HCBS SFY24 Annual Webinar

Thursday, August 3, 2023

Introductions

Agenda

- Staff Updates
- Changes related to STP and PHE ending
- Ongoing monitoring
- HCBS Final Rule/SPA Analysis
- Ineligible setting type exceptions
- CIR summaries
- AMHH overview
- BPHC overview

Staff Updates

Name	Role	Contact	CMHCs
Julia Allen	SET Team Critical Incident Reporting	Julia.Allen@fssa.IN.gov	Aspire Community Howard Regional Gallahue Meridian Park Center Southwestern
Hannah Carlson	SET Team Home and Community Based Services/Settings	Hannah.Carlson2@fssa.IN.gov	Centerstone Edgewater Hamilton Center Northeastern Regional Valley Oaks Health
Amanda Huff	SET Team	Amanda.Huff2@fssa.IN.gov	Bowen Center Cummins Grant-Blackford Sandra Eskenazi Porter-Starke Swanson Center
Jonquil Pettigrew	Set Team Quality Assurance	Jonquil.Pettigrew@fssa.IN.gov	Adult and Child CMHC, Inc. 4 C Health Lifespring Oaklawn Samaritan
Elaine Trepanier	Outpatient/Residential QI Team Lead	Elaine.Trepanier@fssa.IN.gov	

Changes Related to STP and PHE Ending

Public Health Emergency & Medicaid Unwinding Updates

- 4/1/23 Return to "normal" practices prior to the declaration of the Public Health Emergency in 2020
- Auto/Emergency Renewals have been discontinued
- Continuation of telehealth services
  - Started due to PHE, became folded into Indiana Administrative Code

Statewide Transition Plan Fulfillment

- Most notable change: all settings must be assessed and deemed compliant with Final Rule **prior** to application approval.

Ongoing Monitoring

- Due to the State Transition Plan (STP) completion we are currently in an Ongoing Monitoring phase
  - Ongoing Monitoring site visits have been completed for State Fiscal Year 2023 and Ongoing Monitoring site visits for State Fiscal Year 2024 will resume soon

Ongoing Monitoring (cont.)

- In addition to the Ongoing Monitoring Site Visits, Centers for Medicare and Medicaid Services (CMS) is requiring a supplemental provider self-assessment.
- A condensed version of the provider self-assessments will be sent out at the same time as the Ongoing Monitoring Site Visit notifications starting in SFY 2024
  - A blank self-assessment form for each type of site that will be visited will be provided
  - We will be requesting the self-assessments to be returned within 2 weeks of receiving the site visit notification email

RSST: Residential Setting Screening Tool

- Members who receive services through the AMHH and/or BPHC program are required to live and receive HCBS services in settings that meet federal Medicaid guidelines for home and community-based services (HCBS)
- Completed with every member applying for AMHH and/or BPHC with every application (initial, renewal, and modification)
- Any change in member's living situation; RSST must be submitted to DMHA within 15 days of address change
- A completed copy of this screening, with the member's and case manager's signatures in the appropriate section, must be kept with the member's clinical record. In addition, the "Current Living Situation" section on the DARMHA application should reflect the setting

Policy Updates & Analysis

Update Regarding "DFR Denied" Status

- Limited status categories sent to DARMHA from Gainwell
- Planned change to "Undergoing Review"
- Providers should contact DFR about eligibility review status

ANSA

- A qualified Adults Needs and Strengths Assessment (ANSA) user must conduct a face-to-face or telehealth interview with the member and must complete a level of need (LON) assessment within 60 days prior to the submission of the BPHC application, which needs to be submitted in DARMHA*

- The corresponding progress note needs to identify whether the service was provided face-to-face or by telehealth and that the individual participated.

