Optum Behavioral Health - One Care Medicare-Medicaid Plan Overview

Webinar Date: Tuesday, November 16, 2021

OPTUM®

Introduction

Plan Overview

Summary

- One Care MassHealth plus Medicare Program (MMP) covering dual eligible individuals with disabilities aged 21 – 64 years with a program of integrated care providing primary, acute, specialty, and behavioral health care needs, as well as prescription medications, dental, vision and long-term services and support (LTSS) needs
- Physical Disabilities
- Disabled who are homeless
- Multiple chronic illness / cognitive limitations
- Substance Use
- SMI
- IDD

Our network providers are essential partners in improving health outcomes for our members and we are excited to have you aboard.

Program Launch Date:

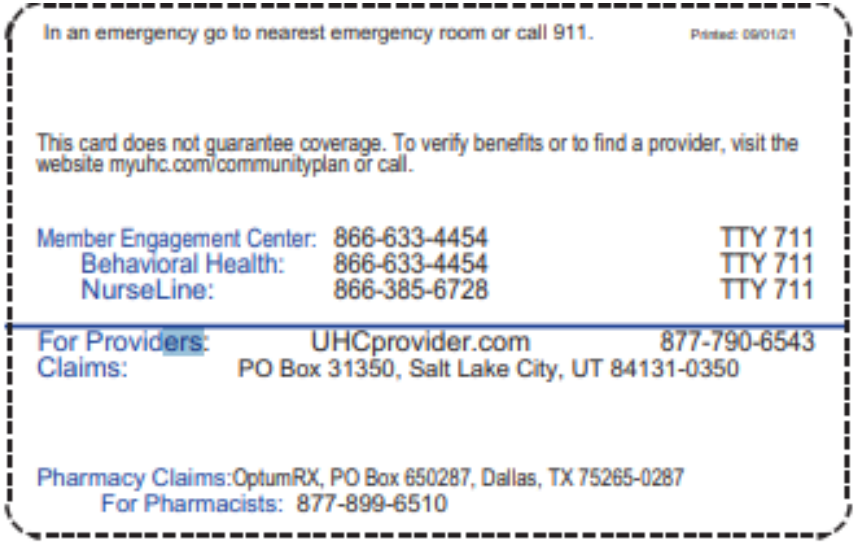
- January 1, 2022

Plan Overview continued

- Individuals aged 21-64 who are dual eligible for both Medicaid and Medicare benefits:
- These individuals require integrated care providing primary, acute, specialty, and behavioral health care needs, as well as prescription medications and long-term services and support (LTSS) needs
- They may have disabilities, be older adults and may also receive behavioral health services.
- Many of these members face barriers while attempting to access health care. These barriers may include speech and hearing, environmental barriers to physical access, cognitive challenges, social prejudices and stereotypes.
- Providers who serve this member population are:
  - Encouraged to work with each member's UnitedHealthcare Connected® for One Care Medicare-Medicaid Plan Care Coordinator to leverage appropriate supports and services.
  - Explore innovative ways to overcome these barriers to allow members access to appropriate levels of care.

Eligibility and Benefits

Member ID Card:



Eligibility and benefits verification using Provider Express

Provider Express - providerexpress.com

Our industry-leading provider website:

- Includes both public and secure pages for behavioral health providers

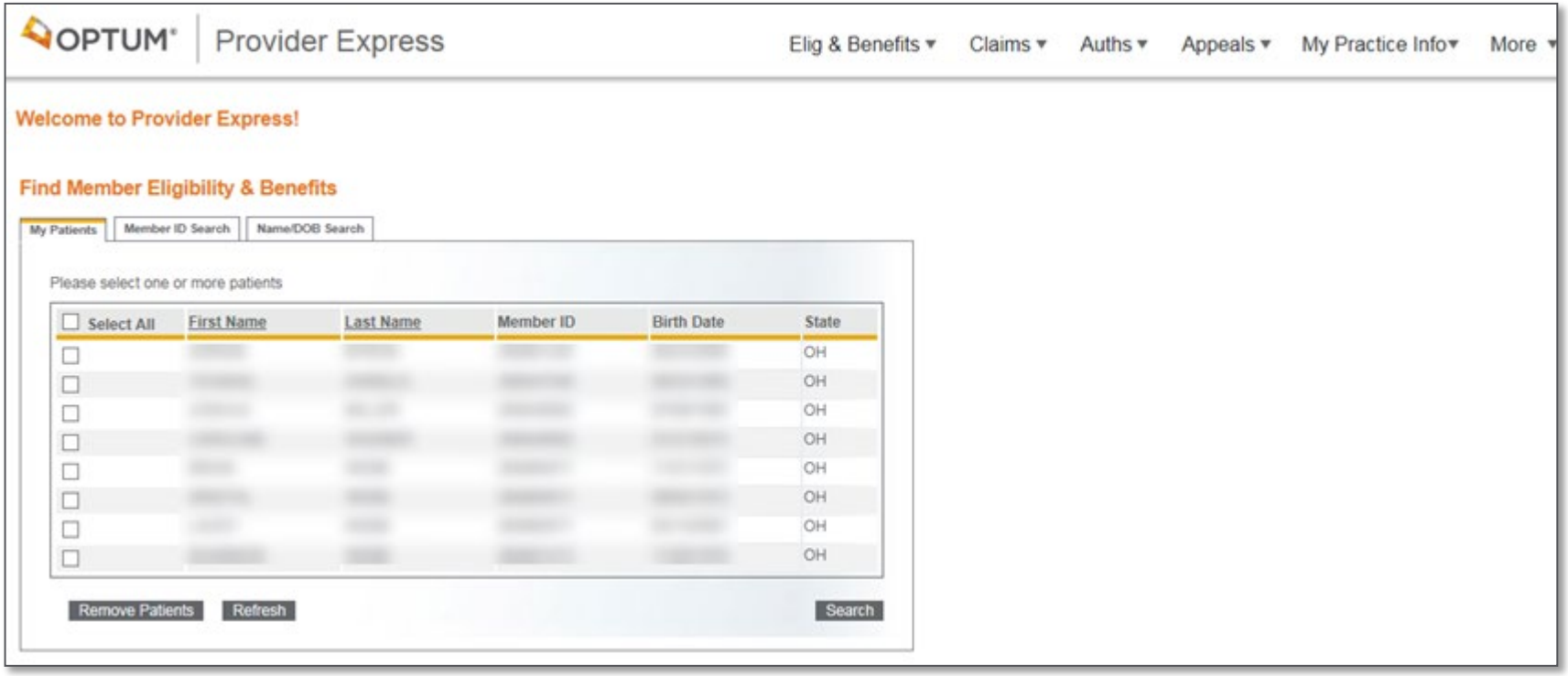
Eligibility & Benefits allow users to search for a member's eligibility by using My Patients list, Member ID Search or the Name/DOB Search:

