PHE Unwind and the Future Ahead

Indiana Council Presentation

Office of Medicaid Policy and Planning

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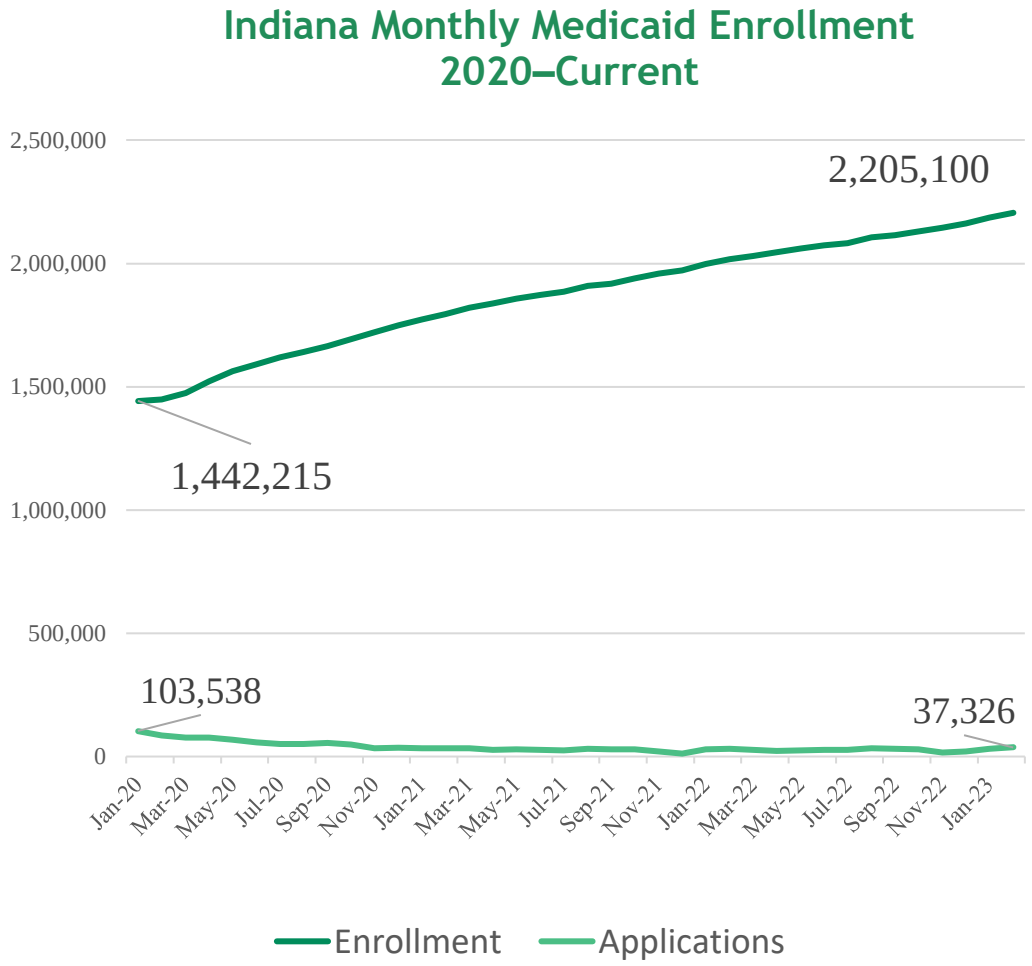
Agenda

- Public Health Emergency Unwind
- HIP Rate Equalization
- Mobile Crisis Updates
- CCBHC Updates

