Salish Integrated Managed Care Operations Symposium

Co-Hosted By:

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
ʔéʔéʔɬxʷaʔ naxʷskáyám’- 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

<table>
<thead>
<tr>
<th>Managed care region</th>
<th>Amerigroup</th>
<th>Community Health Plan</th>
<th>Coordinated Care</th>
<th>Molina Healthcare</th>
<th>United Healthcare</th>
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<tbody>
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<td>As of January 2019</td>
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<td>Greater Columbia</td>
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<td>King</td>
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<td>North Central</td>
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<td>Pierce</td>
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<td>Spokane</td>
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<td>Southwest</td>
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<td>As of July 2019</td>
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<td>North Sound</td>
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<td>Coming January 2020</td>
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<td>Thurston-Mason</td>
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<tr>
<td>Great Rivers</td>
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<tr>
<td>Salish</td>
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*Apple Health Foster Care is a statewide program, provided through Apple Health Care Connections (Coordinated Care of Washington).

Update on Adoption Status

- Integration by 2020 mandated date
- Switched regions to integrate in 2019
- Already integrated

*Southwest (April 2018) North Central (January 2018)
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](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

HCA

Integrated MCO

Required sub-contract

BH - ASO

Required sub-contract

Integrated MCO

Continuum of Integrated Clinical Services and Providers

Member

MCO Introductions
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 life, 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 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
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

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
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 habits and build lifelong friendships.
Molina Healthcare of Washington

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

- 811,000 members in Washington State through Medicaid, Marketplace and Medicare
- Nearly 900 employees in Washington State
- Over 600,000 IMC members (50% of all IMC members statewide)
- 2,400 hours of employee volunteer service in WA last year
- NCQA - Achieved Commendable Accreditation and NCQA’s Multi-Cultural Health Care Distinction for Medicaid
- Strong Medicaid provider network including 101 of 102 state hospitals, close to 40,000 primary/specialty providers in all 39 counties

Over 600,000 IMC members (50% of all IMC members statewide)

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

Get Connected!
Free Cell Phone
If you do not have a smartphone and would like one, you may be eligible for a free phone. Fill out the form to get started.

Virtual Urgent Care
Talk or video chat with a provider 24/7 from your phone, tablet or computer. No appointment needed. Virtual urgent care is available for common conditions like:

- Colds
- Infections
- Fainting
- Ear pain

We can help in your language.
Visit www.molinalinemedicaid.com or call 1-877-4-MDC-WA (463-2962) for more information.

amazon prime
Get 30 days of Amazon Prime - on us!
Molina Medicaid members can get Amazon Prime for 30 days at no cost, including:

- Fast, free shipping
- Special discounts
- Health grants
- Stream movies, TV shows and music

Visit MolinaHealthCare.com/Prime

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 collaboratively 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
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.

UHC Focus on Social Determinants

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

- Providing reliable access to food could save over $215 per member per month in health care costs.
- Creating safe, affordable housing can reduce health care costs by over $350 per member per month.
- Supporting the completion of high school can decrease health care costs by over $140 per member per month.
Credentialing, Rosters and NPIs

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.

<table>
<thead>
<tr>
<th>Category/Scenario</th>
<th>Facility Contract (CMHA, SUD Agency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility/Location Credentialing Required?</td>
<td>Yes</td>
</tr>
<tr>
<td>Individual Practitioner Credentialing Required?</td>
<td>No (Facility-based non-licensed)</td>
</tr>
<tr>
<td>What type of Application is required?</td>
<td>Facility Application (with supporting licensure)</td>
</tr>
<tr>
<td>Are practitioner rosters required?</td>
<td>Yes (for provider directory when appropriate, member care/referral, claims processing)</td>
</tr>
</tbody>
</table>
| 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:

<table>
<thead>
<tr>
<th>MCO</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amerigroup</td>
<td><a href="mailto:WACredentialing@Amerigroup.com">WACredentialing@Amerigroup.com</a></td>
</tr>
<tr>
<td>Coordinated Care</td>
<td><a href="mailto:Contracting@CoordinatedCareHealth.com">Contracting@CoordinatedCareHealth.com</a></td>
</tr>
<tr>
<td>Molina Healthcare</td>
<td><a href="mailto:MHWProviderInfo@MolinaHealthcare.com">MHWProviderInfo@MolinaHealthcare.com</a></td>
</tr>
<tr>
<td>UnitedHealthcare Community Plan</td>
<td><a href="mailto:WAIMC@Optum.com">WAIMC@Optum.com</a></td>
</tr>
</tbody>
</table>
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.

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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:

<table>
<thead>
<tr>
<th>MCO</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amerigroup</td>
<td><a href="mailto:WACredentialing@Amerigroup.com">WACredentialing@Amerigroup.com</a></td>
</tr>
<tr>
<td>Coordinated Care</td>
<td><a href="mailto:Contracting@CoordinatedCareHealth.com">Contracting@CoordinatedCareHealth.com</a></td>
</tr>
<tr>
<td>Molina Healthcare</td>
<td><a href="mailto:MHWProviderInfo@MolinaHealthcare.com">MHWProviderInfo@MolinaHealthcare.com</a></td>
</tr>
<tr>
<td>UnitedHealthcare Community Plan</td>
<td><a href="mailto:WAIMC@Optum.com">WAIMC@Optum.com</a></td>
</tr>
</tbody>
</table>
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!

