Salish Integrated Managed Care Operations Symposium

Co-Hosted By:

Amerigroup RealSolutions in healthcare

coordinated care

MOLINA HEALTHCARE

UnitedHealthcare Community Plan

October 2019

Agenda

- Tribal Welcome and Land Acknowledgement
- IMC Overview and MCO Introductions
- Partnering with MCOs
  - Credentialing, Rosters and NPIs
  - Access to Care and Appointment Standards
  - Eligibility and ID Cards
  - Websites, Portals and Directories
  - Claims and Billing
  - Prior Authorizations
  - Program Integrity and Monitoring
  - Resources
- Questions and Answers

Tribal Welcome

Lower Elwha Klallam Tribe

ʔéʔɬx̣ʷaʔ nəxʷsƛ̓áyəm̓ - The Strong People

Jonathan Arakawa, Elwha Tribal Youth Council

Tribal Land Acknowledgement

We acknowledge that the Lower Elwha Klallam people have lived in this area since time immemorial and that the place where we are today was once the thriving village of (Tse-whit-zen).

Recognized by a treaty with the United States in 1855, we appreciate that the Tribe is building a strong and healthy sovereign nation where Tribal members live their values and culture.

We hope to better understand how we can support the wellbeing of the Lower Elwha Klallam people and encourage our partners here today to do the same. Thank you for joining us in honoring the resilience of the Lower Elwha Klallam people.

IMC Overview

Integrated Managed Care Background

State legislation directed the Health Care Authority to integrate 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

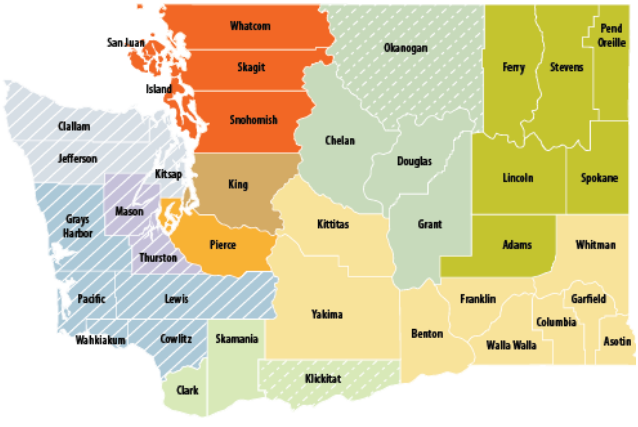
Managed care region	Amerigroup	Community Health Plan	Coordinated Care	Molina Healthcare	United Healthcare
As of January 2019					
Greater Columbia	●	●	●	●	
King	●	●	●	●	●
North Central	●		●	●	
Pierce	●		●	●	●
Spokane	●	●		●	
Southwest	●	●		●	
As of July 2019					
North Sound	●	●	●	●	●
Coming January 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 (GFS) 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

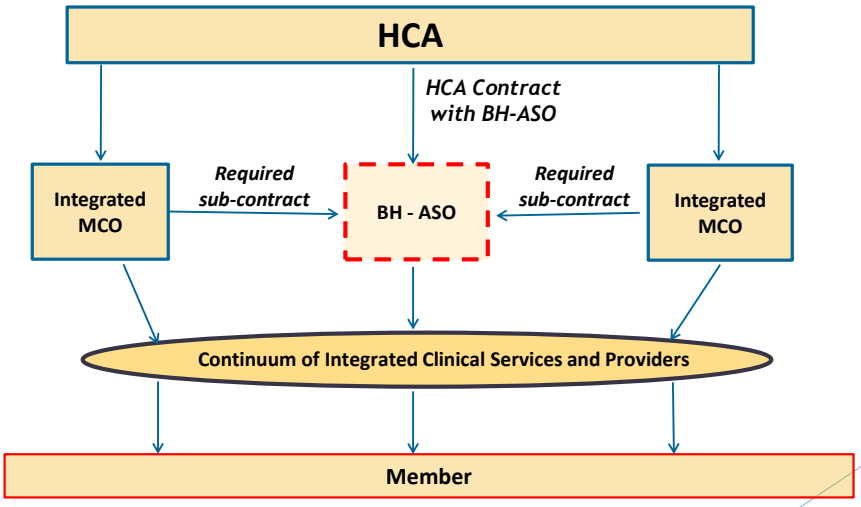
Crisis services for all members of the community
- Includes DCRs

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

Amerigroup RealSolutions in healthcare
coordinated care
MOLINA HEALTHCARE
UnitedHealthcare Community Plan

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

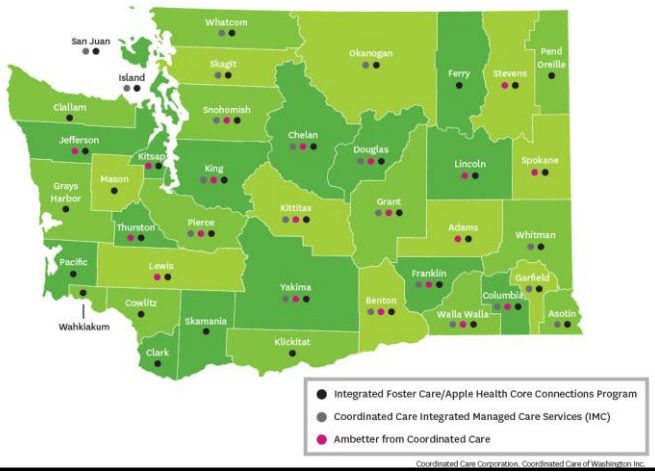
Mission Statement: To be the **highest quality** health plan in Washington, and the **health plan of choice** for members and providers

