BDS Provider, Care\Case Manager Monthly Webinar

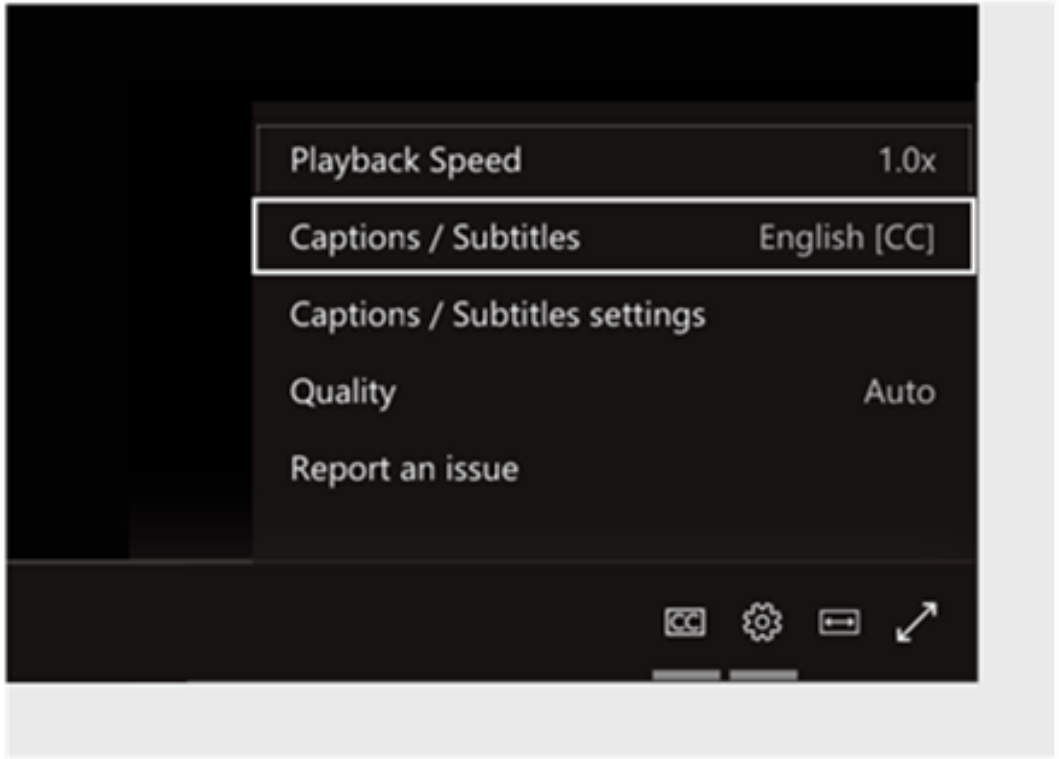
September 26, 2024

Before We Get Started…

How to Use Live Captions

To turn on live captions and subtitles, select **Captions/Subtitles On** CC in your video controls.

To change the caption language, select **Settings** ⚙ > **Captions / Subtitles**, and choose the language you want.



How to Ask a Question

1.) Select Q&A on the right side of the screen.

2.) Type your question in the compose box, and then select Send.

3.) Your question will only be visible to the presenters.

4.) Questions will be answered as time permits.

Webinar Agenda

- IPP Project Guest Speaker:
  Madison Wood-Gonzalez
  Morning Light, Inc.
  NOTE: Postponed
- IPP Project Guest Speaker:
  Sarah VanderZee McKenney, D.Min., M.Div.
  Stone Belt Arc Inc.
  NOTE: Postponed
- Provider Updates for all HCBS Waiver Providers
- Provider Updates for HW/TBI Waiver Providers
- Provider Updates for CIH/FSW Waiver Providers
- Future Webinar Topics Invitation

Provider Updates:
All Providers

Incident Reporting

We have seen an increase in incident reports for positive COVID tests.

As a reminder: effective November 11, 2023, an incident report is no longer be required for an individual who tests positive for COVID.