- The My Patients list is also built using this transaction

Eligibility and benefits, member search

Provider Express offers three methods for searching eligibility:

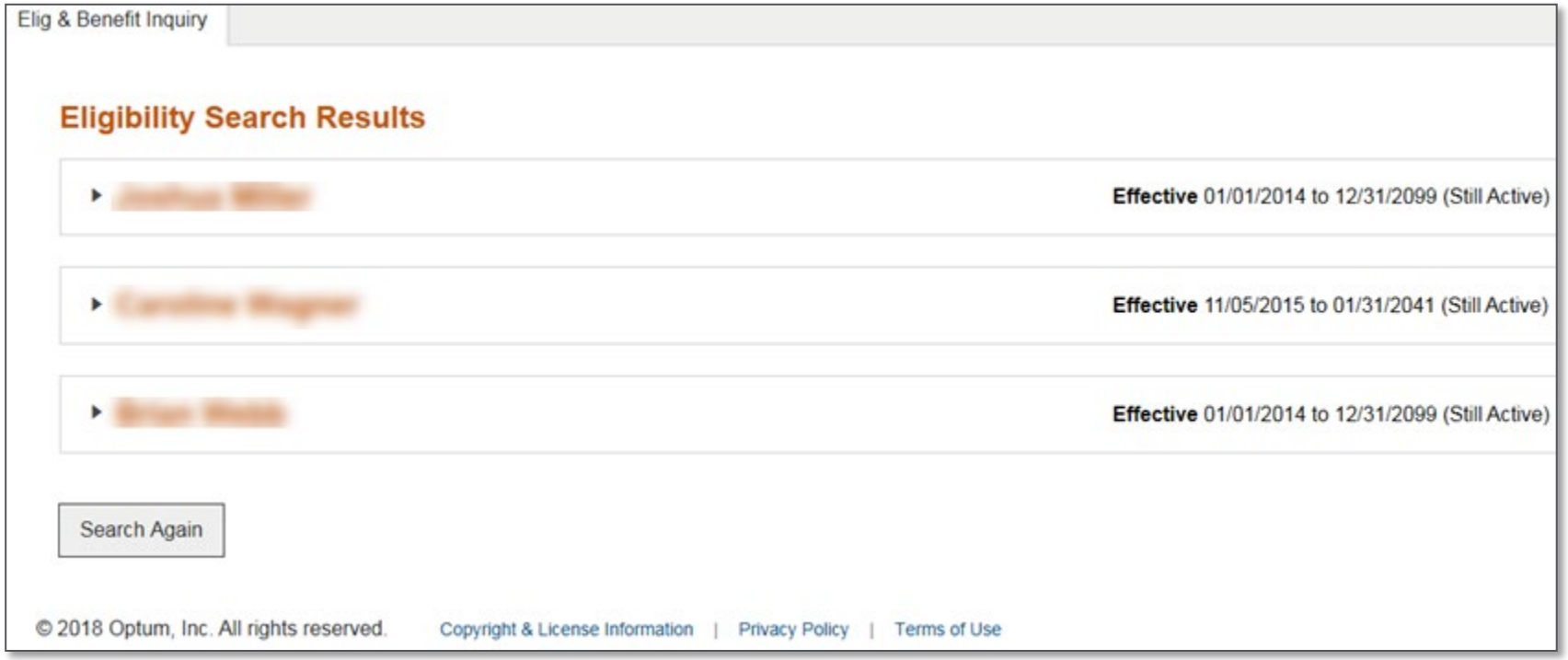
- My Patients (a list you build yourself)
- Member ID
- Name/DOB