- 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



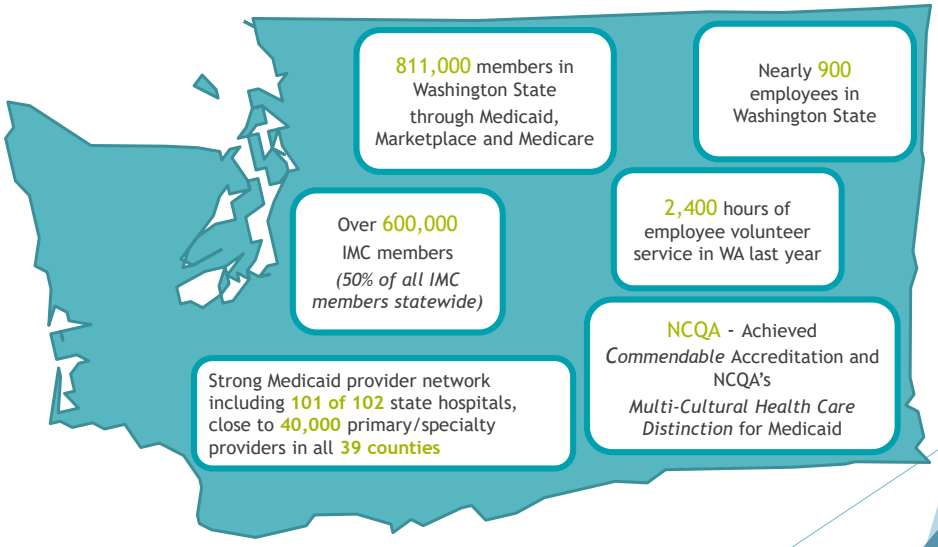
coordinated care

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

Credentialing, Rosters and NPIs

Credentialing

Behavioral Health Agencies (BHA's) delivering Behavioral Health services in the State of Washington as part of Integrated Managed Care are credentialed according to NCQA requirements and MCO credentialing policies and procedures.

All MCOs credential BHAs at the facility level.

Category/Scenario	Facility Contract (CMHA, SUD Agency)
Facility/Location Credentialing Required?	Yes
Individual Practitioner Credentialing Required?	No (Facility-based non-licensed) Yes (Licensed, certified or registered with the state of WA who practice independently)
What type of Application is required?	Facility Application (with supporting licensure)
Are practitioner rosters required?	Yes (for provider directory when appropriate, member care/referral, claims processing)
Re-credentialing Schedule	3 years / 36 months (or sooner if required by state law)

Credentialing

Important 'Good to knows' for Credentialing:

- **Time sensitive**: Credentialing is the FIRST and most CRITICAL step to ensure IMC go-live readiness and is initiated by Providers.
  - Failure to complete credentialing early enough, may result in downstream delays to: portal access, loading providers into MCO systems, claims testing and payments.
- **Multiple Locations**: Credentialing applications must include EACH licensed location.
- **New locations**: New locations must be credentialed with MCOs in a timely manner.
  - MCOs should also be notified of location closures.

Credentialing Process and Inquiries

- Facility credentialing applications vary by EACH MCO.
- All MCOs utilize ProviderSource (OneHealthPort) and/or CAQH as primary credentialing vendors for individual provider credentialing.
- Credentialing materials and inquiries may be submitted to each MCO, as follows:

MCO	Email
Amerigroup	WACredentialing@Amerigroup.com
Coordinated Care	Contracting@CoordinatedCareHealth.com
Molina Healthcare	MHWProviderInfo@MolinaHealthcare.com
UnitedHealthcare Community Plan	WAIMC@Optum.com

Rosters

- When agencies are credentialed at the facility level, we are reliant on provider rosters to ensure MCOs systems are up-to-date.
- MCOs have established a common roster template for all providers to use in order to streamline processes.
- Allow approximately 30-45 days for roster updates to be processed prior to submitting claims to avoid denials and re-work.
- Updated rosters should be sent to MCOs on a regular basis. Failure to send timely roster updates may result in incorrect payments and/or denials.

Reporting Provider Changes/Updates

Providers must give notice at least 60 days in advance of any provider changes such as:

- Provider Terms
- Provider Adds/Updates
- Tax ID Changes
- Group and/or Individual NPI
- Billing and/or Pay to addresses
- Clinic locations (where services are rendered)

Please submit rosters and any other changes/updates to:

MCO	Email
Amerigroup	WACredentialing@Amerigroup.com
Coordinated Care	Contracting@CoordinatedCareHealth.com
Molina Healthcare	MHWProviderInfo@MolinaHealthcare.com
UnitedHealthcare Community Plan	WAIMC@Optum.com

What You Need to Know About NPIs

There is a two-step process related to NPIs:

1. Obtain NPIs for individual providers
   - All providers (all levels, including unlicensed providers) that provide direct, encounterable care to members must obtain an NPI number to report as the servicing/rendering provider on claims.
   - Exceptions are identified in IMC SERI and HCA NPI Q&A about NPIs - where HCA and MCOs are allowing a provider to use the billing provider information in the rendering provider fields. If the provider's situation is not identified as an exception, they should assume the actual rendering provider needs an NPI and needs it registered with HCA. (Exception example: Freestanding E&T billed with Billing Provider NPI.)
2. Enroll individual providers NPIs with HCA to obtain an HCA ProviderOne ID number.
   - More detail on this process on the next slide.

