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

September 2016

United Behavioral Health and United Behavioral Health of New York, I.P.A., Inc. operating under the brand Optum
BH452-122015

Today's speakers

- Lana Kats, MBA, Director of Network Management for NY Public Sector
- Erica Bou, LMHC, CRC, HCBS Administrator
- Barbara Tedesco, MS, CRC, Recovery and Resiliency Manager
- Gayle Parker-Wright, LCSW-R, Network Trainer
- Eunice Hudson, Provider Education Specialist
- Ilana Adler, LMSW, Government Liaison for NY

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

Managed care transition, continued

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

- **October 1, 2015:** both the Mainstream Medicaid and Wellness4Me Plan (HARP) benefits were rolled out for members who are 21 years and older residing in the 5 boroughs of New York City

- **January 1, 2016:** Home and Community Based Services (HCBS) for Wellness4Me members began in the 5 boroughs of New York City

- 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

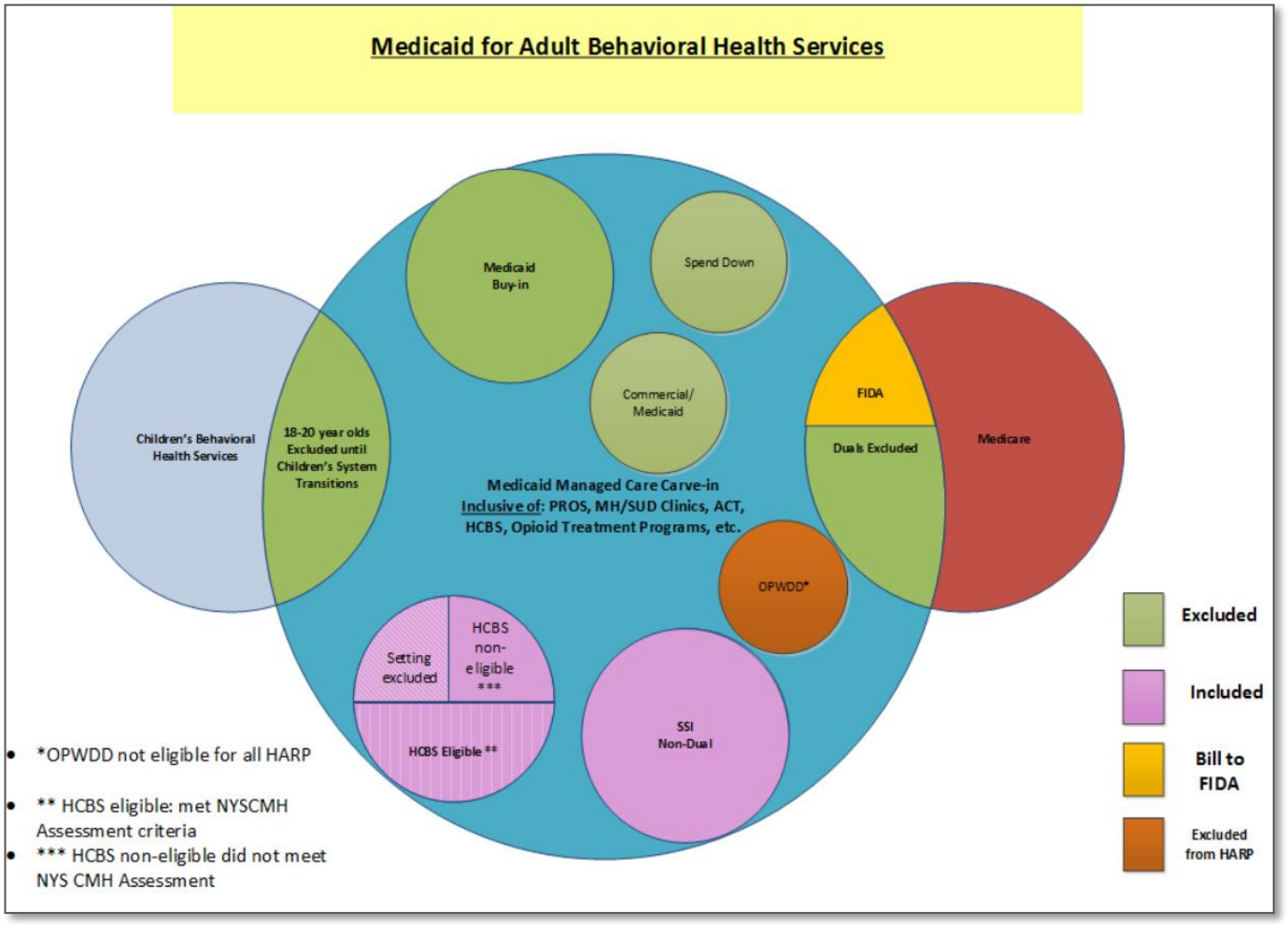
Phase 2

- **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
- **October 1, 2016:** Home and Community Based Services (HCBS) for Wellness4Me members will begin in the rest of state

Phase 3

- **July 1, 2017:** all adults under 21 years old, adolescents and children in New York City (5 Boroughs), Nassau and Suffolk
- **January 1, 2018:** all adults under 21 years old, adolescents and children in the rest of state

Covered populations*



*From MCTAC presentation on 10/20/15

Wellness4Me Plan (HARP) and Mainstream Medicaid

Covered Benefits for HARP and Behavioral Health Benefit		
Services	**HARP Enrolled Members**	**Medicaid Behavioral Health Benefit**
Medically supervised outpatient withdrawal (OASAS services)	Covered	Covered
Outpatient clinic and opioid treatment program (OTP) services (OASAS services)	Covered	Covered
Outpatient clinic services (OMH services)	Covered	Covered
Comprehensive psychiatric emergency program	Covered	Covered
Continuing day treatment	Covered	Covered
Partial hospitalization	Covered	Covered
PROS	Covered	Covered
ACT	Covered	Covered
Intensive case management/ supportive case management	Covered	Covered
Health Home Care Coordination and Management	Covered	Covered
Inpatient hospital detoxification (OASAS service)	Covered	Covered
Inpatient medically supervised inpatient detoxification (OASAS Service)	Covered	Covered
Inpatient treatment (OASAS service)	Covered	Covered
Rehabilitation services for residential SUD treatment supports (OASAS service)	Covered	Covered
Inpatient psychiatric services (OMH service)	Covered	Covered
Rehabilitation services for residents of community residences	Covered	Covered

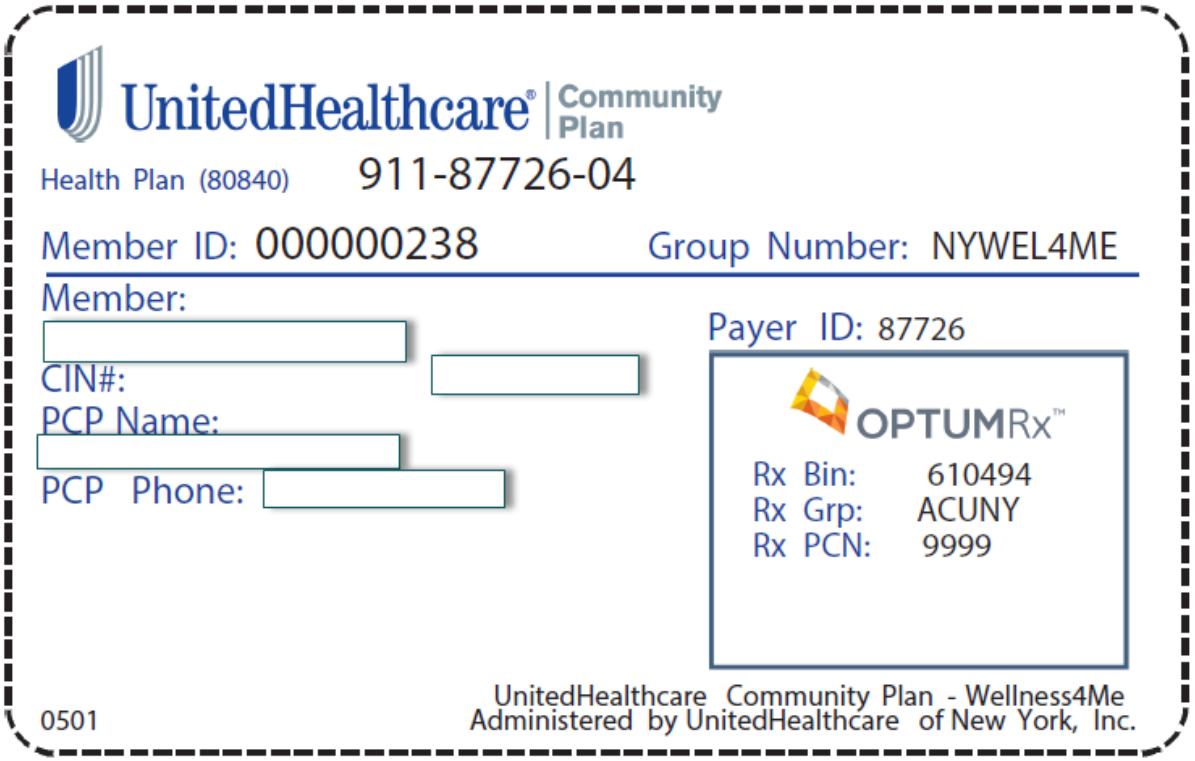
Wellness4Me Plan (HARP) vs. Behavioral Health Benefit

The Home and Community Based Services are ONLY available to members enrolled in Wellness4Me Plan (HARP).