United Behavioral Health operating under the brand Optum

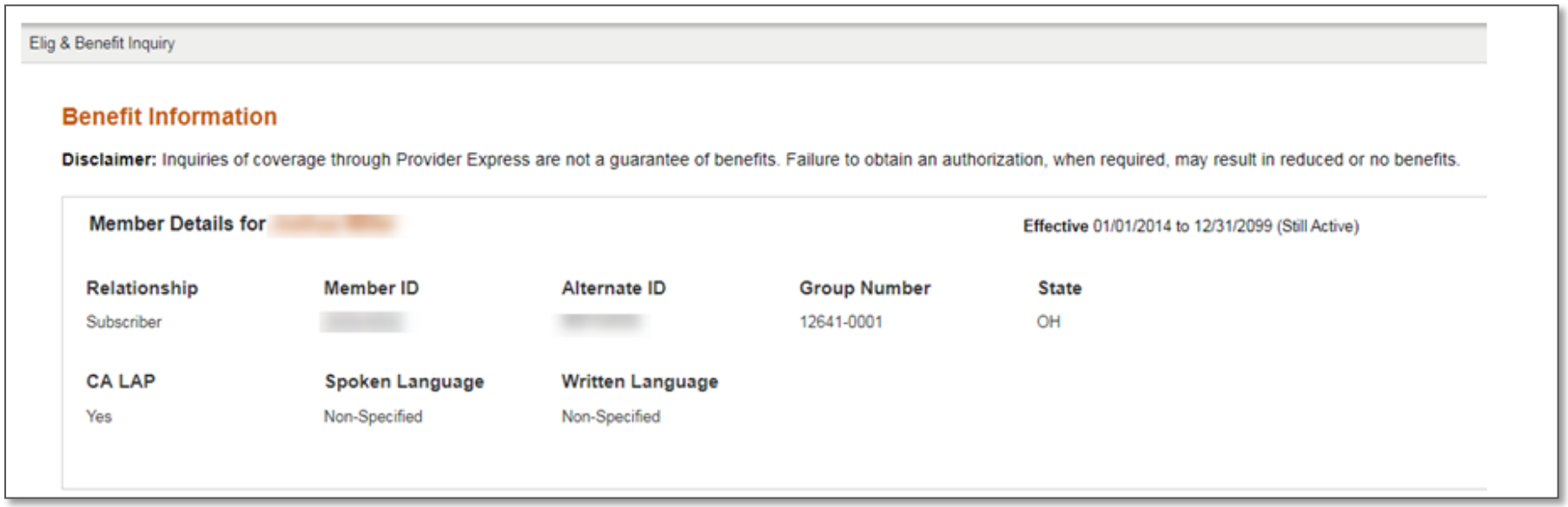
Eligibility and benefits, member search (continued)

If multiple members are selected from the My Patients list, the results show in rows. The triangle to the left of the name expands/collapses the eligibility details.



Eligibility and benefits, viewing benefits

The Member details section includes the Member ID, Alternate ID (if applicable), Group Number, State, the Spoken Language and Written Language the member identified.



Authorizations

Authorization process

Authorizations can be requested in two ways:

1. Contracted providers can request authorizations for most services via the online portal system on Provider Express (providerexpress.com). You will need to log-in to request authorizations.

2. Calling Optum via the number on the member's card

Check authorization status online

Once you have obtained authorization for clinical services, you have the capability in the secure Transactions on *Provider Express* to:

- Look up authorizations, even if the authorization was not generated through *Provider Express*
- View authorization details

Clinical Overview

Clinical Model of Care Overview

- **Social Inclusion**: We identify ways we can help remove barriers that restrict life choices for people with disabilities and chronic illness.
- **Independent Living**: We believe people with disabilities and complex comorbidities have the right to make informed decisions and direct their own life. They are experts on what they need. We learn from them what their goals are and how those can be achieved in community settings when possible.
- **Person-Centered Care**: Our approach to person-centered care is to put the person at the center of our holistic assessment and care planning process. Our care planning process considers what is "*important to*" and not just what is "*important for*" the person.
- **Recovery**: We know recovery is a journey rather than an outcome. Within our recovery approach, we use a variety of peer-run programs.
- **Trauma Informed Care**: We have integrated a culture of trauma informed care in our training, staff development and provider training which is deployed across our national Medicare-Medicaid plans.
- **Wellness**: Wellness is part of our whole person approach to care planning, including physical, social, emotional/spiritual, intellectual and academic/career. We apply these principles of promoting wellness during every touch point with the person

