Behavioral and Primary Healthcare Coordination (BPHC)

Provider Training

January 22, 2014

Agenda

- Conversion from 209b to 1634 State
- Purpose of Program/Definition of Program
- Program Requirements
- Program Eligibility Process
- Application Process
- Timeline for implementation
- Summary

Background: Medicaid Coverage Options

- States have different options for determining Medicaid eligibility for the aged, blind and disabled population.
- Indiana is currently a 209(b) state.
- Legislation was passed authorizing the State's transition to 1634 status.

1634 vs. 209b criteria:

- **1634**: SSI recipients do not make a separate application for Medicaid and are automatically enrolled in Medicaid.
- **209b**: At least one eligibility criteria is more restrictive than SSI and the State must operate a spend-down program.
  - Spend-down operates similar to a deductible and individuals must incur medical expenses each month before Medicaid pays for services.

Conversion to 1634 Status

- Proposed effective date is June 1,2014
- Individuals currently receiving SSI benefits will be enrolled in Medicaid automatically.
- The spend-down provision will no longer operate.

Benefits of 1634 Transition

- Allows the State to cover more aged, blind and disabled enrollees while simultaneously achieving cost savings.
  - Individuals up to 100% FPL who are aged, blind or disabled will be transitioned from spend-down to full Medicaid eligibility, providing more stable health coverage to enrollees.
  - The income thresholds for the Medicare Savings Program, which provides Medicare cost-sharing assistance will be increased.

1634 Transition – Impact to Current MRO Utilizers

- With 1634 transition, current MRO utilizers on spend-down who are over 100% of the federal poverty level* are at risk of losing Medicaid coverage.
- With loss of Medicaid coverage these individuals will no longer have access to intensive community-based mental health services provided under MRO.
  - Duals**: MRO is non-Medicare covered
  - Non-duals: MRO is not covered by most commercial health insurance
- The State is developing a new 1915(i) program to provide continued Medicaid eligibility to this target population in order to preserve access to MRO services.

*$958/month for a single individual or $1,293 for a married couple; these amounts are updated annually

** Refers to individuals enrolled in both Medicare and Medicaid

1915(i) Overview

- State option to provide home and community based services to individuals meeting needs-based and targeting criteria developed by the State
- Institutional level of care not required
- Must be provided statewide and with no waiting list
- The Affordable Care Act created new option
  - Provide 1915(i) to individuals not otherwise Medicaid eligible
  - Individuals in this optional eligibility group eligible for all Medicaid benefits, not only the 1915(i) service

New 1915(i): Behavioral & Primary Healthcare Coordination

- Purpose of 1915(i)
  - The intent of the Behavioral and Primary Healthcare Coordination (BPHC) program is to provide supportive and intensive community based services to individuals with serious mental illness who demonstrate impairment in self-management of healthcare needs.
  - BPHC is intended to assist individual with a serious mental illness who have a co-existing health issue to coordinate and manage both their behavioral health and primary healthcare needs.

Overview: BPHC

- BPHC Program is designed to assist individuals with Serious Mental Illness, who won't otherwise qualify for Medicaid or other 3rd party reimbursement for the level of intense services they need to function safely in the community.
- BPHC Program offers ONE service. The primary function of this program is to be the gateway for individuals meeting the eligibility criteria to access Medicaid benefits.
- This program is not designed to meet all of an individual's identified needs. It is anticipated eligible recipients will access a number of additional Medicaid services to meet their needs.

Overview (Cont'd): BPHC

- It is intended that individuals who will qualify for Medicaid without this program would not need to apply, since they will be able to access Medicaid services without this program.
  - Individuals who are already Medicaid eligible will have continued access to services similar in nature to BPHC.
  - Service units for BPHC will be approved in conjunction with these other complimentary programs, and therefore, individuals would not receive additional service units or benefits by applying for BPHC.

Service Definition

- The BPHC service consists of the provision of the following to assist in the coordination of healthcare services for the recipient:
  - Logistical support.
  - Advocacy and education to assist individuals in navigating the healthcare system.
  - Activities that help recipients:
    - Gain access to needed health services
    - Manage their health conditions, including, but not limited to:
      - Adhering to health regimens.
      - Scheduling and keeping medical appointments.
      - Obtaining and maintaining a primary medical provider.
      - Facilitating communication across medical providers.