Public Health Emergency Unwind

PHE Status

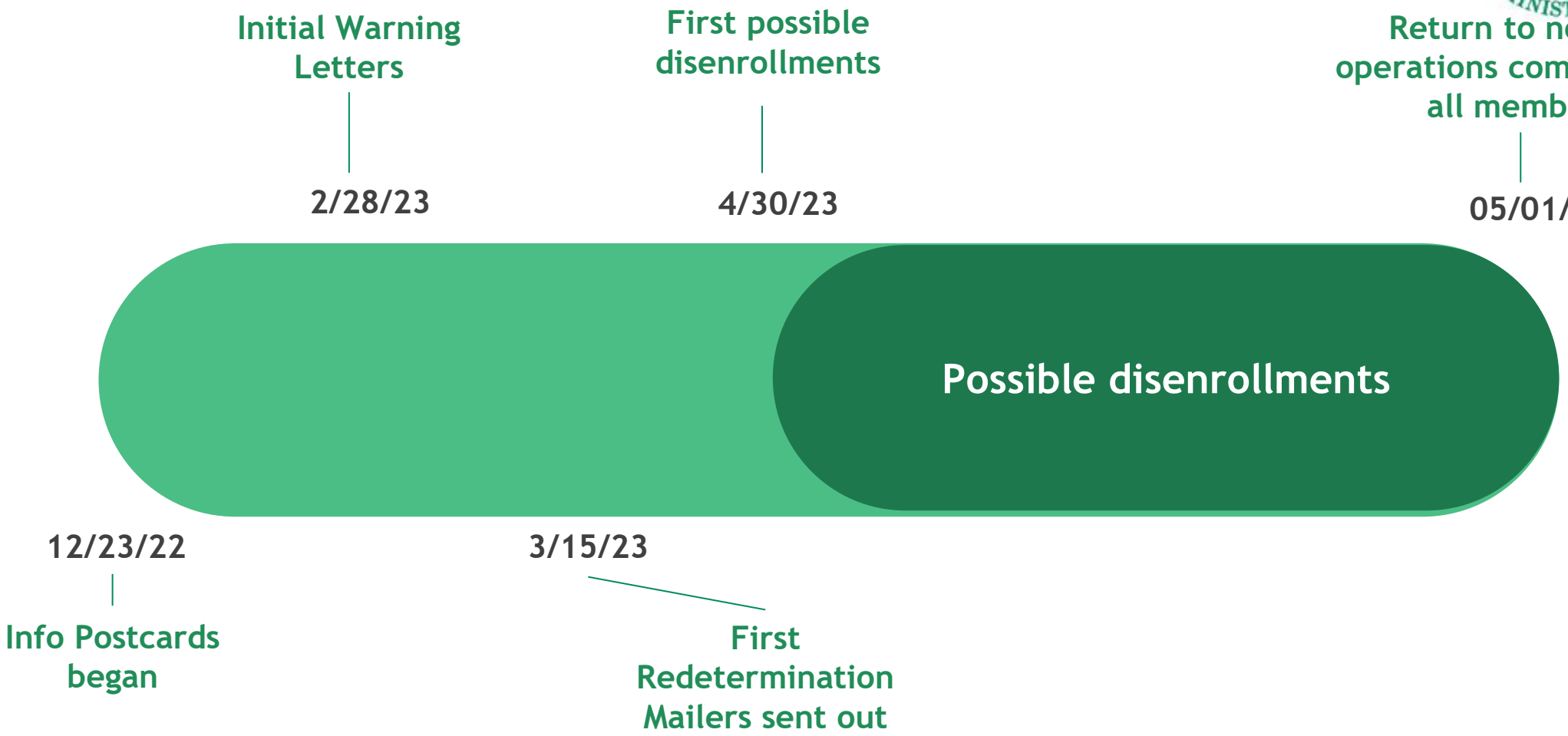
- Prior to the PHE, about 1 in 5 Hoosiers were on Medicaid. During the PHE, we increased to 1 in 3 Hoosiers.
  - 1.44 million members→ 2.14 million members
  - 32% of Indiana's population is currently on Medicaid
  - 490,000 of Indiana Medicaid members protected from closure due to PHE
- As a result of the federal spending bill (The Consolidated Appropriations Act, 2023), the continuous enrollment provisions that Indiana Medicaid has been following since March 2020 will end as of March 31, 2023.
  - Provisions are no longer tied to the PHE



Medicaid Eligibility Review

- Regular determinations of coverage began April 2023.
- States have 12 months to initiate renewals for their Medicaid population, and an additional two months to finish up renewal processing
- Indiana will utilize members' annual renewal dates; these dates are set 12 months from when the Medicaid application was approved, or 12 months from the most recent annual renewal
- We will process roughly 1/12 of our total renewals each month
- This plan will allow us to manage the workload and ensure we are able to do outreach and follow up as each month's group comes due for their renewals and is processed

Redetermination Process



Medicaid Eligibility Review, Cont.

Individuals who have continued to meet all eligibility requirements during the federal PHE will be subject to regular rules starting April; this includes responding to ongoing verification requests when there is a change in circumstances (for example, an increase in income)

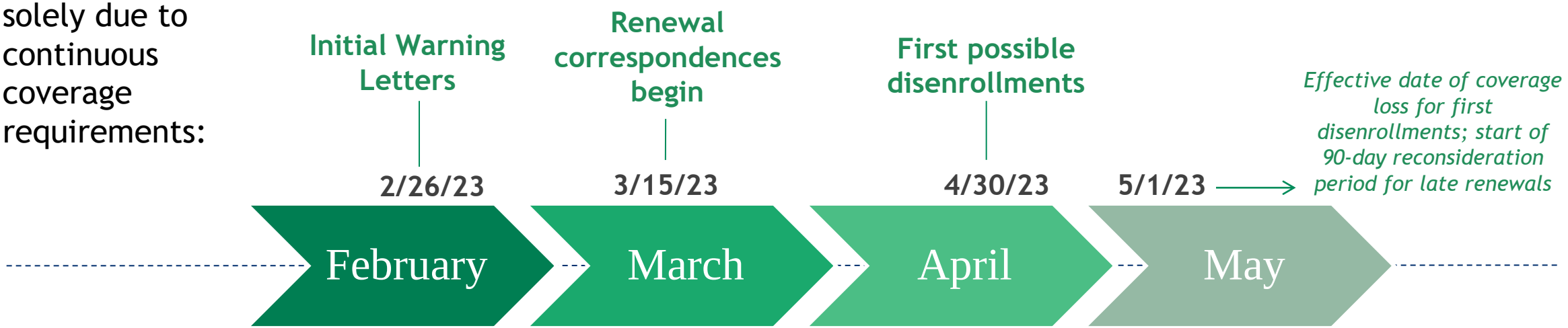
- This is approximately 75% of our total membership
- Starting in April, individuals in this group who do not respond to requests for information or who are determined to no longer qualify for coverage can be disenrolled or moved to a lesser-coverage category
- Regular annual renewal processes will also be followed; many of these members will qualify for auto-renewal with no action required on their part

