Home and Community Based Services (HCBS) Provider Orientation, Wellness4Me

December, 2015

United Behavioral Health and United Behavioral Health of New York, I.P.A., Inc. operating under the brand Optum

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Today’s speakers

- Joyce B. Wale, LCSW, Executive Director, Behavioral Health
- Lana Kats, MBA, Director of Network Management for NY Public Sector
- Seth Mandel, MD, MBA, Behavioral Health Medical Director, Wellness4Me
- Erica Bou, LMHC, CRC, Wellness4Me Administrator
- Barbara Tedesco, MS, CRC, Recovery and Resiliency Manager
- Gayle Parker-Wright, LCSW-R, Network Trainer
- Eunice Hudson, Provider Education Specialist
- Allandro Pierre, MHA, Network Manager
- Steve Welton, MS, LCPC, Senior Manager, Provider Performance
Agenda

• Welcome and Introduction
• Managed Care Transition
• Benefits
• Clinical Vision
• Clinical and Utilization Management Requirements
• Health Homes
• Cultural Competency
• Quality Improvement
• Credentialing and Recredentialing
• Recovery and Resiliency
• Billing
• Provider Express and UnitedHealthcare Online
• Network Services
Our United Culture

**Our mission** is to help people live healthier lives.  
**Our role** is to make health care work for everyone.

**Integrity.**

- Honor commitments
- Never compromise ethics

**Compassion.**

- Walk in the shoes of people we serve and those with whom we work

**Relationships.**

- Build trust through collaboration

**Innovation.**

- Invent the future, learn from the past

**Performance.**

- Demonstrate excellence in everything we do
Managed care transition

• The NYS Office of Mental Health (OMH) is collaborating with the Department of Health (DOH) and Office of Alcoholism and Substance Abuse Services (OASAS) to implement the managed care transition in response to the recommendations and guiding principles set forth by the Medicaid Redesign Team (MRT) Behavioral Health (BH) Subcommittee

• The vision is to create a system that provides New Yorkers with fully integrated behavioral and physical health services offered within a comprehensive, accessible and recovery oriented system
  – For adults 21 and older, the integration of all Medicaid behavioral health (BH) and physical health (PH) benefits under managed care will go into effect October 2015 in NYC and on July 2016 in the rest of New York State and will be delivered through two BH managed care models
Managed care transition, continued

Managed care models:

• **Qualified Mainstream Managed Care Organizations (MCOs):** For all adults served in mainstream MCOs throughout the State, the qualified MCO will integrate all Medicaid State Plan covered services for mental illness, substance use disorders (SUDs), and physical health conditions.

• **Health and Recovery Plans (HARPs):** HARPs will manage care for adults with significant behavioral health needs.
  – They will facilitate the integration of physical health, mental health, and substance use services for individuals requiring specialized expertise, tools, and protocols which are not consistently found within most medical plans.
  – In addition to the State Plan Medicaid services offered by mainstream MCOs, qualified HARPs will offer access to an enhanced benefit package comprised of **Home and Community Based services (HCBS)** designed to provide the individual with a specialized scope of support services not currently covered under the State Plan.
The Managed Care System is being developed based on the Medicaid Redesign Team (MRT) guiding principles

- Person-Centered Care management
- Integration of physical and behavioral health services
- Recovery oriented services
- Patient/Consumer Choice
- Ensure adequate and comprehensive networks
- Tie payment to outcomes
- Track physical and behavioral health spending separately
- Reinvest savings to improve services for BH populations
- Address the unique needs of children, families & older adults
Understanding Wellness4Me

• Wellness4Me is a new UnitedHealthcare Community Plan product for HARP-eligible members

• A member cannot be enrolled in the UnitedHealthcare Wellness4Me Plan and a Managed Medicaid Plan – The member must choose one plan

• The member must clinically qualify for Home and Community Based Services based on the results of the New York State (NYS) Community Mental Health Assessment (needs assessment)
Understanding Wellness4Me, continued

• NYS will “passively” enroll Community Plan members into the Wellness4Me Plan based on diagnosis and claims history

• Members can “opt out” of joining the Wellness4Me Plan and enroll in the Managed Medicaid plan within the first 90 days of enrollment

• Members can dis-enroll from either benefit within the first 90 days of enrollment
  – After 90 days, members must have a good reason to dis-enroll (e.g., moved out of the service area)

• If the Member is not enrolled in a HARP or opts out, they will not be eligible to receive HCBS effective January 1, 2016
Wellness4Me (Health and Recovery Plan, HARP): phase 1

• **Effective October 1, 2015** both the Mainstream Medicaid and Wellness4Me Plan (HARP) benefits were rolled out

• These products are for members who are 21 years and older residing in the 5 boroughs of New York City
  – It will be phased in over a 3 month period

• Home and Community Based Services (HCBS) for Wellness4Me members will begin **January 1, 2016**

• Membership by Borough / County
  – Bronx = Bronx County
  – Brooklyn = Kings County
  – Queens = Queens County
  – Manhattan = New York County
  – Staten Island = Richmond County
Wellness4Me Plan (HARP): phases 2 & 3

Phase 2

- **July 1, 2016**: includes all adults 21+ years old, in the rest of state
  - All New York State, eligible adults 21 and older, who meet the criteria can be enrolled in the Wellness4Me Plan

Phase 3

- **January 1, 2017**: all adults under 21 years old, adolescents and children in New York City (5 Boroughs), Nassau and Suffolk
- **July 1, 2017**: all adults under 21 years old, adolescents and children in the rest of state
Covered populations*

*From MCTAC presentation on 10/20/15
## Covered Benefits for HARP and Behavioral Health Benefit

<table>
<thead>
<tr>
<th>Services</th>
<th>HARP Enrolled Members</th>
<th>Medicaid Behavioral Health Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medically supervised outpatient withdrawal (OASAS services)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Outpatient clinic and opioid treatment program (OTP) services (OASAS services)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Outpatient clinic services (OMH services)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Comprehensive psychiatric emergency program</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Continuing day treatment</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Partial hospitalization</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>PROS</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>ACT</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Intensive case management/ supportive case management</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Health Home Care Coordination and Management</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Inpatient hospital detoxification (OASAS service)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Inpatient medically supervised inpatient detoxification (OASAS Service)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Inpatient treatment (OASAS service)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Rehabilitation services for residential SUD treatment supports (OASAS service)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Inpatient psychiatric services (OMH service)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Rehabilitation services for residents of community residences</td>
<td>Covered</td>
<td>Covered</td>
</tr>
</tbody>
</table>
The Home and Community Based Services are ONLY available to members enrolled in Wellness4Me Plan (HARP).

HCBS will not start until 1/1/2016 to allow time for all HARP members to receive their full assessment and for Plans of Care to be documented.
Membership cards: New York Wellness4Me, front of card
Membership cards: New York Wellness4Me, back of card
Clinical Vision

Seth Mandel, MD, MBA, Behavioral Health Medical Director, Wellness4Me
Our Clinical Vision

Care Advocacy
The purpose of Care Advocacy is intervention on behalf of individuals living with a health issue. We improve the experience of individuals we serve, using a range of tools and resources. We are dedicated to recovery, resiliency, wellness and wellbeing provided at the highest quality and most cost-effective manner.

Service System Solutions
The purpose of Service System Management is to improve the structure of, access to and practice within systems of care. We build relationships within local communities to learn about and improve healthcare systems.

