2024 Virtual Fall Provider Workshops

Dates and Times - Click the Links To Register!

Tuesday October 22 from 9:00-12:00
https://events.teams.microsoft.com/event/088a8643-6762-4229-8ff9-1c3d4ae54ebc@c663f89c-ef9b-418f-bd3d-41e46c0ce068

Wednesday October 23 from 1:30-4:00
https://events.teams.microsoft.com/event/b4794f81-abe7-41e6-9863-e06052133f81@c663f89c-ef9b-418f-bd3d-41e46c0ce068

Thursday October 24 from 9:00-12:00
https://events.teams.microsoft.com/event/3b81142f-f85a-428d-b819-d0c7bd717f28@c663f89c-ef9b-418f-bd3d-41e46c0ce068

Tuesday October 29 from 1:30-4:00
https://events.teams.microsoft.com/event/3fbe2a59-13b6-46ed-9fd7-384064ab0cc0@c663f89c-ef9b-418f-bd3d-41e46c0ce068

Wednesday October 30 from 9:00-12:00
https://events.teams.microsoft.com/event/863c9802-4285-4863-a3e9-a6003ec2590b@c663f89c-ef9b-418f-bd3d-41e46c0ce068

Thursday October 31 from 1:30-4:00
https://events.teams.microsoft.com/event/f19115f6-7994-4573-843b-925bf265f7d6@c663f89c-ef9b-418f-bd3d-41e46c0ce068

gainwell

Morning Session- Part 1
WV Medicaid, WVCHIP, Gainwell Technologies, Acentra Health, Modivcare, Maximus, Highmark Health Options, United Concordia, The Health Plan, Unicare, SkyGen, Aetna Better Health of WV, and Liberty Dental

Afternoon Session- Part 2
WV Medicaid, WVCHIP, Gainwell Technologies, HMS, Acentra Health, and WV Navigator

Questions?
WVProviderFieldRepresentative@GainwellTechnologies.com

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

Housekeeping Rules For Attendees

Please make sure your phone is on mute.

Please make sure you type your questions in the chat box.

Questions will be answered at the end of the presentation during the Q&A session.

A copy of the presentation is available on the WVMMIS Health PAS-OnLine Portal

www.wvmmis.com

1115 Waiver Update

Presented by:
Keith King, Program Manager
Bureau for Medical Services

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

1115 Waiver Overview

Under Section 1115(a) of the Social Security Act, the Secretary of Health and Human Services has authority to approve a state's requests for waiver compliance with provisions of federal Medicaid law.

1115 Waivers are also known as demonstration waivers, as the 1115 allows states to test and evaluate new services, delivery system reforms and/or innovative approaches to care.

An 1115 Waiver must be:

- Likely to promote the Medicaid program objectives.
- Budget neutral to the federal government. This means that costs under a waiver cannot be more than what the federal costs would have been without the waiver.
- Limited in duration to the period necessary to carry out the demonstration. These waivers are typically approved by federal partners at the Centers for Medicare and Medicaid Services (CMS) for a five-year period, though other durations are possible.

Additionally, states must provide a public process for notice of and comment on proposed demonstration applications and extensions.

1115 Waiver Overview (Cont.)

- Currently, the 1115 Substance Use Disorder (SUD) Waiver Demonstration is in its seventh year, operating under a temporary extension from CMS that is planned to expire on December 31, 2024.
- The State plans to extend its Demonstration for another five years. The State is currently in renewal negotiations with federal partners.
- The anticipated effective date of the renewal 1115 is **January 1, 2025.**
- The proposed renewed and expanded waiver is titled *"Evolving West Virginia Medicaid's Behavioral Health Continuum of Care."*
- The renewed waiver intends to authorize additional services for the SUD population, as well as services for individuals with Serious Mental Illness (SMI).

Proposed 1115 Waiver Services

Proposed New 1115 Waiver Services	Population Served
Pre-Release Services for Justice Involved Individuals	SUD
Supported Housing Services	SUD
Recovery Related Support Services (formally Supportive Employment)	SUD
Quick Response Team (QRTs)	SUD

Proposed 1115 Waiver Descriptions

- **Pre-Release Services for Justice-Involved Individuals with SUD:** Provides Medicaid coverage 90 days prior to release to help ensure a smooth transition to community settings with continued healthcare coverage.
- **Supported Housing Services:** Will ensure recovering individuals can obtain stable housing as they transition back into community settings.
- **Recovery Related Support Services:** Will support recovering individuals as they seek employment or and/or other meaningful work or volunteer activities.
- **Quick Response Teams:** Multidisciplinary provider team contacts an individual 24 to 72 hours after an overdose event or substance use-related emergency, providing support to the individual and their family and reducing barriers to treatment.

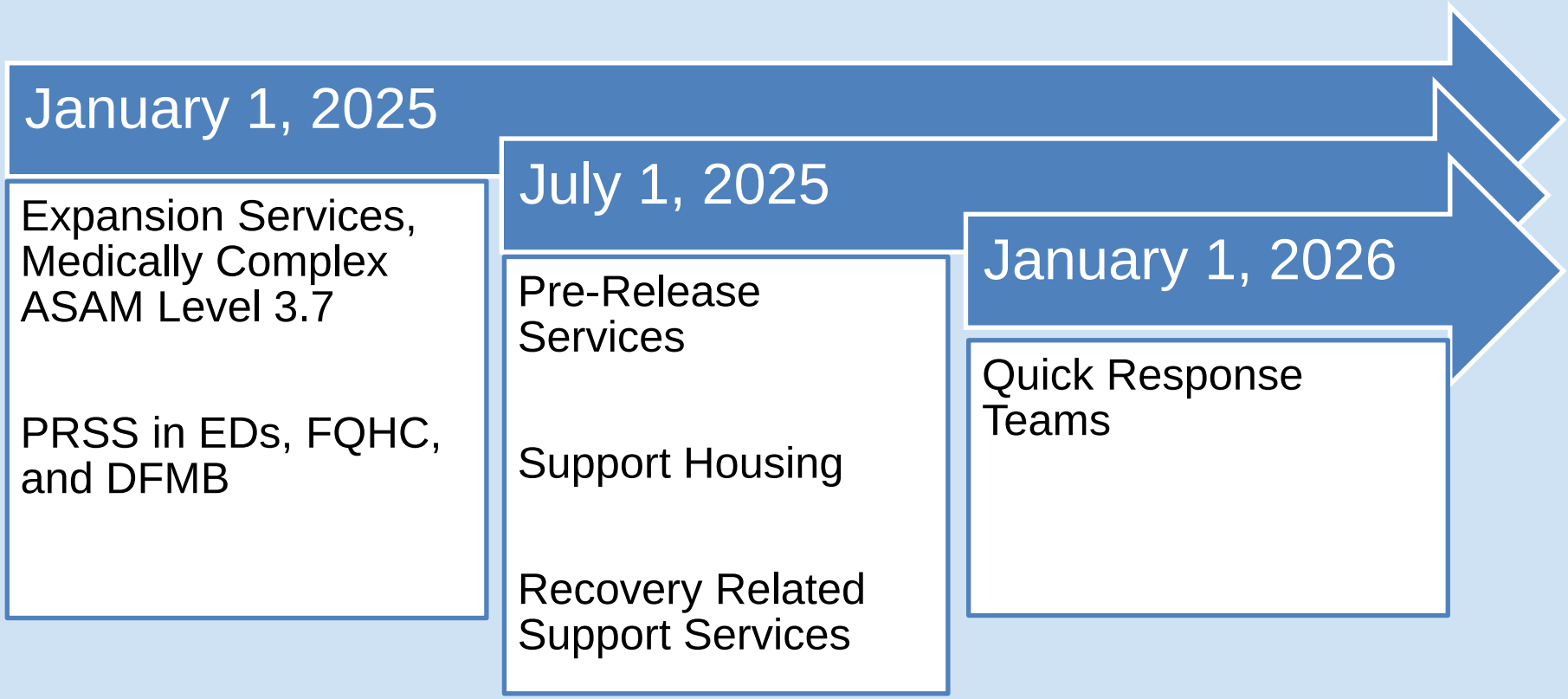
1115 Waiver Expansion Services

WV BMS is expanding two of its current services under the 1115 Waiver

- Expansion of residential level 3.7 to accommodate medically complex individuals.