- **The ANSA must be completed prior to the start of the draft of the BPHC application. The ANSA is used to determine the individual's eligibility for the BPHC program.**

**BPHC Provider Module, page 26 and SPA p. 131-132*

Updates to ANSA Completion Process

- OMPP provided an updated interpretation of the ANSA telehealth practices:
  - IAC identifies that any person who is a CMHC employee and qualified to perform an ANSA can complete the assessment either face-to-face or by telehealth.
  - **OMPP's updated interpretation no longer limits ANSAs being completed via telehealth only by a licensed clinician**
  - **Documentation must indicate whether the ANSA was completed face-to-face or by telehealth.**

Superuser changes as of July 1st, 2023

- Beginning 07/01/2023, documentation of the SuperUser review is required to be documented as part of the attestation or in a progress note.
  - This is as a result of streamlining how this is captured and to ensure for consistency for CMS standards

Denials

- Applications not meeting clinical criteria are subject to denial:
  - Application in pended status for more than 7 days
  - Applicant not meeting one or more of the eligibility criteria (age 19 or over, BPHC-eligible Primary Mental Health Diagnosis, does not reside in a home or community-based setting)
  - Supporting documentation insufficient and the IICP not supporting the needs-based criteria for BPHC service; or not focusing on medical management or medical issues.
  - Applicant not meeting the needs-based criteria via algorithm
  - ANSA score less than 3; No recommendation for intensive community-based care based on the Adult Needs and Strengths Assessment (ANSA)
  - ANSA older than 60 days; At the time the BPHC application was submitted, the effective ANSA recognized by the DARMHA BPHC Application was outside the 60-day allowable window

Appeal Process

- Notification of a denial is sent by email to the clinician and primary contact for the CMHC submitting the application and to the Applicant by certified mail
- Notification includes the instructions for appealing
- Appeals must be received by close of business no later than:
  - 33 calendar days following the effective date of action being appealed, or;
  - 33 calendar days from the date of the notice of agency action, whichever is later

QA trends for SFY23

- 6 agency's overall percentage improved more than 10% since SFY22.
- 6 Agency's overall percentage went down 10% since SFY22
- 5 Agencies did not require a Corrective Action Plan for SFY23.

BPHC Policy & QA Trends

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services.** The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is: 1	
ii.	**Frequency of services.** The State requires (select one):	
	○	**The provision of 1915(i) services at least monthly**
	☑	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the State also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency: Three (3) instances of the BPHC service must be provided to each eligible member every 180 days and documented in progress notes.

BPHC Service Requirements

"If the State also requires a minimum frequency for the provision of 1915(I) services other than monthly (e.g., quarterly), specify the frequency: Three (3) instances of the BPHC service must be provided to each eligible member every 180 days and documented in progress notes."

- Effective 10/1/2020
- BPHC Renewal service can be included as one of the three services*

*BPHC SPA p. 140

Importance of Documentation

- Significant part of the Quality Assurance Review process
- “If it’s not documented, it didn’t happen.”
- Documents progress towards goals
- Progression of development of strengths and skills over time
- Allows others to provide quality service in the absence of “assigned” staff

HCBS Setting Information

- Information regarding all HCBS setting information available at the following link:
  - SFY21 HCBS Final Rule Review and Updates 4/8/21

Ineligible Setting Type Exceptions

Ineligible Settings Exception Requirements

- If the assessment for a newly identified setting ends with the setting being ineligible with HCBS Final Rule, a Settings Exception may now be pursued*

- DMHA and OMPP will maintain the final determination on if Setting Exception Plans are sufficiently fulfilled. If the final determination is an approval, DMHA and OMPP reserve the right to change the status at any time if it is determined that the plan is not adhered to. Any modification to the plan will require additional approval from DMHA.

*42 C.F.R. 441.301(c)(4)(F) & 441.530(a)(vi)(F) & 441.710(a)(vi)(F)

Ineligible Settings Exception Requirements

Any modification of the additional conditions must be supported by a specific assessed need and justified in the person-centered service plan*. The following requirements must be documented in the person-centered service plan:

(1) Identify a specific and individualized assessed need.

(2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

(3) Document less intrusive methods of meeting the need that have been tried but did not work.

(4) Include a clear description of the condition that is directly proportionate to the specific assessed need.

(5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.

(6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(7) Include the informed consent of the individual.

(8) Include an assurance that interventions and supports will cause no harm to the individual.

*§ 441.301(c)(4)(vi)(A) through (D)

Ineligible Settings Exception Requirements (cont.)

