Adult 1915(i) Provider Training – HCBS, QA, AMHH, BPHC

Indiana FSSA/DMHA
Adult 1915(i) AMHH/BPHC State Evaluation Team
March 10, 2016

Agenda

1. Home and Community-Based Services (HCBS) Setting Requirements
2. Quality Assurance Site Visits
3. Adult Mental Health Habilitation (AMHH)
4. Behavioral and Primary Healthcare Coordination (BPHC)
5. Questions

Part 1: HCBS

David Reid
AMHH Program Specialist

HCBS Topics

- Overview of the CMS HCBS Settings Final Rule
- HCBS Residential Setting Screening Tool
- Modification to AMHH and BPHC Applications in DARMHA
- Plan Timeline Summaries
- Important Reminders, Links, and Glossary

Background

- HCBS Final Rule published January 2014, with an effective date of March 17, 2014
- Addressed HCBS setting requirements across **1915(i) State Plan Amendment programs: AMHH and BPHC**
- Federal requirements apply to **all** settings in which a member may reside and/or receive services
- Transition period until March 2019 for existing settings to become fully HCBS compliant

Statewide Transition Plan (STP)

- The STP is required by CMS and must demonstrate how Indiana will ensure all settings where members live, and in which HCBS are delivered, will meet federal HCBS setting requirements by March 2019

- The plan must be submitted to and approved by CMS

- The plan defines activities and timelines for DMHA and provider agencies to accomplish the following:
    1) Identification of affected settings
    2) Assessment of identified settings
    3) Remediation planning and implementation (where required) to:
        a) Bring settings into full compliance
        b) Transition of members to a new setting, or
        c) Transition members to non-HCBS services
    4) Ongoing monitoring of HCBS compliance

Overall Compliance Requirement

- **<u>All members must live in an HCBS-compliant residential setting in order to receive HCBS, regardless of the setting where the service is delivered</u>**
- All settings in which HCBS are delivered must be compliant with federal HCBS setting requirements

What Is (and Is Not) a Home and Community-Based Services (HCBS) Setting?

Per CMS, an HCBS setting can be any of the following:

1) Residential
2) Non-residential
3) Private/Independent Home
4) Provider owned/operated
5) Third-party owned/operated

HCBS settings do NOT include:

1) Nursing facilities
2) Institute for Mental Disease (IMD)
3) Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID)
4) Hospital

Types of HCBS Settings

- Residential
  - POCO residential (group homes, etc.)
  - Non-POCO residential
  - Private/Independent Home (homes, apartments, etc. owned or leased by an individual or the individual's family for their private use)

- Non-residential
  - POCO non-residential (clinics, day service sites, etc.)
  - Non-POCO non-residential (public community settings)

- Presumed Institutional (may apply to POCO and non-POCO settings, residential and non-residential settings)

“Private/Independent Home”

- Per CMS, a member’s private home is presumed to meet federal HCBS requirements

- A “private home” is a residence owned or leased by a member, or a member’s relative, for their private personal use

“POCO”

An important definition and acronym:

POCO

(**P**rovider **O**wned, **C**ontrolled, or **O**perated)

As defined by CMS, a POCO setting is a specific physical place that is owned, co-owned, and/or operated by a provider of HCBS.

“Presumed Institutional”

The HCBS Final Rule states that any setting that has any of the following three qualities of an institution does not meet the federal HCBS requirements:

1) Any setting that is located in a building that is also a **publicly or privately operated facility that provides inpatient institutional care** (that is, a hospital, IMD, ICF/IID, or nursing facility)
2) Any setting in a **building on the grounds of, or immediately adjacent to, a public institution** (defined by CMS as an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control)
3) Any other setting that **has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS**

Qualities of an HCBS Setting: The "Big 5"

CMS established five qualities (the "Big 5") that apply to **ALL** settings

(1) The setting is **integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community**, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS

(2) The setting is **selected by the individual from among setting options**, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board

Qualities of an HCBS Setting: The "Big 5" (cont.)

(3) The setting **ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint**

(4) The setting **optimizes**, but does not regiment, **individual initiative, autonomy, and independence in making life choices**, including but not limited to daily activities, physical environment, and with whom to interact

(5) The setting **facilitates individual choice** regarding services and supports, and who provides them

Additional Required Qualities of POCO Residential Settings (the "POCO 5")

POCO residential settings must meet additional conditions in order to be fully HCBS compliant

(1) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a **legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants under the landlord/tenant law of the state, county, city or other designated entity**

- A residency agreement or other form of written agreement will be in place for each HCBS participant. The written agreement must provide protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law

Additional Required Qualities of POCO Residential Settings (the "POCO 5") – cont.

(2) Each individual has **privacy in their sleeping or living unit**:
- Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors
- Individuals sharing units have a choice of roommates in that setting
- Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement

(3) Individuals have the **freedom and support to control their own schedules and activities**, and have access to food any time

(4) Individuals are able to have **visitors of their choosing at any time**

(5) The setting is **physically accessible** to the individual

HCBS Residential Setting Screening Tool (RSST)

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The HCBS Residential Setting Screening Tool (RSST) will assist providers in identifying what kind of residential setting an AMHH or BPHC applicant is living in (POCO, non-POCO, Private/Independent), and whether that setting is:

1) Fully HCBS compliant
2) Not fully HCBS compliant
3) Potential Presumed Institutional

HCBS RSST

The HCBS RSST must be completed during the application process for **every AMHH and BPHC application submitted on or after April 1, 2016**

- **An attestation will be added** to the AMHH and BPHC applications in DARMHA beginning April 1, 2016, indicating that the tool has been completed with the member prior to application submission
- A signed/dated copy of the completed **tool must be kept in the member's clinical record**, and will be reviewed during 1915(i) QA site visits beginning SFY2017

HCBS RSST Section 1: Consumer Identification

Section 1: Consumer Information

Consumer Name: _____ Date of Screening: _____

Internal ID Number: _____ IICP Number: _____ Program: AMHH / BPHC *(circle one or both)*

Consumer's address: _____

- To be completed for all applicants

HCBS RSST Section 2: Attestation for Private/Independent Home

Section 2: <u>Attestation for "Private/Independent Home" Setting</u>

Most consumers will live in a house, apartment, or other residence which is owned or leased for the consumer's private personal use. An individual's private home (owned or leased), or a relative's home where the individual resides (owned or leased), is considered to be a "Private/Independent Home" and is presumed to meet HCBS requirements.