Medicaid Eligibility Review, Cont.

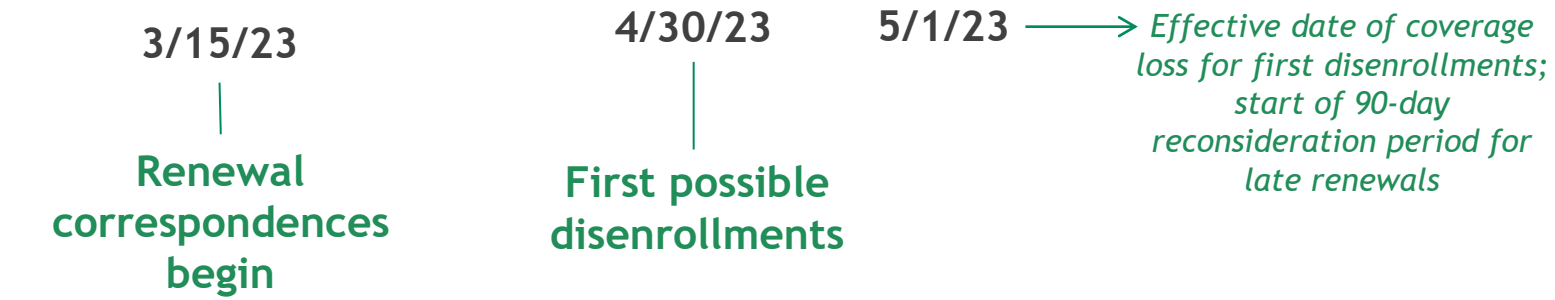
- Up to 500,000 individuals who remained open in their current Medicaid category due to these requirements during the federal PHE will need to take action to keep their Medicaid/HIP eligibility.
- We are using several methods of communication, including postcards and additional notices, to make sure individuals who remained open solely due to PHE rules are aware that their benefits are at risk and they need to take some action.
- We will also be proactively working to ensure we have updated contact information for our members, and following up by phone call or text if we receive returned mail for a member's renewal mailer.

Sample Renewal Notice Timeline

Individuals open solely due to continuous coverage requirements:



Individuals who have continued to meet all eligibility requirements:



Other Tools Available

- Tools available on new webpage:
  - FSSA Benefits Portal
    - We encourage anyone who is currently in one of Indiana Medicaid's health coverage programs, including the Healthy Indiana Plan, Hoosier Healthwise, Hoosier Care Connect or traditional Medicaid, to take action:
    - Go to FSSABenefits.IN.gov
      - Scroll down to "manage your benefits"
      - Click on either "sign into my account" or "create account"
      - Call 800-403-0864 if needed.
  - Posters, postcards (download and print or order) also available on website

in.gov/medicaid/members/member-resources/How-a-return-to-normal-will-impact-some-Indiana-Medicaid-members/

Indiana Administrat... | IHCP Provider Refe... | Provider Code Sets | IHCP Bulletins | IHCP Banner Pages | IHCP Fee Schedules | SharePoint | The Hub | State Plan | Indiana Code | CR Menu | Core | FSSA Data Central | InterQual® | EncoderPro

IN.gov An official website of the Indiana State Government | Accessibility Settings | Language Translation | Governor Eric J. Holcomb

MENU | Indiana Medicaid for Members | Search Members

Children | Pregnant Women | Adults | Aged Blind & Disabled | Home & Community | Programs | Apply for Coverage | Resources

How a return to normal will impact some Indiana Medicaid members

INDIANA MEDICAID / INDIANA MEDICAID FOR MEMBERS / RESOURCES / HOW A RETURN TO NORMAL WILL IMPACT SOME INDIANA MEDICAID MEMBERS

Attention: FSSA is sending text messages to Medicaid members to alert them that they need to take action. Click here for more information and examples.

During the COVID-19 federal public health emergency, due to federal requirements, Indiana Medicaid members were able to keep their coverage without interruption.

The most recent federal spending bill ended Medicaid coverage protections, which means Indiana Medicaid is returning to normal operations.

Eligibility redetermination actions began in April 2023, with a 12-month plan to return to normal operations.