- Expansion of Peer Recovery Support Services (PRSS) to Emergency Departments (ED), Federally Qualified Health Centers (FQHC) and the Drug Free Moms and Babies Program (DFMB).

Proposed 1115 Waiver Timeline



Medicaid QRT implementation will start July 1, 2026.

All dates are subject to change based on approval from CMS.

American Society of Addiction Medicine (ASAM) Update

American Society of Addiction Medicine Update

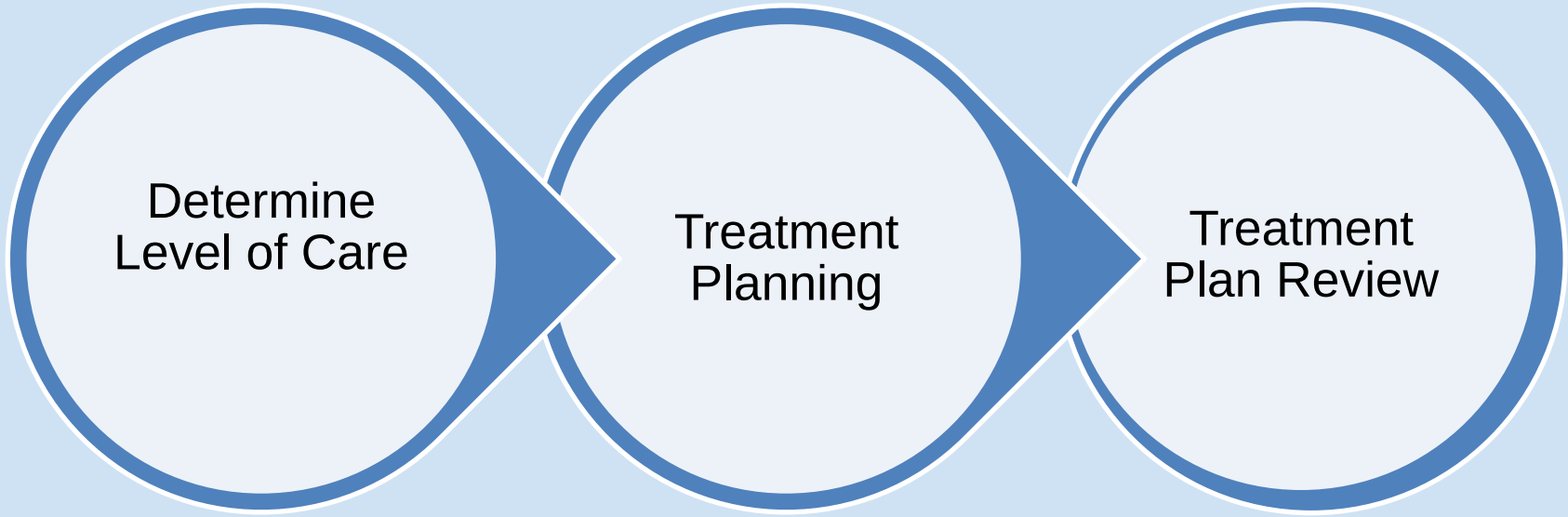
- The American Society of Addiction Medicine (ASAM) is a nationally recognized set of standards used to determine SUD treatment, placement, continued stay and discharge. It is a strength-based multidimensional assessment that considers a member's needs, obstacles and liabilities who struggle with SUD.

- The fourth edition of ASAM was published in late November 2023.

- The fourth edition has numerous changes to the dimensional assessment and treatment planning, the continuum of care, and services and expands on early intervention and recovery support services.

ASAM Update (Cont.)

An ASAM Assessment has three primary goals:



ASAM New Dimensions

New Fourth Edition Dimension	Previous Third Edition Dimension
1. Intoxication, Withdrawal, and Addiction Medicine	1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions	2. Biomedical Conditions and Complications
3. Psychiatric and Cognitive Conditions	3. Emotional, Behavioral, or Cognitive Conditions and Complications
4. Substance Use-Related Risks	4. Readiness to Change
5. Recovery Environment Interactions	5. Relapse, Continued Use or Continued Problem Potential
6. Person-Centered Consideration	6. Recovery/Living Environment

ASAM Dimensions (Cont.)

Dimension 1: Intoxication, Withdrawal, and Addiction Medication

- Intoxication with risk of overdoses
- Severity and anticipated peak withdrawal symptoms
- Assess the need for addiction medicine and Medication-Assisted Treatment

Dimension 2: Biomedical Conditions

- All physical health issues
- Determine any relationship between substance use and comorbid physical problems
- Identify needs that need to be medically managed
- Pregnancy related concerns

ASAM Dimensions (Cont.)

Dimension 3: Psychiatric and Cognitive Conditions:

- Assessing for co-occurring mental health disorders

Dimension 4: Substance Use-Related Risks:

  - Severity of risky behavior
- Likelihood of risky behavior

Dimension 5: Recovery Environment Interactions:

- The ability to function in their current environment
- Safety
- Support

Dimension 6: Person-Centered Consideration:

- Shared decision making
- Patient's preference
- Barrier to access

ASAM Update – Levels of Care Cont.

Co-Occurring Capable (COC)

- Provide symptoms management of both the SUD and MH components in the person's treatment
- Have at least one staff to assess and triage mental health conditions
- Program content should address both conditions

Co-Occurring Enhanced Services (COE)

- COE should have a supportive environment for individuals with serious mental health conditions including those who may experience significant active or unstable symptoms or significant functional impairment/disability
- Psychiatric management with skilled mental health interventions

ASAM Levels of Care

ASAM Level			
Level 1: Outpatient	1.0 Long Term Remission Monitoring	1.5 Outpatient Therapy (COE)	1.7 Medically Managed Outpatient (COE)
Level 2: IOP/HIOP	2.1 Intensive Outpatient (IOP)(COC)	2.5 High-Intensity Outpatient (HIOP) (COE)	2.7 Medically Managed Intensive Outpatient (COE)
Level 3: Residential	3.1 Clinically Managed Low-Intensity Residential (COC)	3.5 Clinically Managed High Intensity Residential (COE)	3.7 Medically Managed Residential (COE and BIO)
Level 4: Inpatient			4.0 Medically Managed Inpatient

ASAM Update – Levels of Care Cont.

Level of Care	Primary Focus	Hours of Clinical Services.
Level 1.0	Recovery management checkups	Quarterly services
Level 1.5	Outpatient therapy	Less than 9 hours per week
Level 1.7	Outpatient medical management, plus psychosocial services	Less than 9 hours per week
Level 2.1	Counseling, therapeutic milieu and psychotherapy as needed	9-19 hours per week
Level 2.5	Psychotherapy, counseling, therapeutic milieu	20 + hours, 5+ days a week
Level 2.7	Daily or near daily medical management with extended nurse monitoring plus psychosocial services	20+ hours, 6+ days a week
Level 3.1	Low intensity residential services	9-19 hours a week
Level 3.5	High intensity residential services	20+ hours a week
Level 3.7	Daily medical management with 24/7 nursing care	20+ hours a week
Level 4	Acute hospital care	As needed

ASAM Update – Levels of Care Cont.

Clinically managed level of care:	Medically managed levels of care:
Level 1.5 Outpatient Therapy	**Level 1.7** Medically Managed Outpatient Treatment
Level 2.1 Intensive Outpatient Treatment	**Level 2.7** Medically Managed Intensive Outpatient Treatment
Level 2.5 High Intensity Outpatient Treatment	**Level 3.7** Medically Managed Residential Treatment
Level 3.1 Clinically Managed Low-Intensity Residential Treatment	**Level 4** Medically Managed Inpatient Treatment
Level 3.5 Clinically Managed High-Intensity Residential Treatment	

ASAM Update – Levels of Care Cont.

