Salish Integrated Managed Care Clinical Symposium

Co-Hosted By:

Amerigroup An Anthem Company | coordinated care | MOLINA HEALTHCARE | UnitedHealthcare Community Plan

October 2019

Agenda

- Tribal Welcome and Land Acknowledgement
- IMC Overview and MCO Introductions
- Partnering with MCOs
  - Access to Care and Appointment Standards
  - Common Utilization Management Guidelines
  - Prior Authorizations
  - Case Management
  - Program Integrity and Monitoring
  - Resources
- Questions and Answers

Tribal Welcome

THE SUQUAMISH TRIBE

dxʷsəq̓ʷəb Place of the Clear Salt Water

Tribal Land Acknowledgement

We acknowledge that the Suquamish, the "people of the clear salt water," had a winter village in Silverdale and a few other villages further south.

As part of the 1855 Treaty of Point Elliott with the United States, the Suquamish Tribe retained the right to self-govern, including providing for the health and welfare of their families. We appreciate their collaboration in the Medicaid Transformation work, particularly as part of the Olympic Accountable Community of Health.

We hope to better understand how we can support the wellbeing of the Suquamish families and encourage our partners here today to do the same.

IMC Overview

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Integrated Managed Care Background

State legislation directed the Health Care Authority to integrate the care delivery and purchasing of physical and behavioral health care for **Medicaid statewide by 2020**.

- Southwest was the only "early adopter" and implemented April 1, 2016.
- North Central implemented January 1, 2018.
- Pierce, Greater Columbia and Spokane implemented January 1, 2019.
- North Sound implemented July 1, 2019.
- Great Rivers, Thurston-Mason and Salish will implement January 1, 2020.

Managed Care Organizations by Regions

Managed care region	Amerigroup	Community Health Plan	Coordinated Care	Molina Healthcare	United Healthcare
As of January 2019					
Greater Columbia	●	●	●	●	
King	●	●	●	●	●
North Central	●		●	●	
Pierce	●		●	●	●
Spokane	●	●		●	
Southwest	●	●		●	
As of July 2019					
North Sound	●	●	●	●	●
Coming January 2020					
Thurston-Mason	●			●	●
Great Rivers	●			●	●
Salish	●			●	●

*Apple Health Foster Care is a statewide program, provided through Apple Health Core Connections (Coordinated Care of Washington).

Washington State Health Care Authority

HCA 19-0025 (1/19)

Update on Adoption Status

Whole Person Care

- Whole person care is an approach to address physical and behavioral health needs in one system through an integrated network of providers, offering:
  - ✓ Member centered care
  - ✓ Better coordinated care for individuals
  - ✓ More seamless access to services

How does this help members?

- In Southwest region, 10 of 19 outcomes measured in the first year showed statistically significant improvement, relative to other regions. https://www.hca.wa.gov/assets/program/FIMC-preliminary-first-year-findings.pdf
- Strong evidence supporting integrated care delivery to effectively address co-morbid conditions and deliver holistic care.
  - Almost 75% of Medicaid enrollees with significant MH and SUD had at least one chronic health condition.
  - 29% of adults with medical conditions have MH disorders.
  - Americans with major mental illness die 14 to 32 years earlier than the general population, often due to untreated physical health conditions.
- MCO contracts require coordination with county-managed programs, criminal justice, long-term supports and services, tribal entities, etc. via an Allied System Coordination Plan.

Two HCA Contracts Cover All Enrollees

Medicaid Covered Services

- Physical Health (e.g. Apple Health)
- Mental Health (MH)
- Substance Use Disorder (SUD)

Non-Medicaid Services

- Behavioral Health services **NOT** covered or funded by Medicaid
- These services are funded by General Fund – State dollars
- Examples of services: room and board, sobering services

Enrollees

- Apple Health IMC Medicaid children, families, adults, blind/disabled
- Behavioral Health Services Only (BHSO) members will only receive behavioral health benefits through MCOs. Medical benefits remain Fee-For-Service.

Services Not Covered by MCO Contracts

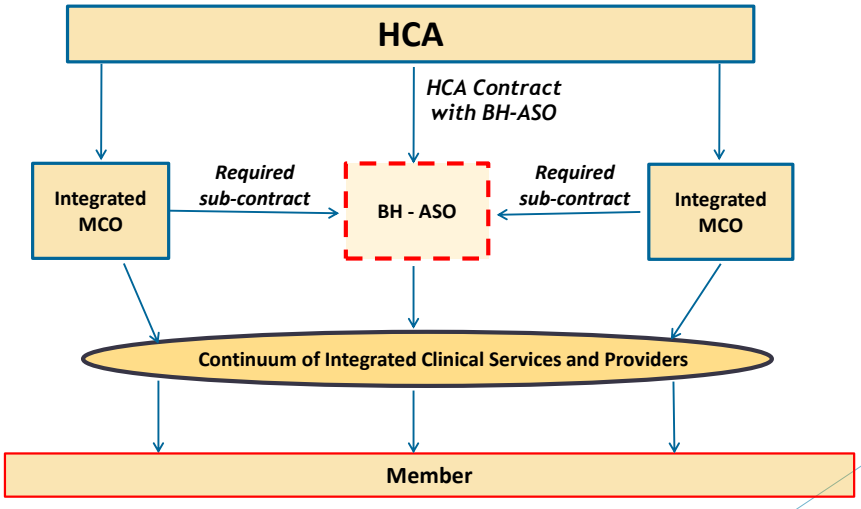
Crisis services for all members of the community
- Includes DCRs

State-funded services for Non-Medicaid individuals

County-funded services for Medicaid and Non-Medicaid individuals

Miscellaneous
- BH Ombudsman
- Behavioral Health Advisory Board
- Federal Block Grant
- Legislative Provisos

Crisis System Management



MCO Introductions

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Amerigroup
An Anthem Company

People Come First

Amerigroup focuses on improving health and wellness one member at a time, by doing the right thing for every member every time. We engage and support members and their families to be active participants in their case and to help them make healthy, informed decisions.

Whole Person Care

Integration is at the heart of our philosophy and approach to the coordination of benefits and services. Our person-centered model helps members access the full array of comprehensive high-quality services and supports they need.

Getting Results

Amerigroup seeks out new and better ways to improve member health outcomes, quality of live, and access to high quality, cost-efficient care and services. We achieve positive outcomes for members and generate value for states through our innovative approaches.

