

ADULT MEDICAID BH REFERRAL CHANGES UNDERWAY

WHAT IS CHANGING?

The current AR Medicaid program under which Behavioral Health Services are provided (RSPMI) will end June 30th 2018. A new program is being implemented in its place, the Outpatient Behavioral Health (OBH) program. Under the OBH program clients who require a full array of services beyond outpatient counseling and medication management will receive an Independent Assessment through a DHS contractor Optum Health Solutions. Clients who receive an assessment will be given a Tier determination:



TIERS OF SERVICE

Tier 1: Counseling level services provided by a mental health professional.

Tier 2: Rehabilitative level services provided by mental health professionals and paraprofessionals employed by a certified agency provider.

Tier 3: Residential level services provided in residential settings.

Clients who receive a Tier 2 or Tier 3 determination will no longer need a PCP referral for behavioral health services. These clients will receive care coordination through the Provider Led Arkansas Shared Savings Entity (PASSE) programs. All clients who receive a Tier 1 determination and those that do not receive an Independent Assessment will need a PCP referral for counseling services in the OBH program. This population includes children, youth and adults. These services can be provided by certified agency providers, certified counselors in private practice and certified school based providers.

LIMITS AND DOCUMENTATION

Each beneficiary may receive up to three (3) OBH Tier 1 Counselor Level Services without a PCP referral. Following those three (3) OBH visits, the beneficiary will need a referral/approval to continue treatment. The referral must be retained in the beneficiary's medical file.

The PCMH will be responsible for coordinating care with a beneficiary's PCP or physician for these OBH Tier 1 Counseling Level Services.

Medical responsibility for beneficiaries shall be vested in an Arkansas-licensed physician.

Verbal referrals from PCPs or PCMHs are acceptable to Medicaid as long as they are documented in the beneficiary's medical chart as described in section 171.410.