Information Management and Technology
The purpose of Information Management and Technology is to create a more engaging, effective and affordable healthcare experience and to empower individuals in their pursuit of well-being.
Our goals

<table>
<thead>
<tr>
<th>Recovery Focus</th>
<th>Improve Access to Care</th>
<th>Integrate Physical and Behavioral Health</th>
<th>Reduce Cost</th>
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</thead>
<tbody>
<tr>
<td>• Apply recovery principles from first call through natural community supports</td>
<td>• Right care at the right time</td>
<td>• No wrong door access to care</td>
<td>• Reduce readmissions to inpatient</td>
</tr>
<tr>
<td>• Support use recovery language and principles in every aspect of our work</td>
<td>• Collaborate with providers to ensure timely access to services</td>
<td>• Eliminate silos through integrated person-centered care plans</td>
<td>• Engage community based crisis stabilization and use of PCP services</td>
</tr>
<tr>
<td></td>
<td>• Broaden provider focus for integrating care</td>
<td></td>
<td>• Increase use of natural community supports</td>
</tr>
</tbody>
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# Tools for system transformation

<table>
<thead>
<tr>
<th>Utilization Management</th>
<th>Care Coordination</th>
<th>Person-Centered Care</th>
<th>Quality Driven Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Review requests for service against LOCG's / LOCADTR:</td>
<td>• Follow-up support after discharge</td>
<td>• Align closely with Health Home and Accountable Care Teams</td>
<td>• Team-Facing Measures:</td>
</tr>
<tr>
<td>– Prior Notification</td>
<td>• Risk assessment and safety planning</td>
<td>• Care plans include:</td>
<td>– Call quality</td>
</tr>
<tr>
<td>– Pre-Certification</td>
<td>• Coordination with community resources</td>
<td>– Strength-based assessment, including culture</td>
<td></td>
</tr>
<tr>
<td>– Prior Authorization</td>
<td>• Support member’s recovery goals</td>
<td>– Measurable/attainable/realtistic/timely objectives</td>
<td></td>
</tr>
<tr>
<td>– Concurrent Review</td>
<td>• Engagement of member, family, and other support systems in development of care plan</td>
<td>– Keeps the person in context of their environment and natural supports</td>
<td></td>
</tr>
<tr>
<td>– Transition Planning for successful discharge</td>
<td></td>
<td></td>
<td>• Performance Improvement Projects</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Provider/Member - Facing Measures include HEDIS/NCQA</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• HCBS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Special Populations</td>
</tr>
</tbody>
</table>
Clinical and Utilization Management Requirements
Erica Bou, LMHC, CRC Wellness4Me Administrator
Wellness4Me: HCBS covered services

- Psychosocial Rehabilitation
- Community Psychiatric Support and Treatment (CPST)
- Habilitation
- Family Support and Training (FST)
- Short-Term Crisis Respite
- Intensive Crisis Respite
- Education Support Services
- Empowerment Services – Peer Supports (OMH)
- Pre-Vocational Services
- Transitional Employment
- Intensive Supported Employment
- Ongoing Supported Employment
- Transportation
HCBS will be subject to calendar year utilization caps at the Member level.

- **Tier 1 HCBS**: limited to $8,000
- **Tier 1 and Tier 2 combined** have an overall cap of $16,000
- **Utilization caps exclude crisis respite**: short-term crisis respite and intensive crisis respite are each limited within their own individual caps to 7 days per episode and 21 days per year

**Tier 1**: Employment, education and peer support
**Tier 2**: Full array of HCBS
Home and Community Based Services

### Eligibility
- HARP enrolled members only
- Wellness4Me is the Community Plan HARP Product
- HCBS services will not be available until 1/1/16
- HARP eligibility is being entered by Maximus and phased in over three months
- Must live in one of the HARP eligible housing settings as defined by the state (slide 25)

### Assessment
- Conflict-free assessment: New York State Community Mental Health Assessment
- Brief and full assessment
- Functional needs are identified based on the assessment results
- Health Home Care Coordinator or State designated care management agency administer the assessment

### Plan of Care
- Health Home Care coordinator or NYS Designated CMA completes Plan of Care (POC) based on the New York State Community Mental Health Assessment
- POC should reflect person-centered goals, strengths and resiliencies
- POC should include all services and referrals for the member
- POC should be reviewed and approved by MCO

### HCBS Providers
- Request notification when member presents for services
- Concurrent reviews will be requested based on frequency, duration and service type as well as any change in member's needs (pending final guidance)
HCBS Prior Authorization Request
<table>
<thead>
<tr>
<th>Service Code:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours per week:</td>
<td></td>
</tr>
<tr>
<td>Date of first service:</td>
<td></td>
</tr>
<tr>
<td>Service Code:</td>
<td></td>
</tr>
</tbody>
</table>

Based on the the NYS Community Mental Health Assessment scores for Tier 2 ONLY

<table>
<thead>
<tr>
<th>Service Request</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial Rehabilitation (P2017):</td>
<td>Y/N</td>
</tr>
<tr>
<td>Community Psychiatric Support and Treatment(I0016):</td>
<td>Y/N</td>
</tr>
<tr>
<td>Family Support and Training (I12014):</td>
<td>Y/N</td>
</tr>
<tr>
<td>Rehabilitation Services (T2017):</td>
<td>Y/N</td>
</tr>
</tbody>
</table>

| Hours per week: |  |
| Date of first Service: |  |
| Service Code: |  |

| Hours per week: |  |
| Date of first Service: |  |
| Service Code: |  |

| Hours per week: |  |
| Date of first Service: |  |
| Service Code: |  |

| Diagnosis Detail: |  |
| Diagnosis Code: |  |
| Diagnosis Code: |  |

| Does the member use tobacco products? | Y/N |
| If yes please inform member of the value added Health Coach Service for Tobacco Recovery that may be accessed by calling 1-866-398-3661 |  |
| Has the member reduced tobacco use? |  |
| If not is ongoing education and support provided to encourage tobacco recovery? | Y/N |

| Has an Initial Service Plan been completed? | Y/N |
| If Yes Date Completed: |  |

| Person Centered Goal |  |
| Domain |  |
| Objective |  |
| Intervention (including service type) |  |
| Anticipated date of completion: |  |

<p>| Objective |  |
| Intervention |  |
| Anticipated date of completion: |  |</p>
<table>
<thead>
<tr>
<th>Person Centered Goal 2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain</td>
<td>--</td>
</tr>
<tr>
<td>Objective</td>
<td>--</td>
</tr>
<tr>
<td>Intervention (including service type)</td>
<td></td>
</tr>
<tr>
<td>Anticipated date of completion:</td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td>--</td>
</tr>
<tr>
<td>Intervention (including service type)</td>
<td></td>
</tr>
<tr>
<td>Anticipated date of completion:</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Person Centered Goal 3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain</td>
<td>--</td>
</tr>
<tr>
<td>Objective</td>
<td>--</td>
</tr>
<tr>
<td>Intervention (including service type)</td>
<td></td>
</tr>
<tr>
<td>Anticipated date of completion:</td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td>--</td>
</tr>
<tr>
<td>Intervention (including service type)</td>
<td></td>
</tr>
<tr>
<td>Anticipated date of completion:</td>
<td></td>
</tr>
</tbody>
</table>

Is the member ready to transition to less intensive community-based services?

What are the key skills, supports, and resources needed to assist the member in making the transition to less intensive services? - Please list recommendations and estimated timeframe to engage member in developing a wellness plan.

### Clinical Resources:

- Care Coordination
- Wellness Resources
- Family and/or social support

### Housing

### Transportation
<table>
<thead>
<tr>
<th>Vocational and Educational Supports</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
## Adult Behavioral Health (BH) HCBS residential settings

<table>
<thead>
<tr>
<th>Adult BH HCBS Approved Settings</th>
<th>Still Under Review</th>
<th>Adult Residential Not Meeting CMS Standard for Community Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>• OMH Supported Housing</td>
<td>• OMH Apartment Treatment Programs</td>
<td></td>
</tr>
<tr>
<td>• Independent Community Housing</td>
<td>• OMH-CR-SRO*</td>
<td>• OMH Community Residence</td>
</tr>
<tr>
<td></td>
<td>• OMH-SP-SRO**</td>
<td>• OMH Adult Home</td>
</tr>
<tr>
<td></td>
<td>• OMH 100% Special Needs SP-SRO</td>
<td>• OMH Housing located adjacent to and on State Hospital grounds</td>
</tr>
<tr>
<td></td>
<td>• OMH-SP SRO Mixed Use</td>
<td>• OASAS Intensive Residential</td>
</tr>
<tr>
<td></td>
<td>• OASAS Supportive Living</td>
<td>• OASAS Community Residence</td>
</tr>
<tr>
<td></td>
<td>• OASAS Residential Reintegration/Scatter Site Setting</td>
<td>• OASAS Inpatient Rehab</td>
</tr>
<tr>
<td></td>
<td>*Community Residence, Single Room Occupancy Housing</td>
<td>• OASAS Residential Rehabilitation</td>
</tr>
<tr>
<td></td>
<td>**Supportive Single Room Occupancy Housing</td>
<td>• OASAS Residential Reintegration/Congregate Setting</td>
</tr>
</tbody>
</table>
HCBS eligibility