Amerigroup
An Anthem Company

Amerigroup in Washington:

- We help provide access to health care for over 187,000 Amerigroup members statewide
- Apple Health
- Integrated Managed Care: one of two statewide MCOs
- Behavioral Health Services Only
- Foundational Community Supports
- Achieved over 80% VBP arrangements
- Multicultural Healthcare and Managed Behavioral Healthcare Organization Distinction from NCQA

Provider Network:

- Over 65,000 providers
- Over 120 Hospitals
- 24 Community Health Centers with over 200 locations

ACCREDITED NCQA MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION

Amerigroup
An Anthem Company

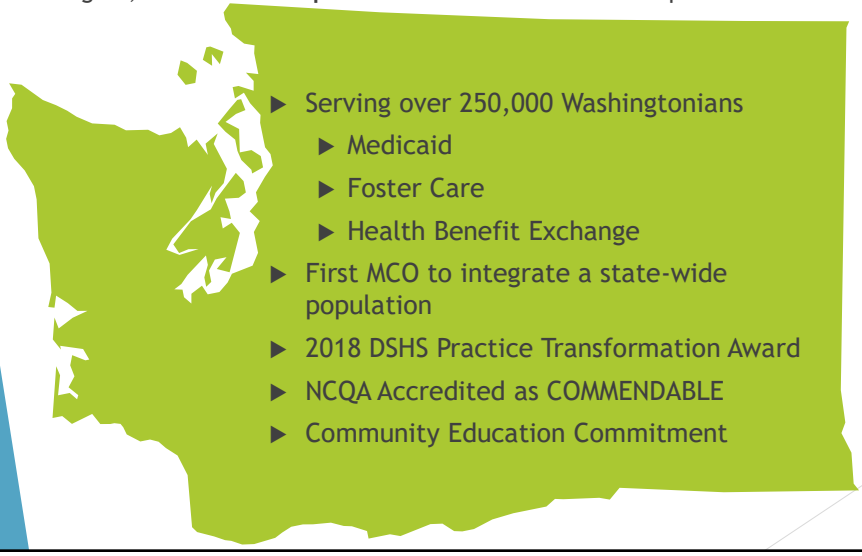
Value Added Benefits:

A Whole Person Health Focus

- Peer Support Specialist registration and renewal payment
- No-cost eyeglasses up to $100 annually for members 21-64
- GED test payment
- Acupuncture
- No-cost sports physicals for members 7-18 years old
- No-cost Boys & Girls Club membership
- $50 gas card for non-medical transportation to access social services
- Taking Care of Baby and Me program
- MyStrength for members 13 years and older
- Light Boxes for members with SAD

coordinated care

Mission Statement: To be the **highest quality** health plan in Washington, and the **health plan of choice** for members and providers

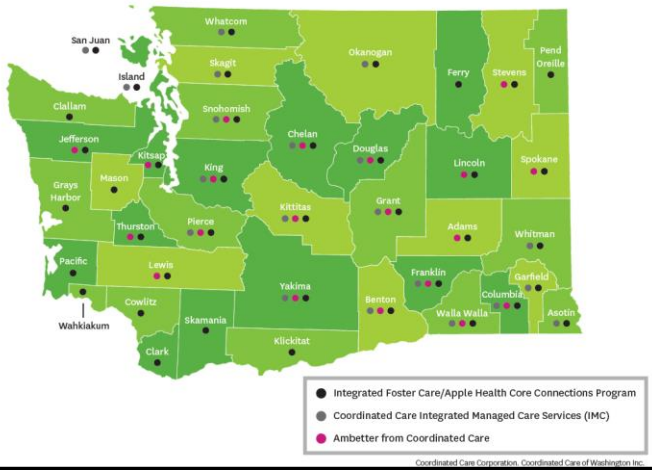


- Serving over 250,000 Washingtonians
  - Medicaid
  - Foster Care
  - Health Benefit Exchange
- First MCO to integrate a state-wide population
- 2018 DSHS Practice Transformation Award
- NCQA Accredited as COMMENDABLE
- Community Education Commitment

Coordinated Care: We've Got You Covered

coordinated care

2020 Coordinated Care Network



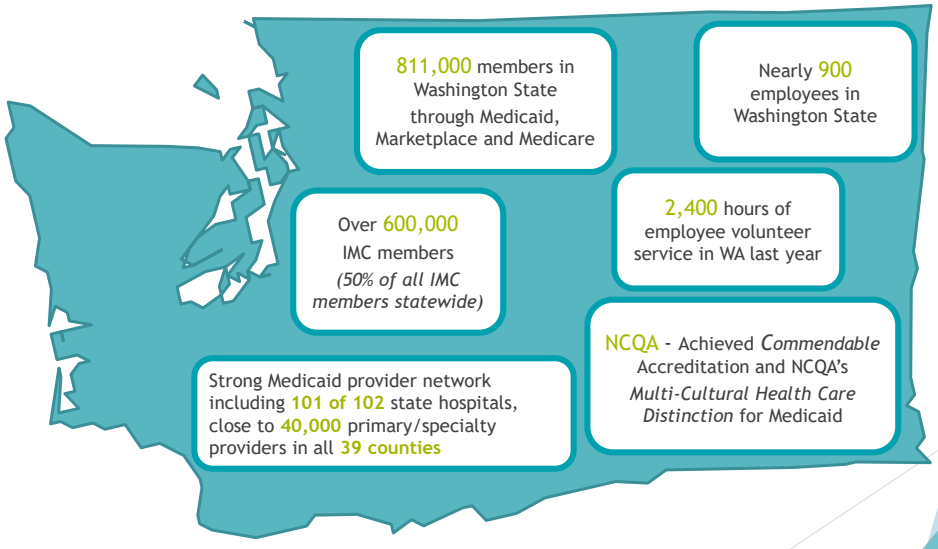
coordinated care

Value-Added Member Benefits

- **Earn Rewards**: Complete preventive exams to earn dollar rewards
- **Start Smart for Your Baby®:** Includes prenatal and postpartum support, education, home monitoring for high-risk pregnancies, no-cost breast pump and no-cost car seat.
- **Safelink:** No-cost cell phone with 1,000 minutes per month and unlimited texting for qualifying members. Access to our staff and 24/7 Nurse Advice line do not count toward monthly minutes.
- **Care Management:** Advocates supporting members dealing with diseases, behavioral/mental health, connecting to community resources and removing barriers to achieving better health.
- **Online Member Account & App**: View rewards balance, change your PCP, complete forms, send secure messages or view/request ID cards
- **Boys and Girls Club Membership**: no-cost annual membership for 6-18 year-olds to participating clubs, where they can exercise, practice healthy abits and build lifelong friendships.

