Washington State Health Care Authority

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Medicare/Medicaid Dual Eligibles

Involuntary Treatment Act Services

Federal and State rules and regulations dictate how to provide and pay for crisis services and involuntary treatment associated with Mental Health (MH) and Substance Use Disorder (SUD) for Medicare/Medicaid clients (dual eligibles) regardless of legal status. While State and local law may designate that particular individuals such as involuntary patients be treated at specific facilities, when providing crisis and ITA services to dual-eligibles, payment and authorization policies must address both Federal and State rules and regulations.

Involuntary Treatment Act (ITA)

Washington State's Involuntary Treatment Act (ITA) provides the legal framework that allows individuals to be detained by Designated Crisis Responders (DCRs) and/or committed by a court order to a mental hospital or institution against their will following due process as required by the 14th amendment.[1] Involuntary civil commitments are meant to provide for the evaluation and treatment of individuals with a mental disorder who may be either gravely disabled or pose a danger to themselves or others, danger to property and who refuse or are unable to enter treatment on their own.

In April 2018, the ITA was extended to individuals with SUD under E3SHB 1713. The law is known as the "Ricky Garcia Act" or "Ricky's Law." The 2018 law applies to the following hospital settings: Emergency Departments; Inpatient units; and any other location, such as an outpatient clinic, where staff may assess or refer a patient to a DCR for an evaluation for a substance use disorder. Involuntary treatment can also be initiated in a community setting by DCRs.

What is a DCR authorized to do?

A DCR will determine if the person presents a harm to self/others/property, or is gravely disabled and is at imminent risk, or if there is a non-emergent risk due to a substance use disorder or mental disorder, or is in need of assisted outpatient behavioral health treatment.

The DCR will conduct an evaluation and investigation:

- Interviewing all reasonably available family, friends, or others.
- Interview the person after informing them of their involuntary treatment rights.
- Consider all available less restrictive treatment options.
- Determine if the person meets criteria for involuntary treatment.

[1] Court Ordered Involuntary Treatment is provided for either a short-term detention or a long-term commitment.

- If the DCR finds the person meets the criteria for involuntary treatment, the DCR will work to find an available treatment bed.
- If there is no available involuntary treatment bed, then the DCR will not detain the person and send in a no bed report to the state.

Involuntary Treatment for Medicare/Medicaid Individuals

Two conditions must be met in order for Medicare to pay for Involuntary Treatment for mental health and substance abuse disorder for dual eligibles.

1. The services are provided by a Medicare approved provider or facility;
2. The service is covered by Medicare.

If the conditions are not met, then either the Behavioral Health – Administrative Service Organization (BH-ASO) or the Integrated Managed Care Organization (MCO) may be responsible for payment.

Providers must bill Medicare first if the BH service is covered, and the individual has a Medicare benefit—even if an individual is on court-ordered involuntary treatment. The provider will receive an Explanation of Benefits (EOB) which will show which services are denied and which services are paid for. For example:

1. The client is ordered to receive involuntary treatment:
    a. The client receives medically necessary BH services which are covered by Medicare (treatment is provided in a hospital and covered by Part A).
    b. The provider/facility that provides the treatment is a Medicare provider (the provider is a psychiatrist).
    c. Medicare pays for the allowable services[2] and sends an EOB to the treating provider.
2. The client is ordered to receive involuntary treatment:
    a. The client receives medically necessary BH services which are not covered by Medicare.
    b. The treatment is covered by Medicaid or state-only funds. The claim is not a cross-over claim.
    c. The BH-ASO or the MCO pays for the treatment.
3. The client is in involuntary treatment:
    a. The client receives medically necessary BH services which are covered by both Medicare and Medicaid.
    b. The provider or facility is not a Medicare provider.
    c. Medicare denies the payment and sends the treating provider an EOB.

[2] Medicare does not pay for room and board for Involuntary treatment in settings that aren't recognized by Medicare as inpatient facilities, ICF-MRs, nursing homes or in youth psychiatric residential treatment facilities. That portion of the payment will always be denied in the EOB. Either the MCO or the BH-ASO will be responsible for the room and board.

d. The BH-ASO or MCO pays for treatment. This is considered a cross-over claim.

Inpatient mental health care is covered under Part A for dual eligible individuals. Medicare imposes a lifetime maximum of 190 days of inpatient psychiatric hospital services, after which no further benefits of that type are available to that individual. In this scenario, the service is no longer a Medicare service after the 190 days – see Example #3 above.