By my signature, I attest that:

1. **I live at the residence identified above**
2. **I have opportunities for full access to the greater community**
3. **The residence is (check one): ____ owned by me (or a family member) for my/our personal use, OR**
   ____ leased/rented by me (or a family member) for my/our personal use

_____ _____

Consumer signature **Date** **Printed name**

Providers: If the member lives in a "Private/Independent Home" setting, select that option under the "Current Living Situation" section of the AMHH or BPHC application in DARMHA and no further residential assessment is required. If the member does not live in a "Private/Independent Home" setting, continue with Section 3.

- Members who live in their own homes (owned or leased), or live in a family member's owned or leased home, are considered to live in a "Private/Independent Home"
- These members will sign the attestation in Section 2, and no further residential assessment is required

HCBS RSST Section 3: Presumed Institutional Screening

Section 3: <u>Screening Questions for Qualities of an Institution ("Potential Presumed Institutional")</u>

1. Is the residence located in a publicly or privately owned facility that also provides inpatient institutional care?	YES	NO
2. Is the residence in a building on the grounds of, or immediately adjacent to, a public institution?	YES	NO
3. Does the residence have the effect of isolating individuals receiving AMHH/BPHC from the broader community?	YES	NO

*An answer of "YES" to <u>any</u> of the three above questions means the residence potentially has the qualities of an institution. Skip Sections 4 and 5 and complete **Section 6: <u>Outcome of Residential Screening</u>**, selecting "Potential Presumed Institutional". If Section 3 has all "NO" responses, continue to Section 4.*

- Must be completed for all residential settings not identified as "Private/Independent Home" in Section 2

HCBS RSST Section 4: POCO Residential Screening

Section 4: <u>Screening Questions for Provider Owned, Controlled, or Operated (POCO) Residential Settings</u>

1. Does the CMHC own, lease, or co-lease this residential location? YES NO
2. Are there CMHC staff assigned to work at this residence? YES NO

*If the answer to <u>both</u> of the above questions is "NO", the setting is non-POCO residential, and Section 5-A must be completed. An answer of "YES" to <u>either</u> of these questions means the setting is POCO residential, and Sections 5-A **and** 5-B be completed.*

The consumer's living situation is: _____ Non-POCO Residential (complete Section 5-A)
_____ POCO Residential (complete Sections 5-A **and** 5-B)

- This section determines whether just the "Big 5" or both the "Big 5" and "POCO 5" criteria must be met

HCBS RSST Section 5-A: Global HCBS Requirements

Section 5-A: <u>Global HCBS Requirements (the "Big 5")</u>

For residences which are not "Private/Independent Home" settings, five qualities must be present (the "Big 5"). Circle YES or NO as to whether the following qualities are present at the member's residence:

YES NO **1. The residence is integrated in and supports full access to the greater community** (individual has access to shops, restaurants, entertainment, community resources, and other activities/services; individual has access to transportation)

YES NO **2. The residence is selected by the individual from among residence options** (individual had a choice of places to live and chose to live here; residence reflects individual's needs and preferences)

YES NO **3. The residence ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint** (individual has own bedroom with a lockable door or shares a bedroom with someone that he/she chose; individual has own bathroom or shares a bathroom that has a lockable door)

YES NO **4. The residence optimizes individual initiative, autonomy, and independence in making life choices** (individual can come and go at any time or agreed to certain access restrictions [curfew, etc.] when choosing to live here; individual can have visitors at any time or agreed to certain visitation restrictions [visiting hours, etc.] when choosing to live here; individual has access to food at all times)

YES NO **5. The residence facilitates individual choice regarding services and supports, and who provides them** (individual decides whether he/she wants mental health or addiction services, who provides them, whether services are provided in the home)

An answer of "NO" to any of the above five questions means the setting does not fully comply with global HCBS requirements. If the response to all five of the above statements is "YES", the residence fully complies with global HCBS requirements. If the residence is a POCO residential setting, complete Section 5-B. Otherwise, proceed to Section 6.

- Must be completed for all settings not determined "Private/Independent Home" in Section 2

HCBS RSST Section 5-B: POCO Residential HCBS Requirements

Section 5-B: <u>POCO Residential Setting HCBS Requirements ("the POCO 5")</u>

Five additional requirements must be met for POCO residential settings where AMHH and/or BPHC consumers live. Circle YES or NO as to whether the following qualities are present at the member's residence, or if modifications to these qualities have been documented in the member's person-centered treatment plan:

YES NO **1. The member has a legally enforceable lease or residency agreement** (individual has the same tenant protections as other people in the community not receiving HCBS)

YES NO **2. The member has privacy in his/her sleeping or living unit** (individual's living unit has lockable entrance doors with only appropriate staff having keys; individual had a choice of roommates [if applicable]; individual is free to furnish and decorate their sleeping or living unit within the lease/residency agreement; individual can close and lock bathroom door; individual can make phone calls, meet with service providers, and/or use computer in private)

YES NO **3. The member has freedom and support to control their own scheduled and activities** (individual can come and go at any time or agreed to certain access restrictions [curfew, etc.] when choosing to live here; individual has access to food at any time; individual is not required to adhere to a set schedule for waking, bathing, eating, exercising, activities, etc.)

YES NO **4. The member is able to have visitors of their choosing at any time** (individual can have visitors at any time or agreed to certain visitation restrictions [visiting hours, etc.] when choosing to live here)

YES NO **5. The setting is physically accessible to the individual** (required modifications for mobility and access are in place)

If the response to all five of the above statements is "YES", the setting fully complies with POCO residential HCBS requirements. If one or more responses are "NO", the setting does not fully comply with POCO residential HCBS requirements. Continue to Section 6.