All levels must:

- Have overdose reversal medication
- Withdraw management with all level of care
- Have to evaluate the need for MAT
- Have to evaluate harm reduction methods
- At least be COC, and some must be COE
- Must be able to incorporate special needs populations
- Should have trauma-sensitive practices
- Should incorporate Nicotine Replacement Therapy

New ASAM, When does this start?

- You can start using the new dimensional assessment now and help new personnel become familiarized and trained with the new dimensional process.

- ASAM is coming out with new guidelines for adolescents, justice-involved individuals and behavioral addiction sometime in the future.

- BMS will start using the new ASAM residential criteria July 1, 2025.

SUD Residential Service Reminder

- Senate Bill 805
- https://www.wvlegislature.gov/Bill_Text_HTML/2024_SESSIONS/RS/bills/sb805%20sub1%20eng.pdf

- This bill requires all SUD Residential facilities to be accredited by the Commission on Accreditation of Rehabilitation Facilities International (CARF), the Joint Commission, or Det Norske Veritas (DNV) by January 1, 2026.

Contact

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1115 Waiver Program Manager
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350 Capitol Street, Room 251
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Fax: (304) 558-4398
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Certified Community Behavioral Health Clinics

Keli Mallory
Program and Grants Manager
Bureau for Medical Services

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

Overview

What are Certified Community Behavioral Health Clinics (CCBHCs)?

- CCBHCs are designed to ensure access to coordinated comprehensive behavioral health care.
- CCBHCs are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age, including developmentally appropriate care for children and youth.
- CCBHCs must meet standards for the range of services they provide and are required to get people into care quickly. An important feature of the CCBHC model is that it requires crisis services to be available 24 hours a day, seven days a week.
- CCBHCs are required to provide a comprehensive array of behavioral health services so that people who need care are not caught trying to piece together the behavioral health support they need across multiple providers.
- CCBHCs must provide care coordination to help people navigate behavioral health care, physical health care, social services, and other systems.

Goals

CCBHCs have the following goals:

- To provide integrated healthcare services that are evidence-based, trauma-informed, recovery-oriented, and person-and-family-centered across a continuum of care throughout the lifespan of the individual.
- To increase access to services by offering a comprehensive range of mental health, substance use disorder (SUD), and primary care screening and monitoring services.
- To maintain and expand upon established collaborative relationships with other service providers and healthcare systems to promote effective coordination of care.

Required Services

- Crisis services
- Treatment planning
- Screening, assessment, diagnosis, and risk assessment
- Outpatient mental health and substance use services
- Targeted case management
- Outpatient primary care screening and monitoring
- Community-based mental healthcare for veterans
- Peer, family support, and counselor services
- Psychiatric rehabilitation services
- West Virginia requires all CCBHCs to provide Children with Serious Emotional Disorder Waiver (CSEDW) services and Assertive Community Treatment (ACT) services

Who Can Apply?

CCBHCs must be non-profit, licensed behavioral health clinics (LBHCs) and meet applicable organizational, staff licensure, and CCBHC certification requirements as defined by the West Virginia Department of Human Services (DoHS).

- Agencies can apply beginning October 1, 2024.
- After review of the application, a site visit will be conducted. Agencies will then receive a letter of their approval/denial.
- Agencies can also be decertified at any time.
- The CCBHC will be provider type 93 with a specialty of W2. This will be a provider type with the managed care organizations (MCOs).
- Six agencies have applied and are now certified CCBHCs:
    - FMRS
    - Seneca
    - Prestera
    - Southern Highlands
    - Westbrook
    - Valley

Contact

Keli Mallory, Program and Grants Manager
West Virginia Department of Human Services
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301
Phone: (304) 352-4230
Fax: (304) 558-4398
Email: Keli.J.Mallory@wv.gov

2024 Fall Provider Workshops

Medicaid, WVCHIP, and Gainwell Technologies

gainwell

WV Nursing Facility Reimbursement Transition to Patient-Driven Payment Model (PDPM)

Effective October 1, 2024, nursing home reimbursement will transition to the Patient-Driven Payment Model (PDPM) methodology. The AAA Resource Utilization Group (RUG) scores that were previously utilized will no longer be accepted for nursing services rendered for dates of service October 1, 2024 and after. Services rendered prior to October 1, 2024, will still be billed with the previous AAA (RUGGS) scores.

Please note that there is also a change for bed hold procedures. Effective October 1,2024 all covered bed holds should be billed through 0185. Revenue 0183 should no longer be utilized. See the updated Provider Manual for additional details: Chapter 514 Nursing Facility Services (wv.gov)

Transition to Patient-Driven Payment Model (PDPM)

The following bill type, revenue codes, and the Health Insurance Prospective Payment System (HIPPS) codes must be billed in order to receive appropriate payment for services provided:

- Bill Type 021X
- Revenue Code 0190 is the room and board (fixed portion of the rate)
- Revenue Code 0550 in skilled nursing (nursing portion of the rate) and must have HIPPS/PDPM code attached
  - For dates of service after October 1, 2024
  - HIPPS/PDPM Codes must be complete and include all 5 characters to be accepted and adjudicated by the State's Medicaid Management Information System (MMIS). If your calculated HIPPS code is 4 characters, a 5th character, "0" must be entered at the end
  - HIPPS/PDPM Code ZZZZZ is to identify there is no Minimum Data Set (MDS) available
- Revenue Code 0189 is the non-covered leave of absence
- Revenue Code 0185 is the covered bed hold leave of absence

Transition to Patient-Driven Payment Model (PDPM)

PDPM Case-Mix Indices

Table 5 of the Medicare FFY 2024 Final Rule

Effective for WV Rates as of October 1, 2024

Nursing HIPPS Code	CMI Classification	Nursing CMI
A	ES3	3.84
B	ES2	2.90
C	ES1	2.77
D	HDE2	2.27
E	HDE1	1.88
F	HBC2	2.12
G	HBC1	1.76
H	LDE2	1.97
I	LDE1	1.64
J	LBC2	1.63
K	LBC1	1.35
L	CDE2	1.77
M	CDE1	1.53
N	CBC2	1.47
O	CA2	1.03
P	CBC1	1.27
Q	CA1	0.89
R	BAB2	0.98
S	BAB1	0.94
T	PDE2	1.48
U	PDE1	1.39
V	PBC2	1.15
W	PA2	0.67
X	PBC1	1.07
Y	PA1	0.62

Transition to Patient-Driven Payment Model (PDPM)

Frequently Asked Questions

Q: Can you tell me what changes on the UB04 will need to occur for your state? For example: What revenue codes will be shown?

A: Revenue codes will be the same and the AAAXX code will be the PDPM code moving forward.

Q: Based on the testing rates provided, is it correct in saying that your state will base their reimbursement on only the Nursing component and the Non-Case Mix?

A: Yes, that is correct.

Q: Are we continuing to use the standard Omnibus Budget Reconciliation Act (OBRA) schedule?

A:There should be no changes to scheduling or any other changes outside of the new PDPM calculation methodology.

