West Virginia Medicaid Health Homes
Provider Manual

Version 1.0

WV Medicaid Health Homes Program

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Introduction

Our Company

KEPRO is a QIO-like entity designated by the Centers for Medicare and Medicaid Services. The combination of KEPRO and APS Healthcare in 2015 created an organization with unequaled experience with utilization management and prior authorization across the spectrum of health and human services. KEPRO brings 31 years of federal and state medical review and quality improvement experience which uniquely compliments APS-WV's 15 year background in Medicaid behavioral health, intellectual/developmental disabilities, waiver program management and state-funded programs.

KEPRO is an integrated care management and quality improvement organization serving public and commercial health care markets.

KEPRO's Mission Statement

To improve lives through healthcare quality and clinical expertise.

KEPRO's Values

Our values do more than hang on the wall. They live in the actions and decisions we make every day. From them we improve lives by building innovative solutions, connecting and collaborating with others, while providing the highest standard of care for those who need it most.

Our Role

KEPRO is the contracted administrative service organization for WV DHHR's Bureau for Medical Services. In this capacity KEPRO administers the Health Homes Program for WV Medicaid members. All policies and procedures are approved by the State prior to implementation.

Medical Necessity

All authorizations requests and provider documentation must meet the following definition of medical necessity.

Services and supplies that are:

- Appropriate and necessary for the symptoms, diagnosis or treatment of an illness;
- Provided for the diagnosis or direct care of an illness;
- Within the standards of good practice;
- Not primarily for the convenience of the plan member or provider; and
- The most appropriate level of care that can be safely provided.

Health Homes

Origin

The Affordable Care Act of 2010 gave state Medicaid agencies the option of creating Health Homes to provide a comprehensive system of care coordination for Medicaid individuals with chronic conditions. West Virginia Department of Health and Human Resources, Bureau for Medical Services began planning the implementation of Health Homes in 2011. The program policy was established in WV Medicaid Chapter 535 and utilized to establish KEPRO's utilization guidelines.

Definition

A Health Home is a comprehensive system of care coordination for Medicaid members with chronic conditions. Health Homes Providers will coordinate all primary, acute, behavioral health and long-term services and supports to treat the "whole-person" across his/her lifespan. Since the focus is on the whole-person, all of the member's health care providers are part of his/her treatment team. The goal of the WV Health Homes Initiative is to improve the member's health while reducing medical costs. Patient-centered Health Homes are intended to create a patient-centered system of care that will achieve three (3) main goals established by Centers for Medicare and Medicaid Services (CMS):

- Improve the experience of care,
- Improve the health of the target population, and
- Reduce per capita health care costs.

The Health Homes service delivery concept is a longitudinal "home" that provides members access to an actively coordinated interdisciplinary array of care: medical, behavioral health, community-based social services, and support for children and adults with chronic conditions.

Health Home services require documentation of at least one of the following services per member per month. Health Home providers are to provide services at the intensity and duration needed to stabilize the member's condition.

Comprehensive Care Management includes the development, implementation, and ongoing reassessment of a comprehensive individualized patient-centered care plan for each Health Home member. The care plan's development basis is the information obtained from a comprehensive risk assessment that identifies the member's needs in areas including: medical, mental health, substance abuse/misuse, and social services. The individualized care plan will include integrated services to meet the member's physical health, behavioral health, rehabilitative, long-term care, and social service needs, as indicated.

The care plan will identify the required core Health Home team members as well as other health and health related providers and resources. These include but are not limited to: health, behavioral health, rehabilitation, long-term care and social services depending on an individual member's need. The care plan will also identify community networks and supports needed for comprehensive quality health care. Goals and timeframes for improving the member's health, overall health care status and identified interventions will be included in the care plan, as well as schedules for plan assessment and update.

Comprehensive care management will assure that the member (or legal health representative) is an active team member in the care plan's development, implementation, and assessment, and is informed about and in agreement with plan components. Member's family and other recognized supports will be involved in the member's care as requested by the member. The member will receive a copy of the care plan initially and any time a change is made.

Care Coordination is the delivery of comprehensive, multidisciplinary care to a member that links all involved resources by maintaining and disseminating current, relevant health and care plan data. Care coordination includes managing resource linkages, referrals, coordination, and follow-up to plan-identified resources. Activities include, but are not limited to, appointment scheduling, conducting referrals and follow-up monitoring, participating in facility discharge processes, and communicating with other providers and members/family members.

Health Promotion includes the provision of health education specific to a member's health and behavioral health; development of self-management plans effectively emphasizing the importance of immunizations and preventive screenings; understanding and management of prescribed medications; supporting improvement of social networks; and providing healthy lifestyle interventions. Areas of focus include, but are not limited to, substance use and smoking prevention and cessation, nutritional counseling, weight management, and increasing physical activity.