Molina Healthcare of Washington

Our Mission: To provide quality health care to people receiving government assistance



Molina Healthcare of Washington

Leading the way to whole person care

Integrated Managed Care

- Selected (with the highest score) to launch IMC in all 10 Washington regions
- Eight years of integrated care experience with HCA's WMIP pilot in Snohomish county
- Third year of experience in SW WA, serving over 85,000 IMC members
- Currently serving well over 50% of all IMC members statewide

Local and Personal Member Support

- Lead organization for the Health Home program
- Close to 900 employees including remote and community-based staff who live and work in the communities they serve
- Community Engagement, Supportive Housing and Supported Employment

Molina Healthcare of Washington

Value-Added Member Benefits

United Healthcare in Washington

- UnitedHealthcare Community Plan serves 185,000 Washington Apple Health members.
- We serve 36,000 Dual Special Needs Plan members, making us the largest DSNP plan in the state
- We are the second largest plan in Western WA
- We serve on the Accountable Communities of Health, where we support mutual goals around health in housing programs, jail transitions, behavioral health integration and maternal-child health programs, and work collaborative with our MCO partners
- We have a long-standing partnerships with safety net providers, including Community Health Centers, low income housing and supportive service providers
- We are implementing Integrated Managed Care in King, Pierce and the North Sound for a 2019 start and in 2020 for the remaining regions

UnitedHealthcare®
Community Plan

Value-Added Benefits - UnitedHealthcare

- Quit For Life® program.
- Member Rewards for Well-Child, Screenings.
- Extra pregnancy support and rewards for moms.
- Support for complex conditions.
- Youth programs with free Boys & Girls Club memberships, Sesame Street™ and youth grants.
- Sports physicals.
- UnitedHealthcare On My Way for teen engagement on health and life.

UnitedHealthcare® Community Plan

UHC Focus on Social Determinants

UHC Focus on Social Determinants of health into its clinical model, collaboration strategies and outreach priorities.

FOOD

Providing reliable access to food could **save over $215** per member per month in health care costs.

HOUSING

Creating safe, affordable housing can **reduce** health care costs **by over $350** per member per month.

EDUCATION

Supporting the completion of high school can **decrease** health care costs **by over $140** per member per month.

UnitedHealthcare® Community Plan

Access to Care and Appointment Standards

Access to Care Standards

- DSHS Access to Care Standards implemented by DBHR (utilized by BHOs) will be eliminated January 1, 2020.
- MCOs will utilize medical necessity criteria rather than the DBHR Access to Care Standards. MCOs will now oversee all Medicaid-covered behavioral health benefits, regardless of diagnosis.
- MCOs will continue to utilize industry standard medical necessity decision making guidelines, based on evidence based practices, for determining levels of services.

Appointment Standards

MCO appointment standards comply with the Health Care Authority (HCA) and the National Committee for Quality Assurance (NCQA) requirements. **Providers must also adhere to these standards.**

Type of Care	Appointment Standard
Preventive Care Appointment	Within 30 calendar days of request
Second Opinions	Within 30 calendar days of request
Non-Urgent, Symptomatic Care	Within 10 calendar days of request
Urgent Care	Within 24 hours
Emergency Care	24 hours/7 days
After-Hours Care	Available by phone 24 hours/seven days
Care Transitions – PCP Visit	Transitional healthcare services by a Primary Care Provider, within 7 calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program
Care Transitions – Home Care	Transitional healthcare services by a home care Mental Health Professional or other Behavioral Health Professional within 7 calendar days of discharge from inpatient or institutional care for physical or behavioral health care, if ordered by the Enrollee's Primary Care Provider or as part of the discharge plan.

Behavioral Health Appointment Standards

MCO appointment standards comply with the Health Care Authority (HCA) and the National Committee for Quality Assurance (NCQA) requirements. **Providers must also adhere to these standards.**

Type of Care	Appointment Standard
Non-life threatening	Within 6 hours
Urgent care	Within 24 hours
Routine care – initial visit	The earlier of 10 business days or 14 calendar days
Routine care – follow-up visits	Within 30 days

Common Utilization Management Guidelines

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Different MCOs, Similar UM Process

What's the same?

- **Types of review:**
  - Pre-Service/Prior Authorization
  - Concurrent
  - Retrospective/Post-Service
- **Standards:**
  - All MCOs and the BH-ASO use standardized, nationally recognized, evidence-based criteria sets to make medical necessity determinations.

What may be slightly different?

- The method of authorization: online submissions/phones/fax
- The forms that you may see for each MCO may have some slight variation.
- Refer to the Prior Auth Grid for specific services that may require authorization.

Types of UM Reviews

- **Pre-Service/Prior Authorization**
  - Services in which authorization must be obtained prior to start of service.
- **Concurrent Review**
  - Services in which continued stay authorization is obtained during a course of care and prior to the end of the episode of care.
- Turnaround time for these authorization requests are based on type of request:

Urgent	Standard/Routine
2 calendar days	5 calendar days
Can extend time if additional information is needed in order to make a determination.	

Types of UM Reviews

- **Retrospective Review**
  - A review conducted after the service has occurred to determine if the services were medically necessary.
  - This may occur when a membership retrospectively enrolled and there are extenuating circumstances such as the facility was unable to identify the member's coverage.
  - The provider or facility may submit a retrospective request prior to claims submission for a medical necessity review.

Medical Necessity

Washington State law defines medical necessity as:

- A requested service that is intended to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that
  - endanger life
  - cause suffering or pain
  - result in an illness or infirmity or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction

- There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service.

Utilization Management

NCQA Definition of Utilization Management:

Evaluating and determining coverage for and appropriateness of medical and behavioral health care services, as well as providing needed assistance to providers and patients, in cooperation with other parties, to ensure appropriate use of resources.

UM UM

Utilization Management Regulations

MCOs must adhere to the following:

- IMC/WrapAround Contracts from HCA
- WACs and RCWs
- HCA Provider/Billing Guides
- HCA Health Technology Assessment Committee
- NCQA Standards

Prior Authorization Overview

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Authorization/Prior Authorization BHOs vs MCOs – Outpatient Services

BHO terminology is "authorization" – MCO terminology is "prior authorization"

- **Current Landscape**: BHOs require authorization to be in place prior to members getting routine outpatient behavioral health services.
- An outpatient service cannot be provided to the member without completing an assessment and submitting a clinical "packet" to the BHO to obtain an authorization.
- **Future Landscape (2020)**: MCOs do not require prior authorizations for the majority of mental health and substance use disorder outpatient services. Prior authorizations are primarily reserved for more intensive services.
  - Refer to Prior Auth Grid for more details
- Outpatient providers will no longer need to submit an intake "packet" to obtain an authorization to begin seeing a new member for services like individual and family therapy, SUD outpatient, and medication management.

How do I Know if I Need to Obtain a Prior Authorization?