- Although the policy in item 6 does not specify a specific time limit for periodic review, DMHA will invoke a minimum of 90-day review to fulfill this requirement.
- If the Setting Exception Plan is approved a deadline for returning the next plan will be given in the confirmation email

Critical Incident Reporting

Changes to COVID-19 Reporting

- **Previous Requirement:** Providers need to report when they have five or more individuals within a residential setting that test positive for COVID-19. Additionally, providers will need to report their COVID-19 positive cases to Indiana Department of Health.
- **Current Requirement:** DMHA will no longer require providers to report when they have five or more individuals within a residential setting that test positive for COVID-19 through the Critical Incident Reporting System. Please refer to IDOH's guidance here.

Reporting Timeframes

Residential Settings

- 24 hours

Outpatient/Community Setting/Patient's Home

- 72 hours

Reporting Compliance

Goal = 86%

	SFY19	SFY20	SFY21	SFY22	SFY23
Timely:	117	189	214	208	165
Total:	167	220	247	228	193
Percentage:	70%	86%	87%	91%	85%

Compliance Process

Details

- The quarter dates vary between programs, as the BPHC began September 1, 2019 and the AMHH began October 1, 2019
- All CMHCs receive a report of compliance for each quarter
- Reports are provided 15 days from end of quarter
- Included in the reports are any additional follow-up forms for the CMHC

Quarters:

Quarter:	BPHC	AMHH
1	6/1 - 8/31	10/1 - 12/21
2	9/1 - 11/30	1/1 - 3/31
3	12/1 - 2/28	4/1 - 6/30
4	3/1 - 5/31	7/1 - 9/30

Non-compliance Actions

Informal Adjustment (IA)

After the first 90 day non-compliant CIR review:

- Verbal or email guidance to the provider and the primary contact or provider supervisor as deemed most appropriate by QA/QI staff.
- DMHA will provide data to show compliance issues including incident date and staff member that submitted CIR

Educational Letter (EL)

After the second 90-day non-compliant CIR review:

- A "Formal Notice" is sent via email (with read receipt or including a request to respond confirming receipt) to the CEO and identified primary contact of the provider
- DMHA will provide data to show compliance issues including incident date and staff member that submitted CIR
- The education letter will identify the next steps if a third 90-day non-compliance review occurs.

****NOTE: If, after two quarters since EL, compliance falls below 86% an IA will be issued again**

Resource: 405 IAC 1-1.4-4 Sanctions against providers; determination after investigation

Non-compliance Actions (cont.)

Corrective Action Plan (CAP)

This occurs after the third 90-day non-compliant CIR review

DMHA Notice: A "Formal Notice" letter written on FSSA letterhead requiring corrective action and an accompanying Corrective Action Plan (CAP) are sent to the provider for response.

****NOTE: If after two quarters since CAP, compliance falls below 86%, an Educational Letter will be issued again**

The CAP must include the following information:

- Responsible party
- Timeframe for completion
- A way for DMHA to verify the CAP has been completed
- Plan to prevent reoccurrence
- Be effective

Resource: 405 IAC 1-1.4-4 Sanctions against providers; determination after investigation

Non-compliance Actions (cont.)

Additional Steps

- Mandatory re-trainings
- Increase visits based on progress
- Increase request for documentation
- Staff member must be re-trained before providing service going forward

Graduate Sanctions

- Decertification of specific staff members
- Referral to FSSA Audit
- Program Integrity

Resource: 405 IAC 1-1.4-4 Sanctions against providers; determination after investigation

Adult Mental Health Habilitation (AMHH)

AMHH and MRO

AMHH and MRO are mutually exclusive programs designed to address different populations with different needs.