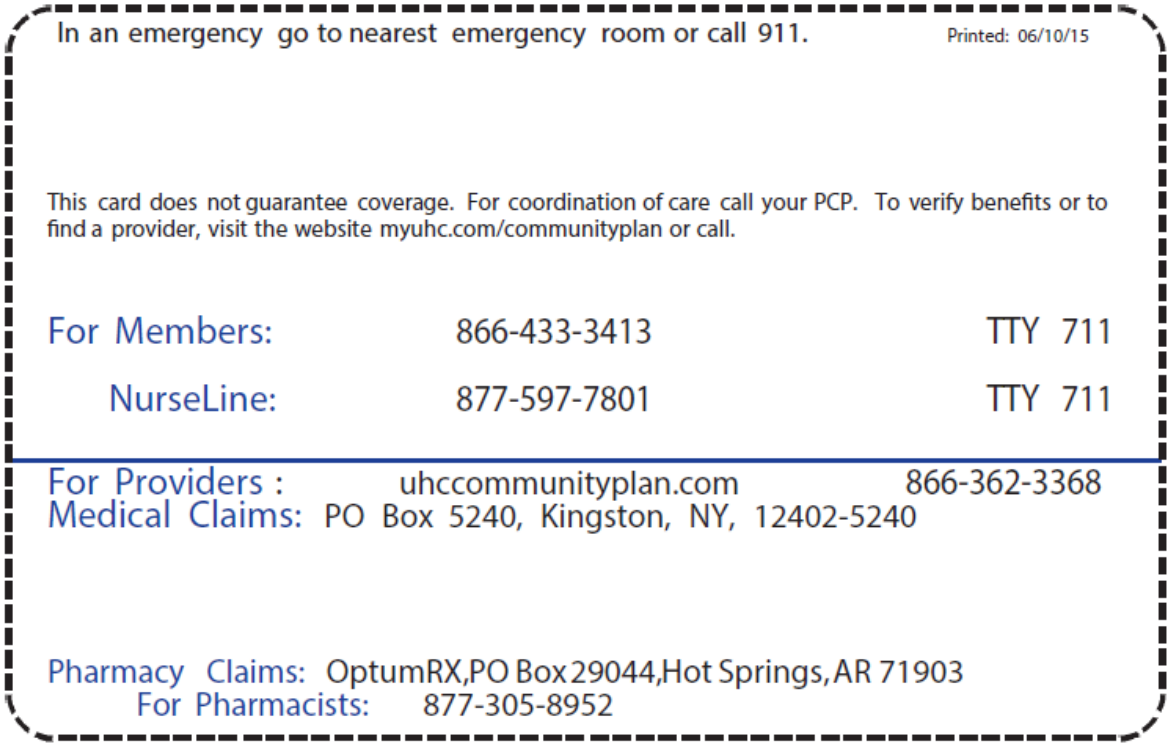
HCBS will not start until 1/1/2016 to allow time for all HARP members to receive their full assessment and for Plans of Care to be documented.

HCBS Services for Adults Meeting Targeting and Functional Needs		
Services	**HARP Enrolled Members**	**Medicaid Behavioral Health**
Rehabilitation • Psychosocial Rehabilitation • Community Psychiatric Support and Treatment (CPST) • Crisis Intervention	Covered	Not Covered
Peer Supports	Covered	Not Covered
Habilitation • Habilitation • Residential Supports in Community Settings	Covered	Not Covered
Respite • Short-term Crisis Respite • Intensive Crisis Respite	Covered	Not Covered
Non-medical transportation	Covered	Not Covered
Family Support and Training	Covered	Not Covered
Employment Supports • Pre-vocational • Transitional Employment • Intensive Supported Employment • On-going Supported Employment	Covered	Not Covered
Education Support Services	Covered	Not Covered
Supports for self-directed care [phased in as a pilot; see details below] • Information and Assistance in Support of Participation Direction • Financial Management Services	Covered	Not Covered

Membership cards: New York Wellness4Me, front of card



Membership cards: New York Wellness4Me, back of card



In an emergency go to nearest emergency room or call 911. Printed: 06/10/15

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

For Members: 866-433-3413 TTY 711

NurseLine: 877-597-7801 TTY 711

For Providers : uhccommunityplan.com 866-362-3368

Medical Claims: PO Box 5240, Kingston, NY, 12402-5240

Pharmacy Claims: OptumRX,PO Box 29044,Hot Springs, AR 71903

For Pharmacists: 877-305-8952

Clinical Vision

Gayle Parker-Wright, LCSW-R, Network Trainer

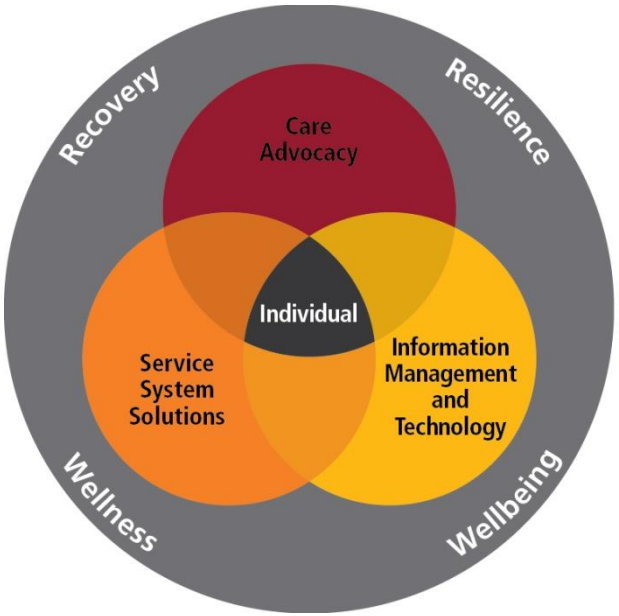
Our Clinical Vision

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

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

Tools for system transformation

Utilization Management

- Review requests for service against LOCG's /LOCADTR:
  - Prior Notification
  - Pre-Certification
  - Prior Authorization
  - Concurrent Review
  - Transition Planning for successful discharge

Care Coordination

- Follow-up support after discharge
- Risk assessment and safety planning
- Coordination with community resources
- Support member's recovery goals
- Engagement of member, family, and other support systems in development of care plan

Person-Centered Care

- Align closely with Health Home and Accountable Care Teams
- Care plans include:
  - Strength-based assessment, including culture
  - Measurable/ attainable/ realistic/timely objectives
  - Keeps the person in context of their environment and natural supports

Quality Driven Outcomes

- Team-Facing Measures:
  - Call quality
  - Inter-rater reliability measures
- Performance Improvement Projects
- Provider/Member - Facing Measures include HEDIS/NCQA
- HCBS
- Special Populations

Clinical and Utilization Management Requirements

Erica Bou, LMHC, CRC HCBS 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 utilization parameters

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 for ROS until 10/1/16
- 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 26)