Health promotion services assist members to participate in the development and implementation of their care plan and emphasize person-centered empowerment to facilitate self-management of chronic health conditions through informed awareness.

Comprehensive Transitional Care and Follow-up is care coordination - designed to prevent avoidable emergency department visits, admissions, and readmission after discharge from an inpatient facility. For each member transferred from one caregiver or site of care to another, the Health Home team ensures proper and timely follow-up care and safe, coordinated transitions, including reconciliation of medications. Through formal relationships and communication systems with health facilities including emergency departments, hospitals, long-term care facilities, residential/rehabilitation settings, as well as with other providers and community-based services, this coordination is accomplished.

Patient and Family Support Services include service provision and resource identification that assist members to attain their highest level of health and functioning. Peer supports, support groups, and self-care programs can be utilized by providers to increase members' and caregivers' knowledge about the member's diseases, promote member engagement and self-management capabilities, while assisting the member to adhere to his/her care plan.

The primary focus of individual and family supports will be strengthened through increased health literacy. This effort will include communicated information that is language, literacy, and culturally appropriate, and designed to improve the member's ability to self-manage their health and participate in the ongoing care planning. Please see Chapter 535 for full information http://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20535%20Health%20Homes/BMS_Health_Homes_Policy.pdf

Authorization/Denial Process

Prior authorization is required for all covered Health Home services. At the time of each Medicaid member's initial enrollment in the WV Health Home Program, the assigned, servicing Health Home Provider must obtain prior authorization for Health Home Service. Assessment data must be submitted via a web application.

Prior authorization for services requires completion of the West Virginia KEPRO – Atrezzo Request and Assessment screens.

To request an authorization:

- The Provider registers with KEPRO to access the submission website at https://atrezzo.kepro.com/Account/Login.aspx
- Health Homes Providers must be approved by the Bureau for Medical Services in order to register with KEPRO.
- The service Provider may then submit the appropriate required information.
- The Provider will be notified electronically via Atrezzo if the request is approved, if additional information is needed to make the decision (pend), if the request for services has been closed for administrative reasons or if the request has been denied.

The Health Homes Program incorporates two (2) service levels to meet each potential member's needs:

1. Level I – Health Homes Standard Service (S0281): The Health Homes membership includes eligibility for services covered by the Health Home Standard Service.

    a. As the standard benefit, the period of authorization for approved requests is four (4) months (four (4) units of service per four-month authorization).
    b. Clinical information may include, but not limited to, hospitalizations, ER utilization, assessment scores, medicine reconciliation and clinical judgment.
    c. Thus, three (3) times during each twelve-month period, it will be necessary to submit information reflecting each member's current condition and situation for reauthorization.
    d. The standard benefit, intended to cover the provision of the six (6) Health Home Services (Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care and Follow-up, Patient and Family Support Services, Referral to Community and Social Support Services) as is required and appropriate to each member's needs.
    e. This periodically submitted data will allow the State to meet the CMS Adult Quality Measures, Health Homes Program Performance Indicators and other reporting requirements.

2. Level II - Health Homes Intensive Service (S0281*TF): This intensive level of service is available for those members determined to require a greater amount of service than that covered under the standard service one (1) time per calendar year (one (1) unit).

    a. It will be necessary for the Provider to submit information reflecting each member's current condition and situation when requesting this intensive level of service. This clinical information may include, but not be limited to, hospitalizations, ER utilization, assessment scores, and clinical judgment documenting a deterioration of the member's condition and crisis situation requiring stabilization.
    b. While the information submitted on the West Virginia KEPRO Atrezzo site is a clinically relevant summary, KEPRO may request additional information to make prior authorization decisions for members who do not clearly meet the UM guidelines for the service.
    c. The assessment, care plans and documentation of services all serve to document the appropriateness and medical necessity of services provided to a member.
    d. In the event the member needs this more intense level of Health Home services, the provider must submit another prior authorization request for this service for approval or denial.

- If the request is approved medically necessary, the authorization for services is documented in Atrezzo.
- If the Level II requires additional information, the Provider will be given three (3) business days to comply and submit.
- Once the additional information is received from the Provider, the KEPRO Director of the Health Homes Program and/or RN Reviewer will review the additional information.
- If the Level II Service is approved medically necessary after additional information review, the authorization for services is documented for Provider use in Atrezzo.
- If, after the additional documentation is received from the Provider and reviewed and still does not meet medical necessity, the request is then sent to the KEPRO Medical Director, who will review for approval/denial decision within 24 hours from the time it was transferred to his/her queue.
- If, after Medical Director Review, the request is approved medically necessary, the Provider will be notified of the decision and the authorization is documented for Provider use in Atrezzo.
- If, after Medical Director Review, the request is denied and does not meet medical necessity, the Provider will be notified of the decision and the Denial letter will be uploaded to Atrezzo for Provider use.
- If the Medical Director denied the service and a second level review is requested, the service request and all the supporting documentation will be sent to a different physician with appropriate credentials.
- If the second physician does not overturn the denial, the provider and member will be notified, outlining the criteria the decision was based upon and information regarding the member's right to a fair hearing.
- In the event a fair hearing is sought by the member, KEPRO will have the required staff available to coordinate and/or participate in the hearing. Any policy/administrative denials issued to Providers and members will indicate the specific policy or administrative reason for the denial and the member's rights to a fair hearing.