- MRO is *rehabilitation*, or focused on regaining lost abilities
- AMHH is *habilitative*, or focused on attaining and maintaining abilities necessary for community-integrated living
- AMHH is designed for individuals who either:
  - a.) have not developed the skills necessary to live independently in the community, or
  - b.) Are at significant risk of deterioration and/or institutionalization without support

AMHH is ideal for transitioning long-term consumers of rehabilitative services with little progress on goals to focus on maintenance of goals

AMHH and MRO Services Comparison

MRO = REHABILITATION

Restoring a pre-existing skill(s) to previous levels of functioning

- Intensive Outpatient Treatment
- Psychosocial Rehabilitation (Clubhouse Services)
- Case Management
- Adult Intensive Rehabilitation Services
- Skills Training and Development
- Behavioral Health Counseling and Therapy
- Addiction Counseling
- Medication Training and Support

AMHH = HABILITATION

Acquiring and maintaining daily living skills that may not have developed as expected

- Adult Day Services
- Supported Community Engagement
- Care Coordination
- Respite care
- HCB Habilitation and Support
- Therapy and Behavioral Counseling
- Addiction Counseling
- Medication Training and Support

AMHH Updates

- SPA renewal application for another 5 years submitted to CMS in March of 2023, if approved will be effective 9/1/2023
- Addition of a Licensed Clinician to provide attestation in addition to psychiatrist and health service provider in psychology (HSPP)
- Diagnosis Updates AMHH-Eligible Primary Mental Health Diagnosis Codes

AMHH Training Resources

- AMHH Website
- AMHH & MRO Service Comparisons
- AMHH Service Qualifications
- AMHH Service Maximums
- AMHH Services Training

Behavioral Physical Healthcare Coordination Overview

Purpose of BPHC

BPHC is an HCBS program designed to support those at risk of institutionalization in managing and coordinating their primary healthcare and behavioral health needs.

- BPHC is a single service, care coordination, which supports client whose mental health symptoms impede their ability to effectively and independently manage their physical health and/or behavioral health needs
- It allows clients living with SMI to receive care in community-integrated settings to a similar level as those not receiving HCBS
- It is concerned with supporting client in goal achievement to attain their maximum level of independence and community engagement.

Mental Health Diagnosis

The Applicant must have a BPHC eligible diagnosis as their Primary Diagnosis.

The following are requirements for describing the diagnosis in an application:

- Symptoms associated with the BPHC Eligible Primary Diagnosis must be provided in list format
- List should consist of symptoms experienced by the client that disrupt their ability to independently manage healthcare needs
- Do not list additional diagnoses, physical health needs, intellectual and developmental delays/disability, or any information that does not directly pertain to the symptomology of the Primary Diagnosis (Additional information could constitute a violation of HIPAA standards)

Lists can be formatted in the following ways:

1. Insomnia
2. Isolative behavior
3. Avolition
4. Anhedonia

Insomnia, isolative behavior, avolition, anhedonia

The client endorses the following symptoms of Major Depressive Disorder:

Insomnia, isolative behavior, avolition, anhedonia

The complete list of BPHC-eligible diagnoses can be found at:
http://provider.indianamedicaid.com/ihcp/Publications/providerCodes/Behavioral_and_Primary_Healthcare_Coordination_Codes.pdf

Physical Health Issues

Provide any physical health issues faced by the client that they have difficulty managing on their own.

Reported physical health issues:

- Do not have to be formally diagnosed but should be presently impacting them.
- Historical injuries/illnesses that result in present-day complications are eligible.
- Physical health issues or injuries from which the client is fully recovered and does not experience complications are not eligible.
- Lack of history of accessing health care is an allowable health condition.

BPHC Service Activities (Renewal Applications)

Effective 10/1/2020, provide three (3) dates the client received BPHC care coordination services with a brief description of the support provided.

- One of three services can be re-application
- If fewer than three services were provided:
  - Provide adequate rationale for lack of engagement **and**
  - Provide a plan for increasing engagement over next package period (can be agency-wide or client-specific)

- ***Chronic, ongoing underutilization may result in a denial***

Justification of Need

The justification narrative should link the symptoms associated with the primary diagnosis to the behaviors that impede the Applicant's ability to manage their physical and/or behavioral health needs on their own.

- The narrative should **only** include information necessary to provide the SET with insight into the challenges the client faces in managing their health care.

- Personal history, family details, description of other services received, additional mental health diagnoses, or any other information not directly related to the symptoms or impeding behavior should not be included.