- Must be completed for all settings determined "POCO Residential" in Section 4

HCBS RSST Section 6: Outcome of Residential Screening

Section 6: <u>Outcome of Residential Screening</u>

By my signature, I attest that I live at the location identified above and that the HCBS compliance designation of my residence is:

_____ Potential Presumed Institutional
_____ POCO, fully HCBS compliant
_____ POCO, not fully HCBS compliant
_____ Non-POCO, fully HCBS compliant
_____ Non-POCO, NOT fully HCBS compliant

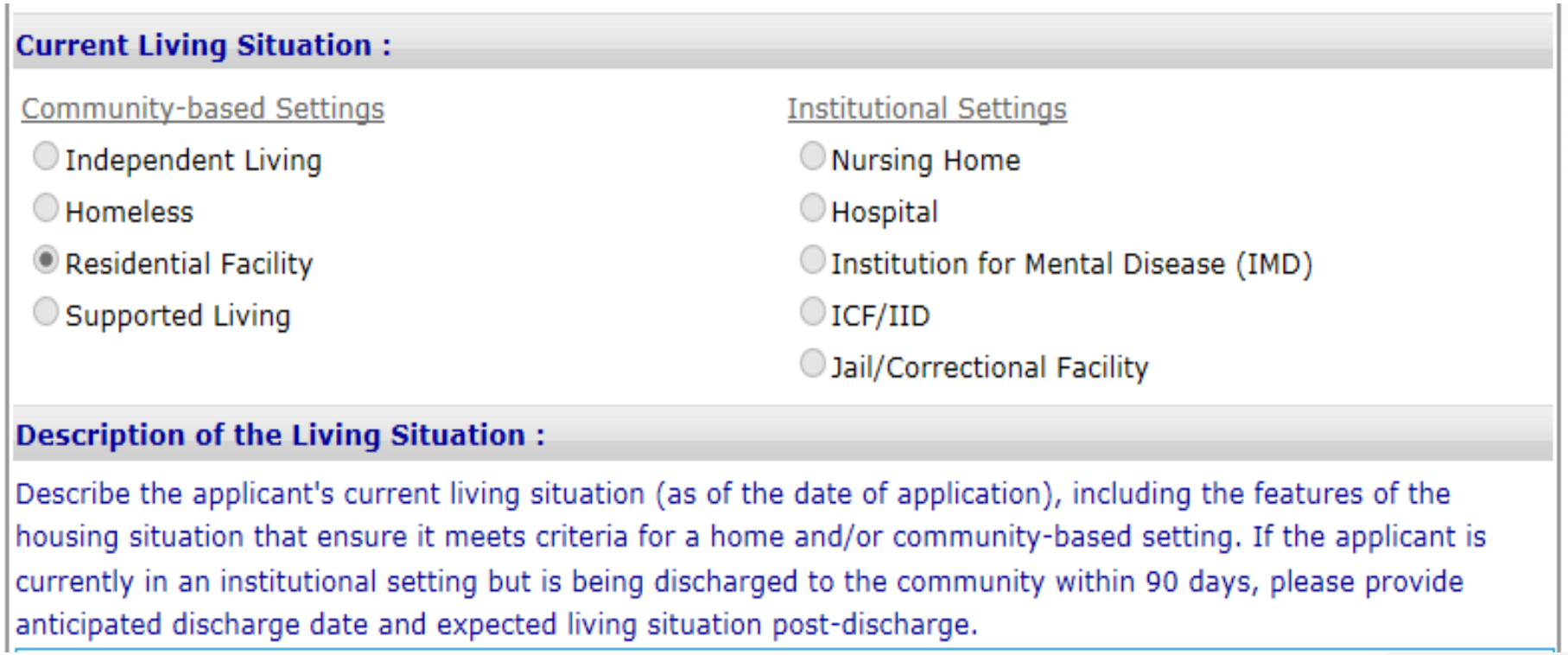
Providers: remember to enter the compliance designation selected above under the "Current Living Situation" section of the consumer's AMHH and/or BPHC application in DARMHA.

_____ _____
Signature of Consumer Date Printed Name of Consumer

- Provides correct selection for "Current Living Situation" section in DARMHA (if other than "Private/Independent Home")

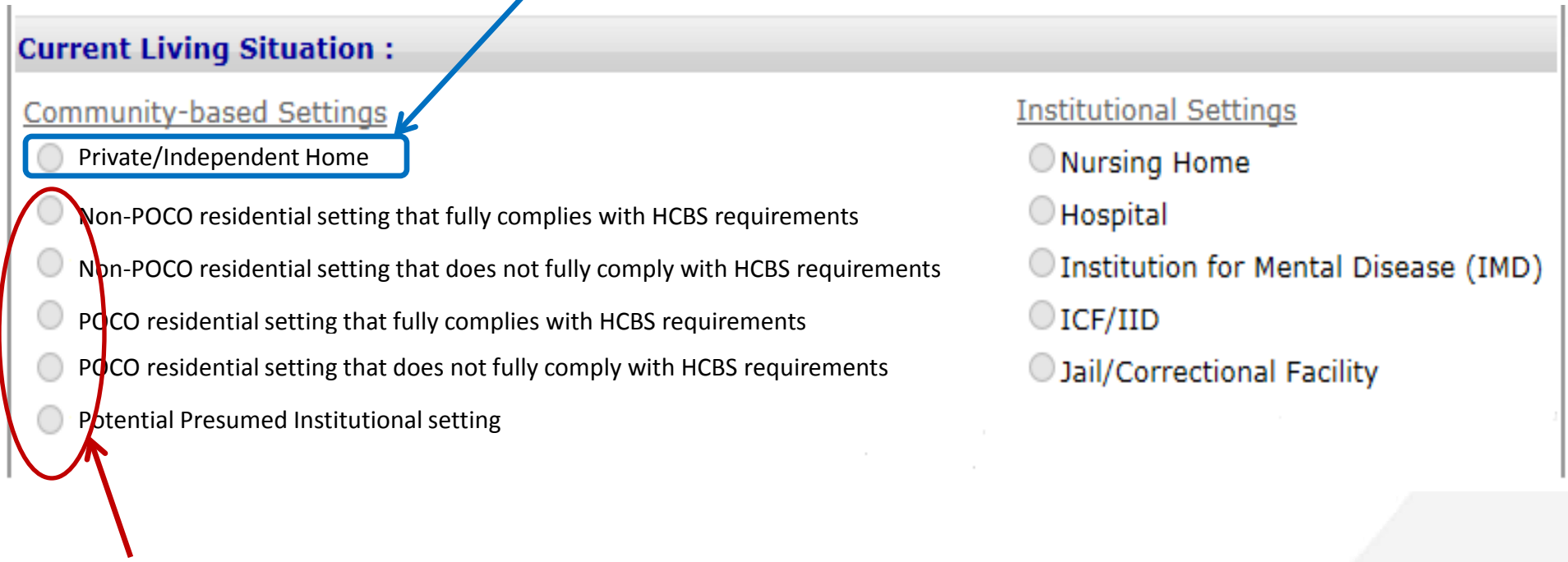
Modifications to the "Current Living Situation" Section and "Attestations" Section of the AMHH and BPHC Applications in DARMHA