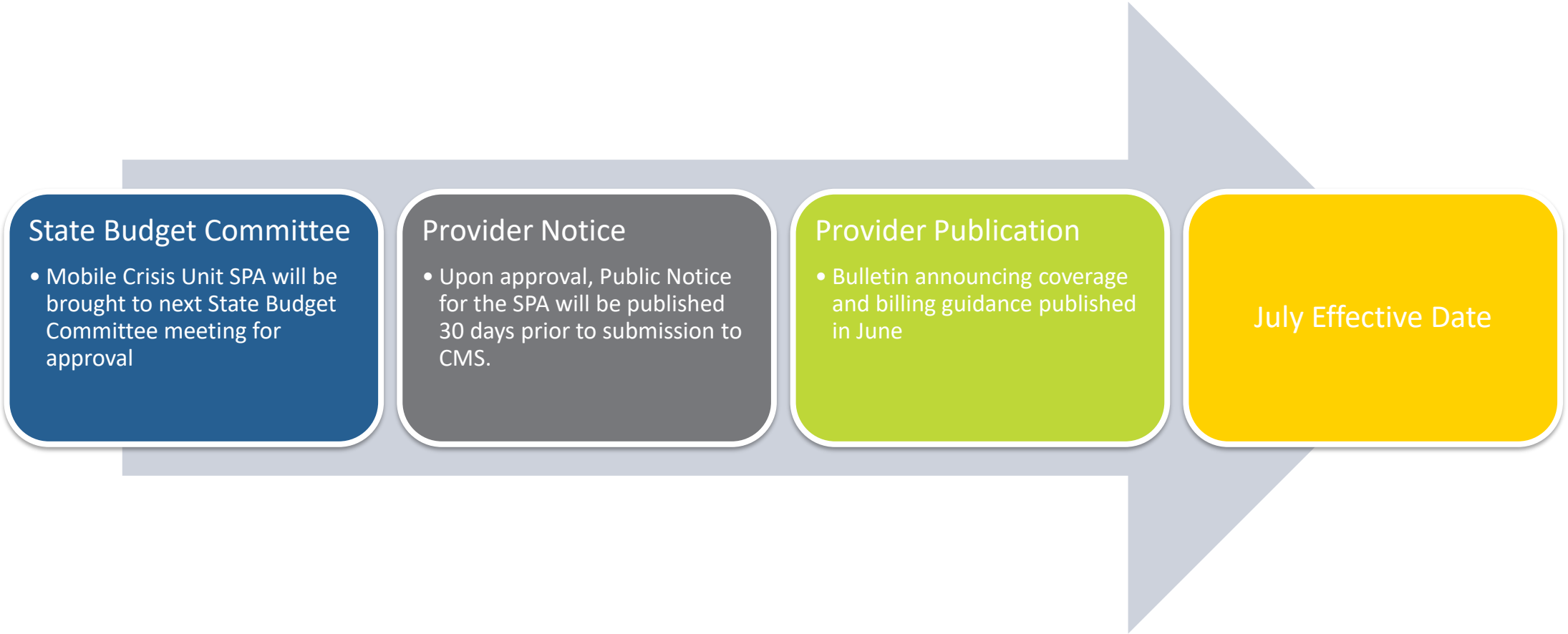
Other PHE-related Policies

- Besides eligibility …not much else is changing!
  - State PHE ended March 3, 2022 via Executive Order 22-09
  - Telehealth policies were permanent as of July 21, 2022 (BT202239)
  - Several PA flexibilities were rescinded March 1, 2022 (BT202215)
- Only Exceptions:
  - Appendix K authorities are ending 6 months post-PHE
  - Rescinding of 1135 waivers (BT202230)

HIP Rate Equalization

Mobile Crisis Unit Updates

Indiana Medicaid Pursuing SPA for MCUs



Mobile Crisis Components

This SPA will:

- Cover mobile crisis units that operate twenty-four (24) hours a day, seven (7) days a week across the state of Indiana.
- Consist of individuals certified in Peer Recovery Services and at least one of the following: behavioral health professionals licensed under IC 25-23.6, other behavioral health professionals as defined in 440 IAC 11-1-12 that work under a community mental health center (CMHC), emergency medical services personnel licensed under IC 16-31, or law enforcement-based co-responder behavioral health teams.
  - Per IC 12-21-8-10 guidelines
- Provide triage/screening, assessments, de-escalation through brief counseling, case management/care coordination services, crisis intervention, transportation, safety planning, peer recovery support, medication training and support, and follow-up stabilization services.
- Ensure that the mobile crisis units complete state training on trauma-informed care, de-escalation strategies, and harm reduction.

