Guidance 12
Behavioral Health Network (BNet) Guidelines and Requirements

Contract Reference: *Sections A-1.1 and C-1.2.3*

Authority: Title XXI of the Social Security Act, *S. 409.8135, F.S., Chapter 65E-11, F.A.C.*

Frequency: *Ongoing*

Due Date: *Ongoing*

A. Background

BNet is a statewide network of behavioral health service providers who serve children ages 5 to 19 years of age who meet all the following criteria:

1. Have a serious emotional disturbance or serious mental health or substance use disorder,
2. Are not eligible for Medicaid,
3. Are eligible for the KidCare subsidy program under Title XXI of the United States Public Health Services Act and,
4. Are enrolled in the Children's Medical Services (CMS) Title XXI Health Plan.

The goal of the BNet program is to treat the entire spectrum of behavioral health disorders and provide 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. 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.

B. Managing Entity Responsibilities

The Managing Entity shall:

1. Contract with a Network Service Provider herein referred to as a "BNet Service Provider" to manage the BNet program and allow the BNet Service Provider to subcontract for services.
2. Implement a written policy to outline key procedures related to BNet and the enrollment of children who are not eligible for Medicaid, including the following key elements:
   a. Designating a Managing Entity BNet Coordinator to oversee the BNet program. The coordinator is responsible for ensuring each child's eligibility and enrollment prior to approving the invoice for payment. The BNet Coordinator will coordinate with:
      i. Contracted BNet Service Providers and their BNet Liaisons,
      ii. Other Managing Entity BNet Coordinators, and
      iii. The BNet State Coordinator.
   b. Form review,
   c. Payment review,

d. Compliance reviews; and

e. Technical assistance.

3. Ensure BNet Service Providers designate a BNet Liaison responsible for managing the enrollment process and communicating with the State BNet Coordinator and the Managing Entity.

4. Require all BNet Service Providers to submit a Statement of Program Cost report annually by September 1.

C. BNet Funding and Network Service Provider Payment Policy

The State Coordinator distributes a monthly final enrollment roster to Managing Entities and BNet Service Providers. BNet Service Providers shall only bill for clients listed on the final roster with an enrollment status code of "Y". The BNet Service Provider is not required to bill for every client with a "Y" status on the roster. The Managing Entity must ensure that the BNet provider's monthly invoice does not exceed the total number of clients with enrolled status "Y" and does not include any client with a different enrolled status for the month.

The capitation rate is based on a statewide average cost of care, which must be validated periodically by linking capitation payments to an annual BNet Service Provider Statement of Program Cost Report. This report briefly summarizes the revenue and expenditures the BNet Service Provider experienced in the contract year ending the prior June 30. Each BNET Service Provider shall submit the following minimum elements in a format to be determined by the Managing Entity annually by September 1. The Managing Entity shall forward each report to the BNet State Coordinator no later than September 20.

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. Administrative costs incurred for BNet services; and
6. Signature and title of the official attesting to the veracity of the report.

D. BNet Service Provider responsibilities

Each BNet Service Provider shall:

1. Conduct outreach to generate referrals.
2. Receive referrals from CMS Health Plan contacts.
3. Provide or contract for BNet services.
4. Determine eligibility for BNet services and request enrollment:

a. **Initial Referral**

i. Upon initial referral, the BNet Liaison must determine whether the family has submitted a KidCare enrollment application within the past 120 days.

ii. If the child is already enrolled in KidCare, the BNet Liaison shall conduct Step II Screening to determine whether an assessment is warranted.

iii. If the child is not enrolled, the BNet Liaison shall assist the family to complete an application or reactivate a previously filed application.

iv. If the initial referral occurs when KidCare enrollment is closed for any reason, the Liaison shall:

1. Complete **Template 6 Form A Part I** and check the "enrollment is closed" box,
2. Inform the parents regarding enrollment restrictions and advise them to submit the application form to KidCare to be screened for Medicaid eligibility, and
3. Connect the family to another resource when the child has unmet behavioral health needs.

b. **Step II: Screening and Assessment**

i. The BNet Liaison shall complete **Template 6 Form A Part I** and **Template 6, Form C, Statement of Understanding**.

ii. If **Template 6 Form A Part I** results in a positive screen for treatability criteria, the Liaison shall conduct or arrange delivery of an assessment using the criteria in **Template 6 Form A Part II**, complete **Template 6 Form A Part II**, and complete Step III.

iii. The BNet Liaison must conduct or arrange a new assessment if no clinical assessment has been completed with the past six months.

iv. If **Template 6 Form A Part 1** results in a determination of ineligibility for BNet services, the Liaison shall submit **Template 6** to the BNet Statewide Coordinator and to the CMS Health Plan.

v. If the results of the child's assessment are negative for BNet clinical eligibility, the Liaison completes **Template 6 Form A Part II** and submits the Form to the BNet State Coordinator and to the CMS Health Plan.

c. **Step III: Final BNet Determination**

Following a positive assessment, the Liaison shall submit a completed **Template 6 Form A** to the BNet State Coordinator and to the CMS Health Plan and request a determination of enrollment and capacity.

i. If the BNet State Coordinator determines there is current capacity to enroll the child, the BNet Service Provider may provide services and may invoice the Managing Entity for the capitated rate for the month of services.

ii. If the BNet State Coordinator determines the child is eligible for BNet services but no capacity is currently available, the State Coordinator will enter the child on the Department's waiting list and notify the Liaison. The Liaison shall notify the CMS Health Plan contact that a slot is not available. When a slot becomes available, reverification of eligibility is only required if it has been six or more months since the screening and assessment.