“Current Living Situation” Section
(current view)



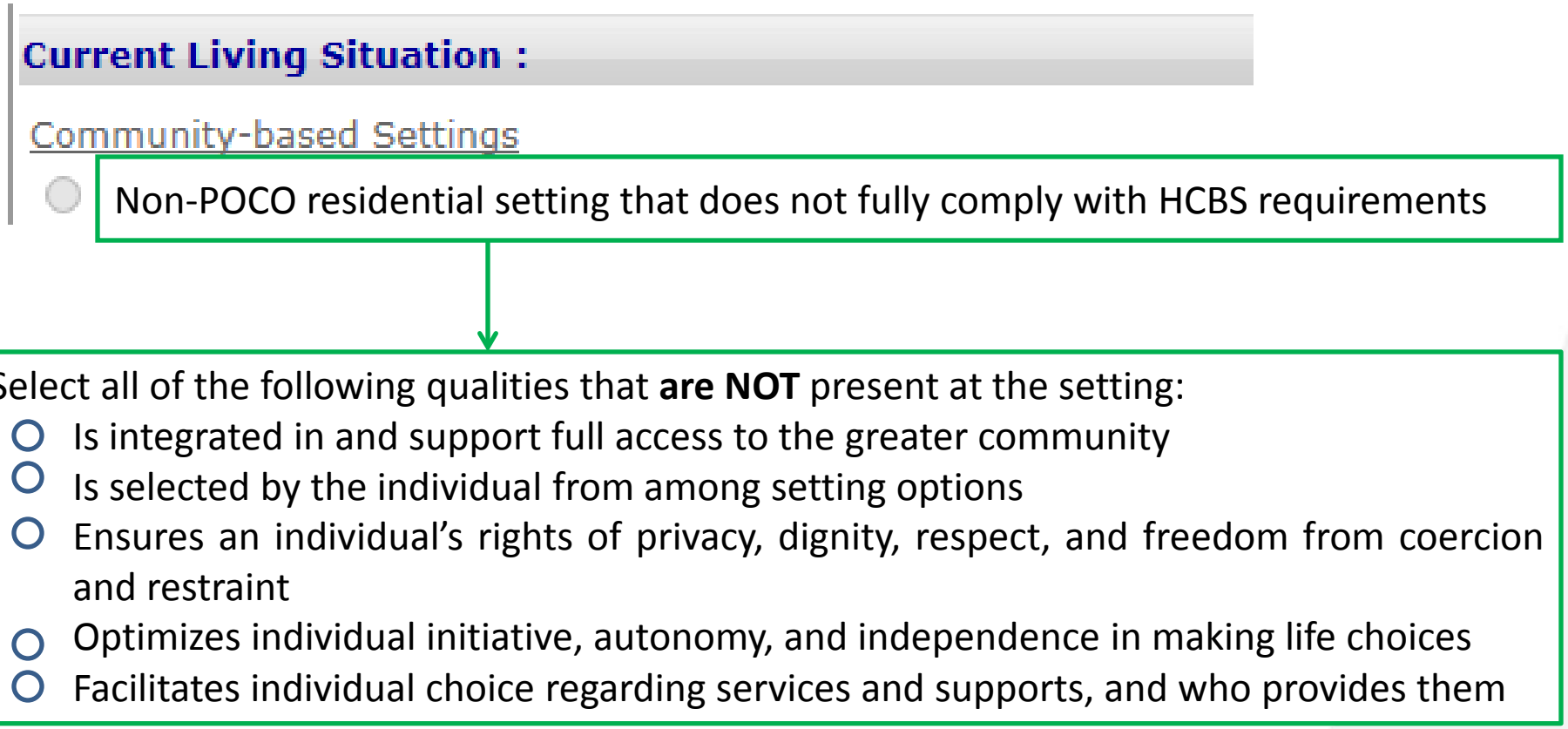
"Current Living Situation" Section
(modified – effective April 1, 2016)

If the setting is a "Private/Independent Home" from Section 2 of the RSST, that is selected here



If not a "Private/Independent Home", the outcome from Section 6 of the HCBS RSST is selected here

"Current Living Situation" Section
(addition - effective April 1, 2016)



"Current Living Situation" Section
(addition - effective April 1, 2016)

Current Living Situation :