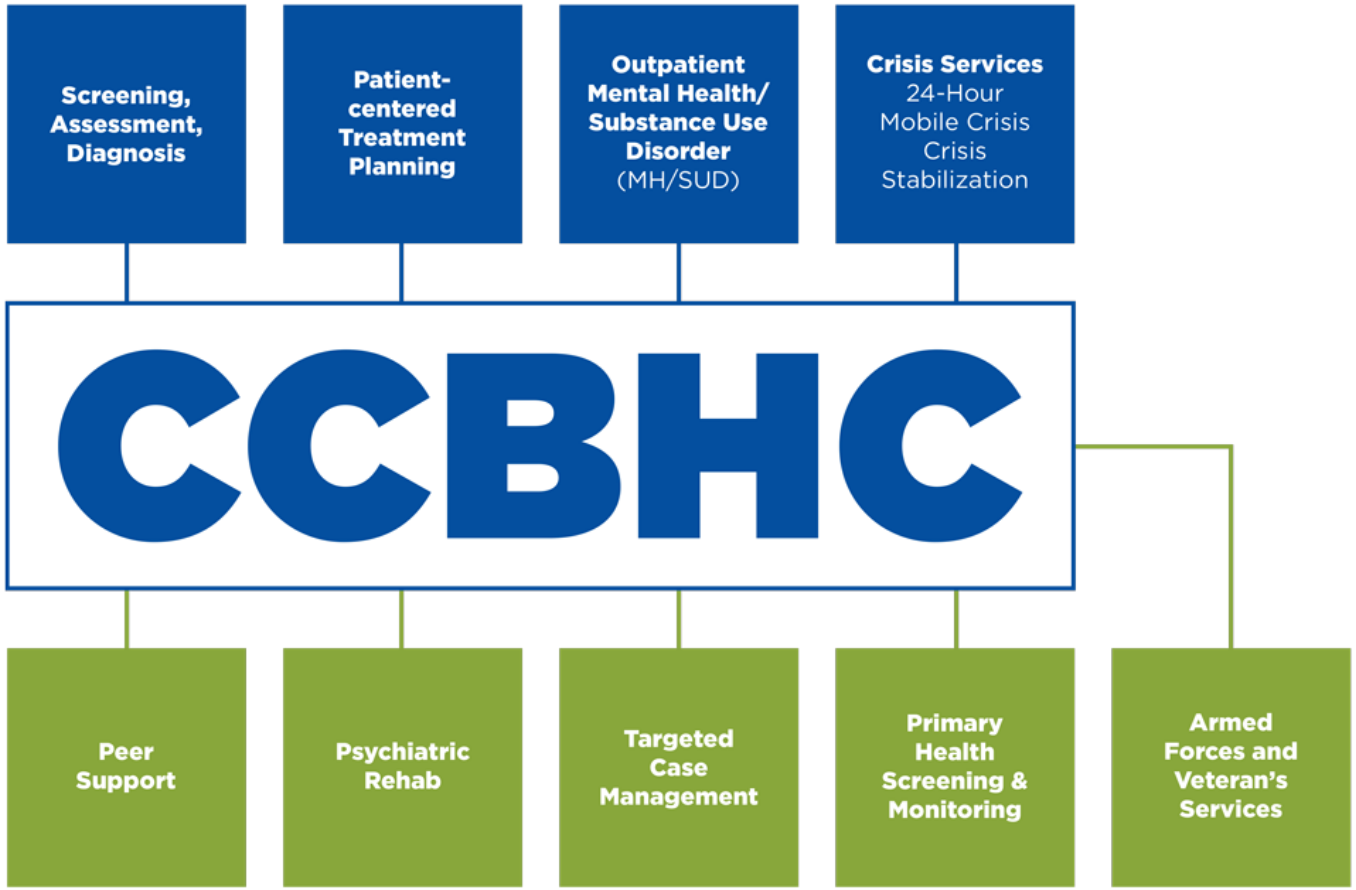
Must be DMHA designated

CCBHC Updates

What is a CCBHC?

- A certified community behavioral health clinic CBHC is a specially-designated clinic that provides comprehensive range of mental health and substance use services.
  - **Ensure access** to integrated services including 24/7 crisis response and medication-assisted treatment (MAT).
  - **Meet strict criteria** regarding access, quality reporting, staffing, and coordination with social services, criminal justice, and education systems
  - **Receive funding** to support the real costs of expanding services to fully meet the need for care in their communities.

