Acentra HEALTH

Utilization Management Contractor Provider Manual for Traumatic Brain Injury Waiver

UMC- TBI Wavier- Provider Manual Table of Contents

Introduction

Acentra Health is a Quality Improvement Organization designated by the Centers for Medicare and Medicaid Services. Acentra Health is an organization with unequaled experience with utilization management and prior authorization across the spectrum of health and human services. Acentra Health brings over 35 years of federal and state medical review and quality improvement experience, along with a background in Medicaid behavioral health, intellectual/developmental disabilities, waiver program management and state-funded programs.

Acentra Health is an integrated care management and quality improvement organization serving both public and commercial health care markets.

We Are Acentra Health

We are a team of experienced leaders, caring clinicians, pioneering technologists, and industry professionals who come together to redefine expectations for the industry. State and federal healthcare agencies, providers and employers turn to us as their vital partner to ensure better healthcare and improve health outcomes. No other company can match the kind of collective expertise we bring to the table. Building on our unique proficiency and insight, we rapidly implement solutions that elevate the healthcare experience and accelerate better outcomes.

This Is How We Lead the Way

Everyone at Acentra Health is eagerly pursuing the best way forward to build solutions that solve our clients' toughest challenges. In fact, we've built a culture that is fueled by passion and driven by purpose.

We Abide by Our Shared Values

At the heart of our company are five essential values that are always present. We live them out knowing they will ensure a warm and inviting culture where everyone can thrive.

- Passion We passionately serve our clients, colleagues, and our community.
- Innovation We solve problems through innovative solutions.
- Collaboration We work collaboratively to accelerate better health outcomes
- Respect We respect each other and embrace diverse perspectives.
- Excellence We strive to demonstrate excellence in everything we do.

We're Committed to One Clear Purpose, Mission, and Vision

Every company needs a North Star. At Acentra Health, we believe we exist for a singular purpose that drives our mission and fuels our vision.

- Our purpose is to accelerate better health outcomes through technology, services, and clinical expertise
- Our mission is to innovate health solutions that deliver maximum value and impact
- Our vision is to be the vital partner for health solutions in the public sector.

Our Role

Acentra Health is the contracted Utilization Management Contractor (UMC) for the WV Department of Human Services (DoHS) Bureau for Medical Services (BMS). In this capacity, Acentra Health administers specific fee-for-service programs operations for the Bureau. BMS approves all policies and procedures prior to implementation.

TBI Waiver Program

The TBI Waiver Program is a long-term care alterative, which provides services that enable individuals to live at home rather than receiving nursing facility care. The program provides home and community-based services to West Virginia residents who are medically and financially eligible to participate in the program.

As the UMC, Acentra Health is responsible for the day-to-day operations and oversight of the TBI Waiver program. This includes conducting the medical evaluations and determining medical eligibility for applicants and annual re-evaluations for waiver participants of the program. In addition, the UMC is responsible for authorizing TBI Waiver services, performing provider agency certification, and quality reviews.

Acentra Health TBI Waiver Contacts

To reach Acentra Health, please use any of the following contacts.

Acentra Health
1007 Bullitt Street, Suite 200
Charleston, WV 25301

Administrative Phone Number:	304-343-9663
TBI Waiver Toll Free:	866-385-8920
Fax:	866-607-9903
Email Address:	wvtbiwaiver@kepro.com
Acentra Health website:	http://wvaso.kepro.com

Acentra Health staff are available by phone 8 a.m. to 5:00 p.m., Monday through Friday.

Initial and Reevaluation Request for Medical Evaluation

Acentra Health is committed to facilitating person-centered care and services alongside providers in the initial and reevaluation request processes.

- Acentra Health will receive, review, and process all Medical Necessity Evaluation Request (MNER) forms for initial medical evaluations to determine eligibility.
- Acentra Health will schedule and conduct medical evaluations and medical re-evaluations using the Pre-Admission Screening tool and Rancho Los Amigos Levels of Cognitive Functioning or Rancho Los Amigos Pediatric Levels of Consciousness when applicants/participants have been deemed financially eligible through their local DHHR.