HCA ProviderOne ID - Required

BHAs **must ensure** that all individual providers have an HCA ProviderOne ID

OR

Enroll as a 'non-billing' provider (if he/she does not wish to serve fee for service Medicaid clients) but each provider must have an active NPI number with the HCA to bill independently.

- 42 CFR 438.602(b) requires all BHA providers to be enrolled by 1/1/2019.
- Both Organizations (Type 1) and Individuals (Type 2) NPI's need to be registered.

HCA ProviderOne ID - Required

- Requirements and Instructions on enrollment are available on HCA's website: http://www.hca.wa.gov/enroll-as-a-provider

Lack of compliance with this HCA requirement can IMPACT claims payment, please ensure you are properly registered and obtain the ProviderOne ID!

35

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. **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

Eligibility and ID Cards

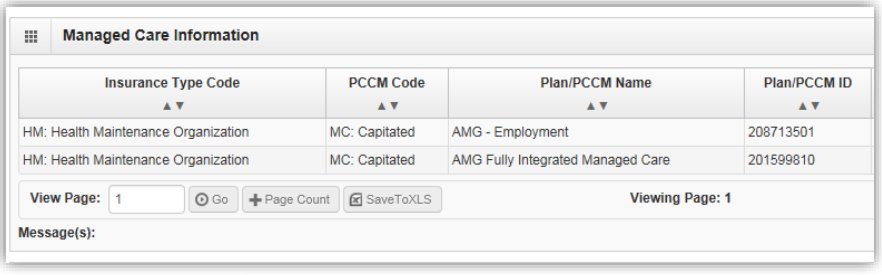
Amerigroup RealSolutions in healthcare
coordinated care
MOLINA HEALTHCARE
UnitedHealthcare Community Plan

Eligibility

- Eligibility should be verified ***before every service***. HCA updates eligibility daily, therefore retrospective or mid-month changes can exist.
- Methods to confirm eligibility:
  - Each MCO Portals
  - HCA ProviderOne: https://www.waproviderone.org/
  - HCA Eligibility Manual: https://www.hca.wa.gov/assets/billers-and-providers/manual_verifyclienteligibility.pdf
- AI/AN members *may opt* into managed care

Eligibility Example - Amerigroup

Member is eligible for Amerigroup Integrated Managed Care effective 1/1/2018.

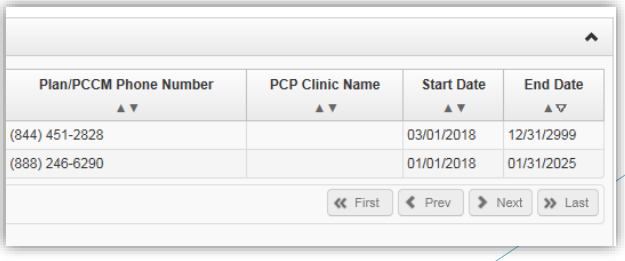


Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID
HM: Health Maintenance Organization	MC: Capitated	AMG - Employment	208713501
HM: Health Maintenance Organization	MC: Capitated	AMG Fully Integrated Managed Care	201599810

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1

Message(s):

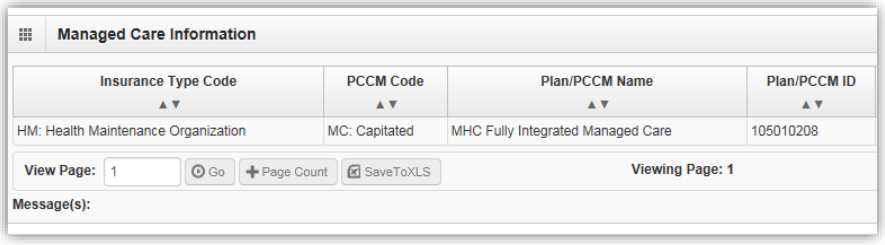


Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
(844) 451-2828		03/01/2018	12/31/2999
(888) 246-6290		01/01/2018	01/31/2025

First Prev Next Last

Eligibility Example - Molina

Member is eligible for Molina Healthcare Integrated Managed Care effective 8/1/2018.