Inpatient alcoholism and SUD are covered under Part A for dual eligible individuals. The provider must state that the services are medically necessary; the services are provided from a Medicare approved provider or facility; and the provider sets up the plan of care. For the full-dual eligible, no cost sharing is applied because Part A is covered by Medicaid.

A court or DCR may only detain or enter a commitment order based on a SUD if there is an available withdrawal management and stabilization facility with adequate space for the individual.

<u>Short-Term Detention and Long-term Commitments</u>

Financial responsibility for Involuntary Treatment is dependent on whether the service is for short-term detention/committment or for long-term commitment. Initial detention is for 72 hours and then an individual may be held for periods of court ordered involuntary inpatient treatment for 14-days which is short term. 90-days or 180 day treatment as further ordered as part of civil commitment process is considered long term care. While a court order provides the legal authority for the hold, medical necessity criteria is still relevant in determining the course of treatment and associated duration of stay (involuntary court ordered treatment is the basis of medical necessity criteria).

For individuals on a petitioned emergency initial detention hold (72 hours) the facility has to document in the medical record on a daily basis to demonstrate the individual continues to meet ITA criteria. If they do not meet criteria, that is when the hold can be released and the individual converted to voluntary status or discharged. Also, during a short term detention the individual has the right to convert to voluntary at any time. It would be up to the facility to determine and document why the individual would not meet a good-faith voluntary status.

Individuals ordered by the court to receive long-term commitments in an approved facility may be discharged before their court ordered length of stay is finished. Long-term commitments do not have to have daily treatment documented in their medical records. Long-term commitments can't be changed to a short-term commitment. A Medical Director or "professional person in charge[3]," may determine the individual no longer meets detention criteria and the hold can be released and the person discharged from the facility.

[3] RCW 71.05.340 Outpatient treatment or care – Conditional release, (1)(a) When, in the opinion of the superintendent or the professional person in charge of the hospital or facility providing involuntary treatment, the committed person can be appropriately served by outpatient treatment prior to or at the expiration of the period of commitment, then such outpatient care may be required as a term of conditional release for a period which,

Payment

Hospitals providing services to individuals enrolled in Managed Care Organizations (MCOs) that provide mental health or SUD treatment in an inpatient hospital setting for dual eligibles should bill Medicare as primary, since Part A pays for inpatient hospital care. HCA or its designees will pay amounts remaining on the crossover claims, however, HCA won't pay the bill unless there is a denial from Medicare in an EOB. As with any other individual requiring ITA services in the state of Washington, HCA pays for ITA services when Medicare benefits are exhausted or Medicare issues a payment denial. Ordinarily, HCA would not pay anything not payable by the primary payor; this principle is suspended for ITA services as standards of medical necessity can vary between Medicare and Medicaid programs, and it is necessary to ensure providers are paid for ITA services when necessary to ensure continued availability of ITA services.

Dual-Eligible Special Needs Plans

Dual-Eligible Special Needs Plans (D-SNPs) are managed care organizations that provide Medicare benefits to individuals who have both Medicare and Medicaid eligibility. A D-SNP is required to provide prescription drugs as part of their benefits package (commonly known as Part D). Since a D-SNP is an authorized Medicare provider, they must provide all Medicare benefits, such as mental health and SUD treatment services according to Part A, Part B and Part D regulations. If a dual-eligible individual is enrolled in a D-SNP, Medicare is always primary and the D-SNP is responsible for payment. When a limit is placed on Medicare coverage, such as the cap on Inpatient Hospital days, Medicaid or state only funds will pay for the ITA as the secondary payer. Dual-eligible individuals receive their Medicaid mental health and SUD benefits from Behavioral Health Services Only coverage and their crisis services from Behavioral Health – Administrative Service Organizations (BH-ASOs).

No Coverage

State-only funds are used when an individual is not covered by Medicare or Medicaid. This includes individuals with court-ordered involuntary treatment. ITAs are covered by the BH-ASOs. BH-ASOs may also provide some crisis services for non-covered individuals, within available resources.

when added to the inpatient treatment period, shall not exceed the period of commitment. If the facility or agency designated to provide outpatient treatment is other than the facility providing involuntary treatment, the outpatient facility so designated must agree in writing to assume such responsibility. A copy of the terms of conditional release shall be given to the patient, the designated crisis responder in the county in which the patient is to receive outpatient treatment, and to the court of original commitment.