Clinical Model of Care Overview

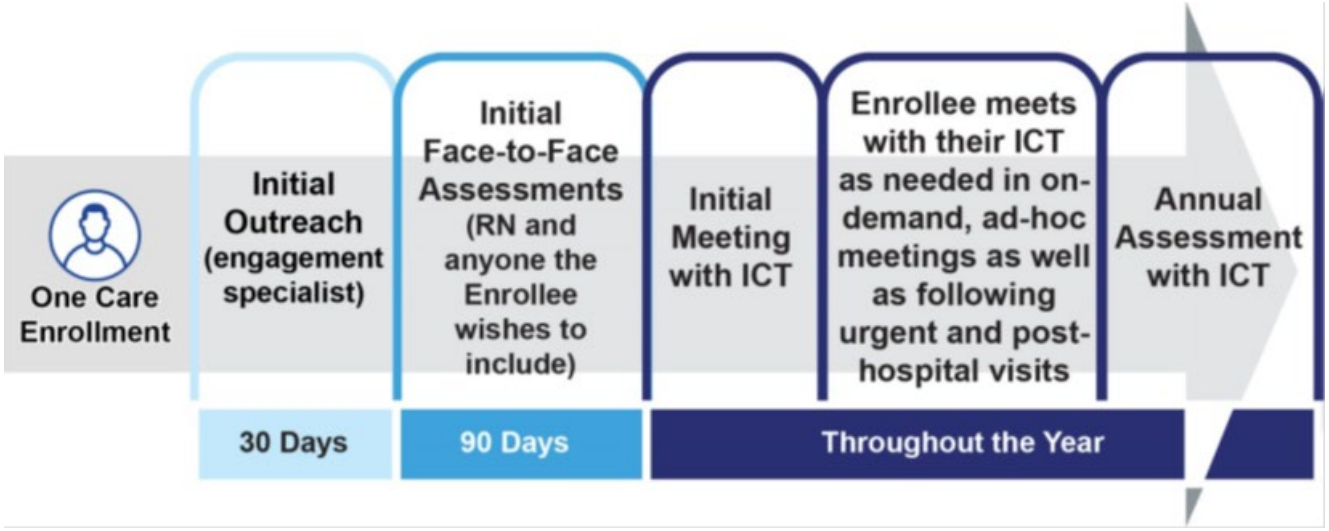
- **One Care Member Engagement Center**
- Replaces the standard call center model for enrollees and builds on innovations, our One Care Member Engagement Center provides direct communication access through a multi-channel engagement center with enrollee services representatives (ESRs) and clinicians who ease the enrollee's interaction with the care delivery system, social supports, benefits and claims.
  - Each enrollee has an assigned ESR who they can contact to resolve issues.
- We designed the center as an innovative best practice enrollee-engagement model to serve enrollees with disabilities and complex illness who have difficulties engaging with traditional call centers.
  - The **expected impact** of implementing this is to decrease or eliminate call transfers, reduce appeals, increase enrollee satisfaction, and ultimately realize program savings by better engaging enrollees

Clinical Model of Care Overview

- **Aunt Bertha**
- 4 out of 5 physicians think patients' social needs that are not met, lead to worse health outcomes and are as important to address as medical conditions.
- To combat this, Aunt Bertha (a web-based database), helps care coordinators, long-term support coordinators (LTS-C) and community health workers connect enrollees to relevant and available social resources that deliver services to individuals at risk for poor health outcomes or inappropriate use of health care services.
    - Food
    - Housing
    - Legal Resources
    - Employment Assistance
    - Childcare
    - Clothing

Clinical Model of Care Overview

- We understand people receiving benefits through our One Care program have complex needs, which may include: people with one or more disabilities, sometimes in combination with chronic illness, behavioral needs, functional or cognitive limitations, and some who may be homeless.
- We focus on the individual and their expressed needs and goals through an integrated holistic approach.
- Below depicts a high-level view of the touch points we will have with individuals through our care management model.



Interdisciplinary Care Team (ICT)

Interdisciplinary Care Team (ICT) and Care Coordinator

- Each Member is assigned a Care Coordinator who will provide person-centered care coordination, develop an Interdisciplinary Care Team (ICT), and an Individualized Care Plan with the participants.
- The team will consider the individual needs of the member including current and unique psycho-social and medical conditions. The functional level, support systems required, clinical and non-clinical needs will also be assessed to develop goals, interventions, and expected outcomes.
- This coordination of behavioral health and long-term services will be documented within the person-centered plan to include recovery goals and supports that promote independent living.

Interdisciplinary Care Team cont..

This team of individuals that will provide person-centered care coordination to the plan participants.

The team consists of:

- Participant and/or his/her designee
- Care Coordinator
- Long Term Service Coordinator (LTS-C) at member's discretion
- Primary Care Physician
- Behavioral health professional
- Participant's home care aide
- Other providers either as requested by the Participant or his/her designee or as recommended by the Care Coordinator or Primary Care Physician and approved by the Participant and/or his/her designee

Care Coordinator

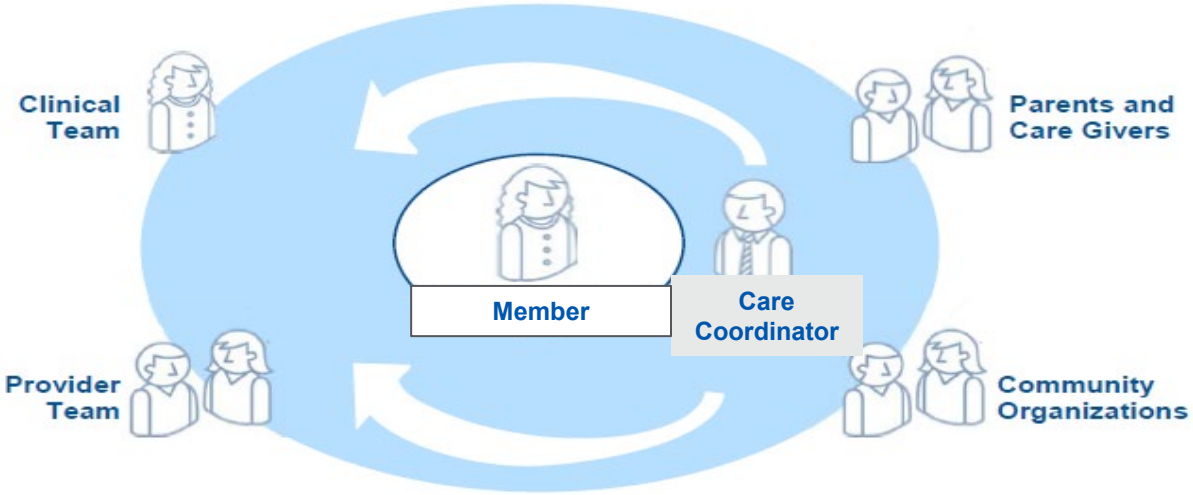
The Care Coordinator

- A designated UnitedHealthcare Connected® for One Care Medicare-Medicaid Plan qualified professional is accountable for each participant's care coordination. This individual functions as the Interdisciplinary Care Team (ICT) Lead who is primarily responsible for conducting, directing, or delegating care management duties, as needed.