NEW YORK STATE
Office of Mental Health
Office of Alcoholism and
Substance Abuse Services

Eligibility Assessment

<table>
<thead>
<tr>
<th>Name (First, Middle Initial, Last)</th>
<th>Health Home where person is enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td>Is person on NARF-eligible list?</td>
</tr>
<tr>
<td>Month / Day / Year</td>
<td>On NARF list</td>
</tr>
<tr>
<td>What was individual's sex of birth?</td>
<td>Not on NARF list</td>
</tr>
<tr>
<td>(as original birth certificate)</td>
<td>Male</td>
</tr>
<tr>
<td>Gender:</td>
<td>Female</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
</tr>
<tr>
<td>Could not (would not) discern</td>
<td>Could not (would not) discern</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>Male</td>
</tr>
<tr>
<td>Unspecified</td>
<td>Female</td>
</tr>
<tr>
<td>Heterosexual or straight</td>
<td>Other</td>
</tr>
<tr>
<td>Homosexual, gay, or lesbian</td>
<td>Other</td>
</tr>
<tr>
<td>Asexual</td>
<td>Not sure</td>
</tr>
<tr>
<td>Other</td>
<td>Could not (would not) discern</td>
</tr>
<tr>
<td>Medical ID (SSN):</td>
<td>Medical ID (SSN):</td>
</tr>
<tr>
<td>Health Home/local Code:</td>
<td>Health Home/local Code:</td>
</tr>
<tr>
<td>Date of Assessment</td>
<td>Date of Assessment:</td>
</tr>
</tbody>
</table>

Residential/Living status at time of assessment
- Own home, apartment/residence
- Rent apartment/residence
- Own apartment/residence
- Own home, apartment/residence
- Own home, apartment/residence
- Own home, apartment/residence
- Own home, apartment/residence
- Own home, apartment/residence
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HCBS eligibility, continued

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**NEW YORK STATE**
Office of Mental Health
Office of Alcoholism and Substance Abuse Services

**Community Mental Health Assessment**

<table>
<thead>
<tr>
<th>SECTION A: IDENTIFICATION INFORMATION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (First, Middle Initial, Last)</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Month / Day / Year</td>
<td></td>
</tr>
<tr>
<td>Sex (M/F)</td>
<td></td>
</tr>
<tr>
<td>Gender (Male/Female/Other/Maybe)</td>
<td></td>
</tr>
<tr>
<td>What was individual's sex of birth?</td>
<td></td>
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<tr>
<td>(If original birth certificate)</td>
<td></td>
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<tr>
<td>Sexual Orientation</td>
<td></td>
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<tr>
<td>Marital Status</td>
<td></td>
</tr>
<tr>
<td>Date of Assessment</td>
<td></td>
</tr>
</tbody>
</table>

**Medicaid ID (CIN)**

**Health Home Local Code**

**Social Security Number**

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**Reasons for Assessment**

- Increased need
- Decline in status
- Significant change in status
- Reassessment
- Other (specify)

**Person's expressed goals of care**

**Identify primary goal**

**Capacity**

- Capable to consent to treatment
- Capable to disclose to information relating to clinical record

**UnitedHealthcare**
Community Plan

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OPTUM™
BH452-122015

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Level of care guidelines

- Where can providers find level of care guidelines?
  - Provider Express (providerexpress.com)
  - New York Medicaid specific level of care guidelines
  - Provider Manual
Level of care guidelines, admission criteria

All of the following criteria must be met

1. The member must be deemed eligible to receive HCBS using the HCBS Eligibility Assessment tool

2. Where the member has been deemed eligible to receive services, a full HCBS Assessment has been completed to determine these services are appropriate for that individual

3. A Plan of Care has been developed, informed and signed by the member, Health Home care manager, and others responsible for implementation. The POC has been approved by the Plan

4. The HCBS provider develops an Individual Service Plan (ISP) that is informed and signed by the member and HCBS provider staff responsible for ISP implementation

5. The ISP and subsequent service request supports the member’s efforts to manage their condition(s) while establishing a purposeful life and sense of membership in a broader community

6. The member must be willing to receive home and community based services as part of their ISP

7. There is no alternative level of care or co-occurring service that would better address the member’s clinical needs as shown in POC and ISP
Level of care guidelines, continued stay criteria

All of the following criteria must be met

1. Member continues to meet admission criteria and an alternative service would not better serve the member

2. Interventions are timely, need based, and consistent with evidence based/best practice and provided by a designated HCBS provider

3. Member is making measurable progress towards a set of clearly defined goals;  
   OR There is evidence that the service plan is modified to address the barriers in treatment progression;  
   OR Continuation of services is necessary to maintain progress already achieved and/or prevent deterioration

4. There is care coordination with physical and behavioral health providers, State, and other community agencies

5. Family/guardian/caregiver is participating in treatment where appropriate
Level of care guidelines, discharge criteria

Criteria #1, 2, 3, 4, or 5 are suitable; criteria #6 is recommended, but optional

1. Member no longer meets admission criteria and/or meets criteria for another more appropriate service, either more or less intensive
2. Member or parent/guardian withdraws consent for treatment
3. Member does not appear to be participating in the ISP
4. Member’s needs have changed and current services are not meeting these needs. Member’s self-identified recovery goals would be better served with an alternate service and/or service level. As a component of the expected discharge alternative services are being explored in collaboration with the member, family members (if applicable), the member’s Health Home and HCBS provider and MCO
5. Member’s ISP goals have been met
6. Member’s support system is in agreement with the aftercare service plan
Level of Care Guidelines (LOCG): provider resource

- Common Criteria for Guidelines- commitment of NYS and MCO’s to decrease provider burden
- Your homework assignment: review all relevant LOCGs
- LOCGs will be posted to Provider Express- visit this site frequently for updates and valuable information
- LOCGs are reviewed and updated annually
- Use it to train staff
- Understanding how to use these guidelines as a clinical tool can greatly improve your managed care experience
Care Advocates use the Level of Care Guidelines when making medical necessity determinations and as guidance when providing referral assistance.

<table>
<thead>
<tr>
<th>Generally accepted standards of practice</th>
<th>Clinically appropriate</th>
<th>Determinations of medical necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Based on credible scientific evidence</td>
<td>• Type, frequency, extent, and duration of services</td>
<td>• Informed by</td>
</tr>
<tr>
<td>• Generally recognized by the relevant medical community</td>
<td>• Considered effective for the treatment of mental illness, substance use disorder, or</td>
<td>• Unique aspects of the case</td>
</tr>
<tr>
<td>• Use evidenced-based outcomes to validate the practice</td>
<td>associated symptoms</td>
<td>• Member’s benefit plan</td>
</tr>
<tr>
<td></td>
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<td>• Available services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ability of provider to meet the member’s immediate needs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Alternatives that exist in the service area</td>
</tr>
</tbody>
</table>

OPTUM

BH452-122015
What happens if medical necessity is not met?

- If a clinical review results in a disagreement about level of care there are a few options:
  - Peer Review
    - Full denial
    - Partial denial
  - Appeals

- When a determination is made that a level of care is not the right care at the right time we will:
  - Work closely with providers to identify a transition plan
  - Assist provider and members in finding services that meet the member’s needs
Evidence-Based Practices

Examples of Evidence-Based Practices (not an all inclusive list)

- Motivational Interviewing
- Person-Centered Care
- Trauma Informed Care
- Risk Assessment and Crisis Intervention
- Integrated Whole Health Model
- Critical Time Intervention
- Recovery and Resiliency
- Individualized Recovery Planning
- Cognitive Behavioral Therapy
- Dialectical Behavioral Therapy
Person-Centered Plan of Care

• Plan of Care (POC)
  – Master integrated document
  – Includes all services: providers, frequency and duration, contact information
  – Ideally POC will be completed by Health Home Care Coordinators
  – POC must be submitted to the Plan for approval
    • Confirm providers in network
    • Verify member eligibility for the services listed
    • Evaluate POC for recovery goals that are person-centered and echo the member’s goals in his/her words
  – Our Care Advocates monitor the POC when:
    • Member is not enrolled or is refusing Health Home care coordination or
    • Member is not Health Home eligible