5. The Liaison must re-verify clinical eligibility of enrolled clients a minimum of every six months from the assessment date on the most recently submitted **Template 6 Form A Part II**. Continued enrollment criteria are:

    a. A qualifying mental health or substance use diagnosis and

    b. a CGAS score of 50 or less, or a comparable score from a successor instrument approved by the Department.

i. A client whose CGAS score exceeds 50, but who is considered unlikely to maintain that level of progress may remain enrolled for up to two additional months after which the client must be reassessed.

ii. If the reassessed score is greater than 50, the provider must disenroll the client.

iii. If the reassessed score is 50 or lower, the client is eligible for continued enrollment, subject to subsequent six-month reverifications.

c. The BNet Liaison shall complete **Template 6, Form B, Part I**:

i. Complete the first two sections to identify the BNet Service Provider and the client,

ii. Check the Reverification box in the first section,

iii. Enter the primary diagnosis and CGAS score, and

iv. Provide a secondary diagnosis, if known.

d. The Liaison initials the form, enters the date of the reverification, and sends the form to the BNet State Coordinator.

6. Disenrollment Processing

There are two categories of disenrollment: those related to loss of clinical eligibility, and those related to loss of Title XXI coverage.

a. Disenrollments related to loss of clinical eligibility apply when:

i. A client's CGAS score exceeds 50,

ii. A client completes treatment,

iii. The primary diagnosis is changed to one not covered,

iv. A client or client's parent or guardian declines services or is noncompliant with services, or

v. A client is admitted to residential treatment exceeding 30 days.

b. Disenrollment's related to loss of Title XXI coverage apply when:

i. A client moves out of state,

ii. A client is incarcerated; or

iii. A client obtains insurance coverage other than Medicaid.

c. The following administrative actions also terminate a client based on information provided in monthly data files from CMS. These terminations do not require a disenrollment form:

i. A client turns 19 years of age,

ii. A client is determined Medicaid eligible,

iii. A parent or guardian fails to pay monthly premium,

iv. A parent or guardian fails to complete renewal, or

v. A parent or guardian requests cancellation of the client's CMS Plan enrollment.

d. The BNet Liaison shall complete and submit **Template 6 Form B Part II** to the BNet State Coordinator to request disenrollment of a client. Completing the form includes:

i. Completing the top section identifying the BNet Service Provider,

ii. Checking the box for Request for Disenrollment,

iii. Completing the second section identifying the client, and

iv. Completing Part II – Assessment – Request for Disenrollment, indicating the reason for disenrollment. Part I should not be completed.

1. If the child has insurance coverage other than Medicaid, the Liaison should identify the other insurance.
2. If either residential treatment or incarceration is indicated, the Liaison should indicate the type of placement or institution.
3. If the child no longer meets BNet criteria, the provider must check the most pertinent choice or specify "other" and briefly explain in the space provided.
4. The Liaison must initial and date the form.

7. **BNet Alternative Services Reporting**

BNet Service Providers report any services that are not reportable to the SAMH Data system on **Template 7 BNet Alternative Services** which consists of Forms 7A and 7B. Form 7A records wraparound services other than pharmaceuticals that were provided to each client. Form 7B records pharmaceuticals purchased and provided to each client.

BNet Service Providers shall submit **Template 7** Forms 7A and 7B to the BNet State Coordinator monthly by the 15th of the month following service or medication provision. Managing Entities may require BNet Service Providers follow addition approval and submission processes.

8. **Residential and Baker Act Coordination**

When a client's mental health symptoms increase, the BNet Liaison shall coordinate services and planning with the CMS Health Plan Care Manager and the Managing Entity to ensure the child receives the appropriate level of services.

a. BNet clients are eligible for up to 10 days of treatment under a Baker Act and up to 30 days of residential treatment annually funded by the BNet Service Provider

b. When more intensive services are necessary, the Liaison shall contact the CMS Health Plan Care Manager to plan interventions designed to avoid a Baker Act or residential treatment.

c. When a client is admitted to a Baker Act Receiving Facility, the Liaison must notify the CMS Health Plan to coordinate payment in the event the admission goes beyond 10 days for the year.

d. When a client is assessed as needing more than 30 days of residential treatment, the Liaison must coordinate with the CMS Health Plan and the Managing Entity to:

i. Consider other services to maintain the enrollee in the community while applying for residential treatment services such as Community Action Treatment Team, case management, or outpatient therapy.

ii. Ensure the family has knowledge of the local mobile response team.

iii. Disenroll individuals from BNet that need more than 30 days of residential treatment because that makes them ineligible for the BNet program.

iv. Coordinate with the CMS Health plan when transitioning out of the BNet program if they have not been placed in residential treatment.

e. When a caregiver initiates the request for residential treatment and does not inform the BNet Service Provider, after learning of situation, the Liaison must notify the CMS Health Plan Care Manager to coordinate services and determine if the child should be disenrolled from BNet.

f. If the individual is still enrolled in BNet when they are admitted to a residential treatment center, disenroll them that month. Payment arrangements should be agreed upon prior to admission.

g. It is recommended that the Liaison request quarterly updates from the CMS Health Plan Care Manager to coordinate assessment for BNet services when the child/youth is discharged to home.