- Acentra Health will notify applicable parties (provider/referral source, applicant/participant, and their legal representative (if applicable)) of medical eligibility determination within prescribed timelines.

Assessment Coordinator

The Assessment Coordinator, employed by the UMC, is a degreed and licensed professional, supervised by a Certified Brain Injury Specialist (CBIS). All medical eligibility assessments take place in the home or community setting chosen by the applicant /program participant and his/her legal representative if applicable.

These medical eligibility assessments include:

- A thorough program overview, a review of the TBI Waiver Handbook.
- Education on reporting abuse and neglect.
- Information on different service delivery model options (selections are documented);
- Available service providers available in the individual's county of residence (selections are documented).
- Information on filing complaints and/or grievances.
- A comprehensive assessment of physical deficits and functional abilities of the individual using the Pre-Admission Screening tool.
- A comprehensive assessment of cognitive deficits using the Rancho Los Amigos Levels of Cognitive Functioning or Rancho Los Amigos Pediatric Levels of Consciousness tool.

Acentra Health determines medical eligibility per TBIW policy, Chapter 512 Traumatic Brain Injury Waiver. Acentra Health is responsible for ensuring that new applicants and existing program participant are medically eligible based on current and accurate evaluations.

Acentra Health will review supplemental medical information to confirm and verify the results of the medical eligibility assessment prior to rendering an eligibility determination.

Level of Care/Review Criteria

To ensure that the medical eligibility determination process is fair, equitable, and consistently applied throughout the State, Acentra Health maintains a variety of practices and interpretive guidelines for all program eligibility assessments administered. BMS reviews and approves all interpretative guidelines for the Pre-Admission Screening, the Rancho Los Amigos Levels of Cognitive Functioning or Rancho Los Amigos Pediatric Levels of Consciousness tool.

Staff is trained to administer assessments and regularly practice activities to ensure consistency within guidelines and evaluations. Tools used during these assessments (the PAS and Rancho Levels of Cognitive Functioning) are regularly evaluated. As needed, Acentra Health recommends updated policies and procedures for BMS consideration.

Notification of Eligibility Status

As applicable, Acentra Health will inform both the individual and the selected provider(s) or Fiscal/Employer Agent of the medical eligibility status: Acentra Health prepares the Notice of Approved Medical Eligibility Letter for the applicant/program participant and legal representative (if applicable), informing the individual of his/her medical eligibility status.

Acentra Health informs the selected providers or F/EA by secure email with the link to the provider portal to review and download medical eligibility document.

Service Authorizations

When initial, annual, or a change in need service authorizations are required for TBIW Program participants, the Case Manager will send by fax or direct data enter in Atrezzo, a Service Request, that includes the completed Service Plan, Assessment, Budget, and the Request for Service Authorization Form. Upon receiving the request, Acentra Health will decide within two (2) business days if the requests Approved, Pending, Closed, or Denial. If an authorization request is pending for additional information, the provider will be notified through Atrezzo the reason for the pending request and will have five (5) business days to provide the additional information, or the request will be closed. If a request is closed for this reason, the provider must resubmit the request for consideration.

Once an authorization request is approved, Acentra Health will process the authorization through the claims payer system and notify the provider agency of the approval. TBI Waiver providers will be able to obtain their notice of approval through the *Prior Authorization Notice* form and an approved final budget to the requesting Case Management Agency, Personal Attendant Agency, or the FE/A (if applicable), in Atrezzo.

Acentra Health completes a thorough review of each and every service request to ensure that assessed needs of the participant have been considered, the participant and/or legal representative was in attendance and was involved in the decision-making process, and that other issues such as medical care, health, and safety are addressed. The review completed by the UMC includes:

- Verifying medical eligibility of participant.
- Verifying financial eligibility of participant.
- Performing a quality review of submitted Participant's Assessment.
- Performing a quality review of submitted Participant's Service Plan.
- Calculating the spending and unit limits.
- Determining if the budget is within service and annual limits and
- Determining if a prorated budget is required due to anchor date alignment.