We are committed to assist members with field-based care advocates, peers, community health workers and housing specialists
Federal HCBS Plan of Care documentation requirements

• Must reflect Member’s strengths and preferences including goals, desired outcomes, living environment, paid and natural supports

• Must be written in common language (understood by the member), and include
  – Assessed needs
  – Positive support and interventions to meet identified needs
  – Measurable recovery goals
  – Clear time frames to achieve goals
  – Specified time frame and procedure to review recovery goals and progress towards the goals
  – Note how interventions support needs and minimize risk factors
  – Document member education of risks and benefits associated with the interventions

• Must document informed consent - finalized and agreed upon by the member and wherever possible the HCBS service provider
Federal Guidelines for Person-Centered Care Planning

- Offers informed choice including involvement of natural supports and people chosen by the member to participate in developing the plan
- Record the HCBS settings that member is considering
- Reflect cultural considerations including language proficiency and access for individuals with disabilities
- Includes method for the member to request updates to the plan when applicable
- Includes strategies for resolving conflict and potential conflict of interest for example:
  - The HCBS provider should not be developing the plan of care and/or providing case management service unless NYS demonstrates the provider is the only willing and qualified entity to provide case management
Service specific plans

- The member's diagnosis or presenting issues warranting services
- The member's problems and strengths
- The member's service goals are consistent with the purpose and intent of the program
- Plan for the provision of additional services to support the recipient outside of the program
- Criteria for discharge planning
- Person-centered care planning is clear and includes
  - Consistent goals and objectives
  - Concrete and easy to understand information (who, what and when)
  - Evaluation of goal attainment
  - Proactive planning to prevent or de-escalate crisis
Proactive approach to crisis planning

Planning for a crisis is best done before the crisis
  – Psychiatric Advance Directives
  – Wellness and Recovery Plans (WRAP)
  – Mental Health First Aid:  http://www.mentalhealthfirstaid.org/cs/

Additional Resources
• http://www.power2u.org/consumerrun-statewide.html
• http://www.cdsdirectory.org/
• http://www.iccd.org/search_form.php

Warm Lines:
• Parachute NYC includes a peer operated Support Line 646–741–HOPE
  – All services are confidential and there is no need for a referral
  – Live answer available from 4:00 p.m. - 12:00 a.m. Eastern time
Wellness4Me Health Homes and Care Coordination

Erica Bou, LMHC, CRC Wellness4Me Administrator
Wellness4Me Care Coordination and Health Homes
Populations Health Homes serve

- Individuals who are experiencing a severe disability or mental illness
- High risk homeless
- Medication Assisted Therapy (MAT)
- Members seeking permanent housing and a sense of community
- Transition from jail/prison
- Court-ordered community dwellers
- Members with complex medical conditions such as obesity, diabetes, asthma, HIV, congestive heart failure, etc.
What is a Health Home?

The six (6) core Health Home functions mandated by the Patient Protection Act are:

<table>
<thead>
<tr>
<th>Operational Priorities</th>
<th>Medical</th>
<th>Behavioral</th>
<th>Social</th>
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<tbody>
<tr>
<td>Transition of care</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Care coordination</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Referral management</td>
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<td>X</td>
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<td>Individual care</td>
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<tr>
<td>Health promotion</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Care support for family/caregiver</td>
<td>X</td>
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<td>X</td>
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Overview of the process

Member Enrollment

- Assigned PCP
- HARP Care Coordinator
- Care Coordinator at Health Home

- Assigned BH Provider
- BH Care Coordinators
Care Coordination

• Care Coordination will include:
  – Documentation of a Plan of Care by the behavioral and medical care team in one document
  – The Care Plan will indicate the activities and strategies to achieve stated care goals for the member
  – The interdisciplinary team that is created from the collaboration among providers facilitates the integration of care
Health information technology and information

Documentation will reside in a platform that is shared and provides reports

- The reports will facilitate tracking of
  - Referrals
  - Met/unmet goals
  - Appointments scheduled 90 days post hospitalization or emergency department visit
  - Hospitalizations or emergency department visits and 7 day follow-up
  - High-risk comorbid members for hospital avoidance
  - Alerts and other activities
Health Home and HARP

- HARP eligible members are flagged on the member assignment list sent to Health Homes
- Health Homes prioritize outreach to HARP eligible members
- UnitedHealthcare provides specific performance metrics for the services provided to Wellness4Me population
- Increased collaboration between United’s Accountable Care Team and HARP Team around Wellness4Me population
- Education is provided to the Health Homes regarding HCBS during monthly joint operation meetings
Cultural Competency

Gayle Parker-Wright, LCSW-R, Network Trainer
Cultural competency

- Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals, that enables effective work in cross-cultural situations
- Competence means having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by members and their communities
Cultural competency, continued

• Culture refers to integrated patterns of human behavior within various racial, ethnic, religious or social groups, including:
  – Language
  – Thoughts
  – Communications
  – Actions
  – Customs
  – Beliefs
  – Values
  – Institutions
Importance and value of cultural competence

• Given the diverse ethnic population in New York, providers must be prepared to provide culturally appropriate services

• Service settings and approaches should be culturally sensitive to engage individuals from diverse backgrounds to access services

• Promoting open discussions about mental health or substance abuse issues is an important step to reduce the stigma many individuals have

• Emphasizing individualized goals and self-sufficiency encourages members to live their lives to the fullest
Quality Improvement
Steve Welton, MS, LCPC, Senior Manager, Provider Performance
Quality improvement

Quality of care is measured and monitored throughout the organization.

Examples of how we measure quality:
- Complaints
- Sentinel Events
- Provider Satisfaction Surveys
- Member Satisfaction Surveys
- Coordination of Care
- Best Practice Guidelines
- HEDIS® measures
Member complaints

As an organization we investigate all member complaints (also known as grievances)

Complaints may be reported in different ways:

- Information is provided by the member and/or family member to the Health Plan or other internal department that reports cases
- Member direct report through calling the Health Plan Customer Service Department

Providers are part of the investigative process:

- Submit medical records for review
- Provide a response to an allegation
- Cooperate as necessary to resolve the investigation
Sentinel Events

What is a Sentinel Event?
Sentinel events are defined as a serious, unexpected occurrence involving a Member that is believed to represent a possible quality of care issue on the part of the practitioner/facility providing services, which has, or may have, deleterious effects on the Member, including death or serious disability, that occurs during the course of a Member receiving behavioral health treatment.

Reporting Sentinel Events to Quality:
• If you are aware of a sentinel event involving a Member, you must notify UnitedHealthcare Community Plan within one business day of the occurrence
• Standardized reporting forms (located here on Provider Express) should be sent directly to the Quality Department through secure fax or email:
  • Fax: 844-342-7704 – Attn: Quality Department
  • Email: NYBH_QIDept@uhc.com
• Additional information about Sentinel Events can be found in the Behavioral Health Provider Manual
An Appeal is any of the procedures that deal with the review of adverse determinations on the health care services a Member is entitled to receive or any amounts that the Member must pay for a covered service.

All Appeals should be submitted to:
UnitedHealthcare Community Plan Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

For questions about Appeals, you may call 866-362-3368
Provider quality audits

• Provider audits are completed for a variety of reasons:

  – On-going monitoring of providers, including Home and Community Based Services providers
  – At the time of Credentialing and Recredentialing for providers without OMH/OASAS certification and without a national accreditation (for example, The Joint Commission or CARF)
  – Quality of Care (QOC) investigation
  – Investigation of member complaints regarding the physical environment of an office or agency
Provider quality audits, continued

Elements reviewed during audits

- Physical environment
- Policies and procedures
- Member treatment records
- Personnel files

Scoring of Audits

- 85% and higher is passing
- Scores between 80 – 84% require a Corrective Action Plan (CAP)
- Scores below 79% require a CAP and re-audit
Audit tools

• There are 8 audit tools for New York Medicaid:
  – Organizational Provider Site Audit Tool
  – Treatment Record Review Tool
  – HCBS Record Tool
  – Case Management Record Tool
  – Psychosocial Rehab Record Tool
  – Peer Support Record Tool
  – Clinician Site Audit Tool
  – Home Office Site Audit Tool

• The audit tools are posted on providerexpress.com: from the home page, choose Our Network > Welcome to the Network > New York > Quality Improvement > Audit Tool Names
Documentation standards