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

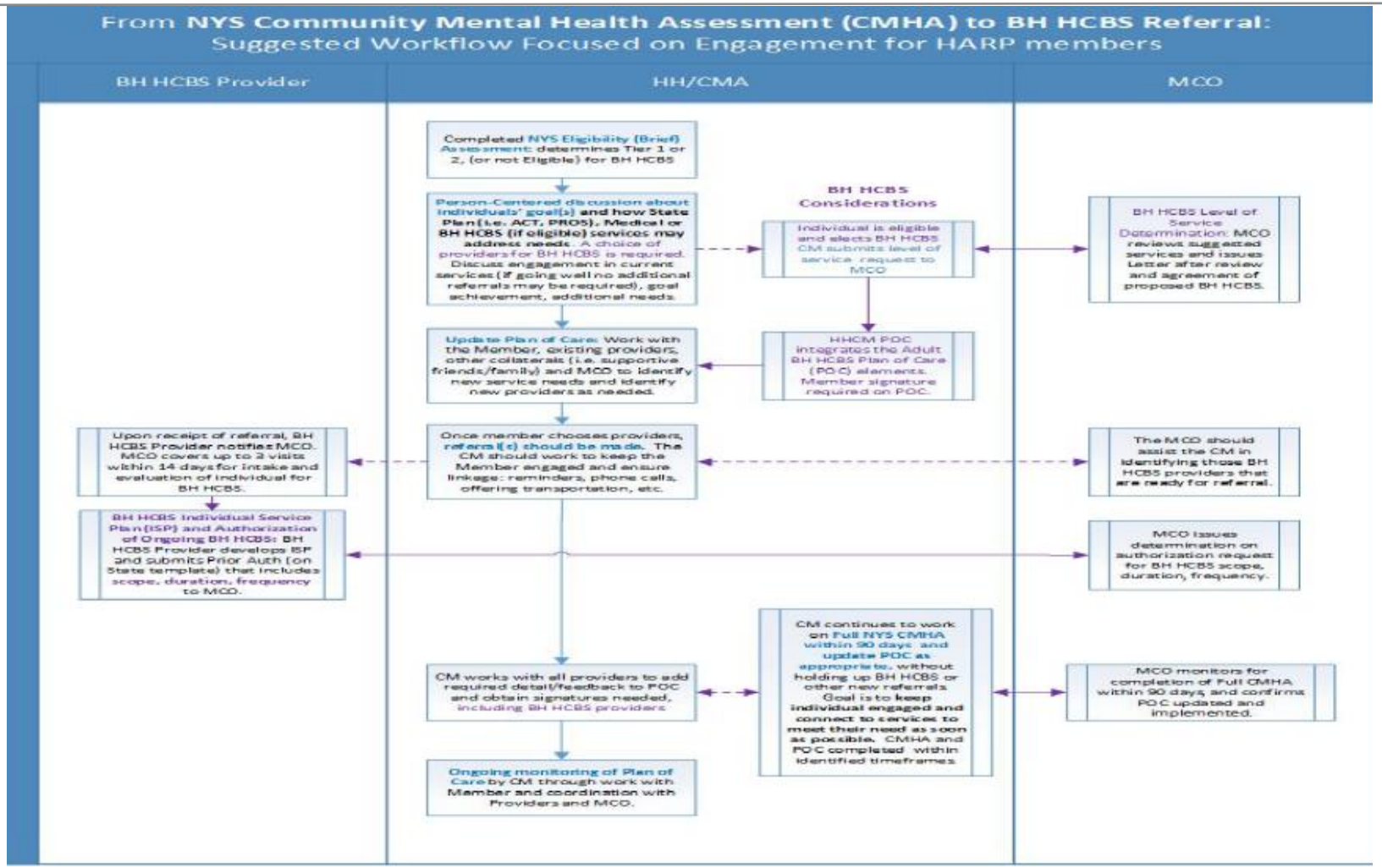
Plan of Care

- 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

NYS Expedited Workflow from Assessment to Referral



Adult Behavioral Health (BH) HCBS residential settings

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

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

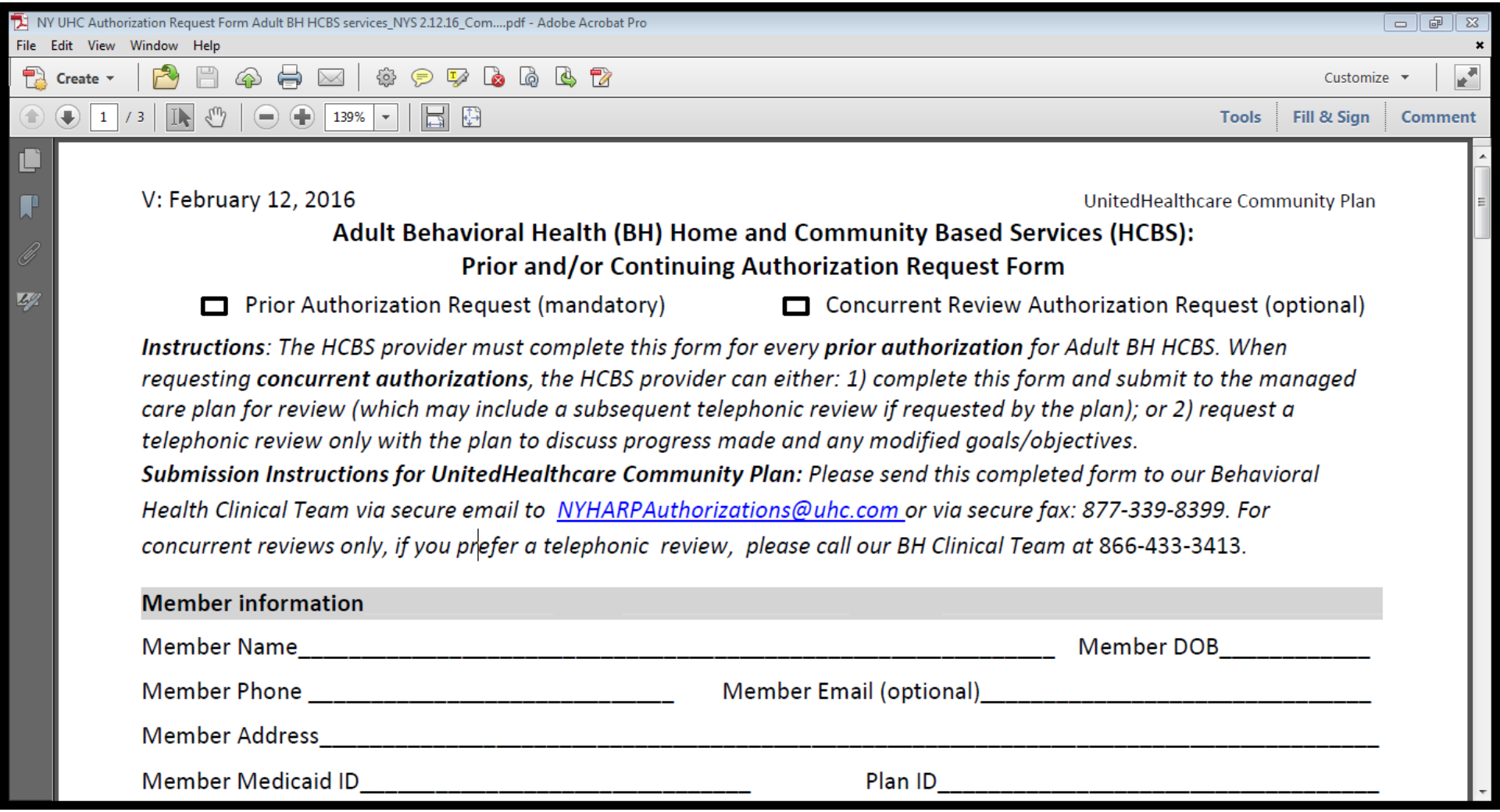
Federal Guidelines for Person-Centered Care Planning

- 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

NYS Allowable Billing Combinations (provided by MCTAC)

NYS Allowable Billing Combinations of OMH/OASAS State Plan Services and HCBS								
HCBS/State Plan Services	OMH Clinic/OLP	OASAS Clinic	OASAS Opioid Treatment Program	OMH ACT	OMH PROS	OMH IPRT/CDT	OMH Partial Hospital	OASAS Outpatient Rehab
PSR	Yes	Yes	Yes				Yes	
CPST							Yes	
Habilitation	Yes	Yes	Yes				Yes	
Family Support and Training	Yes	Yes	Yes			Yes	Yes	Yes
Education Support Services	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Peer Support Services	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Employment Services	Yes	Yes	Yes			Yes	Yes	Yes

