

Behavioral and Primary Healthcare Coordination (BPHC)

Indiana Council of Community Mental Health
Centers Webinar
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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)

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 BPHC 1915(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

June 1, 2014:

Target BPHC implementation

April 1, 2014:

Deadline for CMHCs to submit all BPHC applications to DMHA

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 income between 100 and 300% Federal Poverty Level
 - 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 an 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.

Questions???

Follow Up To Questions From 1/22/14

**Will VA income count as countable income?

- Yes, generally VA income is counted. Depending on how the income is received from the VA, all or a portion may be counted.

**What criteria was used to create the OMPP list of consumers at risk for losing benefits?

- Age 19+
- LON 3+
- MRO dx
- MRO service claim between 1-1-13 and 11-30-13
- Spend down
- Income between 100-300% FPL

BPHC Provider Frequently Asked Questions

NOTE: The State is currently seeking federal approval for the BPHC program through a State Plan Amendment (SPA). Therefore, information in this document is subject to change pending the outcome of the approval process.

The following are excerpts which focus on the initial BPHC conversion process:

4. What information is used by the State Assessment Team to determine if an individual has a medical condition? Are specific medical conditions required for BPHC eligibility?

There are specific items in the BPHC application to assess medical need. In addition to meeting the needs-based criteria, documentation must be included in the application indicating the need for support and assistance in managing a medical condition based on impairment due to mental illness. The State has not defined specific medical conditions required for an individual to be eligible for BPHC; rather, the individual must have a serious mental illness which impacts his ability to manage physical health matters. This could include issues such as lack of an established medical home, frequent emergency room visits, need for a physical or ongoing preventive care, or inability to self-manage any prescribed medications.

BPHC Provider Frequently Asked Questions

5. I have a consumer who is already eligible for Medicaid who I believe fits the eligibility criteria for BPHC. Should I refer him to the BPHC program and complete an application?

The BPHC program is intended primarily to provide Medicaid eligibility for individuals with significant mental health needs over 100% FPL (\$958 per month for a single individual or \$1,293 for a married couple) who would not otherwise be Medicaid eligible. Individuals who are disabled and below 100% FPL may be eligible for full Medicaid benefits. While no one is prohibited from applying to the BPHC program, individuals who are already Medicaid eligible will have continued access to services similar in nature to BPHC, such as MRO and AMHH case management, care coordination and peer supports. 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.

BPHC Provider Frequently Asked Questions

7. What other Medicaid covered services is a BPHC enrollee eligible for?

BPHC enrollees are eligible for Medicaid and therefore eligible to receive all Medicaid covered services.

BPHC Provider Frequently Asked Questions

10. What is the process for becoming a DMHA approved BPHC provider agency?

CMHCs must complete the “CMHC Provider Application and Attestation to Provide Behavioral and Primary Healthcare Coordination” form. This form was sent to all CMHC CEOs by email from DMHA on January 15, 2014 and must be returned by February 3, 2014. Please contact Aaron.Walker@fssa.in.gov for additional information.

BPHC Provider Frequently Asked Questions

12. What is the deadline to submit a BPHC application before the 1634 conversion in order to ensure my clients on spend-down do not have a gap in Medicaid eligibility?

BPHC applications must be submitted electronically to DMHA by April 1, 2014 in order for them to be reviewed and sent to the Division of Family Resources (DFR) for financial eligibility determination and category assignment to be effective June 1, 2014.

BPHC Provider Frequently Asked Questions

15. If an individual is determined eligible for BPHC during the initial program implementation, when will eligibility be effective and when can a provider begin rendering BPHC services?

Eligibility for BPHC will not be effective until June 1, 2014. BPHC services may not be rendered or claimed prior to this date. This implementation date is pending federal approval of the program and therefore may be delayed. Providers will be kept apprised if there is a delay.

BPHC Provider Frequently Asked Questions

17. What is required for a BPHC application?

The following are required components for a complete BPHC application submission via DARMHA. The application includes check boxes for attestations that the required documents and actions have occurred. Signed documentation must be maintained in the clinical record and available for review by the state as requested.

- Completed and signed BPHC application
- Completed and signed proposed BPHC IICP
- Signed attestations
- ANSA LON and eligible diagnosis
- Supporting documentation necessary to demonstrate applicant's level of need meeting BPHC criteria, and need for requested services
- During the conversion phase, incomplete applications will be denied. DMHA will send a denial notice to the referring provider and recipient. The denial notice will include reason for denial. A new, updated application may be submitted.

BPHC Provider Frequently Asked Questions

18. What happens after a BPHC application is submitted?

During the initial conversion period, the DMHA State Evaluation Team will review the BPHC application to determine clinical eligibility. If the individual is found clinically eligible, information is sent to the Division of Family Resources (DFR) which determines all other elements of review for Medicaid eligibility such as income, age, citizenship and state residency. Applicants must meet all eligibility criteria to be deemed eligible for the program.

BPHC Provider Frequently Asked Questions

19. How is an applicant and BPHC provider agency notified that a BPHC application has been approved?

If determined eligible for BPHC, an authorization notification will be sent by HP to the referring BPHC provider notifying them of the BPHC eligibility determination and approved service units. This authorization notice will include the start and end date for BPHC eligibility and the number of approved units. Providers will also be able to access this information via Web interChange.

BPHC Provider Frequently Asked Questions

20. How is an applicant and BPHC provider agency notified that a BPHC application has been denied?

- ▶ If determined clinically ineligible for BPHC, denial letters will be sent by the Division of Mental Health and Addiction (DMHA) to the applicant and provider informing them that their application for services has been denied. The letter will include the reason for denial and information on how to appeal.
- ▶ Individuals applying to BPHC who are found ineligible for Medicaid for reasons other than a clinical denial (e.g., income exceeds 300% FPL, does not meet State residency requirements, etc.), will receive a Medicaid eligibility denial or discontinuance notice from the Division of Family Resources (DFR). This letter will include information on appeal rights and how to file an appeal.

BPHC Provider Frequently Asked Questions

21. How often must eligibility for BPHC be renewed?

- ▶ Renewals for BPHC services must occur at least every six months. To prevent a gap in coverage, the provider agency is responsible for tracking the end date of BPHC services and submitting a renewal application and updated proposed IICP within 30 days of the end of the BPHC service package. The ANSA must be completed within 60 days of the end of the BPHC service package. A report is available in DARMHA to assist providers in tracking the BPHC end date. Service package end dates for MRO and BPHC will be aligned so that renewals will occur at the same time for both programs. To prevent a potential gap in eligibility for Medicaid, **BPHC applications must be submitted at least 30 calendar days prior to the eligibility end date.**

QUESTIONS?