- Responsibilities include:
  - Facilitating Interdisciplinary Care Team (ICT) activities and communications with and on behalf of the member
  - Facilitating assessment of needs
  - Developing, implementing and monitoring the Individualized Care Plan

Care Coordinator

- By coordinating all care through the Care Coordinators, Primary Care Physicians, the Clinical Team and Family, members can be assured that all concerns will be addressed appropriately and efficiently after the member leaves the provider's office.



- The care will be outlined via an Individualized Care Plan (ICP) which will provide a road map for the Care Coordinator and ICT to follow.

Care Coordinator

As part of an integrated health care delivery system for dual eligible members, being able to assess the members needs, providers and members of the Inter-Disciplinary Care Team can review and use screening and social assessment tools

- ✓ How to identify behavioral health needs
- ✓ How to assist the Participant in obtaining behavioral health services
- ✓ How to identify community-based and facility-based LTSS needs
- ✓ How to assist the Participant in obtaining community-based and facility-based LTSS services

These screening and social assessment tools will aid in determining when and how to best treat the member.

As a provider, if you notice a change in the member's ability to perform activities of daily living (ADL) or in their mental health, reach out to the Care Coordinator to determine if a new assessment or change in the Individualized Care Plan (ICP) is needed.

Interdisciplinary Care Team

Features:

- Member-centric, clinical, and operational team
- Addresses medical, behavioral, and social needs

- Comprised of a Care Coordinator, the member, the providers, caregivers and the health plan

Continuity of Care

Continuity of Care

Continuity of Care/Transition of Care

- Optum ensures members continue to receive necessary services upon their enrollment in our One Care program. While a member's Care Coordinator works with the member to assess their needs, members can continue to obtain services from the providers that they've been receiving them from, for a period of up to 90 days from the date of their enrollment; even if that provider is not in the network.

- The Care Coordinator and Integrated Care Team work to ensure members can continue to receive medically necessary services and will help to transition them to a new provider, if UnitedHealthcare is unable to contract with that provider.

Discharge planning

- Effective discharge planning:
  - Addresses how a member's needs are met during a level of care transition or change to a different treating provider
  - Begins at the onset of care and should be documented and reviewed over the course of treatment
  - Focuses on achieving and maintaining a desirable level of functioning after the completion of the current episode of care
- Discharge instructions should be specific, clearly documented and provided to the member prior to discharge:
  - Members discharged from an acute inpatient program must have a follow-up appointment scheduled prior to discharge for a date that is **within seven (7) days of the date of discharge**
- Throughout the treatment and discharge planning process, it is essential that Members be educated regarding:
  - The importance of enlisting community support services
  - Communicating treatment recommendations to all treating professionals
  - Adhering to follow-up care

Utilization management statement

Optum uses written criteria consistent with NCQA and URAC requirements, and applicable State and Federal regulations. For behavioral health services, Optum uses its Clinical Criteria to make coverage determinations.

- Centers for Medicaid and Medicare (CMS) National and Local Coverage Determinations (NCDs/LCDs) American Society of Addiction Medicine (ASAM) Criteria
- Level of Care Utilization System (LOCUS)
- American Psychological Association Psychological and Neuropsychological Billing and Coding Guide
- American Society of Addiction Medicine (ASAM)

Clinical Criteria can be found at providerexpress.com:

- Path: Provider Express > Clinical Resources > Clinical Criteria

Residential Rehabilitation Services (RRS) and Recovery Coach Services

Authorization process for RRS

Residential Rehabilitation Services is a 24-hour structured and comprehensive rehabilitative environment that supports Enrollees' independence and resilience and recovery from alcohol and/or other drug problems.

Substance Use Disorder (SUD) Residential Rehabilitation Services: Optum complies with all requirements outlined in Session Laws, Acts (2014), Chapter 258.

- SUD Residential Rehabilitation Services Level 3.1: no authorization is required for the first ninety (90) days
- SUD Residential Rehabilitation Services, all other Levels: no authorization is required for the first fourteen (14) days

Authorizations can be requested in two ways:

1. Contracted providers can request authorizations for most services via the online portal system on Provider Express (providerexpress.com). You will need to login to request authorizations.
2. Calling Optum via the number on the member's card ASAM Criteria will inform the concurrent review process.

Recovery Coach Services Authorization and Concurrent Review

Our recovery coach works with members to develop coping skills. Skills include encouragement, safety and a sense of responsibility for their own recovery. This benefit also emphasizes support to those with a behavioral health diagnosis while working through SUD treatment and recovery.

- Members may access Recover Coaching services without a referral.
- Please call the number on the back of the member's insurance card for more information.

Behavioral Health HEDIS® Measures

Behavioral Health HEDIS® Measures

Initiation and Engagement of Alcohol and other Drug Dependence Treatment (IET)

The percentage of adolescents and adults who were diagnosed with a new episode of a Substance Use Disorder who initiate treatment within 14 days of an initial Substance Use diagnosis and then who were engaged in ongoing Substance Use treatment within 34 days of the initiation visit. Two rates are reported:

- Initiation: First follow up within 14 days of being diagnosed
- Engagement: If initiation was not a medication treatment event, at least 1 engagement medication treatment event or at least 2 engagement visits within 34 days following the initiation visit. If initiation was a medication treatment event, need 2 engagement visits within 34 days following initiation visit.