Justification format

[**Applicant**]'s symptom of [**insert symptom of primary diagnosis**] causes [**Applicant**] to [**describe the behavior caused by the symptom and the resulting difficulty**].

Example: Dorothy's symptom of paranoia causes her to not trust healthcare providers and follow provider recommendations.

Goals

The goal(s) in the IICP should describe a behavior modification, achievement, improvement in health, etc. The client would like to work towards or accomplish over the course of the eligibility period.

- Preferably written in client's own words
- Reflects client's personal desires
- Should link back to the identified physical and/or mental health needs
- Supports client reaching their desired level of independence
- Ideally can be measured against

Example Goals:

"I would like to lose 30 lbs."

"I want to be able to walk to the store without using my inhaler."

"I want to have fewer panic attacks"

Objectives

Describes the steps or actions necessary for **the client** to take in order to achieve their previously identified goal(s).

- Should build upon the client's strengths, preferences, and any existing natural supports.
- Should not be passive in nature -- "Client will do" **not** "Client will allow"
- Clearly linked to the goal(s) listed in the IICP
- Personalized to the client
- Must be measurable

Example Objectives:

Goal: I would like to lose 30 lbs.

Objectives:

- Client will attend meetings with dietician once a month to plan healthy meals.
- Client will walk to mailbox once a day to increase physical activity.
- Client will reduce soda intake from 3 cans a day to 1 can per day.

Strategies and Eligible Activities

Describe how only BPH Care Coordination activities will be utilized over the package period to support the client in achieving their identified goals and achieve their desired level of independence. **Medication Rehabilitation Option (MRO) and other services should not be included**.

- Coordination of care within and across systems
- Oversight of the entire case/logistical support
- Linkage to services/providers
- Advocacy
- Education
- Physician consults
- Serving as a communication conduit
- Notification of changes in medication regimens and health status
- Coaching for more effective communication with providers

Provider Reference Module available at: https://www.in.gov/medicaid/providers/files/dmha-bphc.pdf

Non-Billable/Non-Covered Service Activities

BPHC consists solely of care coordination and only service activities that fall under the scope of the program as defined in the Final Rule are billable for reimbursement.

- Provision of medical services or treatments including, but not limited to, weight checks, blood pressure screenings, and blood sugar checks.
- Individual, group, or family therapy services
- Any service not described or supported by the client's IICP
- A service provided simultaneously with another service of the same scope and nature
- Leisure/recreational activities
- Life skills, medication, and/or Activities of Daily Living (ADL) training

Service Documentation Requirements

Progress note documentation for services provided to the client must:

- Reflect progress towards the goal(s) from the member's IICP
- Be provided within the eligibility period
- Document the duration of service
- Accurately and adequately describe the service rendered
- Be written and signed by the agency staff rendering services
- Support coordination or management of identified health needs and services
- Identify member strengths utilized
- Incorporate natural supports (where available)
- Describe the service's benefit to the client

- BPHC Progress Note Documentation Webinar

Prior Authorization (PA)

- For most members receiving BPHC, the assigned units (48) are sufficient
- What happens when BPHC units are running out?
- Within the last 60 days of an assigned service package, update the IICP and submit a PA request in DARMHA for review. Select *Modified IICP*
- Requests must include the following information:
  - *Member name*
  - *Member DARMHA, Internal, and IICP ID numbers*
  - *Units remaining in package*
  - *Units being requested*
  - *Description of the activities that led to the exhaustion of BPHC units*
  - *Description of how the additional units requested will be used to support the member's needs and support fulfillment of the IICP over the remainder of the package period*
- Supporting documentation/progress notes may be requested from the SET for final determination
- BPHC Provider Module; pages 56-57

Contact Information

Name	Role	Contact	CMHCs
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Julia Allen	SET Team Critical Incident Reporting	Julia.Allen@fssa.IN.gov	Aspire Community Howard Regional Gallahue Meridian Park Center Southwestern
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AMHH SPA & b4 Waiver Update

- AMHH SPA is expected to be approved by CMS
  - Anticipated to be effective October 1, 2023

- B4 Waiver – undergoing independent assessment
  - Anticipated to take 9 months and will undergo a public comment period

Questions?