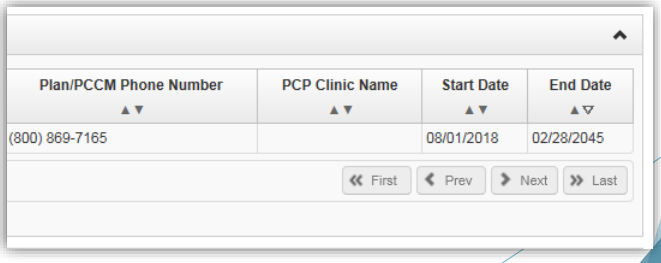


Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID
HM: Health Maintenance Organization	MC: Capitated	MHC Fully Integrated Managed Care	105010208

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1

Message(s):

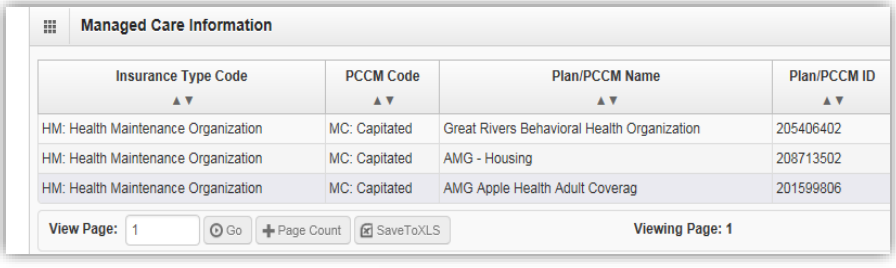


Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
(800) 869-7165		08/01/2018	02/28/2045

First Prev Next Last

Eligibility Example - BHO

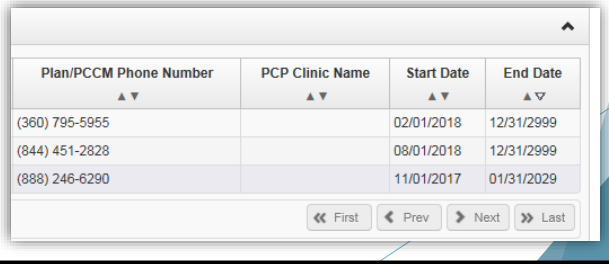
Member is eligible for Great Rivers BHO effect 2/1/2018, AMG FCS Housing effect 8/1/2018 and AMG Apple Health effect 11/1/2017.



Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID
HM: Health Maintenance Organization	MC: Capitated	Great Rivers Behavioral Health Organization	205406402
HM: Health Maintenance Organization	MC: Capitated	AMG - Housing	208713502
HM: Health Maintenance Organization	MC: Capitated	AMG Apple Health Adult Coverag	201599806

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1



Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
(360) 795-5955		02/01/2018	12/31/2999
(844) 451-2828		08/01/2018	12/31/2999
(888) 246-6290		11/01/2017	01/31/2029

First Prev Next Last

Eligibility Example - UnitedHealthcare

Member is eligible for UHC Fully Integrated Managed Care effective 1/1/2019

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID
HM: Health Maintenance Organization	MC: Capitated	UHC Fully Integrated Managed Care	201609409

Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
(877) 542-8997		01/01/2019	12/31/2999

Member is eligible for UHC Behavioral Health Service Only effective 1/1/2019

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID
HM: Health Maintenance Organization	MC: Capitated	UHC Behavioral Health Service Only	201609408

Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
(877) 542-8997		01/01/2019	12/31/2999

Eligibility Example - Ineligible

Member is ineligible.

Demographic and Response Information

Client Demographic Information:

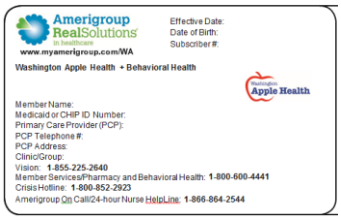
ProviderOne Client ID:
Client First,Middle,Last Name:
CSO/HCS:
County Code: 017-King
CSOR: 040-KING EAST CSO
Date of Birth: 05/22/1981
Gender: Male
Language: ENG-English
Placement:
ACES Client ID:
HIC:

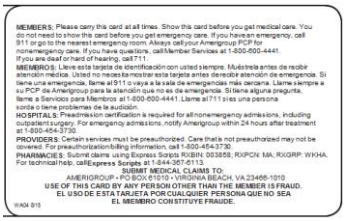
System Response Information:

Valid Request Indicator: Y
Reject Reason Code:
Eligibility or Benefit information Code: 6–Inactive
Follow-Up Action Code: C - Please correct data and resubmit

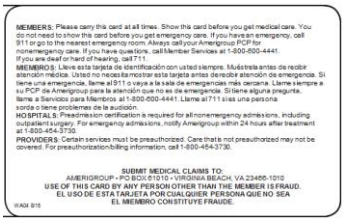
Amerigroup ID Cards

IMC





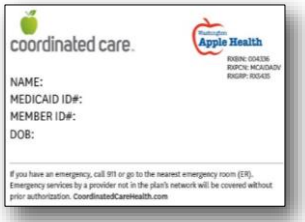
BHSO



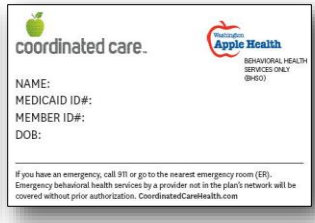
Amerigroup RealSolutions in healthcare

Coordinated Care ID Cards

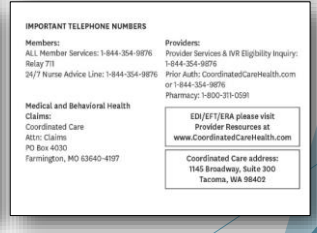
IMC



BHSO



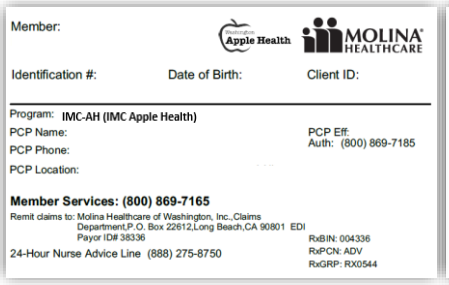
AHFC



coordinated care

Molina Healthcare ID Cards

IMC


Member:

Washington Apple Health | MOLINA HEALTHCARE

Identification #: Date of Birth: Client ID:

Program: **IMC-AH (IMC Apple Health)**

PCP Name:

PCP Phone:

PCP Location:

PCP Eff:

Auth: (800) 869-7185

Member Services: (800) 869-7165

Remit claims to: Molina Healthcare of Washington, Inc.,Claims Department,P.O. Box 22612,Long Beach,CA 90801 EDI Payor ID# 38336

24-Hour Nurse Advice Line (888) 275-8750

RxBIN: 004336
RxPCN: ADV
RxGRP: RX0544


Emergency Services: Call **911** or go to the nearest emergency room.

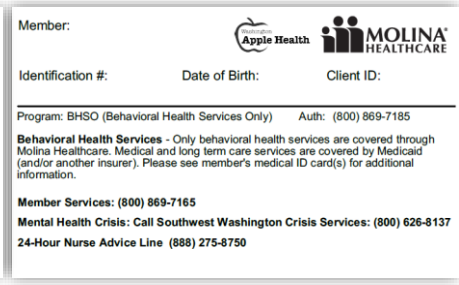
24-Hour Molina Healthcare Nurse Advice Line:
(888) 275-8750 / TTY 711
(866) 648-3537 (Spanish)

Molina Healthcare Member Services:
Log into MyMolina.com or call (800) 869-7165 / TTY 711

PROVIDERS/HOSPITALS:
Prior authorization, post stabilization, eligibility, claim or benefit information:
(800) 869-7185
Hospital Admissions: Authorization must be obtained by the hospital prior to all non-emergency admissions.

www.MolinaHealthcare.com

BHSO


Member:

Washington Apple Health | MOLINA HEALTHCARE

Identification #: Date of Birth: Client ID:

Program: BHSO (Behavioral Health Services Only) Auth: (800) 869-7185

Behavioral Health Services - Only behavioral health services are covered through Molina Healthcare. Medical and long term care services are covered by Medicaid (and/or another insurer). Please see member's medical ID card(s) for additional information.

Member Services: (800) 869-7165

Mental Health Crisis: Call Southwest Washington Crisis Services: (800) 626-8137

24-Hour Nurse Advice Line (888) 275-8750


Emergency Services: Call **911** or go to the nearest emergency room.
Mental Health Crisis: Call Southwest Washington Crisis Services: (800) 626-8137
24-Hour Molina Healthcare Nurse Advice Line:
(888) 275-8750 / TTY 711
(866) 648-3537 (Spanish)

Molina Healthcare Member Services:
Log into MyMolina.com or call (800) 869-7165 / TTY 711

PROVIDERS/HOSPITALS:
Prior authorization, post stabilization, eligibility, claim or benefit information:
(800) 869-7185
Hospital Admissions: Authorization must be obtained by the hospital prior to all non-emergency admissions.

Remit claims to: Molina Healthcare of Washington, Inc.,Claims Department,P.O. Box 22612,Long Beach,CA 90801 EDI Payor ID# 38336

www.MolinaHealthcare.com

MOLINA HEALTHCARE
Your Extended Family.

UnitedHealthcare ID Cards

IMC


UnitedHealthcare | Community Plan

Washington Apple Health

Health Plan (80840) 911-87726-04

Member ID: 000200050 Group Number: WAHLOP

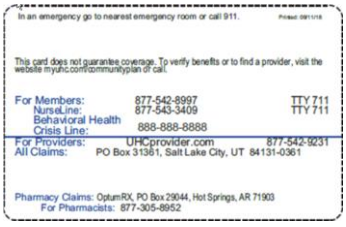
Member:
MEMBER NAME

Payer ID: 87726

PCP Name:PROVIDER NAME
PCP Phone: (888)888-8888

OPTUMRx
Rx Bin: 610494
Rx GRP: ACUWA
Rx PCN: 9999

0501 IMC - Apple Health
Administered by UnitedHealthcare of Washington, Inc.


In an emergency go to nearest emergency room or call 911.

This card does not guarantee coverage. To verify benefits or to find a provider, visit the website myuhc.com/communityplan or call.

For Members: 877-542-8997 TTY 711
NurseLine: 877-543-3409 TTY 711
Behavioral Health Crisis Line: 888-888-8888
For Providers: UHCprovider.com 877-542-9231
All Claims: PO Box 31361, Salt Lake City, UT 84131-0361

Pharmacy Claims: OptumRX, PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 877-305-8652

BHSO


UnitedHealthcare | Community Plan

Washington Apple Health
Behavioral Health Only

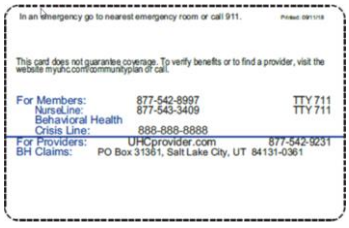
Health Plan (80840) 911-87726-04

Member ID: 000200046 Group Number: WAHLOP

Member:
MEMBER NAME

Payer ID: 87726

0501 Behavioral Health Services Only
Administered by UnitedHealthcare of Washington, Inc.


In an emergency go to nearest emergency room or call 911.