- The clock starts when the patient is first diagnosed with a Substance Use Disorder
- People can enter this measure through IP stay, Emergency Room, or Outpatient
- A follow-up visit with Primary Care Provider or Behavioral Practitioner counts for this measure
- Must have a principal diagnosis of Substance Use Disorder included on the claim
- Each member can be placed in more than one substance use cohort. Members included in separate cohorts will need to have a follow up visit that includes diagnoses for each substance in order to be compliant for each cohort

Behavioral Health HEDIS® Measures

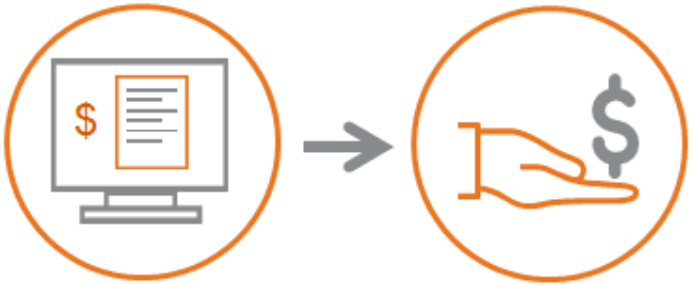
Follow-Up After Hospitalization for Mental Illness (FUH)

- In the 2022 measure technical specifications, NCQA removed Emergency Department (ED) visits and detoxification events with a diagnosis of a substance abuse disorder from the negative look-back period (194 days), so these will show in the denominator (included in the measure). These changes will likely lead to more complex, high risk, treatment resistant members who show up frequently in the ED. Members who frequently admit to the ED will be in the measure multiple times per year. Although, if they get MAT services while in the ED, they will be removed from measure.
- Although community supports, such as AA and NA, are beneficial they do not take the place of engagement with a behavioral health professional
- Includes telehealth (virtual visit), billable telephone, billable e-visit/virtual check-in

Claims

Claims filing made easy

File your claim electronically for a fast, secure and convenient claims experience



Benefits of Electronic Filing:

- **Fast** - Eliminate mail and paper processing delays
- **Convenient** - Easy set-up and intuitive process
- **Secure** - Data security is higher than with paper-based claims
- **Efficient** - Electronic processing helps prevent errors
- **Cost-efficient** - you eliminate mailing costs, and the solutions are free or low-cost

Claims submission option 1, Online: Provider Express

Our network clinicians report the highest level of satisfaction when they submit claims online through *Provider Express:*

- Free
- Available 24/7
- Intuitive and easy-to-use
- HIPAA Compliant
- Real-time, quick claims processing
- Available to clinicians and groups
- Outpatient behavioral and EAP claims

Tips for timely and accurate payments, Provider Express

Filing claims electronically on Provider Express can help prevent these common errors.

Missing or incomplete information	Member demographic info has errors	Unclear or illegible information
Provider Express "Claim Entry" prevents the submission of claim if required fields are blank *Examples*: NPI number, ICD-10 derived diagnosis code	Member information is auto-populated when you use *"Claim Entry"* on *Provider Express* *Examples:* Name, DOB, ID number	The Claim Entry form on *Provider Express* ensures legibility *Examples*: Provider or Member information illegible, diagnosis code unclear

Claims submission option 2: **EDI/ Electronically**

Submit batches of claims electronically, right out your practice management system software:
Payor ID #87726

Please ensure claims submissions comply with all federal and state taxonomy requirements

- Ideal for high volume Providers
- Can be configured for multiple payers
- Clearinghouse may charge small fee

To learn more about Electronic Data Interchange, visit Provider Express. From the Home Page, select Admin Resources > Claim Tips > EDI/Electronic Claims

Claims submission option 3: **Paper**

If you are unable to file electronically, follow these tips to ensure smooth processing of your paper claim:

- Use an original 02/12 Form 1500 claim form (no photocopies)
- Type information to ensure legibility
- Use a DSM-5 derived ICD-10 code for primary diagnosis (Hint: the DSM-5 online manual includes ICD codes along with the DSM diagnostic info)
- Complete all required fields (including ICD indicator and NPI number)

Claims submission option 3: **Paper**

MAOneCare address:

UnitedHealthcare Connected® for One Care Medicare-Medicaid Plan
P.O. Box 31350
Salt Lake City, UT 84131-0350

Standard Timely Filing:

- In-Network Providers – 90 Days from the Date of Service
- Out-of-Network Providers – 180 Days from the Date of Service

Receive payments faster through Optum Pay™

Benefits of Optum Pay™

- Easy set-up
- Payments deposited directly into your bank
- Simplified claims reconciliation
- 24/7 access to your information
- Secure payment and remittance advice

Registering for Optum Pay is easy!

- To enroll by phone call 877.620.6194 (7:00 am to 6:00 pm CST Monday – Friday).
- Click here to get started today

Appeals

Appeals

Provider Disputes

Optum has a formal process for handling practitioner/facility disputes that is compliant with the standards and regulations set forth by National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) and state/federal regulations. These standards and regulations serve as guidelines to ensure that:

- Review turnaround time requirements are met;
- Appropriately qualified professionals are involved in the review of practitioner/facility disputes;
- Relevant clinical/administrative information is consistently gathered and reviewed as part of the investigation;
- Practitioners/facilities are informed of the rationale for disputes that are upheld, in whole or in part.

One (1) level of internal dispute review is available through Optum, unless required by state law or contractual requirement.