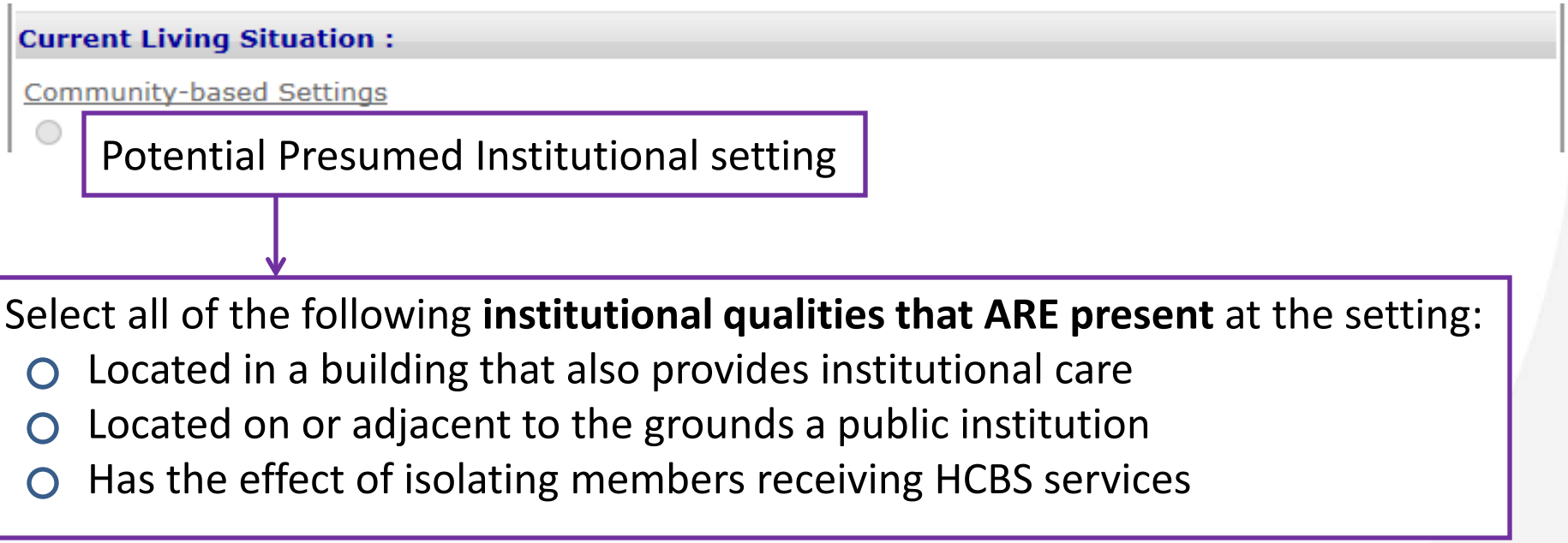
Community-based Settings

- POCO residential setting that does not fully comply with HCBS requirements

Select all of the following qualities **that are NOT present** at the setting:

- Is integrated in and support full access to the greater community
- Is selected by the individual from among setting options
- Ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint
- Optimizes individual initiative, autonomy, and independence in making life choices
- Facilitates individual choice regarding services and supports, and who provides them
- Individual has lease or other legally enforceable agreement
- Individual has privacy in their sleeping or living unit:
  - Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors
  - Individuals sharing units have a choice of roommates in that setting
  - Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement
- Individual has freedom and support to control their own schedules and activities, and has access to food any time
- Individual is able to have visitors of their choosing at any time
- Setting is physically accessible to the individual

"Current Living Situation" Section
(addition - effective April 1, 2016)



New Attestation on AMHH and BPHC Applications in DARMHA

(effective April 1, 2016)

☐ The HCBS Residential Screening Tool has been completed with the applicant, and a signed copy retained in the clinical record

Date: _____

New Attestation on AMHH and BPHC Applications in DARMHA

(effective April 1, 2016)

- The attestation will be visible in DARMHA and available beginning April 1, 2016
- Unlike the other 5 attestations (for BPHC) or 8 attestations (for AMHH), if the attestation is not checked and a date entered, this will not prevent the application from being able to be submitted **(temporarily)**
- This will change: **July 1, 2016**, and the attestation will be required to be completed to enable the application to be submitted

Plan Steps and Milestones – POCO Residential Settings

- **January 2016** – provider self-assessments of POCO residential settings: **COMPLETED**
- **March 15, 2016** – completion of HCBS Resident Surveys
- **March 16 to May 15, 2016** – completion of site-specific assessments and preliminary compliance designations by DMHA
- **May 30, 2016** – all preliminary compliance designation notifications made
- **July 1, 2016** – HCBS Setting Action Plans (for settings opting to remediate) or HCBS Member Transition Plans (for settings opting not to remediate) due to DMHA
- **December 31, 2016** – joint DMHA/provider on-site assessments for "Potential Presumed Institutional" settings complete
- **March 31, 2017** – target date for submission of Heightened Scrutiny evidence to CMS
- **March 2018** – final deadline for completion of remediation activities

Plan Steps and Milestones – POCO Non-Residential Settings

- **April 30, 2016** – provider self-assessments due to DMHA, using the forthcoming web-based "HCBS POCO Non-Residential Setting Screening Tool"
- **May 30, 2016** – all preliminary compliance designation notifications made
- **July 1, 2016** – HCBS Setting Action Plans (for settings opting to remediate) or HCBS Member Transition Plans (for settings opting not to remediate) due to DMHA
- **December 31, 2016** – joint DMHA/provider on-site assessments for "Potential Presumed Institutional" settings complete
- **March 31, 2017** – target date for submission of Heightened Scrutiny evidence to CMS
- **March 2018** – final deadline for completion of remediation activities

Plan Steps and Milestones – Non-POCO Residential Settings

- April 1, 2016 – screening of non-POCO residential settings begins via HCBS Residential Setting Screening Tool and DARMHA application reporting

- Notification to providers of HCBS non-compliant non-POCO residential settings will be made within 15 calendar days of State Evaluation Team (SET) review of submitted application