• Information regarding documentation standards for behavioral health providers can be located in 3 places:
  
  – The Optum Network Manual (located on providerexpress.com): from the home page, choose Clinical Resources > Guidelines/Policies & Manuals > Optum Network Manual > Treatment Record Documentation Requirements
  
  
  – The audit tools
Highlights of documentation standards

- Record must be legible
- All entries must be signed by the rendering provider
- Entries must include the start and stop time or length of time spent in the session (for timed sessions)
- A Psychiatric and medical history, including the presenting problem, is documented
- Risk assessments (initial and on-going), including safety planning when applicable are present
- A Substance abuse screening is completed
- For children and adolescents, a complete developmental history is documented
Documentation standards, continued

- Treatment planning documentation includes
  - Short- and long-term goals that are objective and measurable
  - Time frames for goal attainment
  - Updates to the plan when goals are achieved or new issues are identified
  - Modifications to goals if goals are not achieved
- Coordination of care is completed (and documented) with Primary Care Physicians
- Coordination of care is completed (and documented) with other treating providers
- If the member refuses to allow coordination to occur, that is clearly documented in the treatment record
- Discharge planning should be on-going and a discharge summary is documented when services are completed
- Medical necessity for services that are rendered is clearly documented
HCBS documentation standards

The HCBS documentation requirements for encounters specifically include:

- Name of member
- Type of service provided
- Date of service provided
- Location of service
- Duration of service, including start and end times
- Description of interventions to meet Plan of Care goals
- Outcome(s) or Progress made toward goal achievement
- Follow up/next steps
- Provider name, qualifications, signature and date
Feedback to providers

- Feedback is provided verbally at the conclusion of the audit.
- A written feedback letter is mailed within 30 days for routine audits; for Quality of Care audits, the feedback letter is mailed after the requesting committee reviews the audit results.
- When a Corrective Action Plan is required, it must be submitted within 30 days of the request.
- Re-audits are completed within 3-6 months of acceptance of the Corrective Action Plan.
Behavioral Health Audit Staff

Maria A. Granda, LCSW
Telephone: 612-632-6679
Email: maria.granda@uhc.com

Marie Cavanaugh, LCSW
Telephone: 763-321-3149
Email: marie.cavanaugh@uhc.com

Marie Sze, LMHC
Telephone: 952-687-3639
Email: marie.sze@uhc.com
Credentialing and Recredentialing

Allandro Pierre, MHA, Network Manager
Network participation requirements

- The participation process begins with submission of the provider application
  - Agencies pursuing group contracts complete the Agency Application

- Additional required application materials include
  - Signed Agreement
  - Signed Disclosure of Ownership and Control Interest Statement
    - One per agency if pursuing a group contract

- Pre-contractual site audits
  - Required for unaccredited agencies pursuing group contracts
  - May be waived if licensed/certified by OMH/OASAS

- Approval by Optum Credentialing Committee
Credentialing of groups and agencies

Group Contracts

- For provider group agencies that employ both licensed professional and unlicensed paraprofessional staff to render services under the umbrella of the agency, Optum will execute group contracts with the agency as the contracting entity.
- Group agencies must submit the Agency Application, including the services being provided and the licensed clinical professionals on the staff roster (when requested).
- The individual licensed clinicians on staff do not need to submit CAQH applications or be individually credentialed when they work for the agency under a group contract Agreement.
Recredentialing

• Recredentialing is completed every 36 months (3 years)
  – This time line is established by NCQA
• Several months prior to the recredentialing date, a recredentialing packet will be sent to the provider
• Completion of the entire recredentialing packet is required for the recredentialing process to be completed
• Site audits will be completed for organizational providers as indicated by Optum policy
• Failure to complete the recredentialing paperwork or participate in the recredentialing site audit (when applicable) will impact the provider’s status in the network
• Completion of the recredentialing process takes time, it is important to submit required documentation as soon as possible
Recovery and Resiliency and Peer Support Services
Barbara Tedesco, MS, CRC, Recovery and Resiliency Manager
Origins of recovery: it’s mainstream now

1900-1960
1900’s: Institutionalization - shackles, restraint to early origins of rehabilitation
1940’s: Earliest psychosocial rehabilitation programs
1950’s: Medication, shock therapy
1960’s: Radical/anti-psychiatry movement/de-institutionalization

1970-1990
1970’s: Organized groups fighting for patients’ rights. Community support services
1980’s: Consumers self-help/advocacy groups & peer-run services
1990’s: Surgeon General’s report: recovery, peer services, psychiatric rehab

2000 - present
2000’s: President’s New Freedom Commission validates the concept of recovery; IOM Quality Chasm: mental health is key to overall health
2010’s: Moving from recovery as an add-on for outliers to core
Origins of addiction recovery

Pre-1900-1960
- 1800's: Native American movements
- 1840's: Temperance movements
- 1935: Alcoholics Anonymous

1970-1990
- 1970's: Medication supported treatment (methadone)
- 1980's: Dual diagnosis supports; recovery from addiction becomes fashionable
- 1990's: Recovery advocacy movement: involvement in policy and program development; conversation begins of validating recovery support services

2000's - present
- 2000's: President's New Freedom Commission validates the concept of recovery;
- IOM Quality Chasm: mental health is key to overall health
- 2010's: Moving from recovery as an add-on for outliers to core
New SAMHSA definition

<table>
<thead>
<tr>
<th>Working Definition of Recovery</th>
<th>A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.</th>
</tr>
</thead>
</table>

### Principles of Recovery

- Person-driven
- Occurs via many pathways
- Holistic
- Supported by peers
- Supported through relationships
- Culturally-based and influenced
- Supported by addressing trauma
- Involves individual, family, and community strengths and responsibility
- Based on respect
- Emerges from hope

### Four major domains that support recovery:

- **Health**: Overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way
- **Home**: A stable and safe place to live
- **Purpose**: Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society
- **Community**: Relationships and social networks that provide support, friendship, love, and hope
### Shifting the paradigm

<table>
<thead>
<tr>
<th>Illness/Deficit Focused</th>
<th>Recovery/Person-Centered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mastery of the professional treating deficits – compliance of individual</td>
<td>Partnership emphasizing collaboration, strengths, skill-building, and empowerment leading to resilience</td>
</tr>
<tr>
<td>Services begin with illness assessment and work toward illness reduction goals</td>
<td>Services begin with engagement and work toward quality of life goals</td>
</tr>
<tr>
<td>Recovery from the illness sometimes results after illness and behaviors are managed</td>
<td>Personal recovery is central from beginning to end</td>
</tr>
<tr>
<td>Motivation for change is externally driven</td>
<td>Motivation for change based on personal hope and individuals’ own goals</td>
</tr>
<tr>
<td>Medication compliance is key</td>
<td>Medication is one tool based on informed choice</td>
</tr>
<tr>
<td>Use techniques that promote illness control and reduction of risk</td>
<td>Use techniques that promote personal growth and self-responsibility</td>
</tr>
<tr>
<td>Services are forever and embedded in MH system</td>
<td>Emphasis on personal life management and the use of natural community resources</td>
</tr>
</tbody>
</table>
## Resilience

### Definition of Resilience

“The capacity of a system, enterprise, or a person to maintain its core purpose and integrity in the face of dramatically changed circumstance.”