A budget amount per program participant will be established based on the total cost of the services deemed necessary by assessment and the Service Plan team. See Chapter 512, Traumatic Brain Injury Waiver Policy Manual for additional information on budget development and limitations.

Managed Enrollment

Upon obtaining both financial and medical eligibility verification, an applicant of the TBIW Program will be eligible to receive a funded slot to participate in the program if one is available. When no slot is available, Acentra Health will place eligible applicants on the TBI Waiver Managed Enrollment List (MEL).

Acentra Health will notify an eligible applicant placed on the MEL when a slot becomes available. Until then, they are offered resources and information about programs that the applicant may be eligible for while on the MEL.

If the applicant has been placed on the Managed Enrollment List (MEL), when a funded slot becomes available, the applicant and the case management agency will be notified by the UMC. When an applicant is released from the MEL, financial eligibility must be obtained from the applicant's county DHS office.

Applicants are placed on the MEL based on the date and time a completed and corrected MNER is received at the UMC. Eligible applicants are assigned an available slot on a first-on-first off basis.

Acentra Health is responsible for maintaining an accurate MEL and providing weekly report to BMS.

TBI Waiver Atrezzo Next Generation (ANG)

Acentra Health will develop the TBI Waiver Atrezzo Next Generation (ANG) to comply with all security requirements. The system will incorporate the ability for providers to request authorizations, generation of authorizations, and TBI Waiver attribute information to be exported to Gainwell. The system will serve as a database from which we will produce data for state and federal reporting.

Acentra Health will offer provider training, technical assistance, and a Web User Manual to assist the system user in understanding the functionality of the system and how to perform program tasks once operational.

Education, Training and Technical Assistance

Throughout the year, the UMC will create, schedule, advertise, and provide a variety of trainings for providers. These trainings will provide an overview and information on policy, services for participants, the choice between the TBI Waiver and institutional care, service delivery models, and other related topics. The UMC will conduct trainings which is available in both webinar and in-person format and will also provide training evaluations to continually assess and improve training materials and presentations.

Additionally, the development and maintenance of the TBI Waiver Program Handbook and any other supplemental resources will be the ongoing management responsibility of the UMC. UMC staff will regularly relay updated information, training events, and other announcements with providers for the TBIW Program.

Provider Educator

The Provider Educator, employed by the UMC, is a degreed professional and a Provider Educators direct activity to stimulate, recognize, and support efforts to improve the provision of TBI Waiver services. In addition, Provider Educators help assure quality outcomes are achieved through deliberate, focused training, and evaluation of the TBI Waiver system.

Provider Educators provide ongoing and specific feedback to agencies to assist them in improving both their documentation practices and their utilization management structure. Relative to documentation practices, providers receive on-site technical assistance/trainings, feedback from chart reviews, and consultative reports that may be utilized as tools to enhance agency performance and provide ongoing/continuing growth in developing needed structures to assure improved outcomes.

Training & Technical Assistance

Training and technical assistance are designed to meet providers' needs and will be delivered in two distinct venues involving on-site trainings at the provider location and regional/statewide trainings at convenient locations. A sample of topics includes:

- Person-centered Planning.
- Policy Overview and Updates as Needed.
- Services for Program Participants.
- Choosing a Service Delivery Model.
- The TBI Waiver as Alternative to Institutional Care and
- Identifying and reporting suspected abuse and/or neglect or other critical incidents.

Acentra Health Provider Educators are also accessible by phone or e-mail for providers to contact regarding questions or issues about the program.

Training

Provider trainings may be statewide, regional, or provider specific. While every effort will be made to provide adequate advance notice to providers, some training may require a short planning period to address pressing concerns and meet the needs of providers. Training announcements will include the training topic, learning objectives, target population, date, time, location, and continuing education information. Agency contacts will receive via email the

training announcement that includes directions for registration. All registered participants will receive a confirmation email with Webinar directions, Conference Call-In directions, a copy of the Power Point Presentation, and handouts, one (1) day prior to the scheduled training event. Learning objectives will be established for all trainings, along with a roster of participants, and completed evaluations. The UMC works with various licensing/credentialing boards to gain approval for continuing education credits.