Duplication of services by provider(s) is not allowed.

- It is the responsibility of the Provider(s) to coordinate care and to authorize service appropriately.
- For the members served by multiple behavioral and medical health providers, the Health Home Provider will be the lead Provider in service planning and is considered the primary Provider by KEPRO.

Program Recertification

KEPRO is required to recertify Health Home providers annually to ensure to the WV Health Homes provider and program standards are being met. The results of each review will be analyzed; a list of deficiencies documented (if any) and recommendations will be made to BMS regarding the continued certification of the Health Home provider. Plans of correction may be required by the Bureau to improve performance when standards are not met. Recertification for a Provider will be conducted in the following manner:

1. **Prior to Review**

   - Determine Provider Date of Annual Review.
   - Based upon the date of their first admission.
   - 60 Day Notification sent to Provider.
   - 30 Day Notification sent to Provider.
   - 14 Day Notification which includes a list of 10% of total member roster. If, however, the total member roster at the time of Review is less than 100 members, ten (10) member medical records will be reviewed.

2. **Day of the Review**

   - KEPRO staff member meets with the Provider Agency Director to begin to review the recertification process.
   - Review clinical and personnel records.
   - Exit interview/conference with the Health Home Team to discuss early findings.

3. **Post Review and findings: KEPRO finalizes and sends report to BMS for approval or denial**

   - Full Recertification Status: No deficiencies.
   - Recertification was deficient and requires a submission of a plan of correction (POC) with the following recommendations from BMS.
     - The Provider will have 30 Calendar days from receipt of POC to submit to KEPRO WV Health Homes Director or RN Reviewer, with the deficiencies corrected.
     - KEPRO WV Health Homes Director or RN Reviewer to complete review of POC within three (3) business days:
       - If all recommendations were corrected, then Provider will have Full Recertification Status once BMS has approved.

- If recommendations are not met, the POC will be returned to the Provider for completion and resubmitted to KEPRO WV Health Homes Director or RN Reviewer within three (3) business days.
- KEPRO WV Health Homes Director or RN Reviewer completes review within three (3) business days and submit to BMS for approval or denial.

Training and Technical Assistance

KEPRO works with the Bureau for Medical Services (BMS) to ensure Health Home providers have the training, technical assistance and knowledge needed for success. To meet this goal, KEPRO directly provides training, technical assistance, and education through face-to-face, telephonic and electronic means to all enrolled providers. Newly enrolled providers receive a provider orientation within 30 days of their application being approved by BMS. Topics may include utilization management, actual service provision, quality monitoring, policy/procedure updates, documentation standards and/or use of KEPRO's Atrezzo system.

In addition quarterly stakeholder meetings with all health home providers to discuss the implementation, operations, challenges and opportunities are held. The information gathered is analyzed with the Bureau for possible program changes. If at any time, the review criteria are modified it is via the Bureau's direction or with their written approval prior to implementation.

Claims

Reimbursement for Health Home services is a per member per month (PMPM). All claims are billed through the Departments MMIS vendor.

Quality

External

Specific outcome measures are being monitored through a combination of data sources which include the clinical data reported to KEPRO, Medicaid claims and the WV DHHR Data Warehouse. The specific measures are outlined in the State Plan Amendment. The data is reported to CMS at standard intervals.

Internal

For the past 31 years, KEPRO has provided Utilization Management solutions to public and commercial clients. KEPRO represents 52 government and commercial clients nationwide. Serving broad geographical and client market segments enables us to offer the Department best practices from other states and national efforts to healthcare issues and challenges. As an experience and respected Utilization Management organization, KEPRO reviews over 800,000 medical records on an annual basis, using standard procedures to ensure reliability, accuracy, and timeliness.

Helpful Links:

Bureau for Medical Services Main Page
http://www.dhhr.wv.gov/bms/Pages/default.aspx

Bureau for Medical Services Manuals
http://www.dhhr.wv.gov/bms/Pages/Manuals.aspx

KEPRO- West Virginia
http://wvaso.kepro.com

Bureau for Medical Services- MMIS Contacts
http://www.dhhr.wv.gov/bms/Provider/PCPP/Pages/Provider-Information.aspx