HCBS Prior Authorization Request



V: February 12, 2016

UnitedHealthcare Community Plan

Adult Behavioral Health (BH) Home and Community Based Services (HCBS): Prior and/or Continuing Authorization Request Form

☐ Prior Authorization Request (mandatory) ☐ Concurrent Review Authorization Request (optional)

***Instructions**: The HCBS provider must complete this form for every **prior authorization** for Adult BH HCBS. When requesting **concurrent authorizations**, the HCBS provider can either: 1) complete this form and submit to the managed care plan for review (which may include a subsequent telephonic review if requested by the plan); or 2) request a telephonic review only with the plan to discuss progress made and any modified goals/objectives.*

***Submission Instructions for UnitedHealthcare Community Plan:** Please send this completed form to our Behavioral Health Clinical Team via secure email to NYHARPAuthorizations@uhc.com or via secure fax: 877-339-8399. For concurrent reviews only, if you prefer a telephonic review, please call our BH Clinical Team at 866-433-3413.*

Member information

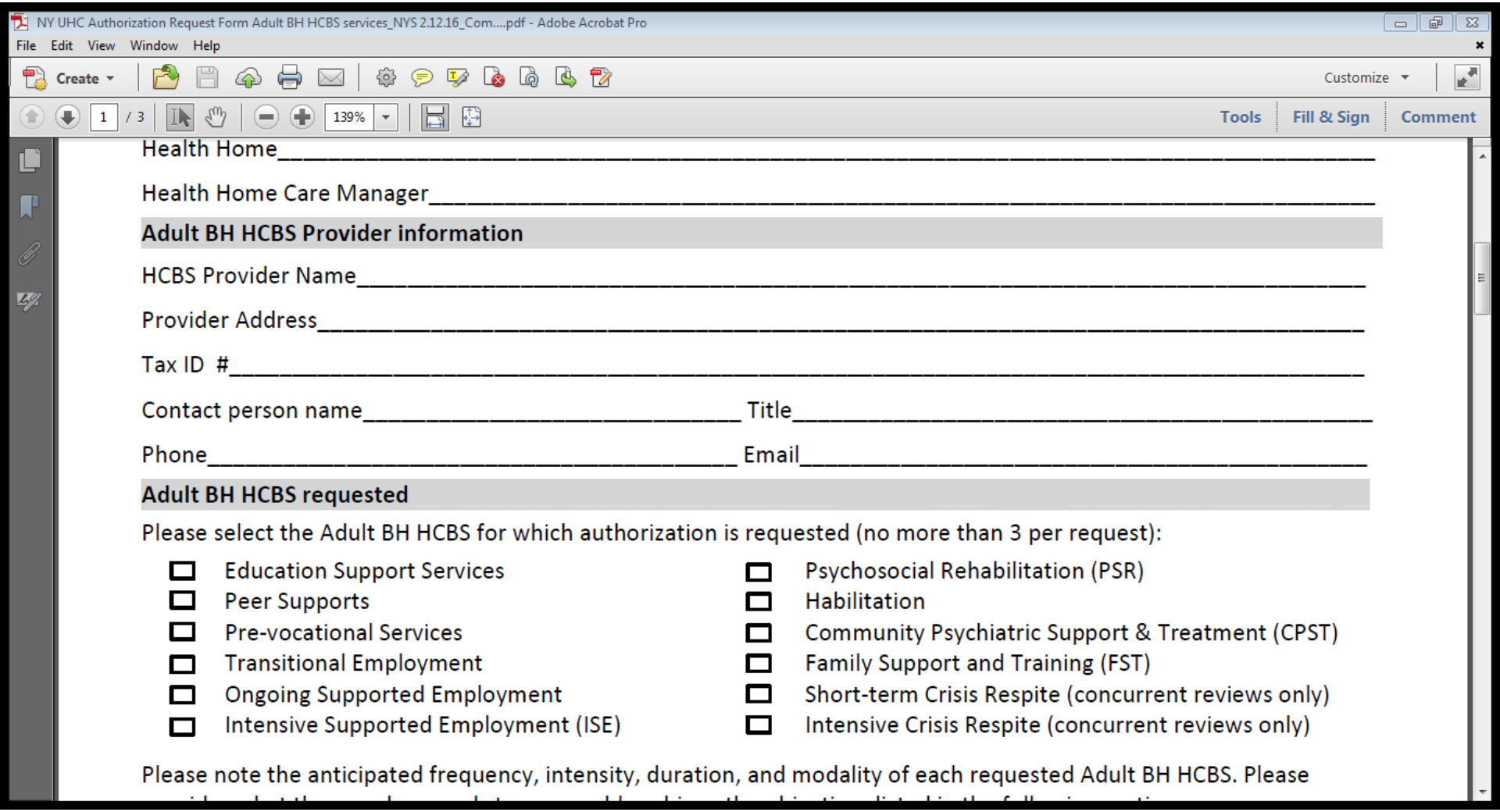
Member Name_____ Member DOB_____

Member Phone _____ Member Email (optional)_____

Member Address_____

Member Medicaid ID_____ Plan ID_____

HCBS Prior Authorization Request pg.2



Health Home_____

Health Home Care Manager_____

Adult BH HCBS Provider information

HCBS Provider Name_____

Provider Address_____

Tax ID #_____

Contact person name_____ Title_____

Phone_____ Email_____

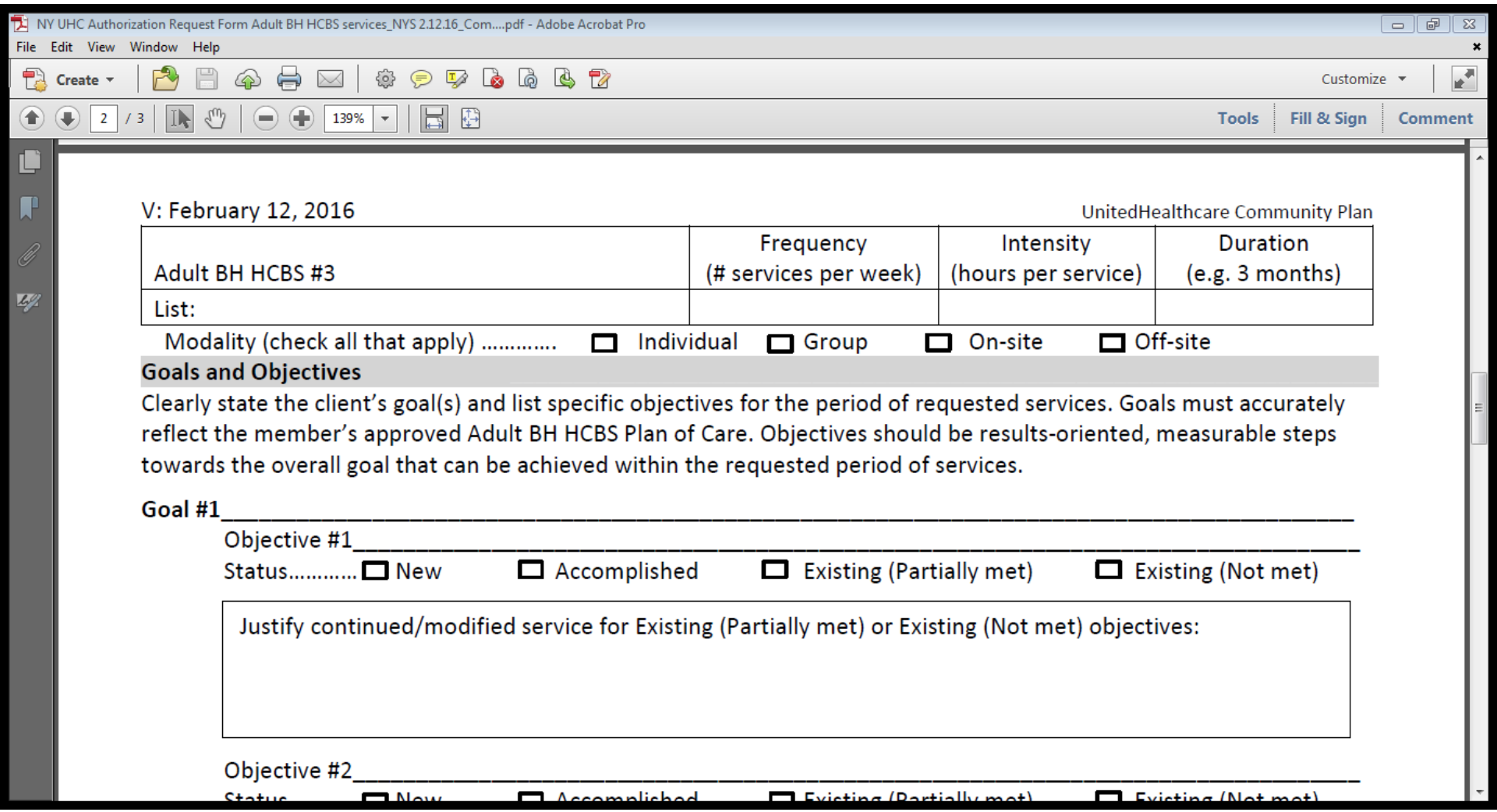
Adult BH HCBS requested

Please select the Adult BH HCBS for which authorization is requested (no more than 3 per request):