Appeals: contact information

Optum
Appeals & Grievances
P.O. Box 30512
Salt Lake City, UT 84130-0512

Fax: 1-855-312-1470

Phone: 1-866-556-8166

Cultural Competency

Cultural competency

- As a health care provider, it is important for you to remember to be culturally sensitive to the diverse population you serve:
  - There are diverse cultural preferences that we ask providers to keep in mind when serving members
  - All services should be conducted in accordance with Title VI of the Civil Rights Act of 1964 and should be provided in a manner that respects the Member's cultural heritage and appropriately uses natural supports in the Member's community

Provider Express Resources:
Provider Express > Clinical Resources > Cultural Competency

Cultural competency, (continued)

Some additional resources for information on Cultural Competency:

- cms.hhs.gov/ocr – Office of Civil Rights
- LEP.gov – Limited English Proficiency (LEP): Site promotes importance of language access to federal programs and federally assisted programs
- diversityrx.org – Promotes language and cultural competency to improve the quality of health care for minorities
- ncihc.org – National Council on Interpreting in Health Care: Organization promotes culturally competent health care

Provider Resources

Provider Resources

Provider Express - providerexpress.com

Our industry-leading provider website:

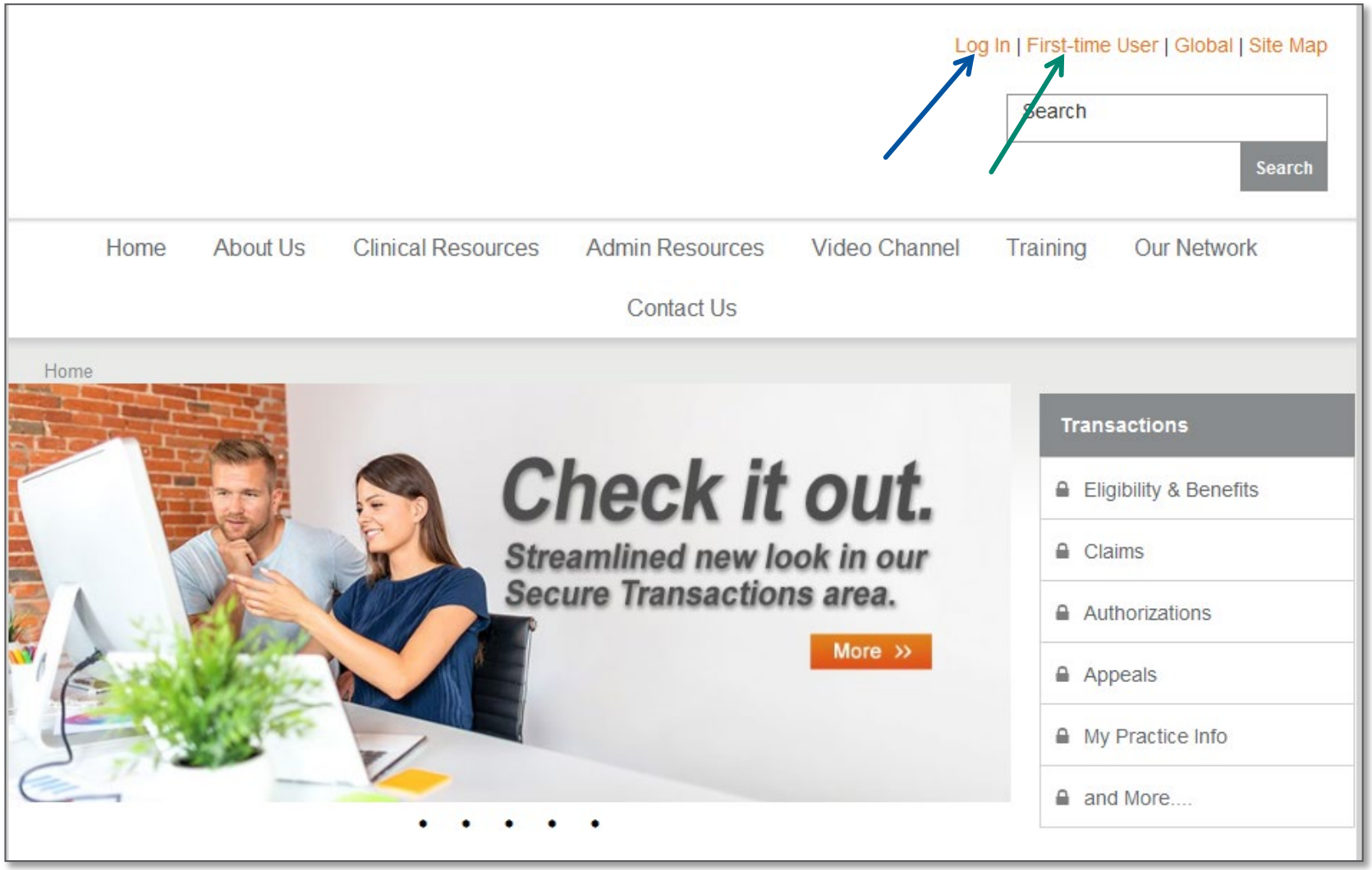
- Includes both public and secure pages for behavioral health providers
- Secure pages:
  - Require registration - One Healthcare ID
  - The password-protected “secure transactions” offers providers access to provider-specific information including the ability to update your practice information
- Public pages
  - General updates and useful information
  - Behavioral Health Toolkit for Medical Providers

Provider resources, (continued)