This card does not guarantee coverage. To verify benefits or to find a provider, visit the website myuhc.com/communityplan or call.

For Members: 877-542-8997 TTY 711
NurseLine: 877-543-3409 TTY 711
Behavioral Health Crisis Line: 888-888-8888
For Providers: UHCprovider.com 877-542-9231
BH Claims: PO Box 31361, Salt Lake City, UT 84131-0361

UnitedHealthcare
Community Plan

Spenddown Individuals

- Spenddown is the amount of medical expenses for which an individual is responsible, similar to an insurance deductible.
- Once spenddown is met, the individual will receive a letter describing their eligibility.
- MCOs do not have visibility as to whether an individual's spenddown has been met. It is only once met, that they are assigned to an MCO.
- ProviderOne Eligibilty: https://www.waproviderone.org/

Incarcerated Individuals

- HCA will "suspend" Medicaid coverage for individuals during incarceration.
- Suspended coverage means the individual is eligible for Medicaid, but all claims payment and managed care assignment is suspended while the individual is in custody
- The benefit to suspended (as opposed to terminated) coverage is that individuals are quickly re-enrolled with their MCO upon release.
- MCOs have developed processes to create "honor" or "presumptive" authorizations for incarcerated members to assist them in accessing services immediately upon release from the correctional facility.

Websites, Portals and Directories

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

Claims and Billing

Claim vs Encounter

Providers are required to submit a claim or encounter for each service that is rendered to an MCO enrollee regardless of the provider's reimbursement arrangement.

	Claim	Encounter
Definition	A bill for services for one member received for a specific date or date range	A claim processed and paid at $0 because the provider is pre-paid for services per the terms of their contract
Payment Method	• Paid Fee for Service (FFS) based on negotiated contract rate w/ MCO. • Typically, each covered service provided to the member is individually paid based on an allowed amount.	• Individual services are not paid • Provider is paid a capitated amount for pre-defined services as outlined in an individual contract

Claim/Encounter Submission

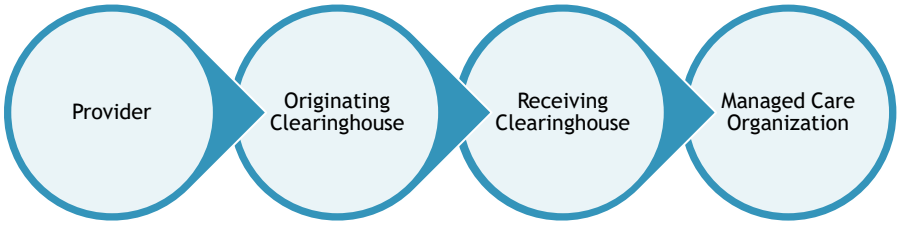
Submission Method	First Time Claims	Corrected Claim
Electronic Data Interchange (EDI) 837 transaction *Preferred method	Submit through clearinghouse	Submit through clearinghouse with appropriate frequency code
MCO's Portal	Reference to MCO website	Corrected claims are submitted by clicking on the original claim, making corrections and submitting
Mailing in a Paper Claim	➢ CMS-1500 for professional claims ➢ UB-04 for institutional claims ➢ All claim forms must meet CMS printing requirements and be printed in Flint OCR Red, J6983, ink ➢ No handwritten claim forms or photocopies will be accepted	➢ Institutional Claims (UB): Must be billed with corrected type of bill (XX7) in field 4, original claim number in field 64 and appropriate frequency code. ➢ Professional Claims (HCFA): Must be billed with original claim number in field 22 along with the appropriate frequency code.

Clearinghouses

Definition
A trading partner securely transmitting claims (837 file) electronically from the provider to the MCO.

Benefits	
• Submits multiple claims to specified payer	• Provides Electronic Remittance Advice (ERA) for automatic updates for payments and adjustments by MCO
• Meets HIPAA compliance standards	• Stand-alone entity
• Scrubs claims for errors prior to submission to MCO to improve accuracy	• The most common Electronic Data Information (EDI) transmissions are known as, files: 837, 277, 999 and 835.
• Allows providers to manage claim status in one place	

Clearinghouse Data Flow



- **Please refer to the Claims/Encounter Process handout for additional information.**

Clean/Non-Clean Claim Definitions

- **Clean Claim** - A clean claim is a claim that can be processed without obtaining additional information from the provider of the service, or from a third party. A clean claim contains all the required data elements on the claim form (see each MCO's billing guide for claim form requirements).
- **Non-Clean Claim** - Non-clean (dirty) claims include, but are not limited to, those that are rejected for missing data elements, submitted on incorrect forms, contain incorrect data (e.g. wrong member ID, invalid CPT/ICD code, etc.).

Timely Filing

The amount of time you have to file a clean claim is dependent on your specific contract terms with each MCO. Please refer to your contract and make note of your timely filing deadlines.

- Timely filing is determined by the number of days between when the MCO receives a ***clean claim*** from you and the date of service.
- Claims that are not received within the required timeframes will be denied and will not be paid unless there are extenuating circumstances (these are rare).
- You must check the member's eligibility on each date of service to make sure you are timely billing the correct payer or MCO. Members can move around between managed care plans.
- Contracted providers have 24 months from date of EOP to appeal a claim decision.