CCBHC Services

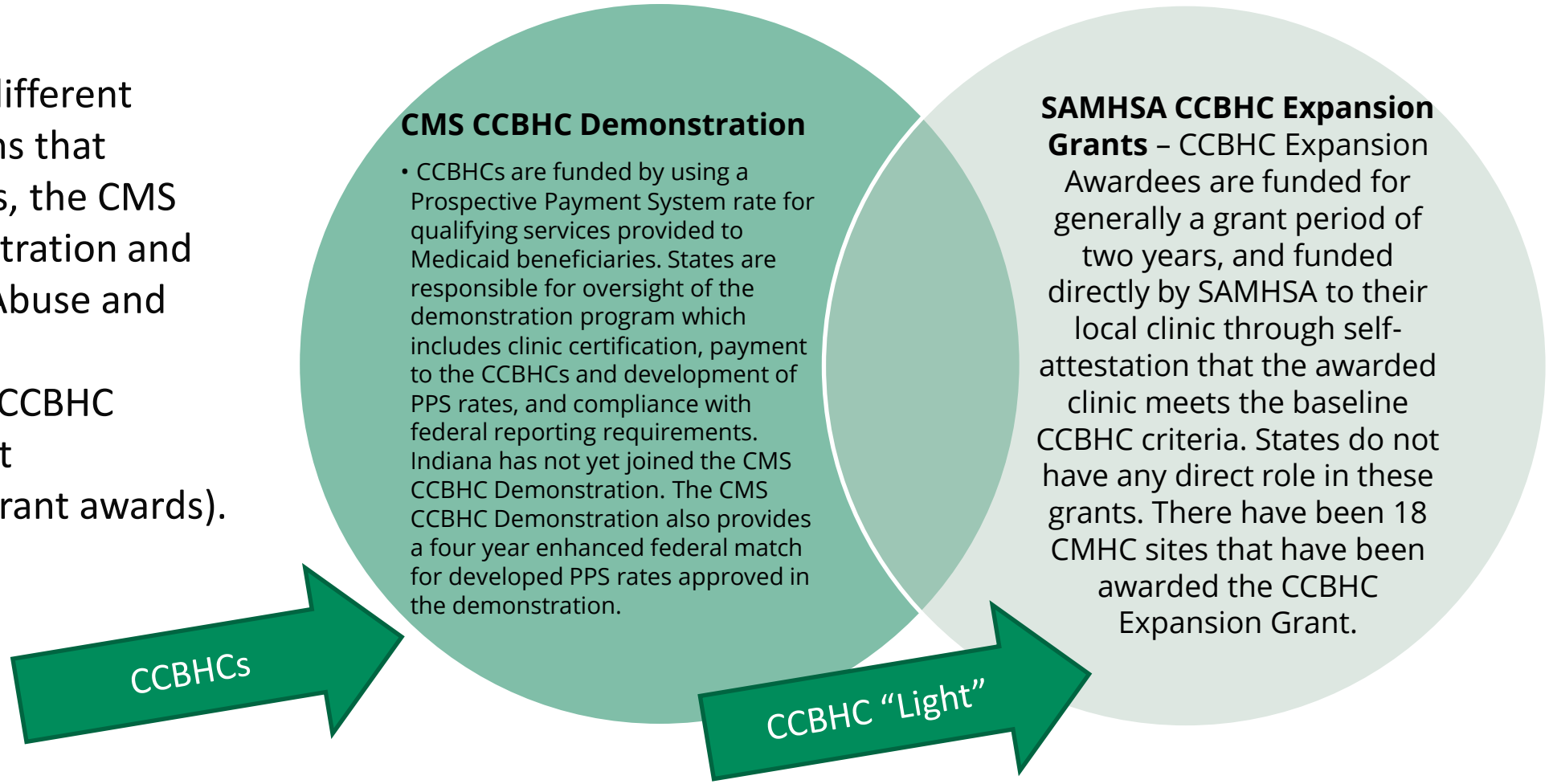


Why a CCBHC Model?

- CCBHC models and grants were authorized under Section 223 of the Protecting Access to Medicare Act (PAMA) (PL 113-93). Program activities aim to integrate behavioral health with physical health care, increase consistent use of evidence-based practices, and improve access to high-quality care.
- Section 223 of Protecting Access to Medicare Act (PAMA) – began in 2015.
- The Excellence in Mental Health and Addiction Act (2021) allows any state or territory the option to participate in the CCBHC demonstration program (prior, only 10 states were allowed in the demonstration) and allocates additional planning grant monies for states to prepare to do so.
- House Bill 1222 (2022) directed the Division of Mental Health and Addiction to develop a plan to strengthen the use of Certified Community Behavioral Health Clinics (CCBHCs) statewide by implementing the CCBHC model at the state level.
- SB 1 (2023) further requires that we pursue the CCBHC CMS Medicaid Demonstration grant and that we also pursue a SPA or a waiver by 2027 if Indiana is selected for the demonstration (2025 if we are not selected).