- Providers have 45 calendar days from date of DMHA notification to:
  - Inform affected members
  - Complete on-site assessment with member(s) and Setting Operating Authority (SOA)
  - Ascertain whether remediation will be undertaken
  - Submit HCBS SOA Setting Action Plan or HCBS Member Transition Plan, as appropriate

Resident Surveys Due March 15th

- Link: https://www.surveymonkey.com/r/9MCPNWC

- Providers must ensure:
  - Each resident at every POCO residential setting has an opportunity to complete the survey (regardless of whether the resident is enrolled in AMHH and/or BPHC)
  - Each resident has the opportunity to complete the survey in private

- Must be completed, electronically or on paper, by March 15, 2016
  - Electronic submissions via SurveyMonkey
  - Paper submissions must be collected and batch mailed to DMHA no later than March 18, 2016

Remediation Timeframes

- DMHA requires ALL remediation activities to be completed no later than March 2018

- **DMHA recommends that agencies establish reasonable shorter timeframes for completion of remediation activates**, based on the identified remediation which must occur at each site

- The SET will monitor ongoing remediation activities beginning with SFY2017 QA site visits

Modifications to the Additional Required Qualities of POCO Residential Settings

<u>Any modification of the additional requirements for POCO residential settings (the "POCO 5") must be supported by a specific assessed need and justified in the person-centered service plan!</u>

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

Modifications to the Additional Required Qualities of POCO Residential Settings

(continued)

Modifications to the "POCO 5" requirements can also be supported by the member's lease or residency agreement, provided that:

1. The member was made aware of the modifications/restrictions before agreeing to live at the setting, **AND**
2. The member's choice to live at the setting with full understanding and acceptance of the modifications/restrictions is documented in the clinical record

Ongoing HCBS Compliance Monitoring

- **Beginning SFY2017 (July 1, 2016),** assessment of HCBS setting compliance will be incorporated into scheduled annual (or more often) AMHH and BPHC QA site visits

- The State Evaluation Team will conduct an on-site assessment of:
  - At least one randomly selected POCO residential setting
  - At least one randomly selected POCO non-residential setting

- The SET will verify inclusion of the signed and dated HCBS Residential Setting Screening Tool in each of the randomly selected consumer clinical charts

- The SET will review HCBS Setting Action Plans and HCBS Member Transition Plans for adherence to schedule and completion of identified remediation and/or transition activities

Important Links

- CMS HCBS Final Rule website
  - **http://www.medicaid.gov/hcbs**
  - Link on this page to the **HCBS Settings Requirements Compliance Toolkit**, which is an INVALUABLE resource for assisting providers in ensuring HCBS setting compliance
- FSSA Home and Community Based Final Rule page. This is where the STP and important information and updates will be posted.
  - **http://www.in.gov/fssa/4917.htm**

Glossary

- **AMHH** – Adult Mental Health Habilitation
- **BPHC** – Behavioral and Primary Healthcare Coordination
- **CMS** – Centers for Medicare & Medicaid Services
- **DARMHA –** Data Assessment Registry Mental Health and Addiction
- **HCBS** – Home and Community-Based Services
- **POCO** – Provider Owned, Controlled, or Operated
- **SET** – State Evaluation Team
- **SFY** – State Fiscal Year (July 1 - June 30)
- **SOA –** Setting Operating Authority
- **STP** – Statewide Transition Plan

QUESTIONS?

QA Topics

- Quality Assurance Visits
- Common Areas of Non-Compliance

Quality Assurance Visits

- SFY2016 Quality Assurance (QA) visits for AMHH and BPHC began July 2015
- **Beginning SFY2017 (July 1, 2016), HCBS compliance will be assessed during on-site QA visits**
- Each provider agency will be reviewed on-site at a minimum once per state fiscal year

QA Site Visit Required Logistics

- Individual access to electronic health record for each SET reviewer, with dedicated auditor logon access
  - SET reviewers require independent EHR access
- Wi-Fi access and passwords for SET's computers
- Any complaints or grievances filed by or on the behalf of the randomly selected members, along with the resolution
- Access to scanned document repository, or hard copies of scanned documents prepared and ready

Common Areas of QA Non-Compliance

- Documentation of face-to-face interviews
- Complaints and Grievances information
- Incomplete Attestations
- Role of the ANSA SuperUser
- Staff Qualifications and Training

Documentation of Required Face-to-face Interviews

- There must be documentation in the member's clinical chart clearly indicating the **ANSA interview** was completed face-to-face

- There must be documentation in the member's clinical chart clearly indicating the **AMHH and/or BPHC interview** was completed face-to-face

- **Reminder - Effective 10/1/15, signed attestations or applications no longer constitute acceptable documentation that required interviews occurred face-to-face**

Complaints and Grievances

- There must be documentation in the member's clinical record confirming they received information explaining how to file a complaint and/or grievance ***BEFORE*** initial eligibility for AMHH and/or BPHC is established
  - Documentation must be signed and dated by the member
  - Documentation must include the telephone numbers for the Consumer Service Line (1-800-901-1133) and Indiana Protection and Advocacy (317-722-5555 or 800-622-4845)
  - Must be documented as being orally explained and copy given to member

Incomplete Attestations

- All required signatures (member or legal guardian, referring care coordinator, ANSA SuperUser, and Psychiatrist/HSPP) must be **signed and dated prior to application submission**

- All required signatures will be reviewed by the SET during on-site QA visits

Role of the SuperUser

- The SuperUser is only required to review the **ANSA associated with the application**

- The SuperUser review must take place between the completion of the ANSA and the submission of the application

Staff Qualifications and Training Documentation

- The request for staff qualifications and training documentation is sent to the agency for completion prior to the QA visit

- Include all staff, even if the staff no longer works at the agency, that provided AMHH or BPHC services during the review period

- Staff providing AMHH or BPHC services must have received an internal training prior to delivering a service, and the date of this training/refresher training must be submitted on the sheet

AMHH Topics

- Identification of Potential Members
- Renewal Application Process
- Approved Package Dates
- Questions

Reminder: AMHH and BPHC are Separate Programs!