- ☐ Education Support Services
- ☐ Peer Supports
- ☐ Pre-vocational Services
- ☐ Transitional Employment
- ☐ Ongoing Supported Employment
- ☐ Intensive Supported Employment (ISE)
- ☐ Psychosocial Rehabilitation (PSR)
- ☐ Habilitation
- ☐ Community Psychiatric Support & Treatment (CPST)
- ☐ Family Support and Training (FST)
- ☐ Short-term Crisis Respite (concurrent reviews only)
- ☐ Intensive Crisis Respite (concurrent reviews only)

Please note the anticipated frequency, intensity, duration, and modality of each requested Adult BH HCBS. Please

HCBS Prior Authorization Request pg. 3



V: February 12, 2016

UnitedHealthcare Community Plan

Adult BH HCBS #3	Frequency (# services per week)	Intensity (hours per service)	Duration (e.g. 3 months)
List:			

Modality (check all that apply) ..... ☐ Individual ☐ Group ☐ On-site ☐ Off-site

Goals and Objectives

Clearly state the client's goal(s) and list specific objectives for the period of requested services. Goals must accurately reflect the member's approved Adult BH HCBS Plan of Care. Objectives should be results-oriented, measurable steps towards the overall goal that can be achieved within the requested period of services.

Goal #1_____

Objective #1_____

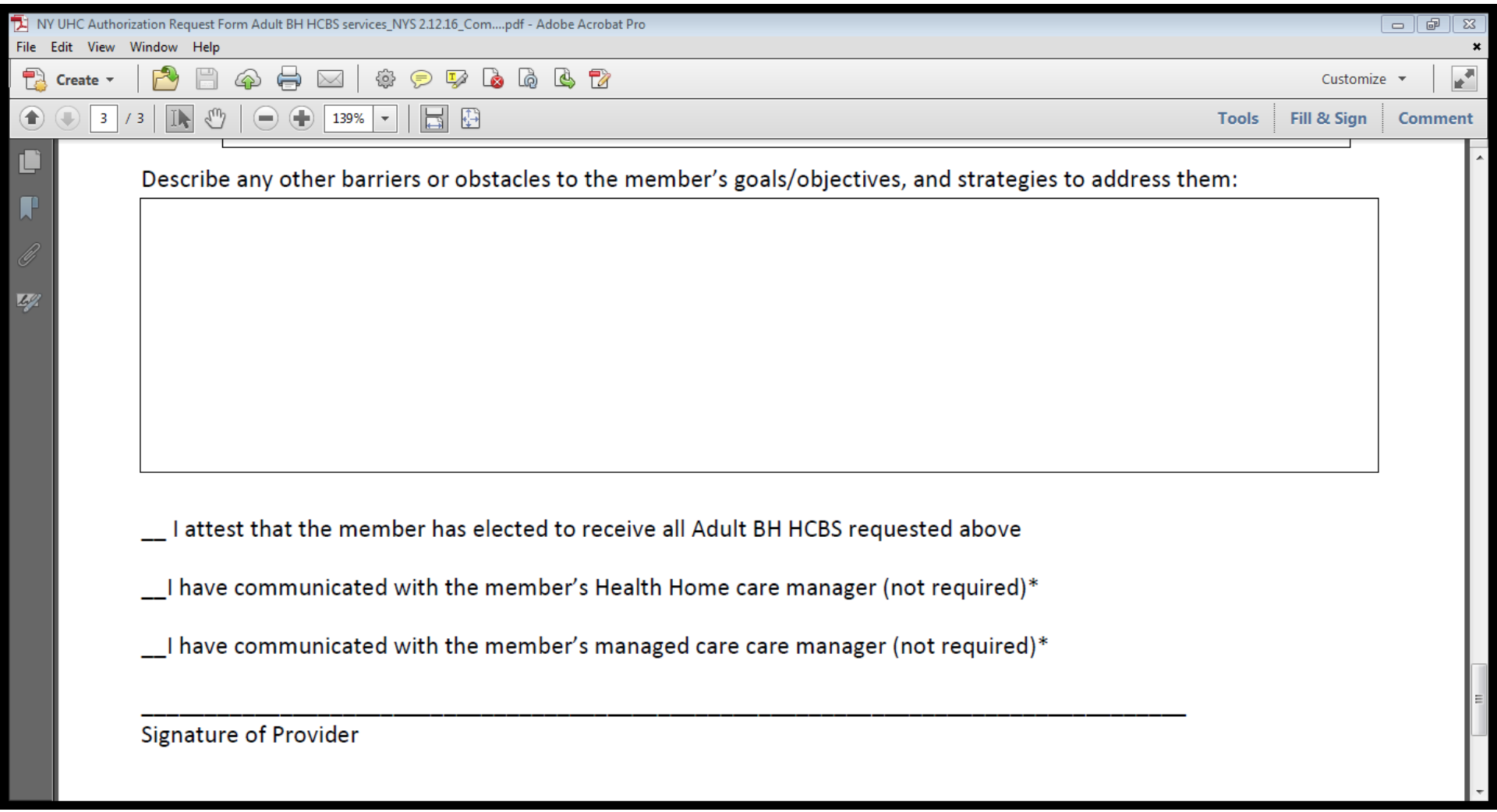
Status..... ☐ New ☐ Accomplished ☐ Existing (Partially met) ☐ Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Objective #2_____

Status ☐ New ☐ Accomplished ☐ Existing (Partially met) ☐ Existing (Not met)

HCBS Prior Authorization Request pg. 4



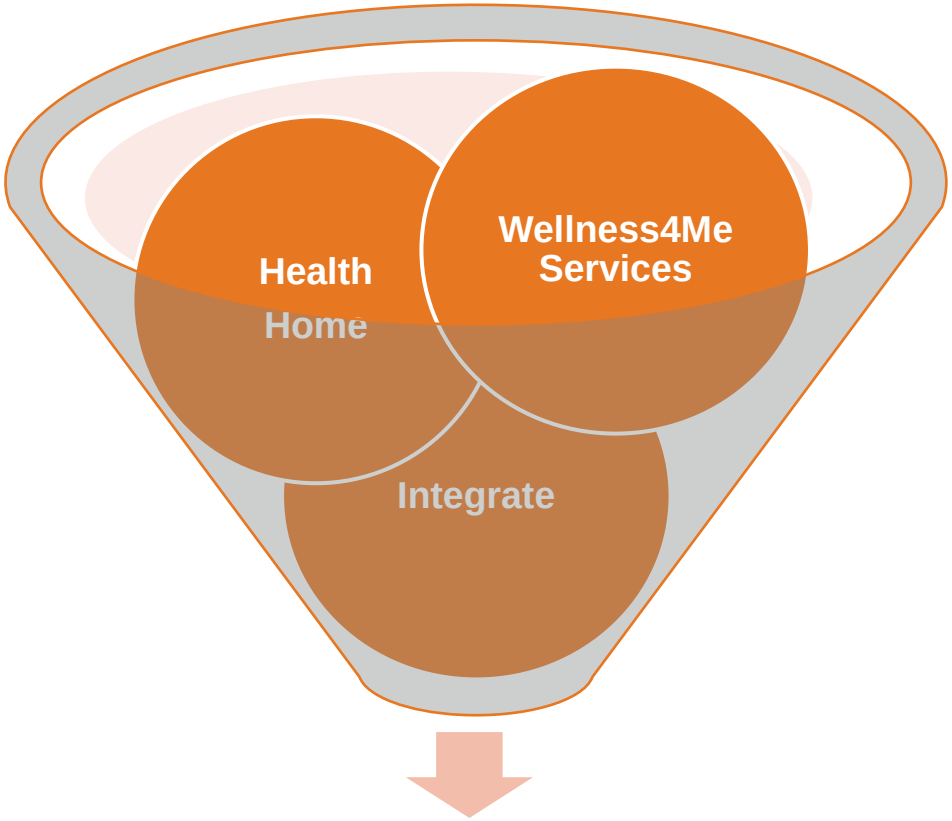
HCBS Service specific plans

- The member's 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

Wellness4Me Health Homes and Care Coordination

Erica Bou, LMHC, CRC HCBS 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 services does a Health Home provide?