Technical Assistance

Acentra Health provides responsive technical assistance to West Virginia's Traumatic Brain Injury Waiver providers. Acentra Health is available for consultative technical assistance, which is scheduled around the consultation process, or general technical assistance that is available on both a scheduled and non-scheduled/as-needed basis. Providers are encouraged to utilize technical assistance provided through Acentra Health. All technical assistance is available by telephone, written communication, or face-to-face communication, and all technical assistance activities are tracked.

Acentra Health's Provider Educators are assigned, so that they can develop an in-depth understanding of each provider. With this knowledge, Provider Educators can offer customized technical assistance to providers on issues regarding service planning, quality activities, and the prior authorization process.

To request any type of technical assistance, providers may contact their assigned Provider Educator or Acentra Health 1 -866-385-8920.

Requesting Approval for Internet-Based Training

Acentra Health will receive, review, and approve or deny requests for internet-based training that a provider agency would like to use to meet the initial and annual training requirements for their staff. These requests must be submitted on the appropriate training request form titled *TBIW Internet-Based Training Request* located at Policy and Forms (wv.gov)

Quality Assurance Activities

To ensure the highest quality of person- centered services and care for all TBIW program participants, ongoing Quality Assurance Activities are overseen by the UMC. These activities verify that provider agencies maintain up-to-date policies and procedures and an overall person-centered continuity of care for the participants they serve.

Initial Provider Certification

Acentra Health is responsible for certifying prospective TBI Waiver providers. The TBI Waiver provider certification criterion is established in Chapter 512 Traumatic Brain Injury Waiver Policy Manual. Interested providers can request an application from Acentra Health by calling 866-385-8920 or emailing wvtbiwaiver@kepro.com .

Acentra Health will send a packet of information to the prospective provider that includes the *Certification Application-Initial*. Prospective providers will be assigned a Provider Educator to provide technical assistance through the initial certification process. The Provider Educator will contact the interested provider to review and explain the initial provider certification application process and offer technical assistance if they choose to apply.

Upon receipt of the completed initial provider, certification application the Provider Educator will conduct a desk review of the information submitted within two business days. If the initial application is not complete, the Provider Educator will contact the provider agency to discuss missing elements and offer additional technical assistance as needed.

Following the receipt of a completed *Certification Application-Initial,* the UMC will conduct an on-site review if required, to verify that the prospective provider meets certification standards. The on-site visit requirement may be waived if the prospective provider is a current Licensed Behavioral Health Center (LBHC) or is enrolled as an Aged and Disabled Waiver (ADW), Personal Care (PC), or Intellectual/Developmental Disabilities Waiver (IDDW) provider at the time of application.

The UMC will notify BMS' fiscal agent (Gainwell) upon satisfactory completion of the onsite review or verification of LBHC, ADW, Personal Care, or IDDW status. Gainwell will provide the provider applicant with an enrollment packet, which includes the TBIW Provider Agreement. Once this process has been completed Gainwell will assign a provider number and send a letter informing the provider agency that it may begin providing and billing for TBIW services.

Continued Provider Certification

Annually, all TBIW providers are required to complete and submit designated evidence to the UMC to document continuing compliance with all certification requirements as specified in Chapter 512. An appropriate official of the provider agency must attest to this evidence.

Acentra Health sends a reminder email to the Executive Director and/or Waiver Contact sixty (60) day prior to the agency's certification date. The email will provide the necessary attachments and instructions for completion and submission of the continuation certification paperwork to the UMC. The email will also provide a date when the agency's re-certification packet is due to

Acentra Health. The email also informs the provider that if the documentation is not provided within thirty (30) days of expiration of current certification, a Provisional Certification may apply. Provider agencies who receive a Provisional Certification will be required to have an onsite review by Acentra Health prior to full re-certification.