- **Eligibility for both programs (AMHH and BPHC) is independent of each other and application must be submitted for both programs**

Four Steps for Identification of Potential Members

1. Meets core criteria
2. Meets needs based criteria
3. Approach member with program
4. Document clinical discussion

1.) Meets AMHH Core Criteria

- Medicaid enrolled
- Age 35 or older
- Level of need of 4 of higher based on ANSA submitted within the last 60 days
- Resides in a setting that meets federal home and community-based services (HCBS) setting requirements (i.e., in the community in a non-institutional setting)
- Eligible diagnosis (ICD-10 format)

2.) Meets AMHH Needs-Based Criteria

ANSA Algorithm

- The algorithm results are developed from a combination items in the most recent ANSA. Please refer to Section 5 of the AMHH Provider Module.
- Able to see if needs based criteria is met as soon as the application is open
- Only around **10%** of individuals meeting core criteria will also meet the needs based algorithm

3.) Approaching Potential Members Regarding the AMHH Program

- Other providers may identify and refer members to the program
- Individuals may approach your agency as a self-referral
- Family members or caregivers may approach your agency on behalf of an individual
- Consumer Pamphlet available on the AMHH website at:
  http://www.in.gov/fssa/dmha/2876.htm

4.) Document Clinical Discussion

- Document discussions of the AMHH program in the member's clinical chart (important to document choices given and the member's decision)

- Agency needs to have a plan for on-going member identification

Strategies for Identifying Potential AMHH Members

1. Data pull from DARMHA or agency's electronic health record for members who meet core eligibility criteria (remember only about 10% of these will meet needs based criteria)
2. Clinical discussion to assess member's need for and benefit from a habilitation approach
3. For those who meet core criteria and may benefit from a habilitation approach, open an AMHH application

AMHH Renewal Applications

- An AMHH eligibility period is up to 360 days and must be renewed in order to continue participation in the AMHH program
- A renewal application is developed in the same way as an initial AMHH application
- All AMHH services deemed necessary must be requested on the renewal application
- The renewal must include a narrative statement discussing progress or lack of progress toward habilitative goals of the member during the existing AMHH service period

AMHH Renewal Applications *(continued)*

- **Renewal applications are required to be submitted in DARMHA at least 30 calendar days (but no more than 60 calendar days) before the AMHH eligibility end date**
- Must continue to meet core and needs based criteria
- All attestations must be signed to capture all providers and members' participation in the application prior to the application submission date. **Attestations must be signed within 60 days prior to the application submission date**.

Habilitative Goals and Objectives

- Goals should address reinforcement, management, adaptation and/or retention of level of functioning
- Goals must be habilitative in nature
- Objectives: At a minimum, an objective must be linked to and supported by one or more requested services

AMHH Start Date Determination

- If the member has a current MRO package and the end date is within 60 days, the AMHH start date is set for the date after the MRO package ends
- If the member has a current MRO package and the end date is more than 60 days from the date of AMHH approval, the AMHH start date is set 15 calendar days from the day of AMHH approval
- Approved renewal applications will start the day following the current AMHH eligibility period

AMHH End Date Determination

- The default end date for AMHH eligibility is 360 days from the identified start date

- The SET may assign an end date for AMHH eligibility sooner than 360 days, if necessary, to align with the member's current BPHC eligibility period

Supported Community Engagement

Face-to-face, individually provided service aimed at:

1. Establishing a meaningful purpose in the community
2. Engaging the member in meaningful community involvement in activities such as volunteerism or community services
3. Developing skills and opportunities that lead to improved integration of the member into the community through increased community engagement

AMHH-Specific Documentation Requirements

- AMHH Crisis Plan
- Service Documentation Requirements
- Location of Service Delivery
- Service Type
- Staff Qualifications

AMHH Crisis Plan

A crisis plan must be present in the member's chart for the SET to review at the QA site visit

- The crisis plan must be developed with the member prior to the start date of AMHH eligibility period
- The crisis plan must be updated at a minimum with every application/renewal
- The SET recommends it be reviewed at every IICP review

Service Documentation Requirements

General documentation of delivered AMHH services must include:

1. Type/title of service being provided
2. Name and qualifications of the staff member providing the service
3. Location or setting where the service was provided
4. Describe focus on member and of the session or service being delivered to or on behalf of the member
5. Symptoms or issues addressed during the session
6. Member's IICP goal(s) being addressed during the session
7. Progress made toward the habilitation goals
8. Date of service rendered (including month, day, and year)

***Services may have their own unique documentation requirements in addition to the general requirements. Review the AMHH Provider Module for this information.**

Location of Service Delivery

- The note needs to clearly indicate the location where the service was delivered

- All settings in which AMHH services are delivered must meet CMS standards for an HCBS setting by March 2019

Documenting Service Type

- The SET needs to be able to clearly identify what **type of service** is being billed in each note
- The type of service delivered must be found on the note or in the documentation

Staff Qualifications

- Agencies must ensure that the staff delivering the service meets the distinct staff qualification for the specific service being delivered

- Service requirements are different across each of the nine services. Please review the AMHH Provider Module to view the staff requirements for each service.

Helpful Resources

- AMHH Provider Module
- AMHH Eligible Diagnoses
- AMHH Consumer Pamphlet

Links to all of these documents can be found at the AMHH website at:

http://www.in.gov/fssa/dmha/2876.htm

Email: amhhservices@fssa.in.gov

QUESTIONS?