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

Operational Priorities	Medical	Behavioral	Social
Transition of care	X	X	X
Care coordination	X	X	X
Referral management	X	X	X
Individual care	X	X	X
Health promotion	X	X	X
Care support for family/caregiver	X	X	X

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

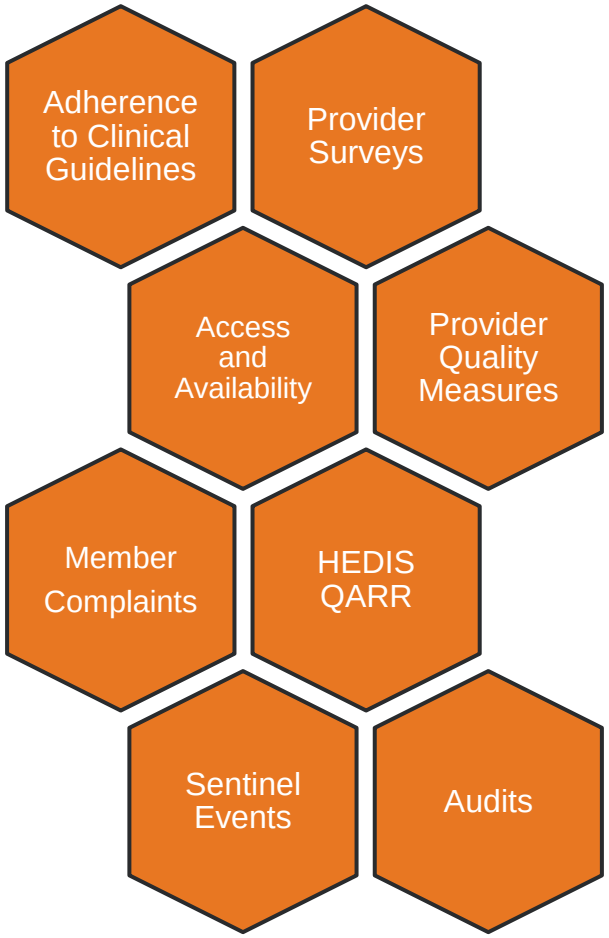
Gayle Parker-Wright, LCSW-R, Network Trainer

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

Appeals

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 New York Mainstream Medicaid and Wellness4Me Behavioral Health Provider Manual (located on Provider Express: from the home page choose Our Network > Welcome to the Network > New York > NY Medicaid Behavioral Health Provider Manual)
  - The audit tools

Documentation standards, continued

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

Provider quality audits, continued

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

Credentialing and Recredentialing

Gayle Parker-Wright, LCSW-R, Network Trainer

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 or HCBS designated
- **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