Proposed 1915(i) BPHC Service Standards:

- Coordination of healthcare services
  - Direct assistance in gaining access to services
  - Coordination of care within & across systems
  - Oversight of the entire case
  - Linkage to services
- Assistance in utilizing the healthcare system
  - Logistical support
  - Advocacy
  - Education
- Referral & linkage to medical providers
- Coordination of services across systems
  - Physician consults
  - Communication conduit
  - Notification of changes in medication regimens & health status
  - Coaching for more effective communication with providers

Provider Qualifications

- BPHC provider agency staff must meet the following qualifications based on service activity provided.
  - BPHC needs assessment, individualized integrated care plan development and adjustments, referral and linkage activities and physician consults:
    - Licensed professional;
    - QBHP; or
    - OBHP.
  - All other BPHC activities including coordination across health systems, monitoring and follow-up activities and reevaluation of the recipients progress toward achieving care plan objectives:
    - Licensed professional;
    - QBHP;
    - OBHP;
    - DMHA/ISDH Certified Community Health Workers and/or Certified Recovery Specialist (CHW/CRS)

Codes and Rates

Tier	Code	Definition	Unit/Rate	Limitations
BPHC- Tier 1	T1016 UC	Designated activities provided by LP, QBHP, and OBHP	1 Unit = 15 minutes 14.53 per unit	48 units combined with T1016 UC U3.
BPHC- Tier 2	T1016 UC U3	Designated activities provided by CHW/CRS	1 Unit= 15 minutes $8.55 per unit	48 units combined with T1016 UC.

Service Limitations & Exclusions

- BPHC services may be provided for a **maximum of 12 hours (48 units) per 6 months**
- Exclusions:
  - Activities billed under MRO Case Management or AMHH Care Coordination
  - The actual or direct provision of medical services or treatment. Examples include, but are not limited to:
    - Medical screenings such as blood pressure screenings or weight checks
    - Medication training and support
    - Individual, group, or family therapy services
  - Crisis intervention services

Proposed BPHC1915(i) Eligibility Criteria

Targeting Criteria

- Age 19 +
  - Individuals under 19 eligible for CHIP so not impacted by 1634 conversion
- MRO eligible primary mental health diagnosis

Needs-Based Criteria

- Demonstrated need related to management of behavioral and physical health
- Demonstrated impairment in self-management of physical and behavioral health services
- ANSA LON 3+
- Demonstrated health need which requires assistance and support in coordinating behavioral health & physical health treatment

Financial/Non-Financial Eligibility

*DFR will determine non-clinical BPHC Eligibility

- To be eligible for BPHC, an individual must have countable income below 300% of the Federal Poverty Level (FPL)

Marital Status	Monthly Income Limit
Single	$2,873
Married	$3,878

There are certain income disregards that may be applied that lower countable income. If there are children or other qualifying dependents in the individual's household, an individual's income may be higher than those listed in this table. A $361 per qualifying individual deduction may applied.

Residence Requirements

- Individual must reside in home and community-based setting.
- Individuals residing in an institution are not eligible.

BPHC Notification to Providers and Consumers

- FSSA's DMHA is notifying CMHCs to prepare for consumer notification by FSSA's DFR pertaining to Medicaid Eligibility.
- FSSA is requesting CMHCs reach out to consumers **as soon as possible** to:
    1. Provide education on possible options
    2. Begin review and completion of the application process for those consumers who may be eligible for BPHC

First Step in Determining BPHC Program Eligibility Assess the following requirements:

- Are age nineteen (19) or older
- Have an eligible primary mental health diagnosis (mirror MRO adult diagnoses)
- The applicant either:
  - (A) resides in a community-based setting that is not an institutional setting, or
  - (B) will be discharged from an institutional setting back to a community-based setting.

Second Step in Determining BPHC Program Eligibility

Assess the following needs-based requirements:

- Based on the behavioral health clinical evaluation, referral form, supporting documentation and DMHA-approved behavioral health assessment tool results, the applicant must meet all of the following needs-based criteria:
  - A. Demonstrated needs related to management of his/her health (physical and behavioral),
  - B. Demonstrated impairment in self-management of healthcare services,
  - C. A health need which requires assistance and support in coordinating healthcare treatment,
  - D. A rating of 3 or higher on ANSA.

Application Process

- CMHC submits evaluation packet through DARMHA
  - Applications may only be submitted by DMHA approved BPHC providers

- For conversion only (applications submitted by 4/1/14) – ANSA completed within the last 6 months

- DMHA Independent Evaluation Team determines clinical eligibility
  a) if clinically eligible sends information to DFR/ICES for financial & non-financial eligibility determination
  b) if not eligible – sends denial notification to CMHC and applicant

BPHC Enrollment Process

- If found clinically eligible, DMHA forwards the BPHC application to DFR to determine financial eligibility and other non-financial (e.g., residency & citizenship)
    a) if DFR determines financial eligibility is yes-
        1) notifies DMHA and HP
        2) sends eligibility notice to enrollee they are eligible for Medicaid
    b) if no-
        1) DFR will notify DMHA
        2) DFR will send Medicaid denial notice to applicant (provider can check eligibility through WebInterchange)
- For initial conversion, BPHC eligibility effective date will be no earlier than June 1, 2014 (BPHC **proposed** implementation date)

Implementation: Eligibility End Date

- Clinical eligibility end date will be aligned with current MRO end date so moving forward the application process will be aligned.
- The table below will be used to determine how many BPHC units will be authorized by the State Evaluation Team.