### Good News

- “New research suggests that there are concrete things we can do to bolster resilience”
- “Resilience appears to be a common phenomenon of basic human adaptation systems”
- “Patterns of resilience depend upon habits of the mind that we can cultivate”


### Facilitators of Resilience

- Trauma informed practices: What happened to you vs. what is wrong with you
- Build optimism, accentuate strengths
- Strong support system, including self-help
- Cultural identity and pride
- Hope
- Creativity and powers of persuasion
- Mindfulness
- Inspire and be inspired
Peer support specialists

<table>
<thead>
<tr>
<th>Certified Peer Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Person who acknowledges “lived experience” and maintains strong recovery strategies</td>
</tr>
<tr>
<td>• Uses recovery strategies and formal training for the benefit of others</td>
</tr>
<tr>
<td>• May offer emotional support, share knowledge, teach skills toward meaningful life goals</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Engaging and retaining people in MH and SU services</td>
</tr>
<tr>
<td>• Supporting people in taking active role in treatment</td>
</tr>
<tr>
<td>• Lowering re-hospitalization rates/reducing ER services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increasing overall satisfaction with services</td>
</tr>
<tr>
<td>• Reducing symptoms and/or substance use</td>
</tr>
<tr>
<td>• Improvements in practical outcomes (employment, housing, etc.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Why</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Supported by New Freedom Commission, SAMHSA, Crossing the Quality Chasm, etc</td>
</tr>
<tr>
<td>• Evidence-based practice</td>
</tr>
<tr>
<td>• It works</td>
</tr>
</tbody>
</table>
Billing and Claims
Eunice Hudson, Provider Education Specialist
Links to resource documents

- HARP Mainstream Billing and Coding Manual
  

- HCBS Manual
  

- Fee Schedule and Rate Codes
  
  https://www.omh.ny.gov/omhweb/bho/phase2.html
Managed Care Technical Assistance Center

The Managed Care Technical Assistance Center (MCTAC) is a training, consultation, and educational resource for all mental health and substance use disorder providers in New York State.

Recent trainings:
- Integrated Managed Care Billing Guidance (guidance on how to submit clean claims)
- HCBS Service Cluster Webinar Series

Also available:
- Interactive glossary of terms
- Managed Care Language Guide
- Frequently Asked Questions
- MCO Plan Comparison Matrix

Website: [http://mctac.org](http://mctac.org)
Wellness4Me: Home and Community Based Services (HCBS)
HCBS billing requirements

Requirements

• 837i claim form (institutional) electronic form
• UB-04 (institutional) paper form
• Value code “24”
• Medicaid Fee-For-Service rate code
• Revenue code 0911
• Valid procedure code(s)
• Procedure code modifiers (as needed)
• Units of service

Location of state billing and coding manual:
Psychosocial Rehabilitation (PSR)

• Three different types of sessions
  – Individual, per 15 minutes
    • Billed in 15 minute units with a limit of 8 units per day (2 hours)
    • May be billed the same day as a PSR group session; can’t be billed on the same day as a PSR individual per diem
    • May be provided on or off-site
    • Staff transportation is billed separately as appropriate
  – Individual, per diem
    • Billed daily with a max of 1 unit
    • May not be billed the same day as a PSR group session or an individual per 15 minutes
    • May be billed on or off-site
    • Staff transportation billed separately as appropriate
  – Group
    • Billed daily in 15 minute units with a limit of 4 units per day (1 Hour)
Community Psychiatric Support & Treatment (CPST)

• Billed daily in 15 minute increments
• Payment is broken into various levels through the use of the procedure codes and, when applicable modifier codes, that indicate the type of staff providing the service
• No group sessions
• May only be provided off-site
• Staff transportation is billed separately as appropriate
Habilitation/Residential Support Services

• Billed daily in 15 minute increments with a limit of 12 units (3 hours) per day
• There are no group sessions for this service
• May be provided on or off-site
• Staff transportation is billed separately as appropriate
Family Support and Training (FST)

• Session provided to one family
  – Billed daily in 15 minute increments with a limit of 12 units per day
  – May be provided on or off-site
  – Staff transportation is billed separately as appropriate
• Group (consists of 2-3 families)
  – Billed daily in 15 minute increments with a limit of 12 units per day
  – May be billed on the same day as a FST one family session
  – May be provided on or off-site
Additional services, continued

**Short Term Crisis Respite**
- Billed daily with a max unit of 1 per day
- Stays may be no longer than 7 days per episode, not to exceed a maximum of 21 days per year (some exceptions apply, see HCBS manual)
- May only be provided in facilities dedicated to this purpose
- Fee includes transportation, do not bill transportation separately

**Intensive Crisis Respite**
- Billed daily with a max unit of 1 per day
- Stays may be no longer than 7 days per episode, not to exceed a maximum of 21 days per year (some exceptions apply, see HCBS manual)
- May only be provided in facilities dedicated to this purpose
- Fee includes transportation, do not bill transportation separately
Additional services, continued

**Education Support Services**
- Billed daily in 1 hour units with a max units of 2 (2 hours)
- May be provided on or off-site
- Staff transportation is billed separately as appropriate

**Empowerment Services, Peer Supports**
- Billed daily in 15 minute units with a limit of 16 units (4 hours) per day
- May be provided on or off-site
- Staff transportation is billed separately as appropriate
Pre-Vocational Services

- Billed daily in 1 hour units with a limit of 2 units (2 hours) per day
- May be provided on or off-site
- Staff transportation is billed separately as appropriate

Transitional Employment

- Billed daily in 15 minute units with a limit of 12 units (3 hours) per day
- May be provided on or off-site
- Staff transportation is billed separately as appropriate
Additional services, continued

**Intensive Supportive Employment**
- Billed daily in 15 minute units with a limit of 12 units (3 hours) per day
- May be provided on or off-site
- Staff transportation is billed separately as appropriate
- Modifier is used to indicate “Complex Level of Care”

**On-Going Supported Employment**
- Billed daily in 15 minute units with a limit of 12 units (3 hours) per day
- May be provided on or off-site
- Staff transportation is billed separately as appropriate
Transportation

Staff transportation, non-emergency

Per mile
- Billed daily in per mile units with a limit of 60 miles for a round trip
- 0.58 cents per mile (per federal guidelines)

Per round trip
- Billed monthly using the first day of the month as date of service
- Each round trip counts as one unit, with a limit of 31 units per calendar month
# HARP HCBS Crosswalk Example

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Rate Code Description</th>
<th>Px Code</th>
<th>Px Code Description</th>
<th>Modifiers</th>
<th>Unit Measure</th>
<th>Units Limits (Claim Line Level)</th>
<th>Other Rate Codes Prohibited on Same Day (Combination Edits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7784</td>
<td>HARP HCBS Psychosocial Rehab - Indv - on-site</td>
<td>H2017</td>
<td>Psychosocial rehabilitation services; per 15 minutes</td>
<td>U1</td>
<td>Per 15 min</td>
<td>8</td>
<td>7785, 7789</td>
</tr>
<tr>
<td>7785</td>
<td>HARP HCBS Psychosocial Rehab - Indv - off-site</td>
<td>H2017</td>
<td>Psychosocial rehabilitation services; per 15 minutes</td>
<td>U2</td>
<td>Per 15 min</td>
<td>8</td>
<td>7784, 7789</td>
</tr>
<tr>
<td>7786</td>
<td>HARP HCBS Psychosocial Rehab - Group 2-3</td>
<td>H2017</td>
<td>Psychosocial rehabilitation services; per 15 minutes</td>
<td>UN or UP</td>
<td>Per 15 min</td>
<td>4</td>
<td>7787, 7788, 7789</td>
</tr>
<tr>
<td>7787</td>
<td>HARP HCBS Psychosocial Rehab - Group 4-5</td>
<td>H2017</td>
<td>Psychosocial rehabilitation services; per 15 minutes</td>
<td>UQ or UR</td>
<td>Per 15 min</td>
<td>4</td>
<td>7786, 7788, 7789</td>
</tr>
<tr>
<td>7788</td>
<td>HARP HCBS Psychosocial Rehab - Group 6-10</td>
<td>H2017</td>
<td>Psychosocial rehabilitation services; per 15 minutes</td>
<td>US</td>
<td>Per 15 min</td>
<td>4</td>
<td>7786, 7787, 7789</td>
</tr>
</tbody>
</table>
Other rate codes prohibited on same day (combination edits): 7785 and 7789
### Required fields, UB-04, top

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s name</td>
<td>Patient’s name</td>
</tr>
<tr>
<td>Billing Provider Information</td>
<td>Billing Provider designated Pay-To</td>
</tr>
<tr>
<td>Birthdate &amp; Sex</td>
<td>Birthdate &amp; Sex</td>
</tr>
<tr>
<td>Patient’s address</td>
<td>Patient’s address</td>
</tr>
<tr>
<td>Revenue code</td>
<td>Revenue code</td>
</tr>
<tr>
<td>Procedure code &amp; Modifier(s)</td>
<td>Procedure code &amp; Modifier(s)</td>
</tr>
<tr>
<td>Service date</td>
<td>Service date</td>
</tr>
<tr>
<td>Service units</td>
<td>Service units</td>
</tr>
<tr>
<td>Total charges</td>
<td>Total charges</td>
</tr>
<tr>
<td>Type of Bill</td>
<td>Type of Bill</td>
</tr>
<tr>
<td>Value code &amp; rate code</td>
<td>Value code &amp; rate code</td>
</tr>
<tr>
<td>From and Through dates</td>
<td>From and Through dates</td>
</tr>
<tr>
<td>TIN</td>
<td>TIN</td>
</tr>
</tbody>
</table>

