IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201967 NOVEMBER 26, 2019

# IHCP enhances access to care for members with serious mental illness

The Indiana Health Coverage Programs (IHCP) will expand access to acute inpatient care for Medicaid members with serious mental illness (SMI) as part of an amendment to the current Section 1115 Healthy Indiana Plan (HIP) 2.0 demonstration waiver. Changes are scheduled to go into effect January 1, 2020, pending approval from the Centers for Medicare & Medicaid Services (CMS).

Changes will apply to all members who are between the ages of 21–64, which includes those enrolled in HIP, Hoosier Care Connect, Hoosier Healthwise, and traditional fee-for-service (FFS) Medicaid. The following eligibility groups are excluded from coverage:

- Limited Services Available to Certain Non-Citizens – *Code of Federal Regulations 42 CFR 435.139*
- Qualified Medicare Beneficiaries (QMBs) Only – *Social Security Act 1902(a)(10)(E)(i)*; *1905(p)*
- Specified Low Income Medicare Beneficiaries (SLMBs) – *1902(a)(10)(E)(iii)*
- Qualified Individual (QI) Program – *1902(a)(10)(E)(iv)*
- Qualified Disabled Working Individual (QDWI) Program – *1902(a)(10)(E)(ii)*; *1905(s)*
- Family Planning – *1902(a)(10)(A)(ii)(XXI)*

### Expanded inpatient treatment for SMI in institutions for mental disease

The IHCP will expand coverage for short-term inpatient stays for members with SMI in facilities that qualify as institutions for mental disease (IMDs). Qualifying providers should meet the requirements listed in the *42 CFR 435.1010*, in which IMD is defined as:

> *A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.*

Providers must also be enrolled as a psychiatric hospital (provider type 01 and provider specialty 011) with more than 16 beds and licensed by the Division of Mental Health and Addiction (DMHA) as a private mental health institution (PMHI) pursuant to *Indiana Administrative Code 440 IAC 1.5*. Facilities that meet this criteria are recognized by the IHCP as qualifying IMDs for providing short-term inpatient stays for SMI. State mental health hospitals (state-operated facilities [SOFs]) do not qualify as eligible IMDs under the demonstration waiver.

## Alignment of average length of stay requirements across service delivery systems

Prior authorization (PA) is required for all inpatient stays. Length of stay will be authorized based on medical necessity. In accordance with federal requirements, the IHCP will be required to achieve a statewide average length of stay of no greater than 30 days, and reimbursement will not be available for inpatient stays longer than 60 days. Claims submitted for inpatient stays more than 60 days will be denied. Questions about FFS PA should be directed to DXC Technology at 1-800-269-5720. Questions regarding managed care PA should be directed to the managed care entity (MCE) with which the member is enrolled. Upon CMS approval of the waiver amendment, this bulletin replaces the guidance provided in *IHCP Bulletin* BT201637.

Coverage and reimbursement information apply to inpatient SMI treatment delivered under the FFS and the managed care delivery systems. Reimbursement will not be extended to IMDs for residential stays.

## Improving care coordination and transitions to the community

As part of the SMI demonstration waiver amendment, the IHCP will establish specific requirements for psychiatric hospitals to facilitate better care coordination and transitions to community-based care. Specifically, the IHCP will explicitly require psychiatric hospitals have protocols in place to:

- Assess for housing insecurity as part of the social work assessment and discharge planning processes and to refer to appropriate resources.
- Ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and follow-up care is assessed.

Compliance with these requirements will be monitored via the annual unannounced site visits of hospitals as part of their recertification.

### QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-457-4584.

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