From: Scott Chad D
To: Allen Patrick
Subject: Kepro Contract - Adult Mental Health Residential
Date: Thursday, December 28, 2017 5:30:35 PM
Attachments:
KEPRO OR November 2017 Invoice.pdf
MH_Res_Report pmpm FY17.xlsx
RE Monthly payments for rehab codes.msg
RE How will we be coordinating Technical Assistance training for residential providers on documentation required for LOC medical necessity review by KePRO.msg
RE KEPRO representation.msg
extension list.xlsx **< Withheld for review related to possible PHI**
RE Exceptional funds request.msg
Per diem rehab rate history.msg
Re Cost allocations from Cascadia.msg
RE Fality Criteria.msg
RE Assistance on follow-up question with DAS Budget.msg
FW Understand that recently KePRO issued 300 denials to clients that no longer qualified for adult residential services - Who is triaging and planning these clients" transition to other settings .msg
RE Conversation regarding KEPRO.msg

Hi Pat ~ Thank you for taking the time to read this.

OHA contracts with a third-party to perform utilization management and review of fee-for-service personal care, habilitation and rehabilitation services provided in OHA licensed settings to individuals diagnosed with a mental health condition. Kepro, the current Independent and Qualified Agent (IQA) for OHA completes prospective and concurrent review of all admissions and continued stay for members in OHA licensed mental health residential settings.

Kepro is a URAC accredited QIO/EQRO and as Oregon's IQA for 1915(i), utilizes Mckessson–Intequal criteria to determine the medical appropriateness of services provided to members in licensed care. Kepro's IQA work is guided by the requirements in Oregon's 1915(i) HCBS SPA and Oregon administrative rule and is performed by a team of eight licensed clinicians under the direction of a medical director and psychiatrist.

In majority of reviews, beginning fully in September of 2017, Kepro has determined members in OHA licensed settings do not need the level of care or services provided, or, in other words, the services are not medically appropriate. For these members, OHA has issued notices of action for either a denial of service or reduction of service. Per rule, OHA can allow up to 60-days continued stay to support transition to an appropriate level of care, service or community setting.

Deficiencies in Oregon's mental health system, Oregon housing market shortages and poor performance by OHA and our contractors has created the circumstance, a large number of individuals able to live outside of a licensed setting cannot transition into a more integrated community setting because there are not sufficient housing, services or supports accessible to them. The historical and current result of this is, OHA pays Medicaid and other general funds to utilize licensed treatment settings as housing and people remain unnecessarily in the state hospital. Most recently, despite outcome of reviews by Kepro, OHA has begun issuing 60+ day authorization extensions to largely maintain the housing component for members residing in

licensed treatment programs whose services have been determined to not be medically necessary even though there are individuals in the state hospital and community that do need the service and even through the members themselves pay for room and board costs.

The barriers faced by individuals ready to transition from hospital, institutional and congregate licensed settings has been well known to OHA for many years and there has been, in my opinion, much support, sufficient funding and many pathways available to reduce and even remove those barriers.

From the work I am engaged in, Oregon's authority provided under the 1915(i) HCBS state plan amendment and the USDOJ (Oregon Performance Plan) provide the support, funding and pathways to solve Oregon's Olmstead and member access issues. For reason's I continue to not understand, neither of those resources have been implemented sufficiently to the extent, Oregon now has hundreds of people who have been determined ready and able to live in an integrated home and community based setting but remain in restrictive and costly levels of care due to a lack of access to basic services and supports. OHA isn't even in alignment with our DHS counterparts in their successes administering Medicaid and HCBS benefits.

The role of my unit (provider clinical support) in achieving Oregon's Olmstead and HCBS goals is to manage the fee for service residential mental health treatment prior authorization process and the CMS required contractor for 1915(i) HCBS services. After having held positions within the former AMH and DMAP divisions in adult services and Medicaid policy and as a member of the USDOJ core team, I moved to the clinical services unit and took the challenge of implementing a correct and compliant medical management process to limit the fraud, waste and abuse occurring in the management of this benefit. I have developed and operationalized a medical management model for the fee for service programs that is defensible and can bear public scrutiny.

It was my expectation and my assumption that other units within OHA had undertaken a similar path in their work. I participated in many meetings around the Oregon Performance plan, HCBS rule compliance, 1915(i) SPA, codes and rates and Choice model (AMHI) contract and program planning. I was aware of other projects being pursued such as MOTS, CCO's, development of an integrated provider contract in MMIS, mental health rate standardization, mental health housing, behavioral health collaborative, behavioral health mapping tool, Assertive Community Treatment, Supported Employment and probably others I'm not remembering. It seems like there has been a lot happening around mental health the past couple of years so I am not fully understanding the current circumstance some of our members find themselves.