HCBS Settings Rule

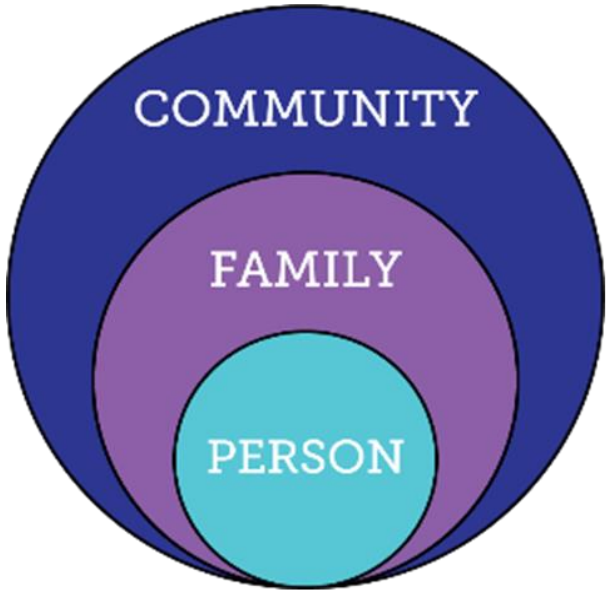
Before a restriction/modification can be implemented these steps must occur

- A specific and individualized assessed need.
- The positive interventions and supports used prior to any modifications or restrictions.
- Less intrusive methods of meeting the need that have been tried but did not work.
- A clear description of the condition that is directly proportionate to the specific assessed need
- 5. A regular collection and review of data to measure the ongoing effectiveness of the modification
- Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated
- Informed consent of the individual.
- An assurance that interventions and supports will cause no harm to the individual.

**Staffing levels can be considered a restriction/modification and should be individualized.

Provider Updates:
H/W and TBI Providers

Services and Supports



Everyone exists within the context of family and community

Traditional

Long Term Services and Supports

Integrated Services and Supports within context of person, family and community

Service Planning

- Waiver services should complement and/or supplement support from families and communities, Medicaid State Plan services, and other federal, state, and local public programs to assist individuals to live in their communities and avoid institutionalization. That means when teams are supporting the individual to identify what goals would help them reach their best life, waiver services should not be the first or only resource that teams consider when looking to address the needs of individuals and families.

- Examples of questions for teams that could assist in planning:
  - What does the individual want to help live their best life?
  - What supports are in place and where are the gaps?
  - What other supports can we help the individual access to meet their needs?
  - How would we support the individual if waiver services went away?

Resources

Person Centered Planning Tools (LifeCourse Nexus)

Trajectories, Intergrated Support Star, Life Domain Vision Tool, Intergrated Supports Schedule

Medicaid State Plan Resources

Home Health FAQ, Home Health Fact Sheet, Home Health Guidance for Care Managers, Medicaid State Health Plan vs Medicaid Waiver Services

Indiana 211

Other great opportunities could include linking the individual to local churches, social clubs, volunteer opportunities, vocational rehabilitation, etc.

Home Health Requirements

- Guidance was created and posted to the Medicaid Strategies webpage in early July. This guidance provided clear documentation expectations for Care Managers when documenting the individual's status toward obtaining Home Health, when applicable.

Home Health Agencies Have Rejected the HH Referral (Can't Find HH Provider)

If a referral for HH has been rejected by at least three Home Health Agencies in the previous twelve months, the service plan may include ATTC services to meet the individual's unmet personal care needs. As the CM, you should work with the individual/family to identify the individual's unmet personal care needs and request an appropriate amount of ATTC hours on the service plan. There is an expectation that the individual/family (assisted by the CM as needed) will reach out to Home Health Agencies on an annual basis.

You can search for home health agencies in your area using the IHCP Provider Locator. Be sure to click the button next to "Other" and select "Home Health Agency." You can then narrow your search by county or zip code.

Documentation Requirement:

The Care Manager must document three HHA rejections. For each rejection, the Care Manager must enter the following information into a Case Note:

- Agency Name
- Agency Contact Name
- Date Agency Contacted
- Date Agency Rejected Referral
- Reason for Rejection

Also, in the "Plan Alteration Comment Box", the Care Manager must add the following reference: *"Additional HH PA Information in CN dated XX/XX/XX."*

Home Health Requirements (cont'd)

While it is not the care manager's responsibility to determine whether the individual meets Home Health criteria, it is important that there is clear documentation as to why the care manager and the individual/family believes the criteria is not met. Submitting the Home Health Indicator checklist alone, is not sufficient.

Note: Preference for a preferred paid caregiver does not remove the requirement to seek Home Health.