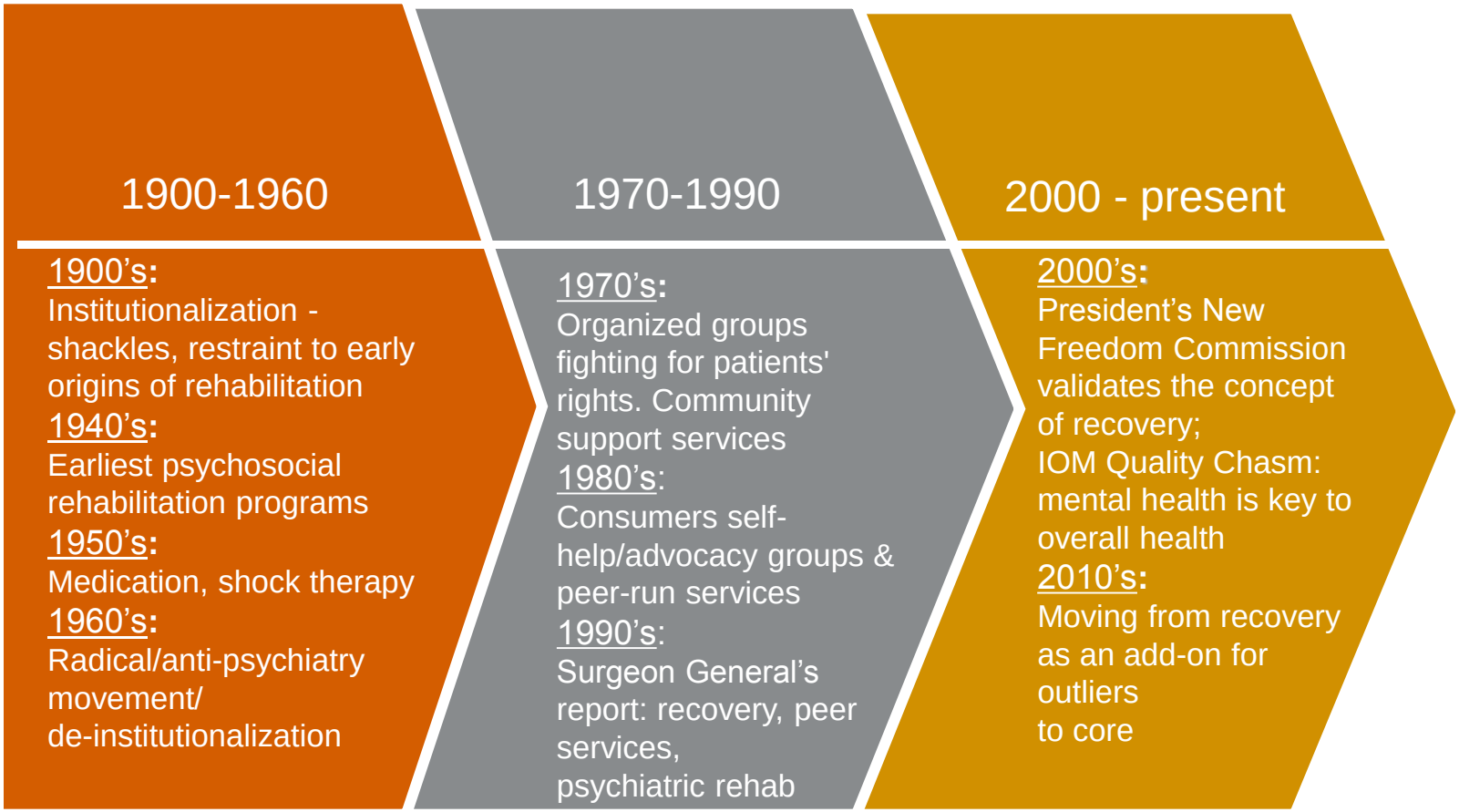
OPTUM™

UnitedHealthcare®
Community Plan

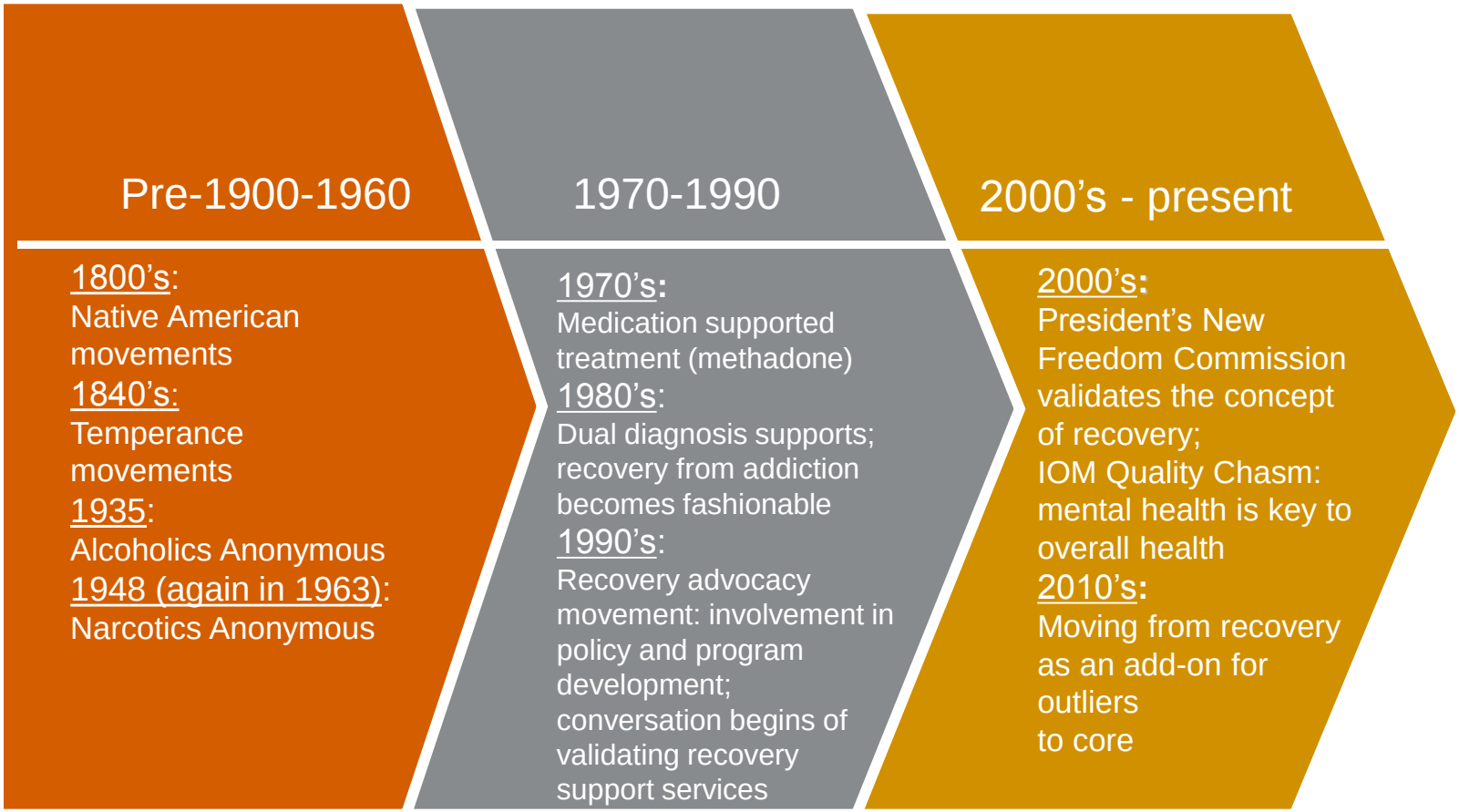
Recovery and Resiliency and Peer Support Services

Barbara Tedesco, MS, CRC, Recovery and Resiliency Manager

Origins of recovery: it's mainstream now



Origins of addiction recovery



New SAMHSA definition

Working Definition of Recovery	**A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.**

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

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

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"

Adapted from: "Resilience: Why Things Bounce Back," Andrew Zolli & Ann Marie Healy (2012)

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

Certified Peer Specialist	• Person who acknowledges "lived experience" and maintains strong recovery strategies • Uses recovery strategies and formal training for the benefit of others • May offer emotional support, share knowledge, teach skills toward meaningful life goals
Effectiveness	• Engaging and retaining people in MH and SU services • Supporting people in taking active role in treatment • Lowering re-hospitalization rates/reducing ER services
Effectiveness	• Increasing overall satisfaction with services • Reducing symptoms and/or substance use • Improvements in practical outcomes (employment, housing, etc.)
Why	• Supported by New Freedom Commission, SAMHSA, Crossing the Quality Chasm, etc • Evidence-based practice • It works

Billing and Claims

Eunice Hudson, Provider Education Specialist

Links to resource documents

- HARP Mainstream Billing and Coding Manual

omh.ny.gov/omhweb/bho/harp-mainstream-billing-manual.pdf

- HCBS Manual

omh.ny.gov/omhweb/News/2014/hcbs-manual.pdf

- Fee Schedule and Rate Codes

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

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:

- omh.ny.gov/omhweb/bho/billing-services.html
- omh.ny.gov/omhweb/bho/hcbs-manual.html
- omh.ny.gov/omhweb/bho/phase2.html

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

Additional services, continued

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)

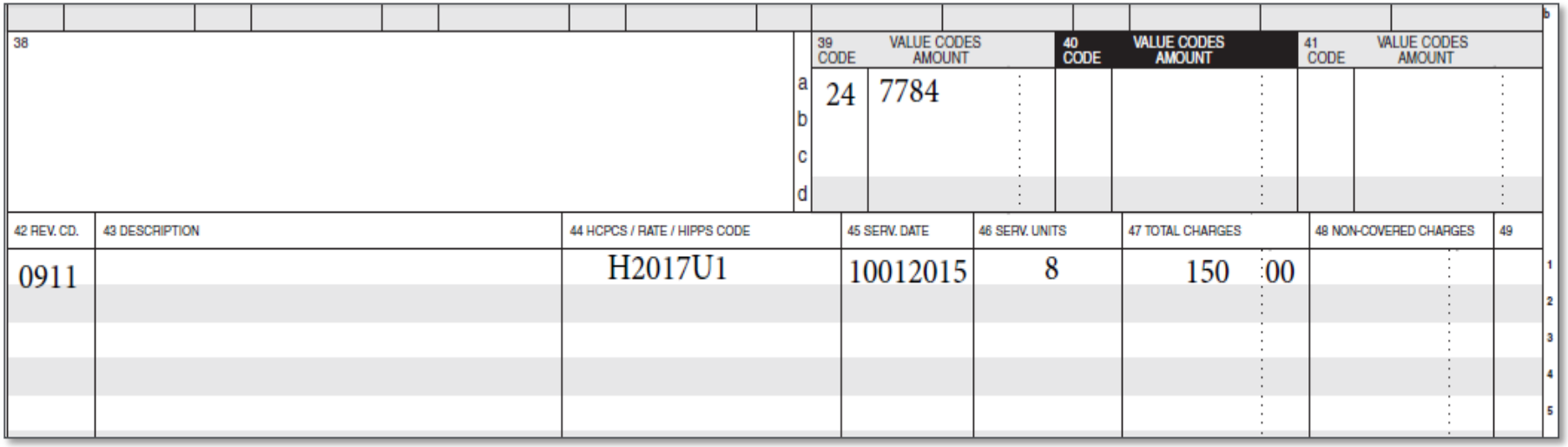
Per round trip

- 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

Rate Code	Rate Code Description	Px Code	Px Code Description	Modi-fiers	Unit Measure	Units Limits (Claim Line Level)	Other rate codes prohibited on same day (combination edits)
7784	HARP HCBS Psychosocial Rehab - Indv - on-site	H2017	Psychosocial rehabilitation services; per 15 minutes	U1	Per 15 min	8	7785, 7789
7785	HARP HCBS Psychosocial Rehab - Indv - off-site	H2017	Psychosocial rehabilitation services; per 15 minutes	U2	Per 15 min	8	7784, 7789
7786	HARP HCBS Psychosocial Rehab - Group 2-3	H2017	Psychosocial rehabilitation services; per 15 minutes	UN or UP	Per 15 min	4	7787, 7788, 7789
7787	HARP HCBS Psychosocial Rehab - Group 4-5	H2017	Psychosocial rehabilitation services; per 15 minutes	UQ or UR	Per 15 min	4	7786, 7788, 7789
7788	HARP HCBS Psychosocial Rehab - Group 6-10	H2017	Psychosocial rehabilitation services; per 15 minutes	US	Per 15 min	4	7786, 7787, 7789

