

Behavioral & Primary Healthcare Coordination (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.

Overview of Program

1. What is the Behavioral and Primary Healthcare Coordination (BPHC) program?

Effective June 1, 2014, pending federal approval, the BPHC program is a new home and community-based benefit for adults with serious mental illness who demonstrate impairment in self-management of healthcare needs. It is designed to assist individuals who do not otherwise qualify for Medicaid or other third party reimbursement for the level of intense services they need to function safely in the community.

2. Why is the State implementing the BPHC program?

BPHC is being implemented as a component of the State's transition to 1634 status. With this transition, the State will no longer operate the Medicaid spend-down program for the aged, blind and disabled, under which recipients are required to incur qualified medical expenses each month before Medicaid pays for services.

With this transition, current spend-down enrollees who have countable income over 100% of the federal poverty level (FPL) would no longer have their MRO services paid for as MRO is non-covered by Medicare and most commercial health insurance including health plans sold through the federal health insurance marketplace. Currently, 100% FPL is \$958 per month for a single individual or \$1,293 for a married couple; these amounts will be updated in 2014 pending the federal government's release of updated standards.

The primary purpose of BPHC is to provide continued Medicaid eligibility for MRO utilizers who currently qualify for Medicaid under spend-down. Individuals who meet the eligibility criteria for BPHC and do not qualify for any other Medicaid category can gain access to Medicaid coverage, and therefore continued coverage of MRO, through this program.

Eligibility Criteria

3. What is the eligibility criteria for the BPHC program?

To be eligible for BPHC, an individual must be age nineteen or older and have a primary mental health diagnosis on the MRO eligible diagnosis list. This includes, but is not limited to, the following general categories: schizophrenic disorder, major depressive

disorder, bipolar disorder, delusional disorder and psychotic disorder. The full list of eligible diagnoses is available in the MRO provider manual at www.indianamedicaid.com.

Additionally, an individual must meet ALL of the following needs-based criteria:

- Demonstrated needs related to management of behavioral and physical health.
- Demonstrated impairment in self-management of physical and behavioral health services.
- A score of 3 or higher on the Adult Needs and Strengths Assessment (ANSA).
- Demonstrated health need which requires assistance and support in coordinating behavioral and physical health treatment.

An individual must have countable income below 300% FPL as outlined below. There are certain income disregards that may be applied that may 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 below; specifically a \$361 per qualifying individual deduction may be applied. These income limits are updated annually when the federal government releases the new FPL standards. There is no asset limit for the program.

Family Size	Monthly Income Limit
Single	\$2,873
Married	\$3,878

Individuals must meet all other Medicaid eligibility requirements such as citizenship and state residency requirements.

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.

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 Services

6. What services are covered under BPHC?

The BPHC program consists of coordination of healthcare services to manage the healthcare needs of recipients. This includes logistical support, advocacy and education to assist individuals in understanding the healthcare system and activities that help recipients gain access to needed physical and behavioral health services and manage their health conditions. This includes direct assistance in gaining access to services, coordination of care within and across systems, oversight of the entire case, and linkage to appropriate services. BPHC includes: (1) assessment of the eligible recipient to determine service needs; (2) development of an individualized integrated care plan (IICP); (3) referral and related activities to help the recipient obtain needed services; (4) monitoring and follow-up; and (5) evaluation.

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.

8. What are the service limits for BPHC?

BPHC services are limited to a maximum of 12 hours, or 48 units, per 6 months. During the program implementation phase, these units of service will be authorized to align with similar complimentary services already authorized in other Medicaid programs (e.g., MRO Case Management).

Provider Qualifications & Requirements

9. What provider types are eligible to provide BPHC services?

Community Mental Health Centers (CMHCs) may be approved as BPHC provider agencies. Licensed professionals, qualified behavioral health professionals (QBHP) and other behavioral health professionals (OBHP) may be eligible to provide all activities covered under the BPHC service. DMHA certified recovery specialists and DMHA certified community health workers employed by CMHCs may provide some of the activities within the BPHC service. DMHA certified recovery specialists/certified

community health workers are not eligible to provide needs assessments, referral and linkage activities or physician consults.

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.

Program Implementation & Transition Period

11. Will there be a process to transition individuals to BPHC to prevent a gap in coverage when the State transitions to 1634 status?

Yes, the State is implementing a transition plan to prevent a gap in coverage for individuals who are currently on spend-down and currently utilizing MRO services who may be eligible for the BPHC program. CMHCs will receive a list of individuals under their care who have been identified as potentially eligible for BPHC based on their income, age and MRO utilization. These individuals will also receive a notice providing them information on the program with instructions on how to apply. CMHCs are being asked to work with their identified consumers to complete the application process to prevent a gap in coverage. CMHCs will be able to generate reports through DMHA’s electronic system, DARHMA, identifying their consumers who have not completed the application process to allow for continual tracking and outreach to impacted enrollees.

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.

13. What is the application process for BPHC during program implementation? How does it differ from the application process that will be in place after the initial implementation period?

Applications for BPHC during the initial program implementation will require an ANSA completed within the last 6 months and completion of a web-based application in DARMHA. The BPHC application includes a brief assessment of an individual’s ability to manage his healthcare, a proposed IICP and supporting documentation.

After the initial implementation period, providers will be required to complete an ANSA within 60 days prior to the end date of a BPHC service package.

14. Does the BPHC service approval process differ during the BPHC program implementation?

At implementation, the clinical eligibility end date for BPHC will be aligned with the current MRO end date in order to align the BPHC and MRO processes moving forward. This will minimize provider workload moving forward. The BPHC application must be submitted 30 calendar days in advance of the eligibility end date to ensure on-going Medicaid eligibility with no break in service.

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.

Application Process

16. Who may submit a BPHC application?

Only a DMHA approved BPHC provider may submit a BPHC application. The BPHC provider agency must ensure the agency staff member providing the face-to-face BPHC evaluation meets the following minimum qualifications:

- Possesses at least a Bachelor's degree in social sciences or related field, with two (2) or more years of clinical experience
- Completed DMHA and OMPP approved training and orientation for BPHC services and the application process
- Completed the Adult Needs and Strengths Assessment (ANSA) Certification training
- Must be a certified ANSA user with supervision by an ANSA super-user

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 online application
- Completed and signed proposed BPHC IICP
- Signed attestations (Document to be kept in clinical chart)
- 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.

Incomplete applications submitted after the initial April 2014 roll-out will be returned to the provider to update and resubmit. If the pending application is not completed and returned through DARMHA within 7 calendar days, the application will be automatically denied.

18. What happens after a BPHC application is submitted?

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.

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.

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.

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.**

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