- The MCO Authorization Grid details which Behavioral Health services require authorization and provides detail as to **what length of time** is initially authorized by EACH MCO.

- **What does Notification Only mean?**

  Emergent, unplanned admissions to acute inpatient BH facilities (such as E&T or acute inpatient detoxification) do not require prior authorization but do require notification of the admission by means of electronic file, fax or phone call within 24 hours of that admission. Clinical information shall be provided for medical necessity determination, known as concurrent review, following this notification.

  Notification Only can be required for lower level services as well.

MCO Combined Prior Auth Grid

Behavioral Health Provider Services Reference Guide

	Prior Authorization Required? *Length of Initial and Continued stay Authorization Please send current (within past 7 days) clinical information to support initial request for "bedded" services. Interval update to recent as				
Service Type and Description	**Amerigroup**	**CHPW**	**Coordinated Care**	**Molina**	**United**
Acute Inpatient Care – Mental Health and SUD • Acute Psychiatric Inpatient; Evaluation and Treatment • Acute Psychiatric admission to Behavioral Health Unit or Freestanding Hospital • Inpatient Acute Withdrawal (Detoxification) ASAM 4.0 * Members admitted on an ITA are reviewed for change in legal status, confirmation of active treatment and transition of care needs. **If ITA, please attach court documents.**	**No.** Emergent admissions require notification only within 24 hours followed by concurrent review. Voluntary Admission requires initial review within 24 hours of admission. **Coordinate with Transitions of Care/Health Home Care coordinator.** *Initial: 3-5 days *Initial and concurrent for ITAs is 14 days.*	**No.** Emergent admissions require notification only within 24 hours followed by concurrent review. Voluntary Admission requires initial review within 24 hours of admission. **Coordinate with Transitions of Care/Health Home Care coordinator.** *Initial: 3-5 days*	**No.** Emergent admissions require notification only within 1 business day followed by concurrent review. Voluntary Admission requires initial review within 24 hours of admission. **Coordinate with Transitions of Care/Health Home Care coordinator.** * Initial and concurrent: 3-5 days*	**No.** Emergent admissions require notification only within 24 hours followed by concurrent review. **Coordinate with Transitions of Care/Health Home Care coordinator.** **Authorization length segments:** * ***Voluntary admissions*** *- Initial and continued stay: 3-5 days (or Medical Director discretion)* * ***ITA admissions*** *– Initial for 72 hours, then dependent on further commitment will authorize 7 day increments. Upon confirmation of 90 day commitment, will authorize 14 day increments (or at Medical Director discretion).*	**No.** Emergent Acute admissions require notification only within 24 hours followed by concurrent review. Voluntary Admission requires initial review within 24 hours of admission. **Coordinate with Whole Person Care/Health Home Care coordinator.** *Initial: 3-5 days*

Updated version is now available

How do Prior Authorization and Concurrent Review Work?

Authorization requests can be submitted by fax, via the organization's web portal, and/or phone based off the individual MCOs processes.

Within the requested time frame, the next steps are:

- **Primary review:**
  - Licensed BH clinician reviews the clinical documentation provided against medical necessity criteria and if criteria is met, will approve and notify the provider of the authorization number and number of days or visits approved. This will include a "next review date" if a continuation of the service is expected.
- **Secondary review:**
  - All requests that do not meet criteria at the primary level will be escalated for review to the appropriate type of health care provider: Psychiatrist, Addictions Medicine specialist, Clinical Psychologist, Pharmacist, etc.

What Happens if Criteria is Not Met?

When a determination is made that a level of care not met or further care is not required a Partial or Full Denial may be issued. A denial will be communicated to the provider within 24 hours of the determination.

The MCO will:

- Work closely with providers to identify a transition plan.
- Assist provider and members in finding services that meet the member's needs.

If there is a disagreement about the adverse determination, there are options:

- Peer to Peer Review – initiated by provider
- Appeals - Member or Member Representative may request an appeal for a denied service or authorization within 60 calendar days of the denial.

Prior Authorization Requests When Bed Date is TBD (Bed date estimated)

Best practice: Provider/Referent should request admission to RTF as close to bed date availability as possible.

Clinical being provided with request should be current and comprehensive. This clinical information can be submitted by the referral source or by the provider of the services.

The process for requesting authorization when bed date is not specified but expected to occur within a "window" of time varies between MCOs/BH-ASO. Best practice is to inquire about individual MCO/BH-ASO practices regarding this process.

Prior Authorizations when Correctional Facilities Release to SUD Residential Facilities "Honor authorizations"/Notifications

When a client who has Apple Health (Medicaid) coverage is incarcerated, they will continue to retain their status as a Medicaid client. However, their Apple Health benefits are suspended while in a correctional facility.

Post-incarceration, benefits cannot be confirmed until the person is released and the ProviderOne suspended status has ended. It can take HCA up to 1 business day to update client's status in ProviderOne.

Steps:

1. **Identify the Managed Care Organization** (MCO) the client was enrolled with prior to incarceration and confirm the plan is still available in your region.
2. If the MCO **approves** the PA for services, the plan will provide a notification of contingent approval to the provider coordinating the admission. This approval is based upon the individual's anticipated reinstatement of benefits. This is referred to as an **"Honor Authorization".**

Transition Authorizations from BHO to MCOs

- These are authorizations for "bedded" BH services already given by the BHO to members in service who become MCO members effective 1/1/2020.
  - BHO provides authorization data to HCA, who will pass to MCOs.
  - MCO confirms member is in active treatment in a level of acuity that requires authorization in order to be paid and which is expected to cross over 1/1/20 with the identified provider of those services. If not in active treatment, MCO will work with provider to determine if there is a scheduled bed date. If no scheduled bed date, provider should follow routine process for authorization request if and when needed.
  - MCO enters transitional authorization of those services to "X" date with instructions to provider on how to complete continued stay review and MCO assumes responsibility for ongoing medical necessity reviews/authorization.