Upon receipt of a completed *Continuation Certification Application*, the UMC will conduct a desk review of the evidence submitted. Desk reviews will be conducted within five (5) business days of receipt of the continuing certification application. The UMC staff will follow established guidelines for conducting the review and render a determination regarding certification status. The UMC staff will compare the provider's previous certification application to the one submitted to verify information such as office locations, address (physical and mailing), and selected counties served. A Change of Location Request Form submitted by the Provider to Acentra Health prior to making any changes must support any changes made.

Acentra Health is responsible for maintaining the TBI Waiver Provider Reference Guide and Freedom of Choice Provider County Selection Forms. No changes to either the TBI Waiver Provider Reference Guide or the County Selection Forms will be made until the Provider successfully completes the change request process.

Acentra Health will notify the TBIW provider of their certification status via email. There are three possible determinations that may result from the review process: Full Certification, Provisional Certification, or not certified.

Quality Reviews

Acentra Health has developed a process for quality reviews that is user-friendly for all provider groups. The goal of the review process is to assist providers in achieving positive outcomes for individuals and families through the services provided. Provider Educators are assigned specific providers with the expressed intent of developing an ongoing relationship where communication and collaboration become routine. Within a consultative atmosphere, providers are given an optimal opportunity to succeed in meeting the documentation standards set forth by BMS.

The review process is guided by a thorough set of record review procedures, supported by several record review tools and provider record review scoring protocols, as well as questions that evaluate the organizational competence of a provider group. Provider Educators may also provide focused reviews for the specific services provided to individuals by an organization or provider. Technical assistance and follow-up activities are made available to providers

on a consistent basis. The tools and scoring instruments are reviewed and approved by BMS.

Acentra Health conducts provider quality reviews of all participating TBI Waiver Providers annually.

Provider Educators will conduct either a desk or on-site reviews. As agents of the Bureau of Medical Services, Provider Educators will explain the purpose of the consultation activities that may include interviews with key staff and the review of specific program participant's charts. Provider Educators will maintain confidentiality by asking Providers to provide an area for record review at their facility that is conducive to preserving confidentiality. If questions arise, providers will be given the opportunity to provide an explanation or to locate missing or misfiled information. Before the Provider Educator leaves the facility, an exit review will be conducted. During the exit review, Provider Educators present feedback to providers pertaining to areas of strength as well as recommendations for improvement when needed. The results of consultations provide opportunities to identify the best of promising practices and to address training needs.

Reviews will be scheduled in advance of the review date by UMC staff. A list of records for potential review will be provided by fax or electronically in advance of the scheduled visit. Ample time will be allowed to pull the requested records. All site visits will occur as scheduled. If a scheduling conflict arises, the consultation will be rescheduled for the earliest possible date agreeable to all parties.

The Provider's Executive Director(s) and Waiver Contact person(s) will receive an email at least 2 weeks (14 calendar days) prior to the start date of the agency's review. This email will inform the agency of the dates of review, tentative names of reviewers, and general instructions.

The Bureau for Medical Services (BMS) has determined that 100% of enrolled program participants will receive a record review. In addition, personnel files of program staff working with TBI Waiver recipients will also be reviewed.

Acentra Health staff will validate the information from the most recent completed certification with a review of the agency policy and procedures, the agency Quality Management Plan, Personal Attendant direct care staff and Case Manager Competency based training curriculum, and a walk through of the agency office setting to monitor office criteria compliance. The walk through will include digital verification (digital photos) that the physical office meets policy requirements.

Acentra Health will communicate the results of the on-site review in writing to the provider and BMS within ten (10) business days of the completed review. The draft reports will include the Review and Disallowance Reports along with the Plan of Correction. The Review Report includes a discussion of the results along with recommendations. The Draft Disallowance Report identifies issues for which the UMC staff found the provider to be out of compliance that may result in potential disallowance. The Plan of Correction (POC) form identifies any quality items found to be deficient during a provider's review. The provider must develop a plan to address how the deficient practice(s) will be corrected; what system will be put into place to prevent recurrence of the deficient practice(s); how service delivery will be monitored in the future to ensure compliance and who will be responsible; and when the Plan of Correction will be implemented and completed.