BPHC Topics

- Application Status in DARMHA
- Tracking Renewal Applications

DARMHA Application Status

- Listing of all DARMHA application statuses and their definitions in the BPHC Provider Module
  - Link is located on the BPHC webpage at: http://www.in.gov/fssa/dmha/2883.htm

- Each provider is responsible for monitoring their agency's BPHC applications submitted to ensure timely processing

- If more information regarding an application is needed, provider may contact BPHC State Evaluation Team (SET) at 317-232-7800

DARMHA Statuses Requiring Additional Provider Involvement

- “DMHA Pending”
- “DMHA Denied”
- “DFR Pending”
- “DFR (HP) Conditional”
- “DFR Mismatch”

“DMHA Pending” Status

- Submitted application was pended by the SET and requires further information from the provider

- Provider is responsible for **checking in DARMHA daily** for any applications in the “DMHA Pending” status

- The provider must:
  1. Review the reason application was pended
  2. Correct/clarify information as needed, and
  3. **Resubmit the application in DARMHA within seven (7) calendar days of application being placed in “DMHA Pending” status**

"DMHA Pending" Status *(continued)*

- Once the pended application has been resubmitted, it will be reviewed by the SET to determine BPHC clinical eligibility
- All applications that remain in "DMHA Pending" after seven (7) calendar days will be "DMHA Denied"
- Once an application has been "DMHA Denied", a new application must be submitted for SET review

"DMHA Denied" Status

- Provider-submitted BPHC application was denied for clinical eligibility by the SET

- Denial notifications are sent to:
  - Provider contacts listed on the application (via e-mail)
  - Consumer applying for BPHC (via USPS mail)

"DMHA Denied" Status *(continued)*

- Once the provider receives the notification of BPHC clinical eligibility denial, the provider must contact the member to inform them of:
  - Receipt of the BPHC clinical denial and the reason for denial
  - Their right to appeal and the appeal process
- After reviewing the denied application, the member may:
  1. appeal;
  2. work with the provider to submit a new BPHC application with updated information for SET review; or
  3. assess other programs/options

"DFR Pending" Status

- Application has been clinically approved by the SET and submitted to **DFR for Medicaid eligibility determination**
  - ➢ It is important to remember that "DFR Pending" is a DARMHA-only status. DFR will not recognize this status.
- DFR may require additional information from the member in order to process their **Medicaid** application
  - ➢ Provider must verify Medicaid eligibility for the member and ensure a Medicaid application has been submitted in conjunction with the BPHC application if member does not have active Medicaid
- Provider can contact DFR at 1-800-403-0864 to determine what information DFR requires to further process the member's Medicaid eligibility

"DFR Pending" Status *(continued)*

- If DFR states no further information is required for processing, member (or authorized representative) may **request** that DFR review the member's Medicaid case for eligibility **for all Medicaid categories**

- If contacting DFR via telephone does not resolve the issue, submit an e-mail for resolution to your agency's regional DFR office. DFR Regional e-mail addresses may be found on the following link: http://www.in.gov/fssa/files/DFR_Map_and County_List.pdf

"DFR Pending" Status *(continued)*

- Once the issue has been resolved and it has been determined the member has active Medicaid, the **provider is advised to continue to track the application in DARMHA** to ensure it is processed timely

- If there has been **no change** to the DARMHA status after **10 business** days of the determination of Medicaid eligibility**, please notify the SET via e-mail** (bphcservice@fssa.in.gov)

“DFR (HP) Conditional” Status

- Renewal BPHC application was submitted to HP for a BPHC service package assignment, but was returned as “member not having active Medicaid”

- Normally occurs when a member has been scheduled for their Medicaid redetermination and has either missed the appointment or not returned the information to Medicaid as required

"DFR (HP) Conditional" Status

(continued)

- Recommend member/authorized representative contact DFR at 1-800-403-0864 to determine what information DFR requires to further process the member's Medicaid eligibility

- If DFR states no further information is required for processing, **request** that DFR review the member's Medicaid case for eligibility for **all Medicaid categories**

"DFR (HP) Conditional" Status

(continued)

- If contacting DFR via telephone does not resolve the issue, submit an e-mail for resolution to your agency's regional DFR office. DFR Regional e-mail addresses may be found on the following link: http://www.in.gov/fssa/files/DFR_Map_and County_List.pdf

- Provider must continue to track the application to ensure it is processed timely

"DFR (HP) Conditional" Status

(continued)

Once the issue has been resolved and the provider has determined the member has active Medicaid, **provider must contact the SET** via e-mail (bphcservice@fssa.in.gov) to **request resubmission** of the member's application to HP

“DFR Mismatch” Status

- BPHC application is clinically approved and was sent to DFR for processing
- DFR rejected the BPHC application due to non-matching information between DARMHA and DFR’s system
- Most common mismatches
  - Member’s name
  - Member’s Social Security #
  - Member’s Recipient ID (RID) #
  - Member’s date of birth

"DFR Mismatch" Status *(continued)*

- Provider must review mismatched information and make corrections as necessary
  - Make corrections in member's DARMHA record, **or**
  - Contact DFR to make corrections in Web interChange
- Once the information has been corrected, **provider must notify the SET** via e-mail (bphcservice@fssa.in.gov) of correction
- Once the SET receives notification, the SET will notify DARMHA to refresh BPHC application to correct information and resubmit application to DFR

BPHC Renewal Applications

- Providers are responsible for monitoring member's application in DARMHA to ensure timely submission of member's renewal application

- **Renewal applications are required to be submitted in DARMHA at least 30 calendar days (but no more than 60 calendar days) before the BPHC eligibility end date**

BPHC Renewal Applications *(continued)*

- **Members have lost Medicaid eligibility due to renewals not being submitted on time**
- Member must continue to meet core and needs based criteria
- Must include current BPHC utilization for service and its benefit to member
- All attestations must be signed and dated to capture all providers and members' participation in the application

DARMHA Renewal Application Report

- DARMHA report to monitor/track application renewals
  - Select “Reports”, then choose

    “**BPHC Expired Application No Renewal**”

    o Date range must be entered

    o Displays all applications that expired and with no renewal submitted, including the days since their BPHC eligibility ended

    OR

    “**BPHC Expiring Applications**”

    o Displays all applications with their upcoming BPHC eligibility end dates

    o *Important note*: “Days til Renewal” column is the current BPHC end date, not the date the renewal should be submitted

QUESTIONS?