Amerigroup Prior Authorization Process

- Confirm if services require prior authorization on our website, https://providers.amerigroup.com/Pages/PLUTO.aspx
- Requests can be submitted via telephone, fax or online
- Providers are notified of authorization decisions via phone or fax
- Providers and members receive faxed and written notice of denial decisions

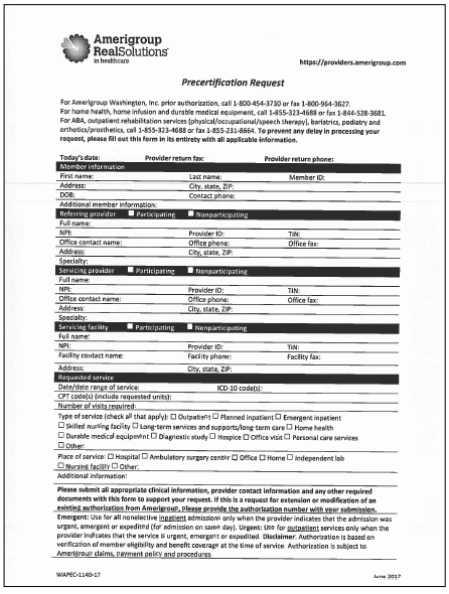
Issues with obtaining a prior authorization can be directed:

Kathleen Boyle, Director of Practice Integration:

Kathleen.Boyle2@Amerigroup.com
206-674-4485

Amerigroup RealSolutions in healthcare

How to Request a Prior Authorization



Amerigroup RealSolutions in healthcare

https://providers.amerigroup.com

Precertification Request

For Amerigroup Washington, Inc. prior authorization, call 1-800-454-3730 or fax 1-800-964-3627.
For home health, home infusion and durable medical equipment, call 1-855-323-4688 or fax 1-844-528-3681.
For ABA, outpatient rehabilitation services (physical/occupational/speech therapy), bariatrics, podiatry and orthotics/prosthetics, call 1-855-323-4688 or fax 1-855-231-8864. To prevent any delay in processing your request, please fill out this form in its entirety with all applicable information.

Today's date: Provider return fax: Provider return phone:

Member information
First name: Last name: Member ID:
Address: City, state, ZIP:
DOB: Contact phone:
Additional member information:

Referring provider ☐ Participating ☐ Nonparticipating
Full name:
NPI: Provider ID: TIN:
Office contact name: Office phone: Office fax:
Address: City, state, ZIP:
Specialty:

Servicing provider ☐ Participating ☐ Nonparticipating
Full name:
NPI: Provider ID: TIN:
Office contact name: Office phone: Office fax:
Address: City, state, ZIP:
Specialty:

Servicing facility ☐ Participating ☐ Nonparticipating
Full name:
NPI: Provider ID: TIN:
Facility contact name: Facility phone: Facility fax:
Address: City, state, ZIP:

Requested service
Date/date range of service: ICD-10 code(s):
CPT code(s) (include requested units):
Number of visits required:
Type of service (check all that apply): ☐ Outpatient ☐ Planned inpatient ☐ Emergent inpatient ☐ Skilled nursing facility ☐ Long-term services and supports/long-term care ☐ Home health ☐ Durable medical equipment ☐ Diagnostic study ☐ Hospice ☐ Office visit ☐ Personal care services ☐ Other:
Place of service: ☐ Hospital ☐ Ambulatory surgery center ☐ Office ☐ Home ☐ Independent lab ☐ Nursing facility ☐ Other:
Additional information:

Please submit all appropriate clinical information, provider contact information and any other required documents with this form to support your request. If this is a request for extension or modification of an existing authorization from Amerigroup, please provide the authorization number with your submission.
Emergent: Use for all nonelective inpatient admission only when the provider indicates that the admission was urgent, emergent or expedited (for admission on same day). **Urgent:** Use for outpatient services only when the provider indicates that the service is urgent, emergent or expedited. **Disclaimer:** Authorization is based on verification of member eligibility and benefit coverage at the time of service. Authorization is subject to Amerigroup claims, payment policy and procedures.

WAPEC-114D-17 June 2017

Portal: https://www.availity.com

Prior authorization forms are online: :
Amerigroup.com/Washington/Providers/Forms

Initial Inpatient Prior Authorization
Telephone: 1-800-454-3730
Fax: 1-877-434-7578

Concurrent Review
Telephone: 1-800-454-3730
Fax: 1-877-434-7578

Outpatient Prior Authorization
Telephone: 1-800-454-3730
Fax: 1-877-434-7578

Address:
705 5th Avenue S., Ste 300
Seattle, WA 98104

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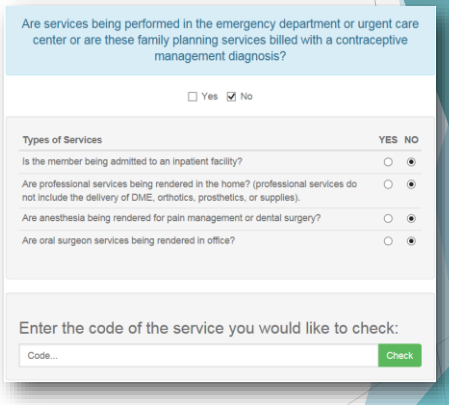
Coordinated Care Prior Authorization

- Use the Pre-Auth Check Tool on our website to determine if PA is required
  - Not a guarantee of payment, please verify benefit coverage/limitations in the HCA guides
  - Emergency stabilization services are exempt
- PA Requests and General Information:
  - Fax form which can be found on our website
- Covered services by OON providers:
  - When continuity of care applies, members are able to access care up to 90 days with previous provider
  - PA is required for many covered services, excluding urgent/emergent



coordinated care

Coordinated Care Prior Authorization Contact Numbers

- Authorization can be requested using a faxed form, or provider web portal
  - Utilization Department Main Contact number:
    - (844)208-8885
  - Fax forms:
    - Behavioral Health Fax Number (833)286-1086
  - Web Portal
- CCW Behavioral Health Leadership
  - Amanda McLendon, Clinical Manager (509)637-5671

coordinated care

Molina Prior Authorization Requests

- BH Prior Authorization request form is located at: www.molinahealthcare.com/providers/wa/medicaid/Pages/home.aspx
  - CLICK – forms in the menu, then Frequently Used Forms from the dropdown menu
- Molina Behavioral Health Prior Authorization Guide:
  - Located within the Provider Web Portal: https://provider.molinahealthcare.com/provider/login
- Molina Prior Authorization by CPT Code Guide
  - Provides prior authorization requirements based on specific procedure code, place of service, etc. Available via the Provider Web Portal: https://provider.molinahealthcare.com/provider/login

MOLINA HEALTHCARE
Your Extended Family.

Molina BH Prior Authorization Contacts

To request an authorization or check the status of a request:

- Provider Web Portal

To fax in a request for services:

- Prior Authorization Fax: (800) 767-7188

To check the status of a request or get assistance with an authorization:

- Healthcare Services (Prior Authorization): (800) 869-7175

For any prior authorization escalated issues that cannot be resolved through the prior authorization line, contact BH UM management:

Denise Kohler, LICSW
Manager BH UM Team
800-869-7175 Ext. 140257

Laurie McCraney RN MBA
Director, Healthcare Services
Desk: 425-354-1572

MOLINA HEALTHCARE
Your Extended Family.