# Months Until MRO Expires	# Units of BPHC Authorized
6	48
5	40
4	32
3	24
2	16
1	8

Example:
- BPHC Start Date: 6/1/14
- MRO End Date: 8/1/14
- # of BPHC Units Authorized: 16
- BPHC End Date: 8/1/14

Implementation Time Line

January 23, 2014:

List of identified consumers sent by DMHA to CMHCs

April 1, 2014:

Deadline for CMHCs to submit all BPHC applications to DMHA

June 1, 2014:

Target BPHC implementation

Summary of BPHC

- Program is to allow current MRO consumers to remain eligible for Medicaid and continue to receive community-based intensive mental healthcare not otherwise offered under other insurance coverage options.
- Providers will need to complete attestation to be a BPHC provider agency by February 3, 2014.
- Providers encouraged to check www.indianamedicaid.com and DMHA website for more information on 1634 conversion and the impact to the consumers they serve.

Advocating for Applicants

- Where to refer a consumer when they are not eligible for BPHC and are at risk of losing benefits:
  - Individuals not on Medicare
    - Indiana Navigator
    - Listing by county available at http://www.in.gov/healthcarereform/2468.htm
  - Individuals on Medicare
    - State Health Insurance Program (SHIP)
    - Listing of in-person counseling locations available at http://www.in.gov/idoi/2507.htm

Next Steps for CMHC's

- DMHA will provide lists of identified MRO consumers that may qualify for BPHC.
  - Are 19 years old or older
  - Have a MRO eligible diagnosis
  - Have a level of need 3 or greater on their most current ANSA
  - Have received a MRO service between January 1 and November 30, 2013
  - Have been on spend-down and will lose eligibility with the transition to 1634
- CMHC to contact consumers & advise them of change & application process.
- CMHC will complete application with individuals on target list.

Next Steps for CMHC's cont'd

- Consumer application and proposed BPHC IICP will be sent to DMHA **by April 1, 2014**. Application will be available February 3, 2014.
- CMHC will monitor individuals on target list who have not completed application through DARMHA report.
- DMHA & OMPP will conduct a weekly call with CMHCs to assist in implementation, answer questions and address concerns.
- Training on billing will be provided at a later date.

BPHC DARMHA Application

BPHC Application Requirements

- The following information is required on the BPHC application:
  - Diagnosis is current and accurate
  - Identification of any health conditions which the consumer is having difficulty managing due to their mental illness
  - Attestations
  - Proposed IICP
  - Health questions
  - Supporting documentation

Healthcare Assessment Items: Rating Criteria

The BPHC application includes a series of questions to assess an individual's ability to manage their healthcare service needs. The table below outlines the rating criteria to be used in scoring each item.

Rating	Level of Need	Appropriate Action
0	No evidence of need	No action needed
1	Significant history or possible need which is not interfering with functioning	Watchful waiting/ Prevention/ Additional assessment
2	Need interferes with functioning	Action/Intervention
3	Need is dangerous or disabling	Immediate and/or Intensive action

Healthcare Assessment Item #1

	PHYSICAL/MEDICAL ***This rating includes both acute/chronic health problems and physical conditions***
0	There is no evidence of physical or medical problems.
1	Mild or well-managed physical or medical problems are indicated. This might include well-managed chronic conditions like diabetes or asthma. A person in need of a physical/medical examination would be rated here.
2	Chronic physical or moderate medical problems are present.
3	Severe, life threatening physical or medical condition exists.

Healthcare Assessment Item #2

	MEDICATION MANAGEMENT ***This item focuses on the individual's ability to manage his/her prescription medication regiment and the impact on their physical and/or mental health symptoms and functioning.***
0	There is no evidence that the person has difficulty managing any prescribed medication.
1	Although usually taking medications consistently, the person takes prescribed medications may occasionally stop, skip, or forget to take medications without causing instability in the underlying conditions. He/she may benefit from reminders and checks to consistently take medications. OR Individual has significant history of problems managing medication, problems that adversely impacted physical and/or mental health.
2	Over the last year, the person takes medications inconsistently, has difficulties with side effects, or misuses medications. OR The underlying medical or behavioral health conditions are unstable or adversely affect the individual's functioning. OR The individual makes frequent visits to physician or urgent care center within the last year.
3	Due to the person's inability to self-manage prescribed medications, his/her mental or physical condition is deteriorating and functioning is severely impaired. Inpatient care may be necessary to stabilize the person's condition. OR This level indicates a person who has refused to take prescribed psychotropic or physical health care medications during the past 180 day period or a person who has abused his or her medications to a significant degree (e.g., overdosing or over using medications to a dangerous degree).

