West Virginia HEALTH HOMES

WV DHHR Bureau for Medical Services

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Health Home Provider Application for Behavioral Health Patient Populations

This Health Home Provider Application is an addendum to the WV Bureau for Medical Services Medicaid Provider Application

Organization Name: _____ Application Date: _____

DBA (if applicable): _____ National Prov. ID: _____

Physical Address: _____ CEO/Director: _____

City State Zip: _____ **Organization's Health Home Contact Person**

Mailing Address: _____ Contact's Name: _____

City State Zip: _____ Phone Numbers: _____

Phone Number: _____ Email Address: _____

Facsimile Number: _____ Mailing Address: _____

Email Address: _____ _____

For informational purposes only, please check all accreditations your organization possesses:

☐ CARF ☐ URAC ☐ JCAHO ☐ Other _____ _____Other_____

Has your organization received National Committee for Quality Assurance Physician Practice Connection® - Patient-Centered Medical Home Recognition? ☐ Yes ☐ No Projected Date_____

HEALTH HOME PROVIDER AGREEMENT

A. Health Home Provider will notify members of their right to choose another provider and to refuse HH Services.

B. Health Home Provider agrees with the Health Home goal to control costs of members' benefits while maintaining quality health care by:

- B.1 preventing unnecessary hospital, residential, and rehabilitation admissions/readmissions.
- B.2 avoiding unnecessary emergency room visits.
- B.3 performing regular medication reconciliations.
- B.4 coordinating care through electronic means when possible including electronic Health Records.

C. Health Home Provider will maintain the mandatory staffing and credentialing criteria for HH staff/team.

D. Health Home Provider will implement the six health home services:

- D.1 Comprehensive Care Management
- D.2 Care Coordination
- D.3 Health Promotion
- D.4 Comprehensive Transitional Care
- D.5 Individual and Family Support Services
- D.6 Referral to Community and Social Support Services

E. Health Home Provider will report information to Managed Care Organizations required to maintain accreditations.

F. Health Home Provider will submit required data to the DHHR BMS or their representative in order to measure program outcomes and report the Adult Quality Measures.

G. Health Home Provider will maintain Memorandums of Understanding with the required providers to serve their Members as described in the WV Health Home Provider Standards.

H. Health Home Provider will obtain Consent/Release of Information agreements with each provider currently serving their Health Home members.

I. Health Home Provider agrees to follow all regulations/requirements in the WV Health Home Provider Standards.

Health Home Service Locations (Include City and County of each Site): _____

_____

_____

_____

_____

AFFIRMATION

I affirm, under the penalties for perjury, that the forgoing and following information is true, accurate, and complete. I understand that payments submitted under this NPI number will be from Federal funds, and that any falsification or concealment of material fact may be prosecuted under Federal and State laws. The West Virginia Bureau for Medical Services (BMS) may ask for additional information regarding any of the information submitted as part of this form and application. BMS will pursue repayment in all instances of improper or duplicate payment. By signing this form, the provider attests that he/she has read and understands the policies and procedures set forth in the West Virginia Health Home Provider Standards.

The owner or an authorized official of the business entity, directly or ultimately responsible for operating the business, is the authorized signatory of this form.

Print Official's Name:_____ Official's Title:_____

Official's Signature: _____ Date: ____ ____ / ____ ____ / ____ ____

Return Complete Applications to: Kim O'Brien, WV DHHR Bureau for Medical Services, 350 Capitol Street, Room 251, Charleston, WV 25301-3706

BMS Use Only - Thank you:

Receipt Date: _____ Final Review Outcome: _____

Review Date: _____ Provider Notification: _____

Reviewer Name _____ Claims Payer Notification: _____

Reviewer Notes: _____

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