United Healthcare BH Prior Authorization Methods

Call

- United HealthCare Call Center: (877) 542-9231
- IP & Res reviews 24/7
- Non-Routine Outpatient: Call during business hours

Online
Preferred method of submission

- Available: https://www.uhcprovider.com/en/prior-auth-advance-notification.html
- Frequently used non-routine services where an authorization can be requested online include: Psychological Testing, Transcranial Magnetic Stimulation (TMS), GFS funded services and ABA/Autism
- For other non-routine services call the number on the back of the Member's ID card to request authorization.

Fax

- IMC Fax Form available and to: (844) 747-9828

UnitedHealthcare Community Plan

United Healthcare BH Prior Authorization Contacts

To request an authorization or check the status of a request:

- Provider Web Portal: Providerexpress.com
- Healthcare Services (Prior Authorization): (877) 542-9231

To fax in a request for services:

- Prior Authorization Fax: (844) 747-9828

For any prior authorization escalated issues that cannot be resolved through the prior authorization line, contact:

Region	Network Contact	Email	Phone
Salish	Christine Rae	Christine.Rae@Optum.com	(206) 926-0224

UnitedHealthcare Community Plan

Case Management Overview

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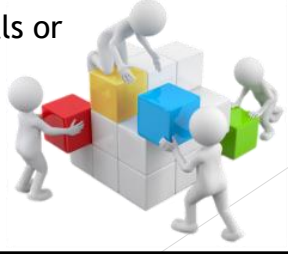
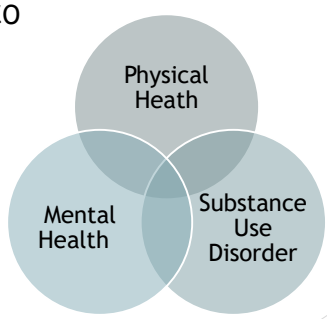
MCO Case Management

- Is NOT intended, in any way, to replace providers' current Case Management services;
- Strives to enhance or supplement current efforts and reduce duplication of work.
- Is a partner at the multidisciplinary team table;
- Is a resource for the members, providers, colleagues and MCO counterparts;
- Collaborates with other existing teams to effectively manage complex individuals or populations; and



Care Coordination with Integrated Managed Care (IMC)

- Community Based Care Coordination
  - Working with PCP and BH providers to coordinate and collaborate
  - Local providers know the patient best
  - Allied Service Coordination (Community Partners)
- Coordination of BH Services by MCO
  - SUD
  - State Facilities
  - Outpatient Wrap Around Care
  - Justice System
  - BH-ASO Crisis Services



Initial Health Screening

Newly enrolled members receive an Initial Health Screening within the first 60 days of enrollment

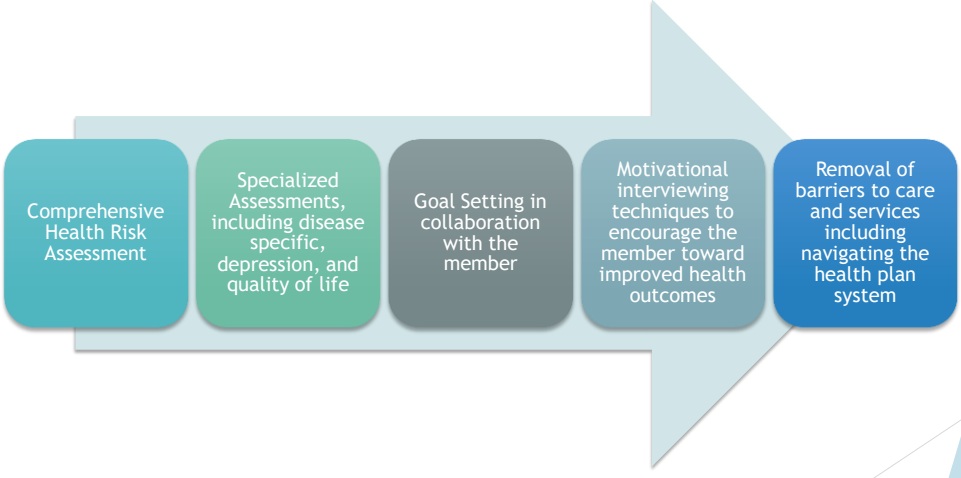
However, many members are difficult to contact

Based on screening results and other utilization data, members are referred to Care Management for further assessment

Examples for Case Management Referrals:

- High utilizer of care
- Members with complex and/or comorbid conditions
- Difficulty managing a chronic condition
- Psychosocial needs impacting management
- Assistance navigating health plan system
- Gaps in care

Case Management Process



Care Management Levels

MCOs offer three levels of Care Management Services:

1. Care Coordination Services (CCS)
   - Focus on short-term or intermittent needs, such as:
     - Access to care/services addressing social needs
     - Improving clinical outcomes
     - Increasing self-management skills
2. Medical Case Management
   - Three to six months engagement
     - Assist members in managing complex healthcare needs
     - Goal setting based on the individual's priorities
     - Integrated care planning

Care Management services are designed to support the overall Wellness of members with a focus on improving health outcomes.

Care Management Levels

3. Complex Case Management (CCM)
   - Focus on individuals with chronic or complex needs requiring ongoing care management. Services include:
     - Person-centered approach to care plan development
     - Utilization of evidence-based practices in screening and intervention
     - Addressing gaps in care
     - Coordination of care across the continuum
     - Designed to meet NCQA Complex Case Management standards

Children's Programs

- Each MCO has designated case managers to support and serve our children and youth population
- Manage transitions into and out of WISe (Wrap Around Intensive)
- Review the " interest" list of youth waiting to be served in WISe
- Support families by attending Family/System partner meetings
- Support families who are seeking or requesting a CLIP (Children's Long term inpatient Program) referral
- Presenting cases to the CLIP committee for review and finding ways to support families to keep them out of CLIP and in their community.
- Manage transitions between Admission and Discharge from a CLIP facility
- Participate in Community based work groups that serve kids, like FYSPRT, Youth Collaboratives and/ or WISe Collaboratives

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WISe Notification Form

- Notification Form should be completed for the following reasons:
  - Enrollment of new WISe client
  - Adverse Benefit Determination (ABD)
    - WISe Provider determines the following:
      - Denial
      - Termination
      - Reduction of Services
      - Suspension

WISe
Wraparound with Intensive Services

Refer to WISe Manual for detailed descriptions of ABDs

WISe Tracker

- Monthly report due by 5th of month
  - Enrollment: Number of WISe members in the program during the month.
  - Service Intensity: Average number of services your WISe enrollees received during the month.
  - Interest List: Members who have been screened but are waiting to get into WISe.