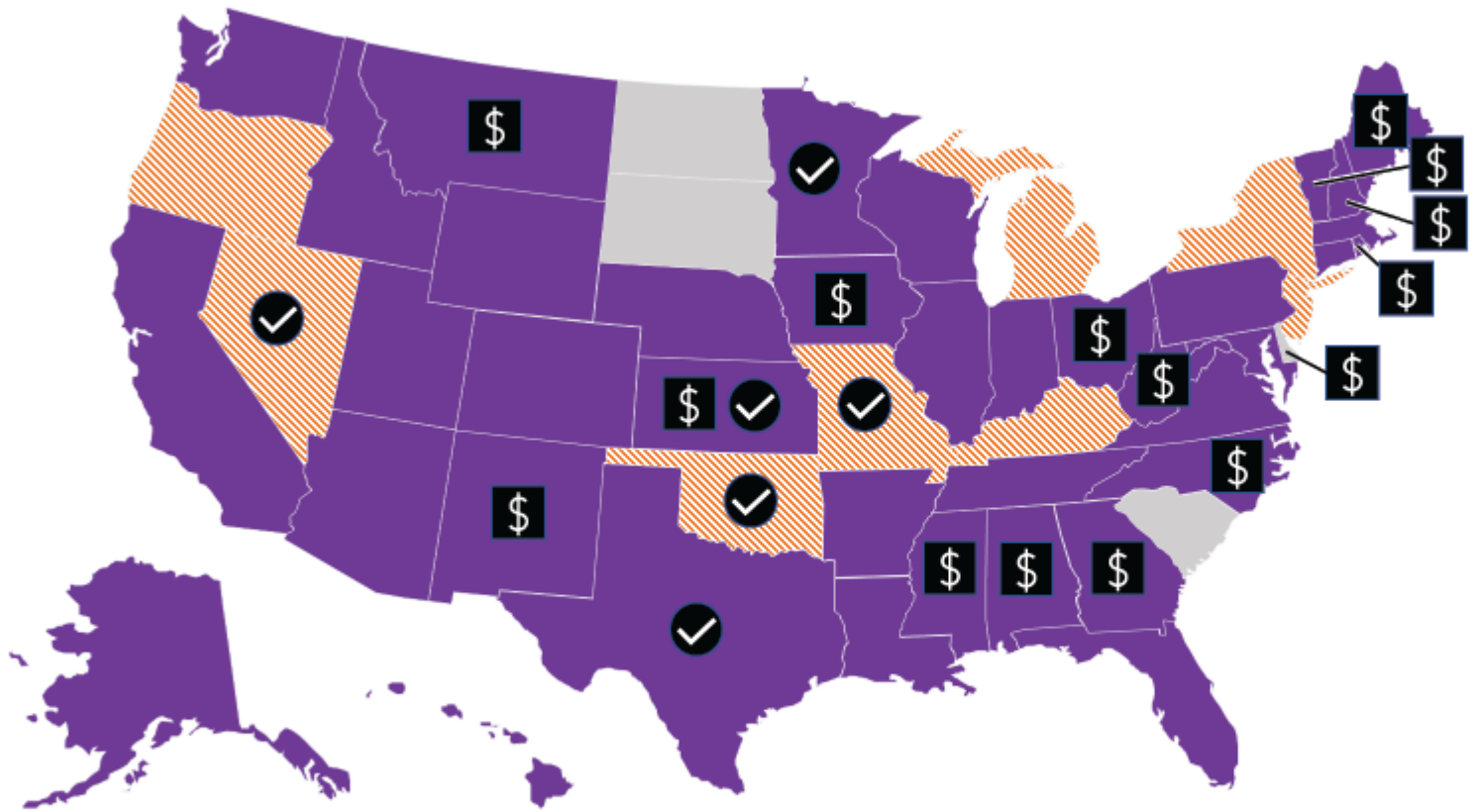
Federal Program Distinctions

- There are two different federal programs that support CCBHCs, the CMS CCBHC Demonstration and the Substance Abuse and Mental Health Administration CCBHC Expansion Grant (discretionary grant awards).



Map of CCBHCs Across the United States (as of March 6, 2023)

Currently, there are over 500 CCBHCs operating across the country, as either CCBHC-E grantees, as clinics participating in their states' Medicaid demonstration, or as a part of independent state CCBHC programs.



Federal CCBHC Medicaid Demonstration (And SAMHSA Expansion Grants)

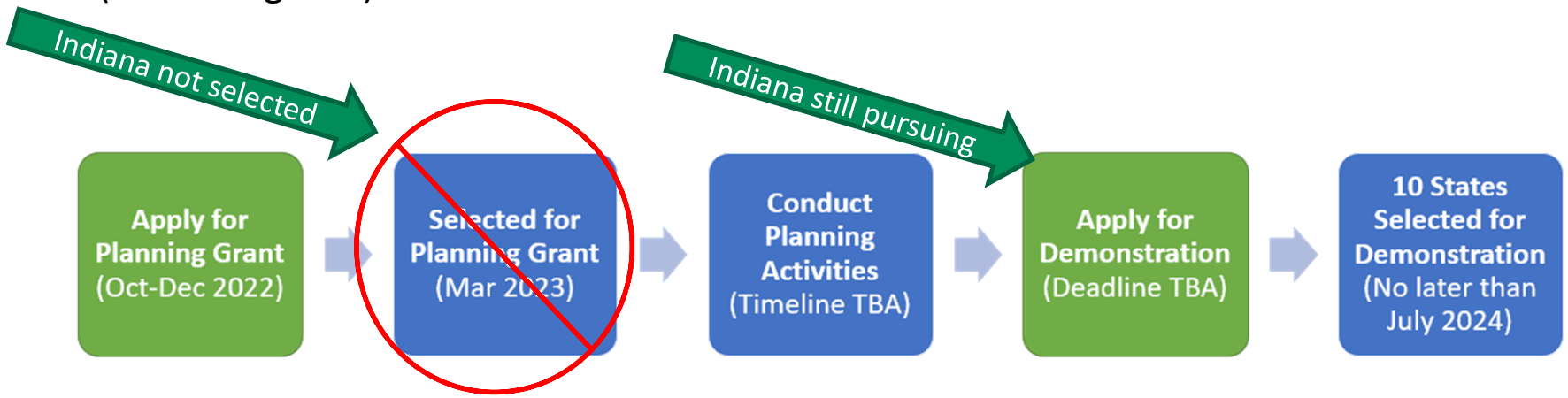
State contains at least one local SAMHSA expansion grantee in the state