In August of this year, because OSH discharge rates were stagnant, I requested Kepro increase their utilization review of the residential system to ensure those who have the ability to transition into the community can and in doing so, create opportunity and access for those waiting to discharge from one of the Oregon state hospitals. I requested a review of all residential recipients be completed by June 30 of 2018. Kepro to date has been successful in identifying some of those who do not

require the services and supports of a licensed setting. However, very few of those determined able to have moved or have been provided with a plan to.

Throughout the process of integrating Kepro into Oregon's mental health system, I've received resistance from providers, from counties and from the state hospitals. I think when you introduce a standardized medical management process into a system accustomed to operating with very limited oversight, resistance is expected. I think OHA is at a place now where Kepro is viewed as a partner and a resource and I've seen that resistance fade and outcomes being achieved as providers understand the requirements for Medicaid reimbursement.

I've also received resistance within OHA, from OHA managers and OHA leadership. That resistance hasn't faded and exists as an inexplicable barrier to this work.

Over the last year, I have been the recipient of dialogue from some HSD and policy leadership regarding the Kepro contract and their work. There has been an overt focus on Kepro's work, not as a process achieving desired outcomes that should be supported by other parts of the behavioral health system and work of other units within OHA, but as a problem that needs to be understood and resolved. I have had multiple inquiries and attended multiple meetings with OHA leadership to discuss provider complaints and concerns about Kepro. In almost all instances, these complaints have been discovered to be issues around provider compliance with prior authorization rules, documentation, billing and general business practices which I've worked with them to resolve and in some cases made allowances to ensure providers are paid for services rendered. There seems to always be an underlying theme that somehow the work Kepro is doing is not appropriate and problematic. There has been and remains a singular focus on preserving (and growing) the current residential provider system with seemingly no consideration given to the actual needs of our members, cost containment, Medicaid compliance, ensuring individuals civil rights or the potential to operationalize and fund HCBS services consistent with direction provided by CMS, SAMHSA, NAMI, MHA and every recognized national partner including the USDOJ.

For me, additional dialogue from OHA leadership last week was concerning and is part of the reason why I am sharing this information with you.

I was invited to a meeting to again discuss Kepro and "all of the denials" they are issuing. In the meeting, some anecdotal examples around the prior authorization process challenges were shared and as always, I committed to investigate and respond to any prospective or concurrent review process challenges that arise. This meeting however, was different in that it was proposed that Kepro "slow down" their work so OHA has time to plan for what is happening with the "Kepro denials". Some ideas proposed were, 1) Conducting review of Medicaid services provided to members under jurisdiction of the PSRB with criteria different than criteria used to review the same services provided to Medicaid members who are not under jurisdiction of the PSRB. 2) Having OHA or CMHP or other staff review the Kepro determinations 3) Provide "technical assistance" to the providers to better document so that they can counter Kepro's denials. There was no discussion about why people

aren't able to transition from licensed settings, only scrutiny on the process that identifies an individual's ability to live in a non-licensed setting and how to ameliorate that. I understand there is even a "Kepro" workgroup being formed to address the denials. ***I would be interested to hear about workgroups being formed to address the work of other units, individuals or contractors whose failures have contributed or caused this current scenario.*** Beyond continuing to pay for unnecessary services, changing medical appropriateness criteria or not reviewing services for medical appropriateness, I don't understand what "slow down" means. I do however have a clear understanding of the processes and tasks needed to move this work forward and question why there isn't a focus on "speeding up" the work needed to support our members in their recovery. It should also be known, Kepro' s work will accelerate in the coming months with upcoming required changes to their contract that include face to face assessment, person centered planning and prospective and concurrent review of OHA patients. These changes are not based on OHA goals alone, these changes are the result of CMS regulations and USDOJ orders.

Needless to say, I don't think it is appropriate for HSD and Health policy leadership to consider or request an adjustment to the work Kepro is doing on behalf of OHA to adhere to Medicaid regulations, maintain program integrity and ensure the appropriateness of services paid to providers for which Oregon claims federal medical assistance payments. It seems like this is an attempt to alter medical management outcomes simply due to the fact other OHA units have not succeeded in their work to develop the service delivery system Oregon has been required to provide for individuals experiencing behavioral health conditions even after being given many years and many resources to do so. It may even be an attempt among OHA leadership to deflect attention or excuse away how deficient they have been in managing their own program outcomes. I question the level of scrutiny by OHA leadership on a contractor performing basic medical management as required by CMS when there is no scrutiny on the units whose work to date is insufficient to the outcomes required and needed to administer a public mental health system and support fee-for-service medical management outcomes.