The provider will have 30 days to submit the POC and comments to the Draft Disallowance Report. Once received, Acentra Health will coordinate results and make final recommendations to be presented to the Review Committee (BMS and OPI). Following the Review Committee meeting, Acentra Health will finalize the Disallowance Report (per committee recommendations) and send it to BMS. BMS will send the Final Disallowance Report to the provider with instructions for repayment.

BMS requires that Acentra Health conduct a six (6) month follow-up review for all approved POCs on quality items found to be deficient during the annual on-site review. The six-month follow-up review will be performed through either a desk review of requested evidence or an on-site review, depending on the deficiencies identified in the original POC. Items found to be deficient related to health/safety and/or welfare of program participants, or deficiencies noted from Chapter 512, Office Criteria will result in an on-site review.

Acentra Health will notify providers via email forty-eight (48) hours prior to the review. This email notification will include how the review will be conducted (desk or on-site) and will serve as the request for specified evidence to be submitted within 48 hours. Evidence supplied by the provider must demonstrate verification that the provider implemented the approved POC within timelines and yield the desired results.

Within 10 business days of the conclusion of the 6-month POC follow up review, Acentra Health will email the following report to the provider and to BMS: 6-month POC Findings- Identifies compliance and/or noncompliance with the strategies outlined in the Provider's approved POC, recommendations for improvement, and technical assistance.

At the conclusion of the on-site quality reviews, providers will be asked to complete a Quality/Utilization Review Satisfaction Survey. The feedback generated from the evaluations assists Acentra Health to continue to improve the quality of our services. Survey items are geared toward assessing the on-site review process as well as the individual Provider Educator.

Quality Improvement Advisory Council

The purpose of the TBI Waiver Quality Improvement Advisory (QIA) Council is to provide guidance and
feedback to Waiver staff in the development of an ongoing quality assurance and improvement system for the TBI Waiver Program. The Council is the focal point of stakeholder input for the TBIW program and plays an integral role in data analysis, trend identification, and the development and implementation of remediation strategies. The role of the Council is to advise and assist BMS and the UMC staff in program planning, development, and evaluation consistent with its stated purpose. In this role, the Council uses the TBIW Performance Measures as a guide to:

- Review findings from evidence-based discovery activities.
- Recommend policy changes to BMS.
- Recommend program priorities and quality initiatives.
- Monitor and evaluate the implementation of TBIW priorities and quality initiatives.
- Monitor and evaluation of policy changes.
- Serve as a liaison between the TBIW program and interested parties; and
- Establish committees and workgroups consistent with their purpose and guidelines.

The Council will consist of eleven (11) voting members. To the extent possible at least four (4) will be current or former TBIW program participants (or their legal representatives/family member) with the remaining members representing other stakeholders such as service providers, direct care workers, family members, and other advocates and allies of people with TBI.
The Council will make every effort to represent all regions of the state. Voting Council members may not be direct employees of the State of West Virginia Department of Health and Human Resources. This is in effect to reduce the potential conflict of interest of Council members working for the state and providing feedback to the state.
TBI Waiver QIA Council meetings are open to the public and Council meeting minutes are posted on the
WVDHHR website located at:

http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/TBIW/Pages/QIA-Council.aspx .

Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) Home and Community Based Services (HCBS

Center for Medicare and Medicaid Services (CMS) developed the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®), Home and Community Based Services (HCBS) Survey for voluntary use in Medicaid HCBS programs as a tool for quality assessment and improvement, as well as for public reporting by states that choose to do so. The West Virginia Bureau for Medical Services (BMS) decided to use this survey instrument.

The purpose of the CAHPS® HCBS Survey is to provide BMS and other program stakeholders with information about the TBI Waiver program Respondents' experience with paid staff who support and/or provide their care.

In contrast to many other experience or satisfaction surveys that are disability-specific, the CAHPS® HCBS survey was designed so that individuals with different types of disabilities (e.g., physical, cognitive, intellectual, behavioral) could respond to the same questionnaire, thus enabling comparisons across programs and disability groups within the state.