Transition to Patient-Driven Payment Model (PDPM)

Frequently Asked Questions

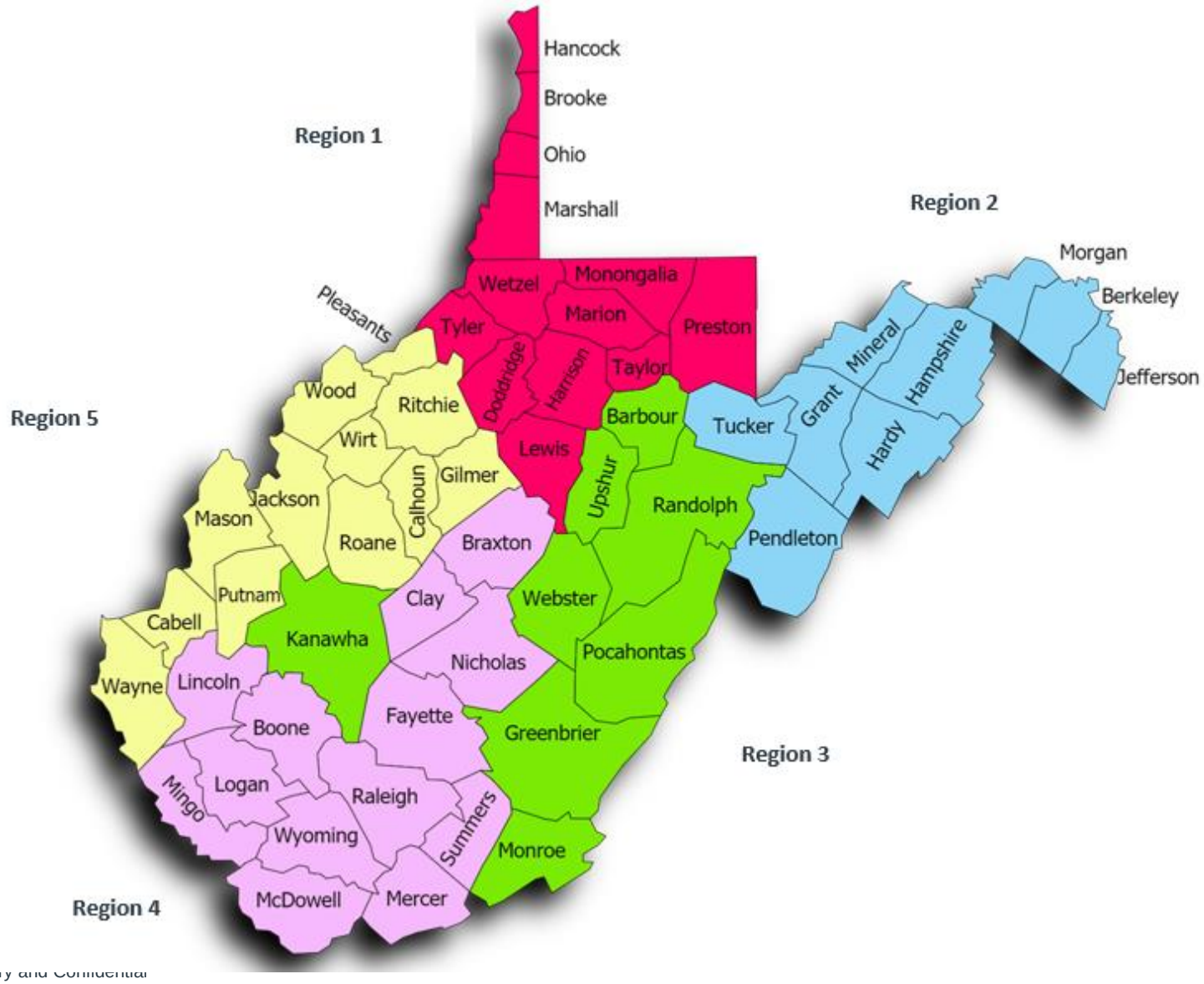
Q: Are there penalties for late or early assessments, i.e. ZZZZZ billing for number of days late?

A: There are no changes to the current policy for late submission.

Q: Is WV still billing assessments on a 3-month basis?

A: Yes, the assessment schedule is the same.

Provider Field Representative Map



Provider Field Representatives

Region 1 Representatives
Interim Coverage:
Brandon Treola btreola@GainwellTechnologies.com
WVU: Katrena Edens kedens@GainwellTechnologies.com
Whitney Choyce wchoyce@GainwellTechnologies.com
Region 2 Representative
Brandon Treola btreola@GainwellTechnologies.com

Region 3 Representatives
Katrena Edens kedens@GainwellTechnologies.com
Michelle Ramsey mmiller222@GainwellTechnologies.com

Region 4 Representative
Stephanie Houghtaling shoughtaling@GainwellTechnologies.com

Region 5 Representative
Whitney Choyce wchoyce@GainwellTechnologies.com


Time for
a break

West Virginia HMS, a Gainwell Technologies Company

Fall Provider Workshop

2024

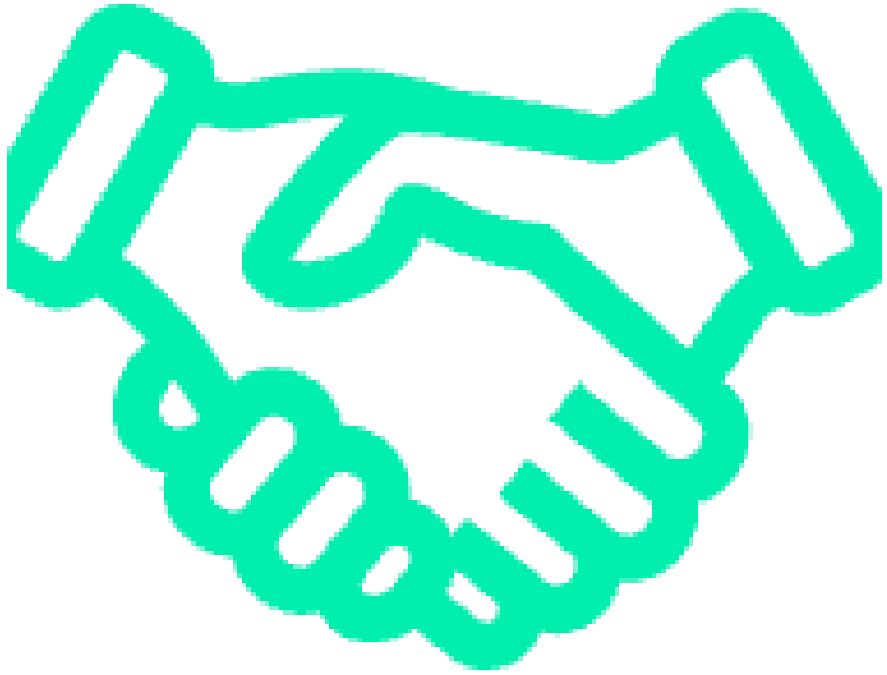
A Gainwell Technologies Company

Agenda

1. HMS, a Gainwell Technologies Introduction
2. HMS Provider Services Overview
   - Third Party Liability (TPL) Services versus Recovery Audit Contract (RAC) Services
3. Payment Analytics Overview
   - High Level Process Overview
   - Provider Notifications and Responses
   - Appeals
   - Contact Information
4. Disallowance Reviews Overview
   - High Level Process Overview
   - Provider Notification and Responses
   - Refund Requests
   - Contact Information

HMS, a Gainwell Technologies Company Introduction

- Health Management Systems (HMS), a Gainwell Technologies Company, is contracted by the State of West Virginia, Department of Human Services (DoHS), Bureau for Medical Services (BMS) to provide a full range of third-party liability (TPL) services.
- HMS has worked with West Virginia providers since 2007 and has worked with over 7,708 providers.
- HMS was awarded WV RAC services in 2021. Payment Analytics was the initial service implemented under RAC in WV, with first letter mailing in September 2022.