CMS-approved payment method for CCBHCs via a SPA or 1115 waiver separate from Demonstration

Chosen to receive one-year planning grant needed to join Medicaid Demonstration starting in March 2023

CCBHC Medicaid Demonstration

- Provides 4 years of enhanced Medicaid match for CCBHC services (E-FMAP)
- Makes planning grants available for new states to develop proposals to participate.
- Appropriates $40M for planning grants and technical assistance to states applying for the grants.
- Requires annual reports to Congress through the year in which the last demonstration ends.
- Order of operations for CCBHC Demo participation –
  - There is a two-step, competitive process for states to be selected for the demonstration (noted in green).



5 Clinic CCBHC Reported Measures

Clinic-Collected Reporting Requirements of a CCBHC*
Time to Services (I-SERV): *SAMHSA – not yet published*
Depression Remission at Six Months (DEP-REM-6) *MN Community Measurement*
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC) *NCQA Measure*
Screening for Clinical Depression and Follow-Up Plan (CDF-CH and CDF-AD) *(see CMS Medicaid Adult and Child Core Sets)*
Screening for Social Drivers of Health (SDOH) *CMS – 2023 Merit Based Incentive Payment System (MIPS) version*

*These measures were changed in the 2023 CCBHC Criteria Update from SAMHSA. These measures will be required beginning July 2024.

13 State Reported Measures

Reporting Requirements of the State*
Patient Experience of Care Survey *SAMHSA*
Youth/Family Experience of Care Survey *SAMHSA*
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD) *CMS (see Medicaid Adult Core Set)*
Follow-Up After Hospitalization for Mental Illness, ages 21+ (FUH-AD) *NCQA (see Medicaid Adult Core Set)*
Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH) *NCQA (see Medicaid Child Core Set)*
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) *NCQA (see Medicaid Adult Core Set)*
Follow-Up After Emergency Department for Mental Illness (FUA-CH and FUM-AD) *NCQA (see Medicaid Adult and Child Core Sets)*

*These measures were changed in the 2023 CCBHC Criteria Update from SAMHSA. These measures will be required beginning July 2024.

13 State Reported Measures

Reporting Requirements of the State*
Follow-Up After Emergency Department for Alcohol or Other Dependence (FUA-CH and FUA-AD) *NCQA (see Medicaid Adult and Child Core Sets)*
Plan All-Cause Readmission Rate (PCR-AD) *NCQA (see Medicaid Adult Core Set)*
Follow-up care for children prescribed ADHD medication (ADD-CH) *NCQA (see Medicaid Child Core Set)*
Antidepressant Medication Management (AMM-BH) *NCQA (see Medicaid Adult Core Set)*
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD) *NCQA (see Medicaid Adult Core Set)*
Hemoglobin A1c Control for Patients with Diabetes (HBD-AD) *CMS (see Medicaid Adult Core Set)*

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PPS Structure and Options

- **Prospective Pay Structure (PPS)**
- **Daily rate (PPS-1):** One payment per client for any day in which the client receives at least one service
- **Monthly rate (PPS-2):** One payment per client for any month in which the client receives at least 1 service
  - Rate may be stratified by population complexity, with higher rates for higher-complexity clients and lower rates for the general population
- **Quality Bonus Payments** are optional in PPS-1 and required in PPS-2.
- CCBHCs are required to develop annual cost reports.
- The cost of DCO services is included in the CCBHC prospective payment rate, and DCO encounters are treated as CCBHC encounters for purposes of the prospective payment.
- Provides an opportunity to work with prospective CCBHCs and build a PPS rate

Options for Medicaid Incorporation:

Medicaid Waiver (e.g., 1115)
Enables states to experiment with delivery system reforms
Requires budget neutrality
Must be renewed every 5 years
State must be sure to specify inclusion of selected CCBHC services (some may not otherwise be included in the plan)
With CMS approval, offers opportunity to continue or establish PPS

State Plan Amendment
Enables states to permanently amend Medicaid plans to include CCBHC as a provider type, with scope of services, criteria and requirements, etc.
Does not require budget neutrality
With CMS approval, can continue PPS
Cannot waive “state-wideness,” may have to certify additional CCBHCs (future CCBHCs may be phased in)

Questions?