The CAHPS®HCBS survey asks program individuals to report on their experiences with different aspects of their Traumatic Brain Injury Waiver providers and services, including the personal attendant direct care staff, case manager, transportation services, and their ability to engage in community life.

The CAHPS® HCBS survey includes a maximum of 69 core questions about the participant's experience of care in the following areas:

1. Staff are reliable and helpful
2. Staff listen and communicate well
3. Case Manager is helpful
4. Choosing the service that matter to you
5. Transportation to medical appointments
6. Personal Safety
7. Planning your time and activities
8. Ratings of providers

Survey data is collected, analyzed, and shared with the TBI Waiver QIA Council members, providers, BMS and other stakeholders.
Data results, findings and recommendations are implemented through Quality Management Plans with the TBI Waiver QIA Council and through Provider trainings.

Complaints

All complaints submitted by providers, members and/or other stakeholders are received, reviewed, tracked, and investigated by Acentra Health as they arise. UMC staff will follow a procedure in responding to these complaints and reporting trends and outcomes to BMS. Each complaint is taken seriously and used to identify needs for improvement and/or technical assistance. Stakeholders may submit complaints verbally or in writing via email or fax.

Upon receipt, Acentra Health will document the complaint and request any needed information for follow-up. If the issue cannot be resolved through technical assistance, information, and referral, Acentra Health staff will further investigate the complaint and/or make referrals to the appropriate entities.

Acentra Health will inform the complainant of procedures in following a chain of command at the provider agency. Every TBI Waiver provider is required to have a grievance/complaint procedure. It is requested that each agency inform program participants and their representatives (if applicable) of this procedure. Acentra Health will request information about steps taken thus far to resolve the complaint at the agency level. These steps may include notifying the Case Manager, Waiver Supervisor, or accessing the agency's grievance/complaint procedure. It is not necessary for participants to exhaust steps at the agency level; they may make direct complaints to Acentra Health at any time.

- If abuse, neglect, or exploitation of a program participant is suspected, Acentra Health will assist the participant in making a referral to Adult or Child Protective Services (APS/CPS). If the complainant cannot or will not make this referral, Acentra Health will do so.
- If a provider agency is suspected of not following procedures consistent with certification, Acentra Health will conduct an on-site or desk review to evaluate compliance.
- If it is suspected that a provider agency is billing for and receiving payment for services inappropriately, Acentra Health will refer and/or work with the Medicaid Fraud Control Unit (MFCU) through a referral to the Office of Program Integrity (OPI) at BMS to investigate the issue.
- Acentra Health may receive anonymous complaints. If the complaint contains enough information to follow up, Acentra Health will do so. If there is no way to follow up based on the information provided, Acentra Health will log the complaint and indicate insufficient information for action. If complainants request anonymity, Acentra Health will notify them it may not be possible to follow up on the complaint.
- If it is suspected that the topic of complaint is systemic, Acentra Health may request additional information to determine the extent of the complaint.

- When Acentra Health investigates, Acentra Health will notify the provider agency of the complaint as long as doing so will not compromise the integrity of the investigation or put a program participant at risk
- When appropriate, Acentra Health may utilize the provider agency's internal investigation system to acquire necessary information. In this event, Acentra Health will request the agency forward specific information for Acentra Health to conduct a desk review.
- When appropriate, Acentra Health may conduct an on-site investigation at the provider agency after consultation with BMS.
- Acentra Health may investigate matters related to TBI Waiver policy manual compliance. For those matters in which the TBI Waiver policy manual overlaps with Adult Protective Services/Child Protective Services or OPI, Acentra Health will work with applicable parties or make referrals as appropriate.

Acentra Health will respond initially verbally or in writing to formal complaints within two business days. Acentra Health will follow-up on complaints in a manner that is least intrusive. Follow-up may require a request for additional information, an interview with staff, the program participant/legal representative or other applicable parties, and/or an on-site visit.