HMS Provider Services in WV

HMS works with the provider community via two distinct service offerings; Disallowance TPL Billings and the Recovery Audit Contract Program

Both services operate out of our Provider Portal. Should you not elect to utilize the portal, paper mailings are then sent

Although these programs have similar processes and platforms, it’s important to note they are two unique programs with different target outcomes

Payment Analytics Process

Identifies claims improperly billed, coded, or paid according to regulatory, policy, contractual and industry rules

HMS executes proprietary rules engine against paid claim data to identify improper payments

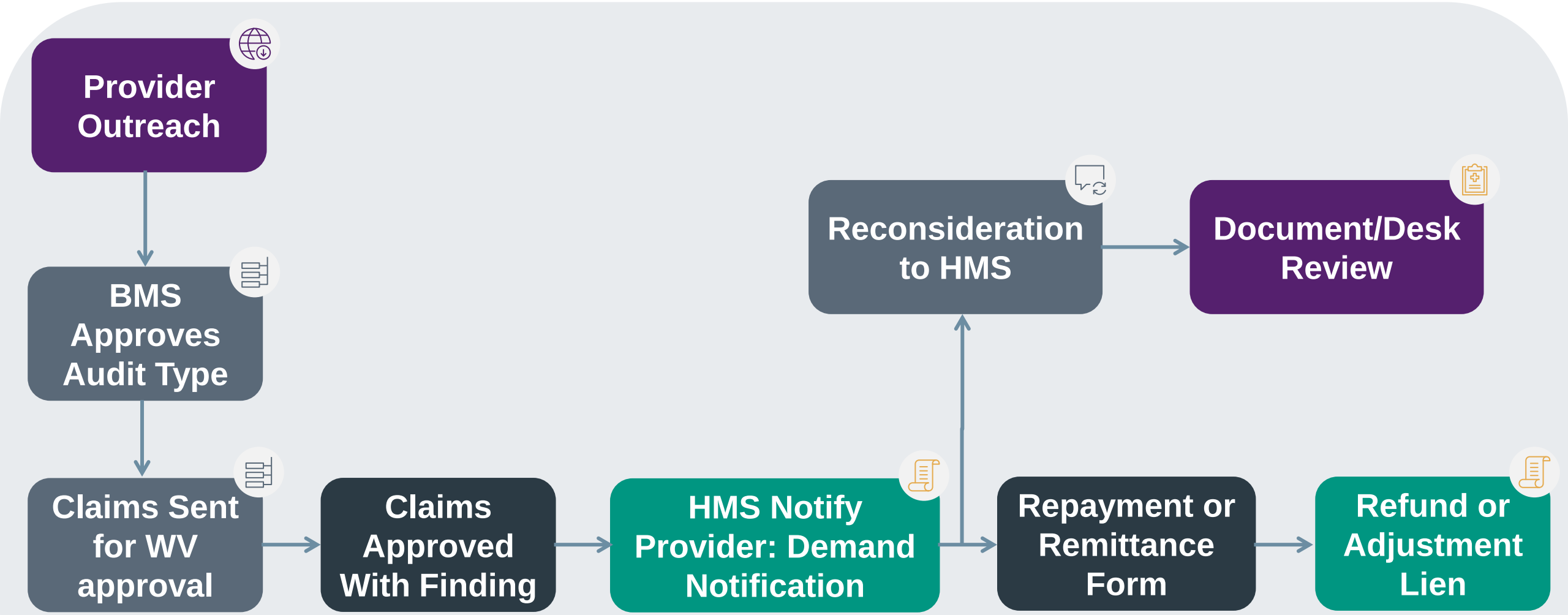
Medical record is not required to determine an inappropriate payment – identification occurs by comparing rules to claim data elements

HMS proprietary rules engine is configured with rules customized to WV Medicaid specific policy and direction

WV Medicaid approves each improper payment type prior to any RAC activity being initiated

The findings from this analysis are reported to West Virginia Medicaid, along with recommendations regarding proper payment of the claim.

Overview of RAC Audit Process – Payment Analytics



Overview of RAC Audit Process – Payment Analytics

Audit Process:

- Demand Notification letter will be mailed to provider with HMS reconsideration instruction
- If the HMS reconsideration is upheld, you have the option to request a Document/Desk review with BMS within 30 days
- Providers will have 30 days to submit a reconsideration to HMS if they disagree
- If you submit a refund check, you are required to include the Remittance Form attached to the refund check
- If providers agree with the finding, you have the option to request a lien, refund the overpayment to BMS, or request other options for lien and payment
- If you do not submit a refund check or request a repayment plan, and agree with the finding, the claim will be offset. If you agree and wish to request a repayment plan, you must notify BMS within 30 days of the HMS Demand Notification or your claim will be offset (lien)

Reconsideration Process

Option will be provided to rebut a RAC finding. If a rebuttal is submitted, HMS will respond to you in writing with an uphold or overturn decision

If you disagree with the uphold decision, the Reconsideration Uphold letter will provide instructions to request a Document/Desk review within 30 days of receipt of the determination

Providers are encouraged to call HMS Provider Relations (866-765-7416) to discuss and resolve issues

Document/Desk Review

- Instructions will be included in the Reconsideration Uphold Letter
- Request for a Document/Desk Review must be received within 30 days of the Reconsideration Uphold Letter
- Submit to:

  Bureau for Medical Services

  Legal Department – Document Desk Review

  350 Capitol Street, Room 251

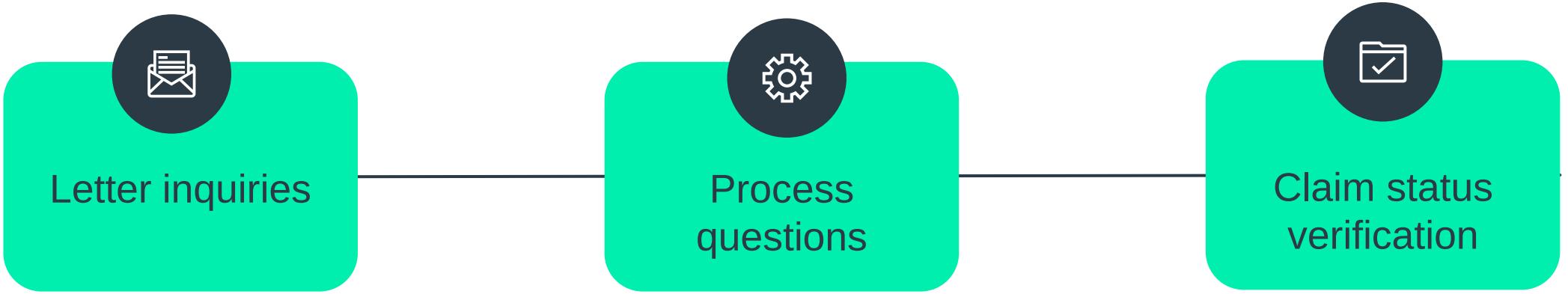
  Charleston, WV 25301-3706

RAC Provider Support

HMS Provider Relations Line **866-765-7416**

HMS Provider Portal **https://hmsportal.hms.com/**

WV Medicaid **304-558-1700**

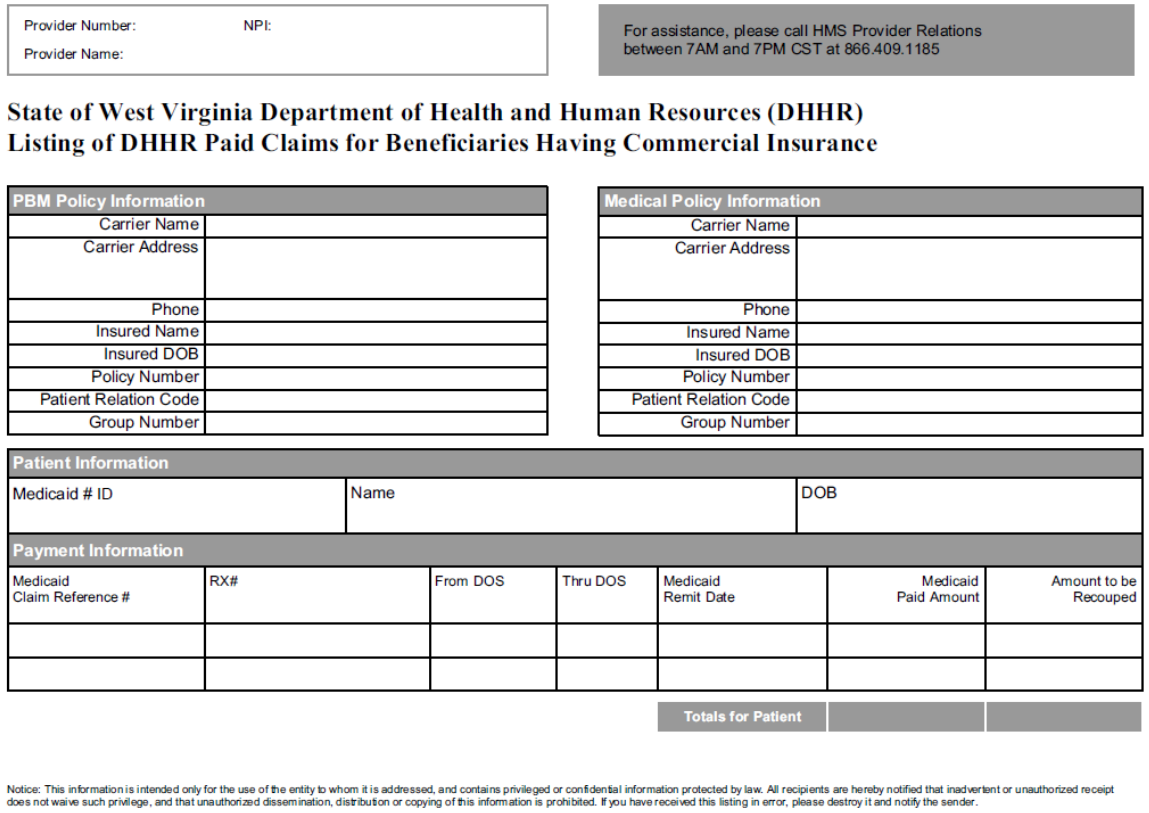


What is a Provider Disallowance Billing Cycle?

- Opportunity for Commercial Insurance Payment
- Fee For Service (FFS) Claims
- Members HMS identified with Other Healthcare Coverage (OHC)
  - Commercial Insurance (CID)
  - Medicare Part A (MCA) – Hospitals
  - Medicare Part B (MCB) – Supplemental
- Specific Provider Types
- Specific Claim types
- Applied Thresholds
- Sensitive Population Omitted

Cycle Notification Process

Claim Selection → Create Provider Billing Listing → Provider Billing Notice via Portal or Mail → Verify Receipt → Monitor & Work Documentation



Provider Number: NPI:
Provider Name:

For assistance, please call HMS Provider Relations between 7AM and 7PM CST at 866.409.1185

State of West Virginia Department of Health and Human Resources (DHHR)
Listing of DHHR Paid Claims for Beneficiaries Having Commercial Insurance

PBM Policy Information	
Carrier Name	
Carrier Address	
Phone	
Insured Name	
Insured DOB	
Policy Number	
Patient Relation Code	
Group Number	

Medical Policy Information	
Carrier Name	
Carrier Address	
Phone	
Insured Name	
Insured DOB	
Policy Number	
Patient Relation Code	
Group Number	

Patient Information		
Medicaid # ID	Name	DOB

Payment Information						
Medicaid Claim Reference #	RX#	From DOS	Thru DOS	Medicaid Remit Date	Medicaid Paid Amount	Amount to be Recouped
				Totals for Patient		

Notice: This information is intended only for the use of the entity to whom it is addressed, and contains privileged or confidential information protected by law. All recipients are hereby notified that inadvertent or unauthorized receipt does not waive such privilege, and that unauthorized dissemination, distribution or copying of this information is prohibited. If you have received this listing in error, please destroy it and notify the sender.

Provider Cycle Responses

- Commercial and Medicare Part A Cycles are released quarterly
- Medicare Part B and Pharmacy Cycles are released bi-monthly
- Response 60 Days from Letter Date
  - Loaded in portal with email notification – preferred method
  - Alternative options - fax, mail, email
  - Documentation should be uploaded to Portal as a PDF
- Extensions
  - Reviewed on case-by-case basis

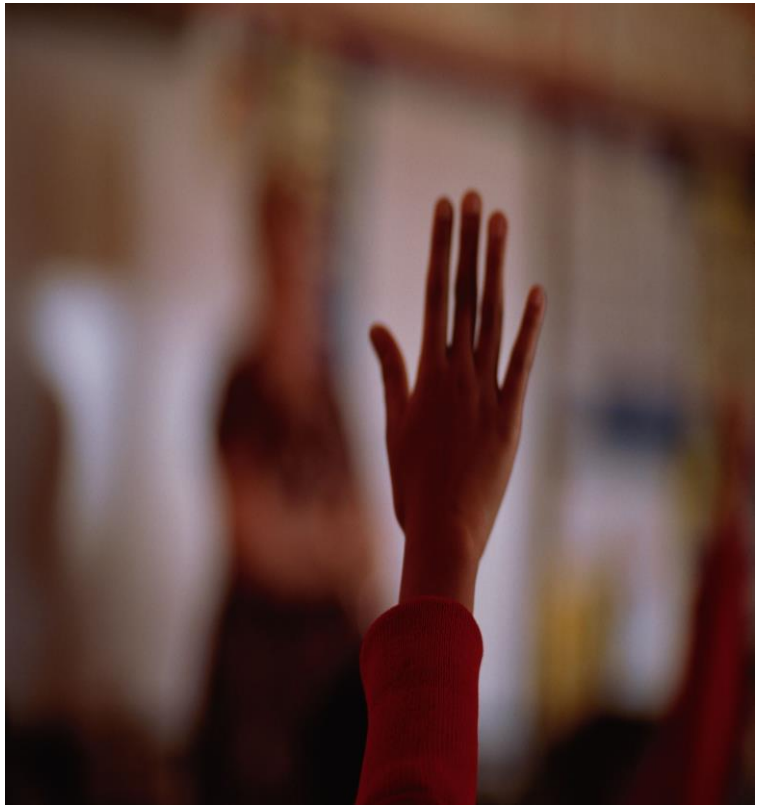
Refund Requests

- In instances where documentation from the carrier is received after the cycle has closed and a recoupment has occurred, providers may submit a refund request
- HMS will review refund requests on BMS's behalf and prepare a packet for their review/approval
  - Refund requests should be submitted to the HMS Provider Relations team for processing
  - A copy of the carrier denial along with proof of recoupment is required for processing

Provider Portal Features

- HMS created and maintains a **Frequently Asked Question (FAQ)** section within the Portal
- **Automatically** receive claim listings on the dates on which we would otherwise mail the listings
- **Manage contact information** by changing addresses and points of contact in real-time
- **Communicate** with the HMS Provider Relations team and directly upload documentation

Disallowance Provider Support



HMS Portal:

https://hmsportal.hms.com

HMS Portal Registration Assistance: (855) 554-6748;
hmsppuserverification@gainwelltechnologies.com

HMS Provider Relations: (866) 409-1185;

Fax: 877-256-1226

prdoc@gainwelltechnologies.com

Thank you

Contact

WVAccountManagement@gainwelltechnologies.com

2024 FALL PROVIDER WORKSHOPS

NAVIGATORS AND MARKETPLACE INSURANCE

WV NAVIGATOR

FIRST CHOICE SERVICES

FCS began in 1999. We've grown from two staff members, one program, and 500 calls per year to over 175 staff members, 15 programs, and 180,000 calls per year!

FIRST CHOICE SERVICES

THERE'S A HELPLINE FOR THAT!

Children's Crisis & Referral Line
(844)HELP 4 WV

West Virginia TOBACCO QUITLINE
1-800-QUIT-NOW 1-877-966-8784

988 SUICIDE & CRISIS LIFELINE

FIRST CHOICE PEERS

1-800-GAMBLER
WV'S PROBLEM GAMBLING HELP NETWORK

West Virginia Crisis Intervention Team

844 HELP 4 WV
WV's Addiction & Mental Health Helpline

Jobs & Hope West Virginia

WHAT IS WV NAVIGATOR?