Rejected vs Denied Claims

What's the Difference?

Rejected	Denied
Does not enter the adjudication system due to missing or incorrect information.	Goes through the adjudication process but is denied for payment.

When billing electronically, your clearinghouse can send you reports of rejected claims (you may need to request this). You must work this report regularly to resolve the issues and resubmit claims. When sending in a paper claim, if it is rejected, it will return to you with a letter explaining the reason for the rejection.

A claim that rejects and does not enter the MCO's claims payment system to be assigned a claim number is not a clean claim and does not count towards timely filing calculations.

Most Common Rejection Reasons

Missing or invalid required data elements or fields on claim form

- Member date of birth
- Member ID number
- Provider taxonomy code
- NPI number
- Service date span
- CLIA number for lab claims

Unreadable claim form

- Ink too faded
- Typing is not fully within the fields, i.e. misaligned
- Ink bleeds into other fields
- Font is too small

Incorrect claim form used

Photocopy of claim form

Hand-written claim form

Claim/Encounter Submission

MCO	Payer ID(s)	Contact Number	Address
Amerigroup	Availity: 26375	Availity: (877) 334-8446	Washington Claims Amerigroup Washington Inc. PO Box 61010 Virginia Beach, VA 23466-1010
Coordinated Care	68069	(877) 644-4613	Claim Processing Department PO Box 4030 Farmington MO 63640-4197
Molina Healthcare	Claims: 38336 Encounter: 43174	(866) 409-2935 EDI.claims@MolinaHealthcare.com	Molina Healthcare of Washington P.O Box 22612 Long Beach, CA 90801
UnitedHealthcare Community Plan	Electronic: 87726 ERA: 04567	(866) 556-8166 Fax (855) 312-1470	UnitedHealthcare PO Box 31365 Salt Lake City UT 84131-0365

Please refer to MCO Provider Manuals for additional information on Claims/Encounters.

Balance Billing

- Providers must accept payment by MCOs as payment in full.
- Balance billing is not permitted unless the provider and member fully complete and sign an HCA 13-879 form--*Agreement to Pay for Healthcare Services*. *additional information, refer to:* WAC 182-502-0160, 42 CFR 447.15, and HCA Memo #10-25.
- Services must be rendered within 90 days from signing the HCA 13-879 form, otherwise a new form must be completed and signed.
- The HCA 13-879 form must be translated into the member's primary language if he or she has limited English proficiency, and if necessary, an interpreter must be provided for the member. If an interpreter is used to complete and sign the form, the interpreter's signature must also be obtained.
- All other requirements for the HCA 13-879 form apply, as outlined in.

Electronic Funds Transfer and Electronic Remittance Advice

Benefits of registering for Electronic Fund Transfer and/or Electronic Remittance Advice:

- Receive payments through direct deposit to bank account
- More timely and secure payments
- Receive notification upon payment
- Download an 835 file or other available reports to use for auto-posting
- Historical EOP search by various methods (i.e. claim number, member name)
- Create custom reports

Providers must register and complete the process for these administrative services.

Electronic Funds Transfer and Electronic Remittance Advice

MCO	Website	Contact Number	Email
Amerigroup	EFT: https://solutions.caqh.org/bpas/Default.aspx?ReturnUrl=/bpas/default.aspx/%22 ERA: www.Availity.com	(844) 815-9763 (800) 454-3730	EFT help: efthelp@enrollhub.caqh.org For ERA, submit email / ticket: https://www.availity.com/about-us/contact-us
Coordinated Care	www.payspanhealth.com	(877) 331-7154	ProviderSupport@payspanhealth.com
Molina Healthcare	https://providernet.administrasource.com/Start.aspx	(877) 389-1160	wco.provider.registration@emdeon.com
UnitedHealthcare Community Plan	https://www.uhcprovider.com/en/claims-payments-billing/electronic-payment-statements.html	(877) 620-6194	n/a

71

Behavioral Health Supplemental Data

This is the non-encounter data that was created in 2016 to replace and combine the TARGET and CIS non-encounter data. The data is needed by HCA in order to meet SAMHSA block grant reporting requirements. The data has also been referred to as "native transactions."

Changes effective January 1, 2020:

- Healthcare Authority has released an updated Behavioral Health Supplemental Transaction Data Guide. The guide along with a list of changes from the older versions is available on HCA website: https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/contractor-and-provider-resources
- All licensed and certified BHAs contracted with the MCOs/BH-ASOs are required to collect this data starting January 1, 2020.
- MCOs and BH-ASOs **must begin submitting data to HCA** no later than April 1, 2020 for Washington to be compliant with the SAMHSA CAP.
- Currently, MCOs are determining a method to collect this data from providers. Our goal is to implement systems/processes that are as similar as possible to minimize the burden on providers. In the meantime, **providers should use** the final HCA guide to begin enhancing their own systems in order to be ready to collect such data.

HCA IMC Service Encounter Reporting Instructions (SERI)

In order to receive federal match for Medicaid services, the Health Care Authority is required under CFR438.818 to ensure that all encounter data complies with HIPAA security and privacy standards. **CFR also requires that providers accurately prepare claims using applicable coding rules and guidelines.** HCA must also guarantee that encounter data is validated for accuracy and completeness; and changes in the IMC SERI guide will ensure that all encounter data is HIPAA and regulatory compliant.