Service Definition Reminders

- When provided by a Legal Guardian of an adult, Services are limited to a maximum of forty (40) hours per week.
- ATTC services will not be reimbursed to a provider for a participant requiring management of *uncontrolled seizures*, infusion therapy; venipuncture; injection; wound care for, decubitus, incision; *ostomy care*; and *tube feedings*.
- HCA services will not be reimbursed to a provider for services provided to household members other than the participant.
- Specialized Medical Equipment and Supplies- Preference for a specific brand name or model is not a medically necessary justification for waiver purchase.

Annual Service Planning and Extensions

- Annual Service Plans (SPs) need to be submitted with enough time for the initial review and take into consideration the time for possible requests for information. When an Annual SP is unable to be authorized before the previous SP expires, an Extension SP is automatically created and authorized for all providers, except Care Management.

- This means providers should continue to provide the support to the individual that was authorized the last month of the previous SP.

Annual Service Planning and Extensions

- It is the Care Manager's responsibility to ensure they are submitting Service Plans that are compliant with the applicable service definition, adhere to all local and federal codes, and provide the information requested by Bureau of Disabilities Services (BDS) in order for BDS to authorize a SP. Once the Annual SP is authorized, the Care Management Organization can then request to be added to the last extension.

Care Management Reminder

For Individuals who have transitioned to PathWays, the AAA may not see an active Service Plan in CaMSS. A Re-Entry or Annual should not be created unless requested by the MCE. Furthermore, a Face-to-Face assessment is not required by the AAA. The MCE will handle the Face-to-Face via the CHAT.

Provider Updates:
CIH and FSW Providers

Behavioral Support Plans

Behavioral Support Plans should contain the following:

- A consensus of the IST that the BSP is feasible for implementation and uses the lease restrictive measures possible.
- Signature of a Level 1 if written by a Level 2.
- Signature/consent from the individual and legal guardian, if applicable, should be obtained before the BSP is considered valid.

**no restrictions/modifications should be implemented without HRC approval as well

Budget Request Information

Pending STBRs/LTBRs

- BDS recognizes there has been a delay in reviewing/acting upon STBRs/LTBRs for the last several months. BDS is approximately 60 days behind in its reviews. BDS continues to receive around 200 STBRs per month. There is a considerable amount of information for BDS staff to review for every STBR, including submitting and monitoring the return of Requests for Information (RFIs). Although BDS provides a deadline to respond to an RFI, the information is not always provided within that timeframe.

- **REMINDER**: RFIs should not be necessary as all information should be provided with the initial STBR/LTBR submission. If CMO/provider receives an RFI, please ensure it is responded to with the requested information and/or clarification. This requires frequent monitoring of the individual's profile in the BDS Portal. *NOTE: if an STBR/LTBR has been RFI'd twice and the information has not been provided by the CMO/provider after the 2nd RFI, it will be denied*.

Pending STBRs/LTBRs (cont'd)

- Appeal rights will be provided with all STBR/LTBR denials.

- If providers are following up with the CMO (including escalation to CM Supervisor or CMO Quality Assurance/Compliance) and are not receiving a response about an STBR/LTBR, please email BDS.Help@fssa.in.gov, and BDS can address.

- There have been several instances of an STBR submitted to the CM Supervisor, and the STBR 'sits' for weeks, even months. CM Supervisors must review budget requests in a timely manner. A justification for any late submission **must** be noted in the 'Comments' section. (*Please refer to the July 25 and August 22 CM/Provider webinar slides.*)

Pending STBRs/LTBRs (cont'd)

- **REMINDER**: to be considered timely, the STBR must have a status of 'Submit to Central Office' within 45 days. A team meeting/discussion and appropriate linked case note must also be completed prior to the STBR submission.

- **REMINDER**: both providers and CMOs can view the status of an STBR/LTBR in the Portal. If needed, a provider or CMO can email BDS.Help@fssa.in.gov to inquire about pending STBRs that have not been acted upon (i.e., more than 60 days). *PLEASE DO NOT SUBMIT A JIRA TICKET*.

Future Provider Webinar Topic Ideas?

The BDS Provider Webinar primarily offers an opportunity for BDS to share current news, updates, and to offer brief training opportunities. We want to hear your ideas about additional webinar topics that would be helpful to you across the H&W, TBI, CIH, or FSW waivers. This webinar is a monthly opportunity to discuss updates and issues impacting Indiana's HCBS Waiver providers and other providers of services administered by DDRS.

Share your topic ideas at:
BDSProviderServices@fssa.in.gov