Healthcare Assessment Item #3

	MANAGEMENT OF HEALTHCARE: ***This item focuses on the individual's awareness of co-occurring behavioral and physical health care needs and the individual's ability to manage both.***
0	There is no evidence that the person has any co-occurring physical health and mental health conditions nor physical health risk factors (antipsychotic medications, depression, lifestyle risks (smoking, obesity, and inactivity), transportation issues, negative symptoms, or financial barriers to health care. He/she recognizes physical and behavioral health issues, risk factors, and manages them successfully.
1	The person is aware that he/she requires both physical healthcare and behavioral healthcare, but occasionally has difficulty managing symptoms, and health regimens, or making lifestyle changes. Functioning is impaired, such as occasionally missing scheduled appointments; he/she may benefit from reminders and checks to consistently keep appointments, and monitor symptoms.
2	The person has moderate difficulty managing physical or behavioral health care. He/she may not consistently follow mental health or physical health care plans, routinely see a primary care physician, frequently miss scheduled appointments, has interpersonal problems with health care team, or faces barriers to accessing comprehensive, coordinated health care (lack of transportation, long wait for appointments, does not understand treatment plans, is not screened for lifestyle risks), or does make needed lifestyle changes. OR Side effects and related risk factors for poor physical health are not monitored. OR Individual has visited the ER in the last year.
3	The person is poorly managing his/her healthcare risking serious or life-threatening complications. OR The individual does not have a primary health care provider whom they saw within the last year. OR Individual uses the ER for primary health care. OR Individual refuses or is unable to participate in either physical or behavioral healthcare, is experiencing an exacerbation of the physical or behavioral health condition, or may be experiencing complications due to multiple health care conditions. OR External barriers prevent the individual receiving physical and/or mental health care. OR Individual has been hospitalized within the last year.

Healthcare Assessment Item #4

	COORDINATION OF HEALTHCARE: ***This item focuses on the individuals with chronic or acute physical health conditions as well as behavioral health diagnoses and his/her participation in integrated healthcare.***
0	The individual has accessible, responsive primary physical and mental health providers. Medical and behavioral and care are coordinated across all necessary disciplines (medical and behavioral), resulting in stable mental and physical health symptoms and functioning. AND Both mental and physical health care are well coordinated and managed by the individual and/or health care team, resulting in stable, healthy functioning.
1	Mild care coordination issues occasionally occur between the individual's mental health treatment and support team and active primary health care provider. Such issues are resolved by individual or health care team.
2	Moderate care coordination issues between mental and physical health care providers are evident. For example, the individual has risks or is developing a chronic physical health condition and is not screened or monitored for physical health risks from psychotropic medication side effects or life style risks.. OR The individual has frequent outpatient visits or urgent care visits over the past 3 months in order to stabilize or treat his/her acute or chronic physical condition or behavioral health condition. OR He/she requires support and coordination of medical and behavioral health issues to increase and maintain stability. OR Individual may not be able to communicate across multiple medical/behavioral health providers. OR Physical health care providers may not understand the individual's mental health needs, attribute physical symptoms to psychological issues, not measure and monitor lifestyle risks, or provide vague treatment instructions. External barriers to accessing physical care exist.
3	Evidence of severe care coordination issues across mental and physical health may result in dangerous or disabling mental or physical health care outcomes or institutional placement. The individual experiences reoccurring problems with limited periods of stability. OR The individual has any ER visits or inpatient hospitalizations within the last year. OR The individual does not have a primary health care provider or has not seen the primary health care provider within the last year. A state hospital or nursing home admission has been considered. External barriers prevent access to physical health care.

DARMHA Application Overview

- BPHC Application View
  - General
    - Applicant information will pre-populate based on DARMHA ID
      - This includes name, age, diagnosis, most recent ANSA scoring, and BPHC algorithm
    - Current living situation
    - Justification of Need
    - Consumer's Current Situation
    - Contacts
      - Applying case manager
      - Alternative agency provider contact

DARMHA Application Overview

- BPHC Application View
  - IICP Form
    - Needs Statement
    - Goal
    - Objective/s
    - Strategies
    - Information on other supports or services; or lack thereof

DARMHA Application Overview

- BPHC Application View
  - Treatment Team Attestations
    - The applicant has been given choice of providers.
    - The applicant has been given choice of the service.
    - The applicant has participated in the development of the IICP.
    - The proposed IICP is individualized to meet the applicant's needs.
    - The program requirements and financial requirements have been reviewed with the consumer.

DARMHA Application Overview

- BPHC Application View
  - Discharge from BPHC (when necessary)
    - Discharge date
    - Reason for discharge (drop-down)
    - Support Summary

Questions???