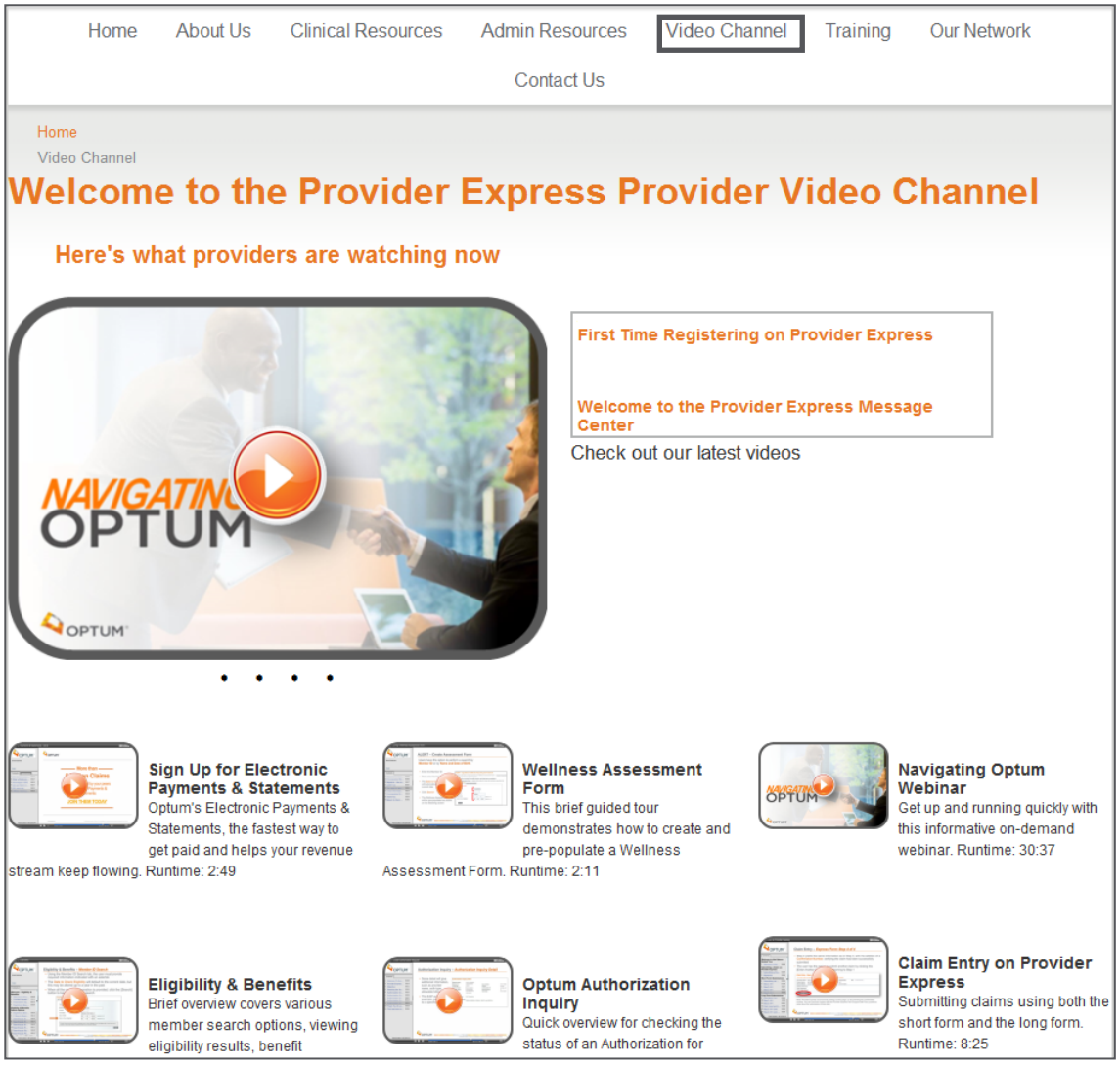
Public Pages: general updates and other useful information:

- Access forms library
- Find network contacts
- Review clinical guidelines
- Access *Network Notes*, the provider newsletter
- Clinical Criteria
- Training/Webinar offerings

Provider Express



Provider Express Video Channel



Provider Service Line – Claims Customer Service

- You can contact a claims representative via Provider Express's Live Chat by logging in and selecting Claim Inquiry. Locate the claim and towards the upper right on either "detail" page (above the member's ID #), click the link "Have questions about claim status?"
- As always, you are able contact the Customer Service number on the back of the member's insurance card or on the Explanation of Benefits (EOB) / Provider Remittance Advice (PRA) weekdays, 8:00 a.m. to 6:00 p.m.
- Please be sure to obtain a tracking number from your call for escalation purposes

Provider Relations – Escalated Issues

For escalated issues please contact Provider Relations. Please have a tracking number available.

- **Pamela Connolly, Director, Provider Relations & Advocacy** (MA, NH, ME) pamela.connolly@optum.com
- **Claire Tigges, Sr Provider Relations Advocate** - Plymouth, Bristol, Barnstable, Dukes, Nantucket Counties claire.tigges@optum.com
- **Valbona Lamaj, Sr Provider Relations Advocate** - Worcester, Berkshire, Hamden, Franklin, Hampshire Counties valbona_lamaj@optum.com
- **Karen O'Connor, Provider Relations Advocate** - Suffolk, Norfolk Counties karen.oconnor@optum.com
- **Glenys Palomino, Provider Relations Advocate** – Essex, Middlesex Counties glenys_palomino@optum.com

Questions