work in our system as BHRD is responsible to report this information to the MCOs, but the 60-day notice requirement is not for individual clinician changes. |
| **Reporting (Encounter) Services** | |
| Is reporting EBP codes mandatory? | Yes. If an agency uses Evidence Based Practices, the EBP code should be reported through the encounter. |
| Related to EBP – Only one EBP code per encounter – What if the individual provider is multi-theoretical? Would we narrow it down to only on EBP used during encounter then mention other EBP in qualitative progress. Note? | At this time, the HealthCare Authority is only able to accept one EBP code per encounter. Encounters should reflect the clinician's best assessment of which EBP code reflects the majority of the work done that day. The documentation in the qualitative progress note could focus on both the EBP code that was reported, as well as note any other EBP that were completed with the client. |
| Can we get a sample service with the EDI along with it? Maybe a before and after EDI file? | The EDI files and samples have been shared with the ISAC Committee. Please refer to the ISAC Dictionary or ISAC Committee members if this document is still needed. |
| **KCIT and ECLS** | |
| How do we go about obtaining a KCICN / ECLS access? And to clarify, is there required for each individual or can we have one for a facility? | Agencies can submit EARS forms for their staff members to obtain ECLS access. This is not required for each individual at an agency. Each agency must determine internal workflows needed, and identify staffing needs for ECLS. |
| Please clarify: Will all people enrolled in an MCO be in ECLS or will ECLS only have current / past BH clients? | MCOs are sending King County all King county IMC, BHSO, and Foster Medicaid individuals to King County and King County is uploading this in to ECLS. |
| So all clinicians will now need access to ECLS to determine per encounter eligibility. Is the county ready to authorize all of these access requests? | The county is prepared to meet agency need for access to ECLS. Agencies must determine internal workflows and staffing needs for ECLS access. |
| **Random** | |
| How do MCOs conduct audit? Is there any guidelines in place – providers could have an access? | King County is responsible for conducting audits of delegated activities. |
| If incarcerated and no HCA coverage – Who handles the professional service? Who do we bill? If we bill facility and they deny saying to bill HCA who pays? | If a client is incarcerated, the client is not eligible for Medicaid-funded services. The entity that covers needed services is the Jail Healthcare system |
| **Mental Health Residential** | |
| Do leaves from residential MH facilities still go to KC for approval? | Yes. As MH Residential Services have been delegated to King County, leaves from residential MH facilities will go through BHRD. |

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| You have not addressed how MH residential services will be paid. Will this continues to be paid for through KC or move to the MCO's? Will critical Incidents for these clients go to MCO or CK? | MH Residential Services have been delegated to King County and will continue to go through existing BHRD workflows. Critical incidents for Medicaid clients will go to the MCOs. For non-Medicaid clients, Critical Incidents will go to BHRD. |