MCOs will be outreaching to Providers to discuss expectations and procedures in greater detail.

Transitions of Care

- Transitional care services are provided to all members who are transitioning from one level/setting of care to another;
- Development/completion of a standardized discharge screening tool;
- Development of an individual plan to reduce the risk of readmission or treatment recidivism, to include:
  - Information that supports discharge care needs, medication management, action to ensure follow-up appointments are attended, and follow-up for self-management
  - When to seek medical or emergency care
  - Including formal and informal caregivers in this process, as the member allows
  - Written discharge plan
  - Follow-up plan

Transitions of Care

- Organized post-discharge services, such as home health or therapy or post-acute placement
- Telephonic follow-up to reinforce the discharge plan and problem solving,
  2-3 days post-discharge;
- A plan in the event a problem arises following discharge;
- A face to face visit to the member, while in the hospital, for those who are at high risk of readmission, to coordinate the transition;
- For members at high risk for readmission, a face to face visit, an in-person assessment for post-discharge support within seven (7) calendar days of hospital discharge.
- Scheduled outpatient Behavioral Health and/or primary care visits within seven (7) calendar days and again within 30 days following discharge and/or physical or mental health home health care services delivered within seven (7) calendar days of discharge.

Program Integrity and Monitoring

Program Integrity and Monitoring • Advance Directives • Critical Incidents • Member Grievance and Appeal • Behavioral Health Ombudsman

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Program Integrity

- Detection, prevention, mitigation, and investigation of Fraud, Waste, and Abuse (FWA)—we all strive to consistently be good stewards of public dollars and ensure proper care is being delivered to our members.
- **Prevent**—we use data mining algorithms to detect and prevent potential wasteful or abusive billing
  - **Examples:** Incorrect coding, misalignment with CMS requirements for the Medicaid program, or lack of medical necessity for the service being provided
  - Through prevention activities, claims are denied before being paid and MCO staff reach out to ***educate*** on proper billing practices
- **Mitigation and Recovery**—we also use data mining algorithms on *paid* claims to detect for FWA and improperly paid claims or claims paid against medical necessity; we work with the provider to recover the funds that were improperly paid and educate on reasons why and future prevention
- **Investigation**—Each MCO has investigation units to investigate potential fraud and/or abuse activities; if activities are found, we are required to report individual providers or provider agencies to HCA and CMS

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Monitoring

All MCOs complete the following monitoring which may result in chart reviews and periodic auditing activities:

- Quality of Care Issues
- Critical Incident Investigations
- Over and Under Utilization Monitoring
- "HEDIS season" chart requests
- Utilization Management
- Annual training attestations (joint MCO training available)
  - Enrollee Rights and Responsibilities
  - Advanced Directives
  - Fraud, Waste, and Abuse
  - False Claims Act

Member Grievance and Appeal

- A Member may express dissatisfaction pertaining to quality of care, the way the member was treated, problems getting care and billing issues.
  - Member should be referred to their MCO to report a grievance. **Only members can file a grievance**, or designate someone to file on their behalf with written authorization.
  - MCO will confirm receipt of the grievance within two business days of receipt.
  - Grievances are resolved within 45 days and the Member will be advised of the resolution.
- A Member or Member Representative may request an appeal for a denied service or authorization within 60 calendar days of the denial.
  - For WISe appeals, please follow the WISe Manual.

How Can a Member Report a Grievance or Request an Appeal?

MCO	Contact Number	Email
Amerigroup	(800) 600-4441	WA-Grievance@Amerigroup.com
Coordinated Care	(877) 644-4613	WAQualityDept@Centene.com
Molina Healthcare	(800) 869-7165	MHWMemberServicesWeb@MolinaHealthcare.com
UnitedHealthcare Community Plan	(866) 556-8166	WACS_Appeals@UHC.com

Please refer to MCO Provider Manuals for additional information on the Member Grievance and Appeal process.

Advance Directives

An Advance Directive gives written instructions about a patient's medical care in the event that the patient is unable to express his or her medical wishes.

For the State of Washington there are three types of Advance Directives:

1. **Health Care Directive/Living Will:** Specifies an individual's wishes about end of life care.
2. **Durable Power of Attorney:** Names another person to consent to, stop, or refuse treatment if an individual is incapable of doing so.
3. **Mental Health (MH) Advance Directive:** Allows a person with capacity to state mental health treatment preferences in a legal document that will govern during periods of incapacity.

Advance Directives

To be valid, a Mental Health Advance Directive must:

- Be in writing;
- Include language indicating a clear intent to create a directive;
- Be dated and signed by the patient, or be dated and signed in the patient's presence at his or her direction;
- State whether the directive may or may not be revoked during a period of incapacity;
- Be witnessed in writing by at least two adult witnesses;
- Conform substantially to the statutory format.

Providers must know and follow applicable regulations regarding Advance Directives (per WAC and/or RCW) and are expected to comply with a member's Advance Directive appropriate to their available services. MCOs may request provider assistance in obtaining copies of Advance Directives when a member indicates they have them or request assistance in creating them.

Critical Incidents

Definition	Who?
Critical Incident is an event involving a member or provider with impact to health and safety.	Anyone (member, provider, MCO staff, etc.) may identify and report a Critical Incident.

- An event may lead to both a Critical Incident and/or Grievance, but they are separate reports and systems based on the definitions.
- In addition to HCA and MCO requirements, providers are also responsible for maintaining incident and grievance/complaint reporting systems as outlined In WAC and RCW appropriate to their agency and facility licensure.

Critical Incident – Individual vs Population Based Reporting

- HCA provides a category list of incidents to be submitted individually in the Incident Reporting System within one (1) business day
- Additional events are tracked, monitored, and investigated for Population Based reporting, submitted to HCA by MCO biannually
  - Review of trends in categories, demographics, etc.
  - Report on efforts in follow-up and prevention actions
- Providers submit Critical Incident reports to MCOs for Individual and Population-Based reporting categories or requirements as requested

HCA Individual Incident Reporting Categories

- Homicide or attempted homicide by an Enrollee
- A major injury or major trauma that has the potential to cause prolonged disability or death of an Enrollee that occurs in a facility licensed by the state of Washington to provide publicly funded behavioral health services
- An unexpected death of an Enrollee that occurs in a facility licensed by the state of Washington to provide publicly funded behavioral health services
- Abuse, neglect or exploitation of an Enrollee
  - Not to include child abuse

HCA Individual Incident Reporting Categories

- Violent acts allegedly committed by an Enrollee
  - Arson, assault resulting in serious bodily harm, homicide or attempted homicide by abuse, drive by shooting, extortion, kidnapping, rape, sexual assault or indecent liberties, robbery, or vehicular homicide
- Unauthorized leave of a mentally ill offender or a sexual or violent offender from a mental health facility, secure Community Transition Facilities (i.e. Evaluation and Treatment Centers, Crisis Stabilization Units, Secure Detox Units, and Triage Facilities) that accept involuntary admissions
- Any event involving an Enrollee that has attracted or is likely to attract media attention

Critical Incident Reporting Process

Critical Incident Occurs	• Provider notifies MCO of incident using Critical Incident Report Form within one (1) business day of reporter's awareness of the incident.
Critical Incident is Reported	• MCO enters incident into Incident Reporting System by COB on the date received from the reporter.
Critical Incident is Closed	• MCO completes investigation and follow-up actions within **45 days.** HCA alone has the ability to "close" an incident and may request additional follow up from the MCO.