Incident Management System (IMS)

Any incidents involving a participant utilizing TBI Waiver services must be entered into the West Virginia Incident Management System (WV IMS). Acentra Health is responsible for monitoring reported incidents to ensure that agencies take the necessary and require actions as outlined in policy within timelines. If it is found that agencies have not followed up as required, Acentra Health will contact the agency to request follow-up and provide technical assistance, as necessary. If it is noted a significant issue with a particular provider, Acentra Health will offer training and technical assistance to the agency in an effort to remedy the issue.

Appeals/Hearings

Medicaid recipients may request a Medicaid Fair Hearing any time a denial or reduction in eligibility or service occurs. This formal process provides the applicant/program participant and/or legal representative to appeal a decision if the individual feels aggrieved by an adverse action that is consistent with state and federal law. An impartial Board of Review (BOR) Hearing Officer conducts Medicaid Fair Hearings.

Acentra Health will provide notification of potential and final denied eligibility and results of evaluation to applicants/participants and their legal representative (if

applicable). In the event, applicants/participants may seek to appeal this decision and follow the policy for submitting an appeal.

If the applicants/participants and their legal representative (if applicable) request a hearing within 13 days from the date of the Final Denial letter, services will continue at the current level until a final decision is made by the Hearing Officer.
If the BOR receives the request for a hearing within 90 days of the date on the Final Denial letter, however it is after 13 days, a hearing will be scheduled, however services will not continue. Individuals who choose to pursue Medicaid Fair Hearing may seek legal counsel; if this occurs, they are required to notify the BOR, who will in turn notify BMS. BMS will also secure legal representation at that time. Note that if legal counsel is secured, all communication must occur between attorneys.

BMS, or BMS counsel if applicable, will attempt to schedule a pre-hearing conference once all parties have received the Scheduling Order for the Medicaid Fair Hearing. The pre-hearing conference is a mechanism by which BMS and the individual can attempt to negotiate again. If the pre-hearing conference results in successful negotiation, the individual will withdraw from the hearing. If an agreement cannot be reached, the hearing will take place as scheduled.

If a pre-hearing conference should take place, the UMC will schedule the conference, attend, and assist in the review of the provided information in the appeal. Additionally, the UMC will provide any resolutions to the appeal by writing for follow up to all parties involved.

The Medicaid Fair Hearing is a formal proceeding at which BMS, and the individual will present testimony to a hearing officer regarding the denial that has occurred. The hearing, which will be recorded, may be held via telephone, videoconference, or in person at BMS, per the individual's choice. The hearing officer does not render a decision immediately following the hearing. Rather, he/she will review the recording of the hearing and provide a written decision to the parties within 90 days date of the Final denial letter. The hearing officer will either decide to:

- **Uphold** BMS' decision: the hearing officer agrees with BMS' original decision to deny the request or
- **Reverse** BMS' decision: the hearing officer does not agree with BMS' original decision to deny the request and finds in favor of the person who receives services.

In the event BMS' decision is upheld, the individual may request that the decision be reviewed by the BOR. If a satisfactory outcome is not achieved with

that review, the decision can be appealed via State Circuit Court; if the Circuit Court upholds the decision, it can be appealed via the State Supreme Court.

Medicaid Fraud Reporting - If at any time Acentra Health suspects Medicaid Fraud, a referral will be made to OPI.

For Additional Information

Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301
Phone: 304.558.1700
Fax: 304.558.4398
Website:
http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/TBIW/Pages/default.aspx

Utilization Management Contractor
Acentra Health
1007 Bullitt Street, Suite 200
Charleston, WV 25301
Phone: 866.385.8920
Fax: 866.607.9903
Email: WVTBIWaiver@kepro.com
Website: http://wvaso.kepro.com

Fiscal Employer Agent (Personal Options)
Palco
Website: https://palcofirst.com/west-virginia/
Phone: 866-710-0456
Email: customersupport@palcofirst.com

Claims Processing
Gainwell
For Providers: 888.483.0793
For Members: 304.343.3380
Fax: 304.348.3380
Website: https://www.wvmmis.com/default.aspx

West Virginia Adult and Child Protective Services
Phone: 800.352.6513
Website: http://www.dhhr.wv.gov/bcf/Services/Pages/default.aspx

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