

Trevor Douglass, D.C., M.P.H, Manager
Provider Clinical Support Unit

Number: OHP-IM-16-024

Authorized Signature

Issue Date: 06/24/2016

Topic: Medical Benefits

Subject: July 1, 2016 changes for Oregon Health Plan fee-for-service behavioral health authorizations

Applies to:

- | | |
|--|---|
| <input type="checkbox"/> All DHS employees | <input type="checkbox"/> County Mental Health Directors |
| <input type="checkbox"/> Area Agencies on Aging | <input type="checkbox"/> Aging and People with Disabilities |
| <input type="checkbox"/> Children, Adults and Families | <input checked="" type="checkbox"/> Other (please specify): Health Systems
Medicaid/CHIP staff |
| <input type="checkbox"/> County DD Program Managers | |

Message:

Starting July 1, 2016, KEPRO (formerly known as APS Healthcare) will review all fee-for-service behavioral health authorizations submitted by type 33 (Mental Health) providers. This includes:

- 1915i eligibility determinations, currently requested through Acumentra Health
- Plan of Care (POC) requests for adult foster care, residential personal care/habilitation services, currently requested using the [OHA 8069](#) form
- Prior authorization (PA) requests for outpatient rehabilitation, community habilitation or applied behavioral analysis services, currently requested using the [OHA 8060](#) form

What this change means:

This month, Acumentra Health will stop reviewing 1915(i) eligibility determinations, and the Provider Clinical Support Unit will stop reviewing POC and PA requests.

Starting July 1, 2016, the forms and resources for these types of requests will be available on the KEPRO website at www.ohpcc.org.

Providers can submit requests to KEPRO by:

- **Mail:** KEPRO, P.O. Box 2960, Tualatin, OR 97062
- **Phone:** 1-844-658-1729
- **Fax:** 1-844-673-8034
- **Email:** OR1915i@kepro.com

Staff will still be able to review the status of POC and PA requests in MMIS. This does not change any requirements for POC, PA or 1915(i) requests.

To learn more:

See the following:

- Oregon Administrative Rules for [Medicaid Payment for Behavioral Health Services](#)
- The [division's recent letter for behavioral health providers](#) (shared through the Provider Web Portal, SEIU and the Oregon Residential Provider Association)
- [Questions and answers](#) about KEPRO's scope of work

If you have any questions about this information, contact:

Contact(s):	Chad Scott, Operations and Policy Analyst		
Phone:	503-947-5031	Fax:	503-373-7689
E-mail:	chad.d.scott@state.or.us		

Questions and answers about KEPRO scope of work

Prepared for Oregon Residential Providers Association, June 23, 2016

When will we be able to see the new forms—not until 7/1/16?

By July 1, KEPRO will publish the new Plan of Care and Prior Authorization request forms. The only differences will be KEPRO branding and improvements for the user.

What will KEPRO's turnaround time be for approving authorizations?

Approval of authorizations depends on the type of request (service type, amount of service, duration) and completeness of the submitted request. For complete requests, KEPRO will provide an authorization decision within 10 business days of receiving the request. This includes entry of the authorization into MMIS.

What if there's a disagreement with KEPRO's evaluation, is there an appeal process?

If the question is related to prior authorization denial, all providers and members will receive a notice of action notifying them of the decision and their appeal rights described in OAR 410-120-0000.

Will there be a unit / several workers assigned to an organization or will organizations have their own assigned worker?

OHA is not prescribing to KEPRO the processes required to meet the outcomes defined in the contract and I do not have any information to respond to this question at this time.

What are the expectations around the person-centered-planning process from a provider and KEPRO perspective?

KEPRO will conduct person-centered assessment and planning based on CMS requirements for person-centeredness. Provider's roles in this process are described below.

Standards for person centered assessment

1. Recipient provides informed consent for the assessment.
2. Recipient receives appropriate support during the assessment, including the use of any necessary on-site staff.
3. Recipient and, if applicable, the Recipient's authorized representative, are consulted. Opportunity is provided for the Recipient to identify other persons to be consulted, such as the Recipient's spouse, family, guardian, and treating and consulting health and support professionals.
4. Examination of the Recipient's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the service plan.
5. Examination of the Recipient's physical and mental healthcare and support needs, strengths and preferences, available service and housing options, and a caregiver assessment, when unpaid caregivers will be relied upon to implement the service plan.
6. Consideration to community partner recommendations.

7. When applicable, consideration of the Oregon State Hospital interdisciplinary treatment team recommendations.

Standards for Person-centered Planning.

1. Recipient directs the process to the maximum extent possible and is enabled to make informed choices and decisions. Persons chosen by the Recipient are included in the planning.
2. Information is provided in plain language in a manner accessible to individuals with disabilities and persons whose English proficiency is limited. Cultural factors must be considered.
3. The written plan of care will be commensurate with the Recipient's level of need and the scope of the services and supports available that reflects the Recipient's strengths and preferences and includes individually identified goals and desired outcomes.
4. The plan of care will describe any clinical and support needs identified through a functional needs assessment and indicate the paid and unpaid services and supports and the providers responsible for implementation.
5. The plan of care will include risk factors and measures to minimize the risk factors, such as individualized backup plans and strategies.
6. The plan of care will document and justify any modification that supports a specific and individualized assessed need

How is the state/KEPRO going to manage the person-centered-process, what will look like and how will it be managed?

Through conflict-free case management processes, KEPRO will engage in the processes leading to the development of a person-centered plan. This includes onsite and face-to-face person-centered assessment and planning for individuals ready to transition from OSH and for individuals ready to transition from a licensed residential setting.

KEPRO will engage in processes for ensuring that services are delivered according to guidance included in the support plan which includes coordinating services, monitoring the quality of services, monitoring the participant, and reporting compliance of contracted entities responsible for implementing the support plan.

What is the role of the workers of KEPRO in comparison to the County "AMHI" staff?

Specific to the interaction with KEPRO's scope of work, Choice Model contractors will be responsible for implementation of the person-centered plan. They will receive the person-centered plan from KEPRO.

What will AMHI look like in this new system?

That is not yet defined. The AMHI (Choice Model) contracts have not been amended to reflect a change in scope of work.