- FREE, federally grant funded program
- Provides health insurance enrollment assistance for the Health Insurance Marketplace, Medicaid, and the Children's Health Insurance Program (CHIP)
- Helps consumers review plans so they can ensure they are enrolling in the plan that is best for them
- Can assist people over the phone, via telehealth, or in-person at one of our 5 offices across the state (with a new office in Beckley)
- Participates in events across the state to provide in-person assistance

REASONS TO WORK WITH A NAVIGATOR

- Health insurance is confusing!
- People are more likely to enroll in the marketplace coverage if they have someone to help them with the enrollment process.
- Navigators can help people maintain health coverage when their Medicaid coverage ends.
- Navigators provide unbiased information about the health plans that are available.
- Coverage to Care – Navigators offer follow-up throughout the year to ensure clients understand their benefits and they don’t have any barriers to accessing quality healthcare.

WV CARRIERS

CareSource®

HIGHMARK® West Virginia

MARKETPLACE COVERAGE

- The Health Insurance Marketplace provides health insurance shopping and enrollment services for individuals and families
- Marketplace determines eligibility for:
  - Coverage in Marketplace plans
  - Advance payments of the premium tax credit
  - Cost-sharing reductions to lower out-of-pocket costs
  - Medicaid and CHIP

WHO'S ELIGIBLE FOR MARKETPLACE COVERAGE?

- You must:
  - Live in the United States in a state served by the Marketplace
  - Be a US citizen, US national, or lawfully present immigrant (and expected to be for the entire time coverage is sought)
  - Not be incarcerated (unless pending disposition of charges)

ADVANCED PREMIUM TAX CREDITS (APTC)

- Consumers who aren't eligible for other qualifying coverage, like through a job, Medicare, Medicaid, or CHIP, may be eligible.
- The amount of Premium Tax Credit depends on the household income.
- The APTC is reconciled when a consumer files their taxes.
  - If the income is more than reported on the application, the consumer may have to pay back some of the APTC they received.
  - It's very important that consumers report any income or household changes throughout the year.

COST SHARING REDUCTIONS (CSR)

- Lower out-of-pocket costs on deductibles, copayments, and coinsurance
- To be eligible, you must:
  - Have income at or below 250% of the federal poverty level (FPL)
  - Be eligible for advance payments of the premium tax credit
  - Enroll in a Marketplace Silver level plan

COST-SHARING EXAMPLES

Single, 35-year-old Female:

Income	APTC	Premium	Deductible	OOP Max	Dr. Copay
$20,200	$813	$0	$300	$800	$0
$25,000	$785	$26.70	$1,000	$2,800	$5
$30,000*	$743	$68.70	$6,000	$7,250	$25
$35,000*	$688	$123.70	$6,500	$9,100	$30

*$0 premium plan is also available with $3,800 deductible, a $9,100 OOP max, and $65 copay

PLANS MORE AFFORDABLE THAN EVER

- As part of the American Rescue Plan, subsidies were greatly increased, making plans more affordable than ever
- Higher income earners now also qualify for subsidies
- These changes were recently continued through 2025 as part of the Inflation Reduction Act

FAMILY COVERAGE WITH EMPLOYER INSURANCE

- What happens if you have an offer of health coverage from your or a spouse's job?
  - If the cost of insurance through your or your spouse's employer is more than 9.02% of your household income, you now qualify for Advanced Premium Tax Credits on the Marketplace.
  - The cost through your employer may be affordable for you, but not for your family. If so, your family would qualify for the Advanced Premium Tax Credits.

WHEN CAN YOU ENROLL?

- During the annual Open Enrollment Period
  - Open Enrollment is **November 1, 2024 through January 15, 2025**
    - For January 1st coverage, enroll by December 15th
- During a Special Enrollment Period
  - Changes in your household: marriage; added a dependent; divorce
  - Moved from a different state
  - Lost your health insurance in the past 60 days
- If you are below 150% FPL, you can enroll at any time
- If you're a member of a federally recognized Indian tribe or Alaska native shareholder, you can enroll once per month
- Anytime you become ineligible for Medicaid or CHIP

SPECIAL ENROLLMENT PERIODS WHEN LOSING MEDICAID/CHIP

- Special Enrollment Period for anyone who lost Medicaid since April 2023 through November 2024
- Starting December, consumers have **90 days** after losing Medicaid or CHIP coverage to enroll via a Special Enrollment Period

HOW IT WORKS

- Call 304-356-5834 to schedule an appointment or to receive immediate assistance
- Have the following information ready for your appointment:
  - Dates of birth and social security numbers for everyone in the household
  - Yearly income information for the household
  - Names of your doctors
  - List of prescriptions

HOW TO REFER PATIENTS TO WV NAVIGATOR

- Contact us to:
  - Receive business cards or flyers to hand out to patients
  - Set up an enrollment event where a navigator will come and provide one-on-one enrollment assistance with your patients

WV NAVIGATOR

844-WV-CARES
304-356-5834

WVNAVIGATOR.COM

NBAILEY@FIRSTCHOICESERVICES.ORG

Fall 2024 Provider Workshops, Afternoon Session

Service Planning Brief Overview

Christy Gallaher, MA, AADC, Licensed Psychologist

Behavioral Health/Substance Use Disorder Team Leader

Agenda

- Introduction to Acentra Health
- Review Medical Necessity Criteria
- Treatment Strategy versus Service Planning
- Discuss Key Service Planning Components
- Review Service Planning Timelines

Acentra Health: Bureau for Medical Services Utilization Management Contractor

Acentra Health was founded when CNSI merged with Kepro in December 2022. Headquartered in McLean, Virginia, the combined company helps government-sponsored healthcare agencies and payers expand healthcare access, enhance quality, improve health outcomes, and lower costs through clinical services, provider management, health claims and encounter processing, data interoperability, and health analytics services and solutions.

Medical Necessity

All Substance Use Disorder Waiver services are subject to medical necessity determination defined as services and supplies that are:

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

The following five factors are included in medical necessity determination:

- Diagnosis
- Level of functioning
- Evidence of clinical stability
- Available support system
- Service is the appropriate level of care

Focused Care Requires a Treatment Strategy

- Members determined to have a behavioral health disorder which may be addressed through the low frequency of professional treatment services.
- Treatment team consists of the professional and the member and/or member's designated legal representative who establish a treatment strategy.
- The provider must develop a treatment strategy that relates directly to the behavioral health condition(s) identified as being medically necessary to treat.
- No formal Service Plan Team Meeting (H0032) required, and that service may not be authorized or billed.
- Example Treatment Strategy: "Ima will learn ways to manage her anxiety during weekly Individual Therapy sessions."

Coordinated Care Requires Service Planning

- Members who have severe and/or chronic behavioral health conditions that necessitate a team approach to provide medically necessary services.
- Available for Licensed Behavioral Health Centers.
- Treatment is usually provided on a more intensive basis (i.e., several times per week, if not daily).
- Team consists of personnel ranging from paraprofessionals through psychiatrists in providing care.
- Member is likely to have a case manager who is responsible for coordinating and facilitating care.
  - Not necessarily referencing Targeted Case Management services but rather someone who is coordinating care.
- Coordinated Care members must have a Service Plan that “coordinates” the team approach to care.

Recovery Plan for Peer Recovery Support Services

- If clinical services have been terminated but recovery services continue, a recovery plan/strategy is developed to reflect recovery goals and objectives.

- This should include:
  - determining wellness markers
  - recognizing triggers
  - determining warning signs
  - managing crisis

- Peer Recovery Support Specialist (PRSS) should be able to recognize signs of relapse and assist in making appropriate referrals to clinical services if relapse occurs.

- This recovery plan must be signed by the member, the Peer Recovery Support Specialist and their immediate supervisor (Master's level) and reviewed/updated on a 90-day basis.

Why Develop Service Plans?