The most current SERI Guide and interim guidance issued by HCA between SERI Guide updates can be found:

https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/service-encounter-reporting-instructions-seri

Evidence-Based Practice Codes

What are Evidence-Based Practice (EBP) codes and how are they used?

EBP codes are specially designated identifiers on a claim or encounter that are used to report specific research, or evidence-based practices for children's public mental health care provided by licensed or certified mental health providers to children 18 and under in Washington State. EBP encounter data is used for reporting to the legislature and other reporting requirements related to the provision of mental health services to children.

How should providers report EBPs under IMC?

The rules for coding and submitting EBPs under IMC are slightly different:

- The EBP code must be reported as a nine-digit number beginning with '860'. The next three digits must represent the appropriate EBP code as outlined in the Evidence-Based Practices Reporting Guide. The last three digits must be reported as '000'.

Example: 860163000 should be used when reporting Child-Parent Psychotherapy

- Report one EBP code per encounter in the 2300 REF02 Prior Authorization field of the standard 837 file submission.
- The REF01 field should contain the 'G1' qualifier (prior authorization).
- The REF02 field should contain the nine-digit EBP code.

Example: REF*G1*860163000

Evidence-Based Practice Codes

Will MCOs validate EBP codes on encounters and claims?

Yes. You should check with each MCO for specific validations that might apply. In general you should be ensuring the following:

- The value must match a valid 9 digit EBP code: Begins with an 860, followed by a valid 3 digit EBP code and ending with 000.
- The EBP code should only be used in conjunction with a valid CPT code per the Evidence-Based Practices Reporting Guide (under the "Eligible Encounter Codes" section).

Evidence-Based Practice Reporting Guides and additional information about EBPs can be found here:

https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/evidence-based-and-research-based-practices

Prior Authorizations

Amerigroup RealSolutions in healthcare

coordinated care

MOLINA HEALTHCARE

UnitedHealthcare Community Plan

Prior Authorization Requests

- Prior Authorization of covered services allows for determination of medical necessity prior to rendering of a service.
- The MCO's follow HCA contractual requirements on standard and urgent response times:
  - Standard: 5 days – 14 days
  - Urgent: 24 hrs – 72 hrs
- Turn around times are extended, with provider notification, if additional information is needed. To avoid delays, please submit complete information with the initial request.

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

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

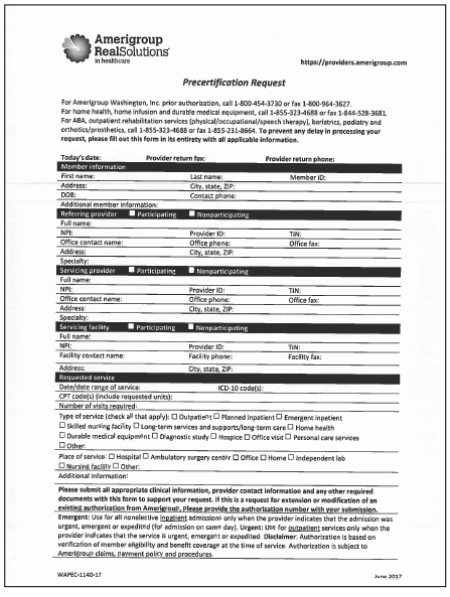
Issues with obtaining a prior authorization can be directed:

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 1-855-231-8664. 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-1140-17 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

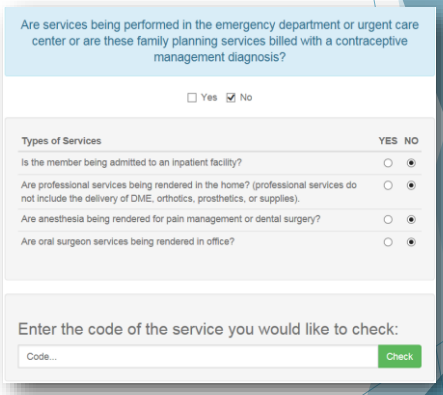
Outpatient Prior Authorization
Telephone: 1-800-454-3730
Fax: 1-877-434-7578

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

Amerigroup An Anthem Company

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

- Prior Authorization Check Tool
  - https://www.coordinatedcarehealth.com/providers/preauth-check/medicaid-pre-auth.html
- Prior Authorization General Information:
  - https://www.coordinatedcarehealth.com/providers/resources/prior-authorization.html
- Prior Authorization and Concurrent Review Forms
  - https://www.coordinatedcarehealth.com/providers/resources/forms-resources.html
    - Choose “Behavioral Health Forms and Guides”
- Request PA in one of the following ways:
  - Fax to (866)286-1086 (notifications and prior authorization requests)

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

Program Integrity and Monitoring

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

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

88

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
  - Advance Directives
  - Fraud, Waste, and Abuse
  - False Claims Act

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.

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.

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

99

Where to Report a Critical Incident

The Critical Incident Form are available on each MCO's website 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 Brokers • Frequently Used Forms • Helpful Links

Amerigroup RealSolutions in healthcare

coordinated care

MOLINA HEALTHCARE

UnitedHealthcare Community Plan

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

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/waIMC-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

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

Thank you for joining us today!

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