**Example:**

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Example Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s name</td>
<td>John Doe</td>
</tr>
<tr>
<td>Birthdate &amp; Sex</td>
<td>01/01/2020</td>
</tr>
<tr>
<td>Billing Provider Information</td>
<td>Provider X</td>
</tr>
<tr>
<td>Service date</td>
<td>01/01/2020</td>
</tr>
<tr>
<td>Service units</td>
<td>10 units</td>
</tr>
<tr>
<td>Total charges</td>
<td>$99.99</td>
</tr>
<tr>
<td>Type of Bill</td>
<td>Medical</td>
</tr>
<tr>
<td>Value code &amp; rate code</td>
<td>$100.00 / $20</td>
</tr>
</tbody>
</table>

**Notes:**
- Ensure all required fields are completed.
- Verify accuracy of all codes and dates.
Required fields, UB-04, bottom

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured ID #</td>
<td>Insured's unique identification number</td>
</tr>
<tr>
<td>Program NPI</td>
<td>Providers' NPI for the program</td>
</tr>
<tr>
<td>Attending NPI</td>
<td>Provider's NPI who treated the patient</td>
</tr>
<tr>
<td>Unlicensed practitioners (i.e. CASAC)</td>
<td>Unlicensed practitioners who provided care</td>
</tr>
<tr>
<td>Referring provider</td>
<td>Provider who referred the patient to the attending provider</td>
</tr>
</tbody>
</table>

**Notes:**
- UB-04: Uniform Billing Code used for hospital inpatient claims.
Service combinations

<table>
<thead>
<tr>
<th>HCBs/State Plan Services</th>
<th>OMH Clinic/OLP</th>
<th>OASAS Clinic</th>
<th>OASAS Opioid Treatment Program</th>
<th>OMH ACT</th>
<th>OMH PROS</th>
<th>OMH IPRT/CDT</th>
<th>OMH Partial Hospital</th>
<th>OASAS Outpatient Rehab</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSR</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>CPST</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Habilitation</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Family Support and Training</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Education Support Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Peer Support Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Employment Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Submission of Claims
Clean claim

A claim with no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim is considered a clean claim.

• All required fields are
  – Complete
  – Legible

All claim submissions must include:
  – Member’s name, Medicaid identification number and date of birth
  – Provider’s Federal Tax I.D. number (TIN)
  – National Provider Identifier (NPI)
  – A complete diagnosis (ICD-10-CM)

Providers are responsible for billing in accordance with nationally recognized CMS Correct Coding Initiative (CCI) standards. Additional information is available at [cms.gov](http://cms.gov)
Claims submission deadline

- Providers must initially submit claims within one hundred and twenty (120) days after the date of the service
- Paper clean claims will be paid within 45 days of receipt
- Electronic clean claims will be paid within 30 days of receipt
- If a provider wants to appeal a claim payment or denial, the appeal must be submitted within 90 days after receipt of the Provider Remittance Advice (PRA)
Claims submission option 1: EDI/Electronically

• Electronic Data Interchange (EDI) is an electronic-based exchange of information
• Performing claim submission electronically offers distinct benefits
  – It’s fast – eliminates mail and paper processing delays
  – It’s efficient – electronic processing helps catch and reduce pre-submission errors, so more claims auto-adjudicate
  – It’s complete - you get feedback that your claim was received by the payer
  – It’s cost-efficient - you eliminate mailing costs, the solutions are free or low-cost
• You may use any clearinghouse vendor to submit claims
• Payer ID for submitting claims is 87726
• Additional information regarding EDI is available on UHCCommunityplan.com
Claims submission option 2: hardcopy

Paper claims submitted via U.S. Postal Service should be mailed to:

Optum Behavioral Health
P.O. Box 30760
Salt Lake City, UT 84130-0760

Appeals submitted via U.S. Postal Service should be mailed to:

United Healthcare Community Plan, Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364
Electronic Payments & Statements (EPS)

• Faster Payments, better cash flow
• Less work, more time
• No need to change your current posting process
  • For more information call 866-842-3278, option 5
  • Or visit https://www.unitedhealthcareonline.com
Provider Express
UnitedHealthcare Online
Live and Work Well

Lana Kats, MBA, Director of Network Management for NY Public Sector
Our industry-leading provider website includes both public and secure pages for behavioral health providers. Public pages include general updates and useful information. Secure pages require registration and are available only to network providers. The password-protected “secure transactions” provides New York Medicaid providers access to provider-specific information.
Provider Express, (continued)

Public Pages include general updates and other useful information:

- Download standard forms (i.e. provider demographic updates, psych testing forms)
- Find network contacts
- Review clinical guidelines
- Access archived issues of Network Notes, the provider newsletter
- Level of Care Guidelines
- Training/Webinar offerings
Provider Express, (continued)

- Secure pages are available only to Optum in-network providers and require registration
- Providers will be able to update their practice information using the “My Practice Info” feature
- To request a User ID, select the “First-time User” link in the upper right corner of the home page
- If you need assistance or have questions about the registration process, call the Provider Express Support Center at **866-209-9320** (toll-free) from 7 a.m. to 9 p.m. Central time, or chat with a tech support representative online
Provider Express – Tech Support Live Chat feature

If you are contracted in the Optum/OHBS-CA network, you can use the registration process to create your account within Provider Express.

**Register**

The following information is required to register:

**Providers** (individually-contracted clinicians):
1. Provider First Name
2. Provider Last Name
3. Tax ID
4. NPI (Type I - Individual)
5. Last 4 digits of Provider's SSN

**Groups/Practices** (contracted for outpatient, professional services):
1. Group/Practice Name
2. Tax ID
3. NPI (Type II - Organization)

**Facilities** (contracted for inpatient, IOP and other facility-related services):
1. Facility Name
2. Federal Tax ID
3. NPI (Type II - Organization)

If you need assistance or have questions about the registration process, call the Provider Express Support Center at 1-866-239-9320 (toll-free) from 7 A.M. to 9 P.M. Central time or chat with a tech support representative online.

Provider Express Support

Click here for live chat
My Practice Info – Group Login

- Group logins will see a difference in the My Practice Info page due to how they are set up in the internal system.
- Clicking on the “View Address Info” button will display the locations page specific to that group.

![My Practice Info - Review Practice Profile](image-url)
My Practice Info – Practice Locations for Group Logins

• The Practice Locations page for group logins also looks different from individual logins
• Users can click on the “update” or “delete” links to the right of any address, and/or can click on the Add New Location button at the bottom
• With any of these updates, if there are individually-contracted providers for that group, there are options to choose which provider(s) the update/delete/add affects
UnitedHealthcare provider website

**unitedhealthcareonline.com**

- Secure transactions for Medicaid include:
  - Check eligibility and authorization or notification of benefits requirements
  - Submit professional claims and view claim status
  - Make claim adjustment requests
  - Register for Electronic Payments and Statements (EPS), including Electronic Funds Transfer (EFT)
  - To request a user ID to the secure transactions on the [unitedhealthcareonline.com](http://unitedhealthcareonline.com), select Enroll Today from the Home Page; you may obtain additional information through the Help Desk at 866-842-3278

- For member eligibility, claim status, and reference materials, go to [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) > Tools and Resources > UnitedHealthcare Community Plan Resources

- Customer Service for website support: 800-600-9007
UnitedHealthcare Online – login page
Training

Training Opportunities:
Unitedhealthcareonline.com Overview
EPS Introduction
EDI 101: Basics and Beyond
Electronic Payments & Statements (EPS)

EPS is our solution for electronic remittance advice (ERA) and electronic funds transfer (EFT). EPS allows you to access your explanation of benefits (EOBs) online and receive direct deposit of claim payments into your checking or savings account.

- Faster payments, better cash flow
- Eliminate mail delivery and check-clearing time to receive your payments 5 to 7 days faster.
- Less work, more time
- No more envelopes to open, paper checks to track or trips to the bank. More than 850,000 physicians, health care professionals, facilities and billing companies use EPS today for its easier reconciliation experience, reduced paperwork and the greater efficiency it brings to administration.