Outcomes	Promote positive outcomes for the member
Guidance	Guide the member and all service providers through the course of treatment
Measure	Measure success/failure against a standard
Document	Provide a means for documentation
Inform	Inform members of the team
Comprehensive	Cover course of care for the member (not just 90-day) increments

Service Plan Definition

Procedure Code: H0032
Service Unit: 15 minutes
Telehealth: Available with GT Modifier
Service Limits: 16 units per 90-day period. If member is in Focused Care, H0032 cannot be billed.
Prior Authorization: Required. Refer Utilization Management Guidelines.

WV BMS Provider Manual Chapter 503.16 Definition: “An individual service plan is required for all members receiving services through Coordinated Care. The treatment team consists of the member and/or guardian, and/or member’s representative (if requested), the member's case manager, representatives of each professional discipline, and provider and/or program providing services to that person (inter- and intra-agency). If a member is served by multiple behavioral health providers, all providers must be invited to participate in the service planning session. All members of the team must receive adequate notice of the treatment team meeting. If a member of the team does not attend, the team decides whether to proceed in his or her absence. If the team elects to proceed, documentation must describe the circumstances. A PA [Physician Assistant] or APRN [Advanced Practice Registered Nurse] may serve on the committee in place of the physician.”

Who Should be at the Service Plan Meeting?

Service planning is a team approach. All services to be provided to the member must be represented at the team meeting:

- Member and/or guardian
- A representative of every service being provided to the member must be present
- Physician (or Extender) or Psychologist (or Supervised Psychologist) or Approved Licensed Professional Clinician (LPC/LICSW) must be physically present when one of the following is met:
    - Member receives psychotropic medications from physician at the agency
    - Member is diagnosed with Major Affective or Psychotic Disorder*
    - Member is diagnosed with Autism
    - Member has an I/D Diagnosis
    - Member has major medical problems in addition to behavioral health disorder and receiving medications from the agency physician
    - The presence of the physician or physician extender has been specifically requested by the case manager or the member
- If Physician/Psychologist/Licensed Clinician is not required to be present, they must review and sign the signature page within 72 hours

* See Reference for Diagnosis(es) requiring Physician/Approved Licensed Professional attendance

Service Plan Signature Page

To substantiate the presence of the required team, the signatures on the service plan must contain:

- ✓ Signature of every member of the team, including the member
- ✓ Credentials of all staff, included with signature
- ✓ Date of attendance for every attendee
- ✓ Start/stop times of attendance for every attendee

• If an individual (i.e., DoHS guardian) did not attend, indication on the signature page that the individual was not present but invited is sufficient.

• If staff participate via Telehealth, it should be noted on the signature page.

• If the Supervised Psychologist attends the meeting, the Supervising Licensed Psychologist must review and sign with credentials.

Service Plan Timelines

Initial Service Plan

- Must be developed within 7 days of admission with the entire team present.

Master Service Plan

- Must be developed within 30 days of admission with the entire team present.
  - Can be developed earlier for services that occur multiple times a week (i.e., Comprehensive Community Support Services, aka CCSS or CFT, etc.)
  - Intensive Service program plans must be developed within 7 days of admission.
  - Comprehensive Psychiatric Supportive Treatment (aka “CSU” or “Crisis Stab”) must be developed within 24 hours of admission.
  - Substance Use Disorder Residential Adult Services (SUD RAS) must be developed within 72 hours.

Service Plan Reviews

- Occur every 90-days with the entire team present.
  - SUD RAS must be reviewed every 7 days.
  - Intensive Services programs should have an informal quarterly review.

- Any service provided when Service Plans are out of timelines is considered an “invalid” service.

The Service Plan Guides Quality of Care

- The Service Plan should be commensurate with the members previously assessed need(s).
- If previously assessed needs are not included on the Plan, (i.e., due to prioritization of members issues), the clinical record should indicate why this is the case.
- Service documentation should be tied to the Service Plan component objectives.
- The Service Plan should drive the clinical treatment the member receives throughout their care.
- The Service Plan should be consistent with the level of care the member is receiving.
- Each service the member is receiving should be indicated on the Service Plan with sufficient component objectives to be commensurate with the length of time in treatment.
- The Plans goals and objectives should be reflective of medically necessary criteria and service definition for associated services.

Service Plan Components

1. Goals
2. Objectives (Outcome & Component)
3. Methods/Interventions
4. Realistic Achievement Dates
5. Discharge Criteria

- All components reflect the member's assessed behavioral health needs and meet service definition.

Service Plan Components

Goal:

- An expected result or condition that is specified in a statement of relatively broad scope and provides guidance in establishing intermediate objectives toward its attainment.
- Goals are stated positively with an anticipated outcome/end result.
- Goals are client centered (member's name in the goal).
- Goals are related to member's documented assessed need(s).
  - Example: Ima will learn how to live a substance free lifestyle in order to return to her natural living environment.

Outcome Objective:

- Describes how the member will be different at the completion of treatment.
- Must be stated in measurable terms.
- Serves to measure how close the member is to attaining the identified goal.
- Need at least one outcome objective for each goal included on the service plan.
- Establishes the period of treatment necessary for attainment of the goal.
  - Example: Ima will have zero (0) positive drug screens for 3 consecutive months by January 1, 2025.

Service Plan Components Continued

Component Objectives

- The treatment or “service” objectives.
  - The service that will be utilized is listed under each objective.
  - Objectives reflect service definition, as well as member’s documented assessed needs.
- Must be oriented towards achieving the goal.
- Specific, measurable, and demonstrate action, movement, or learning on the part of the member.
- Describe the steps (more than one) that the member will take towards achieving the goal.
- The amount of Component Objectives should be appropriate for attaining the goal and commensurate with time spent in services (reflected in the frequency of service delivery indicated on the plan).

Example Component Objectives

Appropriate Example:

✓Component 1: Ima will learn (Therapy) and practice (SIC) at least three coping skills to manage her symptoms of depression. Individual Therapy 4x a month, SIC 2x a month. January 1, 2025

✓Component 2: Ima will explore at least 3 contributing factors to her depression by November 15, 2024.

- Individual Therapy 1x per month
- Group Therapy, 3x per month

Inappropriate Example:

✗Component 1: Client will attend all Therapy appointments.

✗Component 2: Client will explore his history of substance use and irrational cognitions that contributed to giving in to cravings by November 30, 2024. Supportive Counseling

Discharge Planning

- To identify when the member is ready to leave a service or level of care.
  - Individualized for each member.
- To describe a member's plans after discharge.
- Can be between levels of care as well as discharge from the agency.
- Must be based on 2 clinical benchmarks (CAFAS scores, Beck Depression Inventory, etc.).
  - Can integrate Outcome Objectives, if measurable, as Discharge Criteria.
- Discharge planning starts on "day one" of treatment.

Service Plan Reviews

- Occurs a minimum of every 90 days.
- May occur at critical junctures.
- Entire team is present.
- Lead clinician directs the meeting.
- Review of all the member’s goals and objectives.
- Determine if goals and objectives need to be continued, discontinued, or modified.
- Confirm the Service Plan continues to meet the members assessed need and level of care.
- Ensure achievement dates are active and current, or if they need extended.
- Determine if additional goals, objectives, and/or services need to be added, or current ones amended.
- Includes a summary of services.
- Progress and/or impediments to progress and determine if the cause is member or agency based.
- Includes all meeting participants signatures, credentials (when applicable), dates and start and stop time demonstrative of each members required attendance.

Further Training

- We strongly encourage utilizing training opportunities for Service Planning related specifically to your agency's program needs.

- Retrospective Scoring Tools & Previous Webinars for service delivery may be reviewed at:
- https://wvaso.acentra.com/
- Trainer/Consultants can provide:
  - Technical Assistance (email, phone or virtual)
  - Virtual Trainings
  - Onsite Trainings
  - Informal Documentation Review
  - Simulated Reviews

Acentra Behavioral Health Contact Information

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Q&A