Last week, I also received inquiries through the hearings unit regarding the purpose of issuing denials and holding hearings if there is no intent to discontinue authorization and payment for a service. To date, <u>every</u> hearing request that has been filed was cancelled due to determination the services aren't actually being denied therefore a hearing is not necessary.

This led me to consider the following;

1) I don't think that I or anyone within OHA has authority to authorize Medicaid payment for services determined as not medically appropriate and claim federal match for those payments.
2) I don't think anyone in OHA has authority to change medical necessity criteria outside of a standard process.
3) I am concerned with my role in overpayments and putting OHA at risk of disallowance resulting from the authorization of unnecessary services.

4) I can't think of a reason to justify the expense of contracting with an IQA, adhering to HCBS regulations or engaging in medical management when the rest of the system is so far behind and those activities serve to provide nothing than more data regarding the lack of need for licensed residential services.

Here is some less subjective information for consideration;

~Just so you know, I am a mental health counselor by training, not an accountant, but here is what I see as the scope of this current issue~

The OHA office of health analytics - mental health residential claims report shows, for FY16-17 - the average cost per person for the services comprising mental health residential treatment is $39,599 (/12 = $3299 PMPM). OHA will spend $3299.00 per month for each member provided an authorization extension for services determined to not be medically appropriate. (not including unmatched GF payments, rehab reimbursement and cost of the .75% matched Kepro contract)

Beginning January 2018, OHA will have authorized $2.6 million in services that are not medically appropriate which will likely continue and increase exponentially. This already places OHA at risk of $1.6 million disallowance.

As of today, Kepro has made 410 determinations resulting in denial of continued stay. The table below includes only those 214 denials I have verified as being not medically appropriate and not due to documentation or prior authorization process errors. I will be reviewing the remaining denials and any new denials and anticipate OHA needing to extend services for up to 500 individuals by completion of this review.

#FY 2016-17 Average Cost Per Person = $39,599.00						
Month	**60+ Extensions**	**PMPM**	**# Month**	**TF (100%)**	**GF (36.38%)**	**FF (63.62%)**
AUG	3	$3,299.92	6	$59,398.56	$21,609.20	$37,789.36
SEP	40	$3,299.92	5	$659,984.00	$240,102.18	$419,881.82
OCT	130	$3,299.92	4	$1,715,958.40	$624,265.67	$1,091,692.73
NOV	3	$3,299.92	3	$29,699.28	$10,804.60	$18,894.68
DEC	14	$3,299.92	2	$92,397.76	$33,614.31	$58,783.45
JAN	24	$3,299.92	1	$79,198.08	$28,812.26	$50,385.82
			TOTAL	**$2,636,636.08**	**$959,208.21**	**$1,677,427.87**

As the administrator of the Kepro contract and person responsible for ensuring medical appropriateness of a $200,000,000.00 biannual Medicaid benefit, I am hoping through this e-mail to obtain immediate guidance on this issue and highlight the need for swift and significant action to address these issues.

Questions:

- ***Is it an option to not require or ensure Medicaid funded services are medically appropriate?***
- ***Is it allowable for OHA to continue to provide authorization and reimbursement for services that are not medically necessary based on determination by an IQA?***
- ***If not, at what point should OHA discontinue authorization and deny payment regardless of housing or community transition options available to members who do not want or who have been determined to no longer require the services and supports provided in a licensed setting?***
- ***If Oregon cannot or will not enforce determinations made by an independent reviewer, is it appropriate to continue to fund and claim federal medical assistance for claims paid for those services and payments made to an IQA contractor for those determinations?***

And a general question;

- ***Why, after so many years under USDOJ direction and HCBS authority are people in Oregon who reside in restrictive levels of care simply not able to access the Medicaid services and supports they need in a setting of their choice?***

One last related item. It's my understanding OHA has or will be requesting additional funds from LFO to increase rates paid to providers of residential services. I also understand OHA leadership presented for the LFO related to this and did not represent a recent $12 million increase in Medicaid payments to mental health residential providers.

- ***Why would OHA need more funding for a service currently representing an overpayment and which has been demonstrated as not appropriate for the majority of recipients?***

- ***Why is OHA not seeking funding for (non-licensed residential) home and community based services knowing the lack of Medicaid service available to members outside of licensed care?***

- ***Why was a $1.4 million monthly increase in expenditure to a provider group lobbying the legislature for additional funding not represented by OHA to the LFO?***

Looking forward to some guidance and please let me know if you have any questions.

Thank you,

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