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.

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Appointment Standard</th>
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</thead>
<tbody>
<tr>
<td>Preventive Care Appointment</td>
<td>Within 30 calendar days of request</td>
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<tr>
<td>Second Opinions</td>
<td>Within 30 calendar days of request</td>
</tr>
<tr>
<td>Non-Urgent, Symptomatic Care</td>
<td>Within 10 calendar days of request</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>24 hours/7 days</td>
</tr>
<tr>
<td>After-Hours Care</td>
<td>Available by phone 24 hours/seven days</td>
</tr>
<tr>
<td>Care Transitions - PCP Visit</td>
<td>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</td>
</tr>
<tr>
<td>Care Transitions - Home Care</td>
<td>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.</td>
</tr>
</tbody>
</table>
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.**

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Appointment Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-life threatening</td>
<td>Within 6 hours</td>
</tr>
<tr>
<td>Urgent care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Routine care - initial visit</td>
<td>The earlier of 10 business days or 14 calendar days</td>
</tr>
<tr>
<td>Routine care - follow-up visits</td>
<td>Within 30 days</td>
</tr>
</tbody>
</table>

Eligibility and ID Cards
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.wapoviderone.org/](https://www.wapoviderone.org/)
- 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](image)
Eligibility Example - Molina

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

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.
Eligibility Example - UnitedHealthcare

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

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

Eligibility Example - Ineligible

Member is ineligible.
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 Eligibility: https://www.wapproviderone.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
- Frequently Used Forms
- Preferred Drug List
- Provider Newsletters and Announcements
- Provider Training and Resource Materials
- Clinical Practice Guidelines
- HEDIS Guides
- Provider Manuals
- Provider Portal Link
- Verify Prior Auth requirements
### MCO Website Links for Providers

<table>
<thead>
<tr>
<th>MCO</th>
<th>Website Link</th>
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<tbody>
<tr>
<td>Amerigroup</td>
<td><a href="https://providers.amerigroup.com/WA">https://providers.amerigroup.com/WA</a></td>
</tr>
<tr>
<td>Coordinated Care</td>
<td><a href="www.coordinatedcarehealth.com/providers.html">www.coordinatedcarehealth.com/providers.html</a></td>
</tr>
<tr>
<td>Molina Healthcare</td>
<td><a href="www.molinahealthcare.com/providers/wa/medicaid/Pages/home.aspx">www.molinahealthcare.com/providers/wa/medicaid/Pages/home.aspx</a></td>
</tr>
<tr>
<td>UnitedHealthcare Community Plan</td>
<td><a href="www.uhcprovider.com/communityplan">www.uhcprovider.com/communityplan</a></td>
</tr>
</tbody>
</table>

### 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**

<table>
<thead>
<tr>
<th>MCO</th>
<th>Portal Link</th>
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</thead>
<tbody>
<tr>
<td>Coordinated Care</td>
<td><a href="http://www.coordinatedcarehealth.com/login.html">www.coordinatedcarehealth.com/login.html</a></td>
</tr>
</tbody>
</table>

**Provider Directory Links**

- Amerigoup
- Coordinated Care
  - [https://providersearch.coordinatedcarehealth.com/](https://providersearch.coordinatedcarehealth.com/)
- Molina Healthcare
  - [https://providersearch.molinahealthcare.com/](https://providersearch.molinahealthcare.com/)
- UnitedHealthcare Community Plan:
## 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.**

<table>
<thead>
<tr>
<th></th>
<th>Claim</th>
<th>Encounter</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>A bill for services for one member received for a specific date or date range</td>
<td>A claim processed and paid at $0 because the provider is pre-paid for services per the terms of their contract</td>
</tr>
</tbody>
</table>
| **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 |

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**Claim**

**Encounter**
Claim/Encounter Submission

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

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
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**
- Does not enter the adjudication system due to missing or incorrect information.

**Denied**
- 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**

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

*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

<table>
<thead>
<tr>
<th>MCO</th>
<th>Website</th>
<th>Contact Number</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ERA: <a href="http://www.Availity.com">www.Availity.com</a></td>
<td>(800) 454-3730</td>
<td>For ERA, submit email / ticket:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><a href="https://www.availity.com/about-us/contact-us">https://www.availity.com/about-us/contact-us</a></td>
</tr>
<tr>
<td>Coordinated Care</td>
<td><a href="http://www.payspanhealth.com">www.payspanhealth.com</a></td>
<td>(877) 331-7154</td>
<td><a href="mailto:ProviderSupport@payspanhealth.com">ProviderSupport@payspanhealth.com</a></td>
</tr>
<tr>
<td>Molina Healthcare</td>
<td><a href="https://providernet.adminsource.com/Start.aspx">https://providernet.adminsource.com/Start.aspx</a></td>
<td>(877) 389-1160</td>
<td><a href="mailto:wco.provider.registration@emdeon.com">wco.provider.registration@emdeon.com</a></td>
</tr>
<tr>
<td>Community Plan</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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 CFR 438.818 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:

Prior Authorizations
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

<table>
<thead>
<tr>
<th>SERVICE TYPE AND DESCRIPTION</th>
<th>AMEGROUP</th>
<th>CHPW</th>
<th>COORDINATED CARE</th>
<th>MOLINA</th>
<th>UNITED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Inpatient Care - Mental Health &amp; SUD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Psychiatric Hospitalization and Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Psychiatric admission to Behavioral Health Unit or Freestanding Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Acute Withdrawal (Detoxification)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Members admitted on an ETA are reviewed for changes in level, status, commission of actual treatment and transition of care needs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*If ETA, please attach court documents.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No. transient 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. transient admissions require notification only within 24 hours followed by concurrent review.
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No. transient 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

*Updated version is now available

Updated version is now available

*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](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

How to Request a Prior Authorization

Portal: [https://www.availity.com](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
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 Prior Authorization

- Prior Authorization Check Tool
  - [https://www.coordinatedcarehealth.com/providers/preauth-check/medicaid-pre-auth.html](https://www.coordinatedcarehealth.com/providers/preauth-check/medicaid-pre-auth.html)
- Prior Authorization General Information:
  - [https://www.coordinatedcarehealth.com/providers/resources/prior-authorization.html](https://www.coordinatedcarehealth.com/providers/resources/prior-authorization.html)
- Prior Authorization and Concurrent Review Forms
  - [https://www.coordinatedcarehealth.com/providers/resources/forms-resources.html](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)
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 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
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
  - 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

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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:

<table>
<thead>
<tr>
<th>Region</th>
<th>Network Contact</th>
<th>Email</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salish</td>
<td>Christine Rae</td>
<td><a href="mailto:Christine.Rae@Optum.com">Christine.Rae@Optum.com</a></td>
<td>(206) 926-0224</td>
</tr>
</tbody>
</table>


Program Integrity and Monitoring

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

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
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

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?

<table>
<thead>
<tr>
<th>MCO</th>
<th>Contact Number</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amerigroup</td>
<td>(800) 600-4441</td>
<td><a href="mailto:WA-Grievance@Amerigroup.com">WA-Grievance@Amerigroup.com</a></td>
</tr>
<tr>
<td>Coordinated Care</td>
<td>(877) 644-4613</td>
<td><a href="mailto:WAQualityDept@Centene.com">WAQualityDept@Centene.com</a></td>
</tr>
<tr>
<td>Molina Healthcare</td>
<td>(800) 869-7165</td>
<td><a href="mailto:MHWMemberServicesWeb@MolinaHealthcare.com">MHWMemberServicesWeb@MolinaHealthcare.com</a></td>
</tr>
<tr>
<td>UnitedHealthcare Community Plan</td>
<td>(866) 556-8166</td>
<td><a href="mailto:WACS_Appeals@UHC.com">WACS_Appeals@UHC.com</a></td>
</tr>
</tbody>
</table>

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

Critical Incidents

<table>
<thead>
<tr>
<th>Definition</th>
<th>Who?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Incident is an event involving a member or provider with impact to health and safety.</td>
<td>Anyone (member, provider, MCO staff, etc.) may identify and report a Critical Incident.</td>
</tr>
</tbody>
</table>

- 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

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.

<table>
<thead>
<tr>
<th>MCO</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amerigroup</td>
<td><a href="mailto:QMNotification@Anthem.com">QMNotification@Anthem.com</a></td>
</tr>
<tr>
<td>Coordinated Care</td>
<td><a href="mailto:WABHcriticalincidents@CoordinatedCareHealth.com">WABHcriticalincidents@CoordinatedCareHealth.com</a></td>
</tr>
<tr>
<td>Molina Healthcare</td>
<td><a href="mailto:MHW_Critical_Incidents@MolinaHealthcare.com">MHW_Critical_Incidents@MolinaHealthcare.com</a></td>
</tr>
<tr>
<td>UnitedHealthcare Community Plan</td>
<td><a href="mailto:WA_CriticalInc@UHC.com">WA_CriticalInc@UHC.com</a></td>
</tr>
</tbody>
</table>
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.

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<th>Region</th>
<th>Contact Information</th>
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<td>Salish Ombuds</td>
<td>Phone: (888) 377-8174 or (360) 392-1582</td>
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<td>Fax: (360) 692-1595</td>
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Resources

- Interpreter Services
- HCA Transportation Brokers
- Frequently Used Forms
- Helpful Links
Interpreter Services

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

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

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

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

HCA Transportation Brokers

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

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

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<th>Transportation Broker</th>
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| 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
  ➢ Coordinated Care: https://www.coordinatedcarehealth.com/providers/resources/forms-resources.html


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

Questions and Answers

Thank you for joining us today!