Population-Based Reporting Categories

- Biannual summary reports by MCOs must include:
  - Incidents identified through the Individual Critical Incidents process
  - A credible threat to Enrollee safety
  - Any allegation of financial exploitation of an enrollee
  - Suicide and attempted suicide
  - Other incidents as defined in MCO policies and procedures

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Where to Report a Critical Incident

The Critical Incident Form are available on each MCO's websit and to be submitted to the emails listed.

MCO	Email
Amerigroup	QMNotification@Anthem.com
Coordinated Care	WABHcriticalincidents@CoordinatedCareHealth.com
Molina Healthcare	MHW_Critical_Incidents@MolinaHealthcare.com
UnitedHealthcare Community Plan	WA_Criticalinc@UHC.com

Behavioral Health Ombudsman

- The OMBUDS service:
  - receives, investigates, advocates for, and assists eligible individuals with the resolution of grievances, the appeal processes when applicable, and, if necessary, the administrative fair hearing process;
  - is responsive to the age and demographic character of the region and assists and advocates for individuals with resolving issues, grievances, and appeals at the lowest possible level;
  - is independent of service providers; and
  - coordinates and collaborates with allied services to improve the effectiveness of advocacy and reduce duplication.
- Behavioral Health Ombuds members must be current consumers of the mental health or substance use disorder system, or past consumers or family members of past consumers.

Region	Contact Information
Salish Ombuds	Phone: (888) 377-8174 or (360) 392-1582 Fax: 360-692-1595

Resources

Interpreter Services • HCA Transportation Broker • MCO Websites • Provider Portals • Frequently Use Forms • Helpful Links

Interpreter Services

Members or potential members are entitled to receive interpreter services free of charge. Services shall be provided as needed for all interactions with members including, but not limited to:

- Customer Service
- When receiving covered services from any provider
- Emergency Services
- Steps necessary to file grievances and appeals

Providers of Medicaid covered outpatient services must arrange for interpreter services through HCA's vendor Universal Language Service (Universal): https://universallanguageservice.com/

- You must register an HCA account with Universal in order to request an interpreter.
- Universal will train providers how to access an interpreter using their online service portal.
- The HCA Interpreter Services program is available to healthcare providers serving limited English proficient (LEP), Deaf, DeafBlind, and Hard of Hearing Medicaid clients and individuals applying for or receiving DSHS or DCYF services.

HCA Transportation Brokers

- Medicaid clients may be eligible for non-emergency medical transportation, which can be arranged and paid for Medicaid clients with no other means to access medical care through HCA contracted brokers listed below. 7-14 days advance notice is recommended.

- The HCA Non-Emergency Medical Transportation (NEMT) program now allows non-emergency transportation for all clients going to and/or from SUD or MH facilities for any length of stay.

Transportation Broker		
Region	Broker	Contact
Salish	Paratransit Services	(360) 377-7007 (800) 846-5438 TDD/TTY: 1-800-934-5438

MCO Website Content

- Clinical and Payment Policies
- Clinical Practice Guidelines
- Frequently Used Forms
- HEDIS Guides
- Preferred Drug List
- Provider Manuals
- Provider Newsletters and Announcements
- Provider Portal Link
- Provider Training and Resource Materials
- Verify Prior Auth requirements

MCO Website Links for Providers

MCO	Website Link
Amerigroup	https://providers.amerigroup.com/WA
Coordinated Care	www.coordinatedcarehealth.com/providers.html
Molina Healthcare	www.molinahealthcare.com/providers/wa/medicaid/Pages/home.aspx
UnitedHealthcare Community Plan	www.uhcprovider.com/communityplan

Provider Portal Content

- Authorization status and submission
- Case management referrals
- Check member eligibility and benefits
- Claim audit tool
- Claim submission and status
- Claim correction and resubmission
- Member rosters
- Member care gaps
- Secure transactions
- Update practice information

MCO Portal Links for Providers

MCO	Portal Link
Amerigroup	https://apps.availity.com/availity/web/public.elegant.login?source=MBU
Coordinated Care	www.coordinatedcarehealth.com/login.html
Molina Healthcare	Access Molina WebPortal via OneHealthPort. If new to OneHealthPort, register here: http://www.onehealthport.com/sso/register-your-organization
UnitedHealthcare Community Plan	www.uhcprovider.com/en/health-plans-by-state/washington-health-plans/wa-comm-plan-home.html?rfid=UHCCP

Provider Directory Links

- Amerigroup
  https://apps.availity.com/availity/web/public.elegant.login?source=MBU
- Coordinated Care
  https://providersearch.coordinatedcarehealth.com/
- Molina Healthcare
  https://providersearch.molinahealthcare.com/
- UnitedHealthcare Community Plan:
  https://www.uhcprovider.com/en/find-a-provider-referral-directory.html

Available on MCOs Websites

Frequently Used Forms:

- PCP Change
- Critical Incident Report
- Release of Information/Authorization for Use and Disclosure of PHI
- Prior Authorization/Concurrent Review Request
- BH Prior Authorization/Concurrent Review Request
- Care Management Referral
- Appeal Consent

Helpful Links

- Provider Manuals
  - Amerigroup: https://providers.amerigroup.com/ProviderDocuments/WAWA_Provider_Manual.pdf
  - Coordinated Care: https://www.coordinatedcarehealth.com/providers/resources/forms-resources.html
  - Molina Healthcare: http://www.molinahealthcare.com/providers/wa/medicaid/manual/Pages/provman.aspx
  - UnitedHealthcare Community Plan: https://www.providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelines/stateAddendums/walMC-NetworkManual.pdf
- WISe Manual- https://www.hca.wa.gov/assets/billers-and-providers/wise-wraparound-intensive-services-manual.pdf
- SERI: https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/service-encounter-reporting-instructions-seri
- HCA Billing Guides: https://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides

Questions and Answers

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Thank you for joining us today!

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