No need to change your current posting process
With EPS all you need is a computer and internet connection, no special software or system upgrades are necessary. Here’s how it works:

1. You and your designees receive email notifications when payments are deposited.
2. View the deposit amount and all EOBs associated with that deposit by logging onto EPS.
3. Choose your posting method. Online remittance advices mirror paper remits so you can post from the screen, download a copy, or print EOBs. If you wish, autostep using the free electronic remittance file (385).

Enrollment in EPS currently applies to payments from UnitedHealthcare Commercial, UnitedHealthcare Medicare Solutions, UnitedHealthcare Oxford, UnitedHealthcare Community Plan of Arizona, California, Delaware, Florida, Hawaii, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Nebraska, New Jersey, New Mexico, New York, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas, Washington and Wisconsin.

*Jan. 1, 2016

Use the links below to learn more, or call 866-842-3278, option 5.

Enroll Now
Viewing Electronic Remittance Advice (ERA), 835

Electronic Payments and Statements

Imagine this: claims payments from health plans are deposited directly into your bank account. Every business day, a member of your staff logs into a secure website to view claims paid and view, download or print remittance advice to reconcile your patient accounts.

It’s real, and it’s what more than 65,000 doctors, hospitals, clinics and other health care providers are enjoying today. Isn’t it time you did, too?

How to enroll

Enrolling in Optum Electronic Payments and Statements is quick and simple. Fill out the Enrollment Form and follow the instructions to enroll online.

There is no charge to you for the service, and you don’t have to buy or install any software. All you need is an internet connection and a desire to speed up claims payments from our participating health plans.

Benefits to you:

- Claims payments made by electronic funds transfer (EFT) from health plans are deposited directly to your designated bank. You may be paid five to seven days faster than if you received paper checks by mail.
- Information is posted online one business day prior to the bank deposit, so you always know what’s coming. We also email you once a day when claims payments have been made.
- Electronic remittance advice (ERAs) are posted three to five days faster than mailed information, too. This lets you identify patient responsibility for care sooner.
- Unique payment identifier — EFTs and ERAs are tied together with a unique payment identification number to make reconciliation faster and easier.
- Claims payment histories are available and searchable on our website for up to 13 months.
- You can work faster by bundling claims data for date periods and batches you select.

http://www.optumhealthfinancial.com/
Live and Work Well
Planning resources: https://www.liveandworkwell.com/public/

Personal Empowerment Kits

No matter where you are on your journey to well-being, it’s important that you build your resiliency. You might be prescribed medication that will help you, but you need to do more to achieve your long-term recovery and well-being. These toolkits offer a range of different tools you can use depending on your personal preferences. Do you like the idea of using a game to build resiliency? How about a graphic novel approach? Perhaps you prefer journaling or meditation? How about tracking your journey to long-term recovery and well-being?

You’ll find all that and more in these toolkits:

- Addiction Recovery Tools
- Family Recovery and Resiliency Tools
- Recovery, Resiliency and Empowerment Tools
- Smartphone Apps for Substance Use Disorder Treatment/Recovery
- Tools You Can Use
Network Services

Lana Kats, MBA, Director of Network Management for NY Public Sector
Reminders: appointment availability standards

Time frames represent requirements based on the date of the appointment request.

- **Rehabilitation and Habilitation**
  - Non Urgent MH/SUD: within 2 weeks
  - Follow-up to emergency or hospital discharge: within 5 days

- **Educational and Employment Support Services**
  - Non Urgent MH/SUD: within 2 weeks

- **Peer Supports Services (PSS)**
  - Urgent Care: within 24 hours
  - Non Urgent MH/SUD: within 1 week*
  - Follow-up to emergency or hospital discharge: within 5 days

*Unless appointment is pursuant to emergency or hospital discharge, in which case the standard is within 5 days; or if PSS are needed more urgently for symptom management, the standard is within 24 hours
Appointment availability standards, continued

Time frames represent requirements based on the date of the appointment request.

- Psychosocial Rehabilitation*
  - Non Urgent MH/SUD: within 2 weeks

- Community Psychiatric Support and Training*
  - Non Urgent MH/SUD: within 2 weeks

- Family Support and Training*
  - Non Urgent MH/SUD: within 2 weeks

- Educational and Employment Support Services
  - Non Urgent MH/SUD: within 2 weeks

*Unless appointment is pursuant to an emergency or hospital discharge or release from incarceration, in which case the standard is within 5 days of request.
Provider Service Quick Guide
Mainstream Medicaid & Wellness4Me

Call Center for UnitedHealthcare
1-800-362-3368

Websites & What's Available

- providerexpress.com
- uhccommunityplan.com
- unitedhealthcareonline.com

- A website for Health Care Professionals, Community Organizations and Members
- For providers the links will direct you to important information in your state
- Directs you to our secure provider site UnitedHealthcare Online®

- Check member eligibility
- Check claim status & payments
- Claims Reconsideration
- Electronic Data Interchange (EDI) Information
- Tutorials
- EDI Support: 900-210-8315 or email ac_edi_ops@uhc.com

Claims Submission

- Paper Claim submission:
  Optum Behavioral Health
  P.O. Box 30780
  Salt Lake City, UT 84130-9760

  Claims must be submitted within 120 days from the date of service
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Appeals                              | UnitedHealthcare Community Plan, Appeals  
P.O. Box 31364  
Salt Lake City, UT 84131 |
| Care Advocacy                        | 1-866-362-3368 |
| Best Practice Guidelines             | We have adopted Best Practice Guidelines, which were developed by nationally recognized organizations. Provider Express > Guidelines/Policies & Manuals > Best Practice Guidelines |
| Utilization Management Guidelines    | Additional details about utilization management guidelines are located in the New York Medicaid Behavioral Health Manual  
**Prior Authorization is not required for:**  
- Outpatient mental health and substance use clinic services  
- Initial medically necessary emergency and post-stabilization services, including emergency behavioral health care  
- Urgent care  
- Crisis stabilization, including mental health  
- Post-stabilization care services  
- Personalized Recovery Oriented Services (PROS) pre-admission status  
- Opioid Treatment Program (OTP)  
- Substance use disorder intensive outpatient  
- Substance use disorder day rehabilitation  
- Medically supervised outpatient substance withdrawal |
|                                      | **Prior Authorization is required for:**  
- Facility-based care  
- Non-routine outpatient care including but not limited to, psychological testing and extended sessions of 53 minutes or more  
- Home and Community Based Services (HCBS)  
- Personalized Recovery Oriented Services (PROS) admission (60 days) & active rehabilitation status  
- Continuing Day Treatment (CDT)  
- Mental Health Intensive Outpatient Program (MHIOp)  
- Assertive Community Treatment (ACT)  
- Partial Hospitalization  
- Residential substance use treatment |
| Medical Transportation               | UnitedHealthcare Community Plan Transportation Reservation line: 1-866-913-2497  
UnitedHealthcare Community Plan Ride Assistance (Where’s my ride): 1-866-913-2498 |
Svetlana (Lana) Kats – Director of Network Management for NY Public Sector
Tel: 212-898-3182
Email: svetlana.kats@uhc.com

New York Network Management – Mainstream Medicaid and Wellness4Me
77 Water Street, 14th Floor
New York, NY 10005
Email: NYHarp_ProvServices@optum.com
Phone: 877-614-0484
Fax: 877-958-7745
Behavioral Health Network Managers

Afrika Zyonne-Kumani – Manhattan, Bronx & Westchester
Tel: 518-313-4871
Email: afrika.zyonne-kumani@uhc.com

Allandro Pierre – Queens, Nassau & Suffolk
Tel: 952-202-3839
Email: allandro.pierre@uhc.com

Jenny Morfin – Brooklyn & Richmond
Tel: 763-321-2093
Email: jenny.morfin@uhc.com
Contact us, continued

**Eunice Hudson** – Provider Education Specialist
Tel: 612-642-7131
Email: eunice.hudson@uhc.com

**Gayle Parker-Wright** – Network Trainer
Tel: 612-642-7307
Email: gayle.parker-wright@uhc.com
Thank You
We Appreciate Your Attendance Today