HARP HCBS example, UB-04

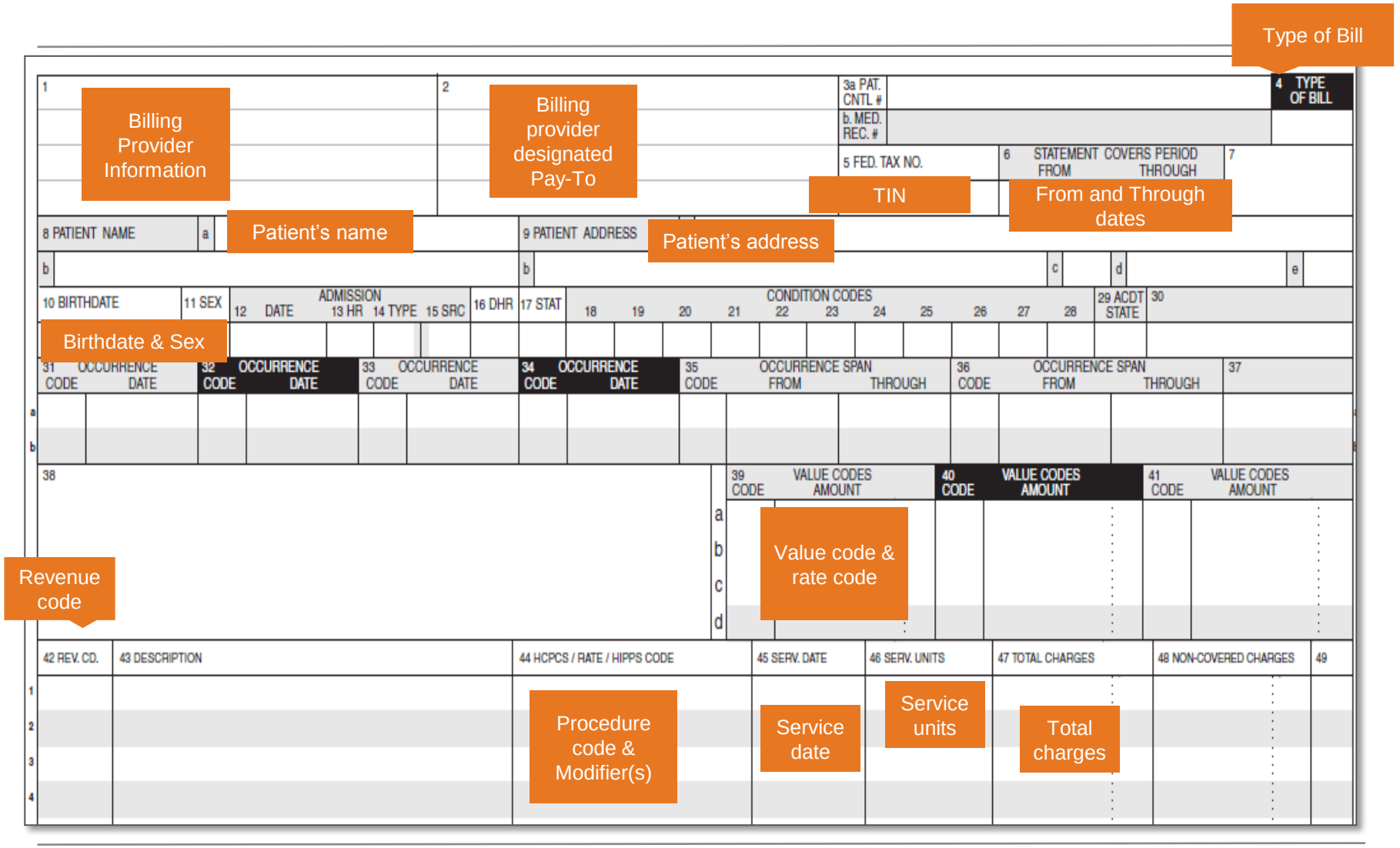


38		39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
	a	24	7784				
	b						
	c						
	d						

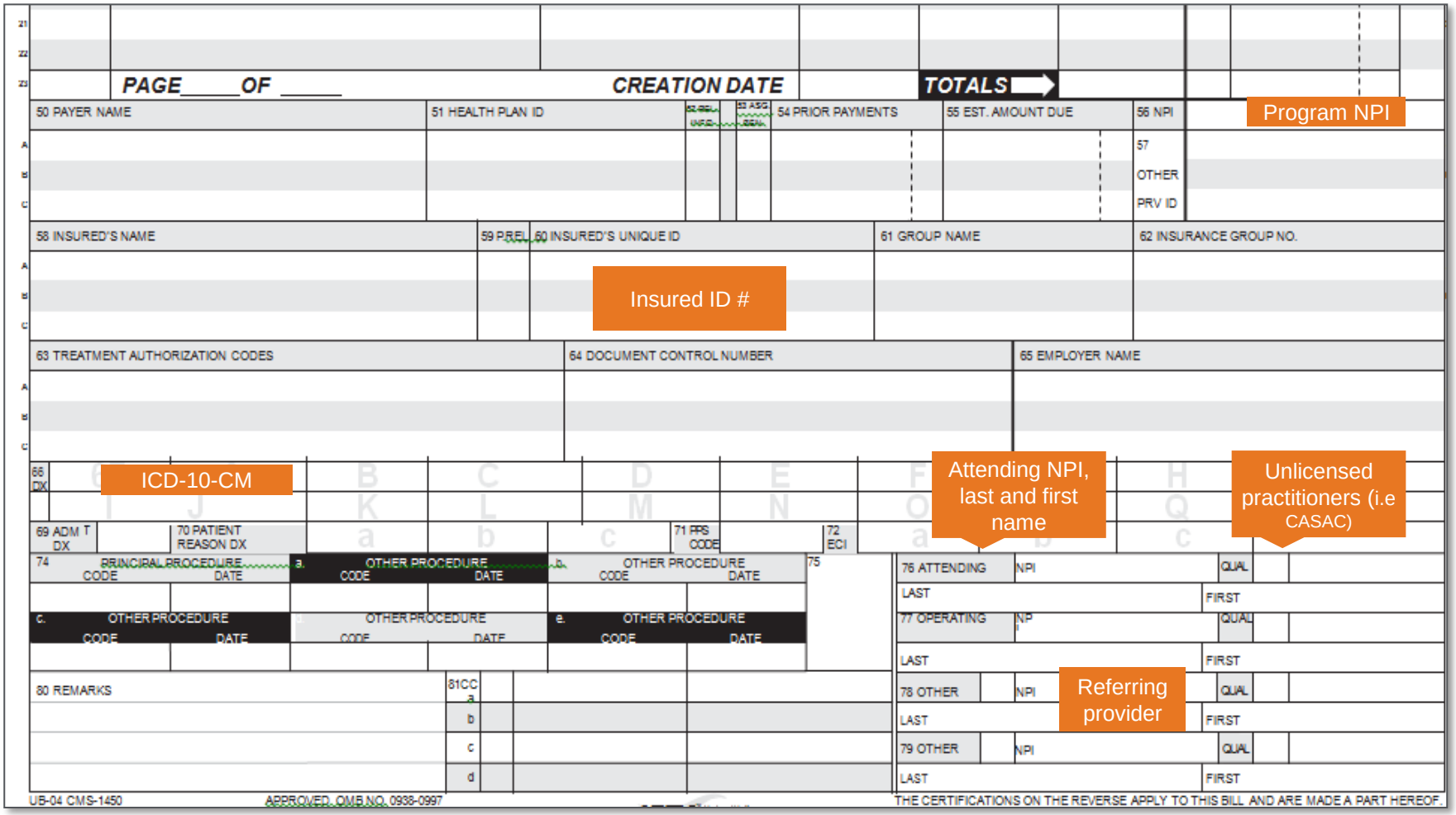
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
0911		H2017U1	10012015	8	150 00			1
								2
								3
								4
								5

Other rate codes prohibited on same day (combination edits): 7785 and 7789

Required fields, UB-04, top



Required fields, UB-04, bottom



Service combinations

NYS Allowable Billing Combinations of OMH/OASAS State Plan Services and HCBS								
HCBS/State Plan Services	OMH Clinic/OLP	OASAS Clinic	OASAS Opioid Treatment Program	OMH ACT	OMH PROS	OMH IPRT/CDT	OMH Partial Hospital	OASAS Outpatient Rehab
PSR	Yes	Yes	Yes				Yes	
CPST							Yes	
Habilitation	Yes	Yes	Yes				Yes	
Family Support and Training	Yes	Yes	Yes			Yes	Yes	Yes
Education Support Services	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Peer Support Services	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Employment Services	Yes	Yes	Yes			Yes	Yes	Yes

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

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

Ilana Adler, LMSW, Government Liaison for NY

Provider Express

Provider Express - providerexpress.com

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)

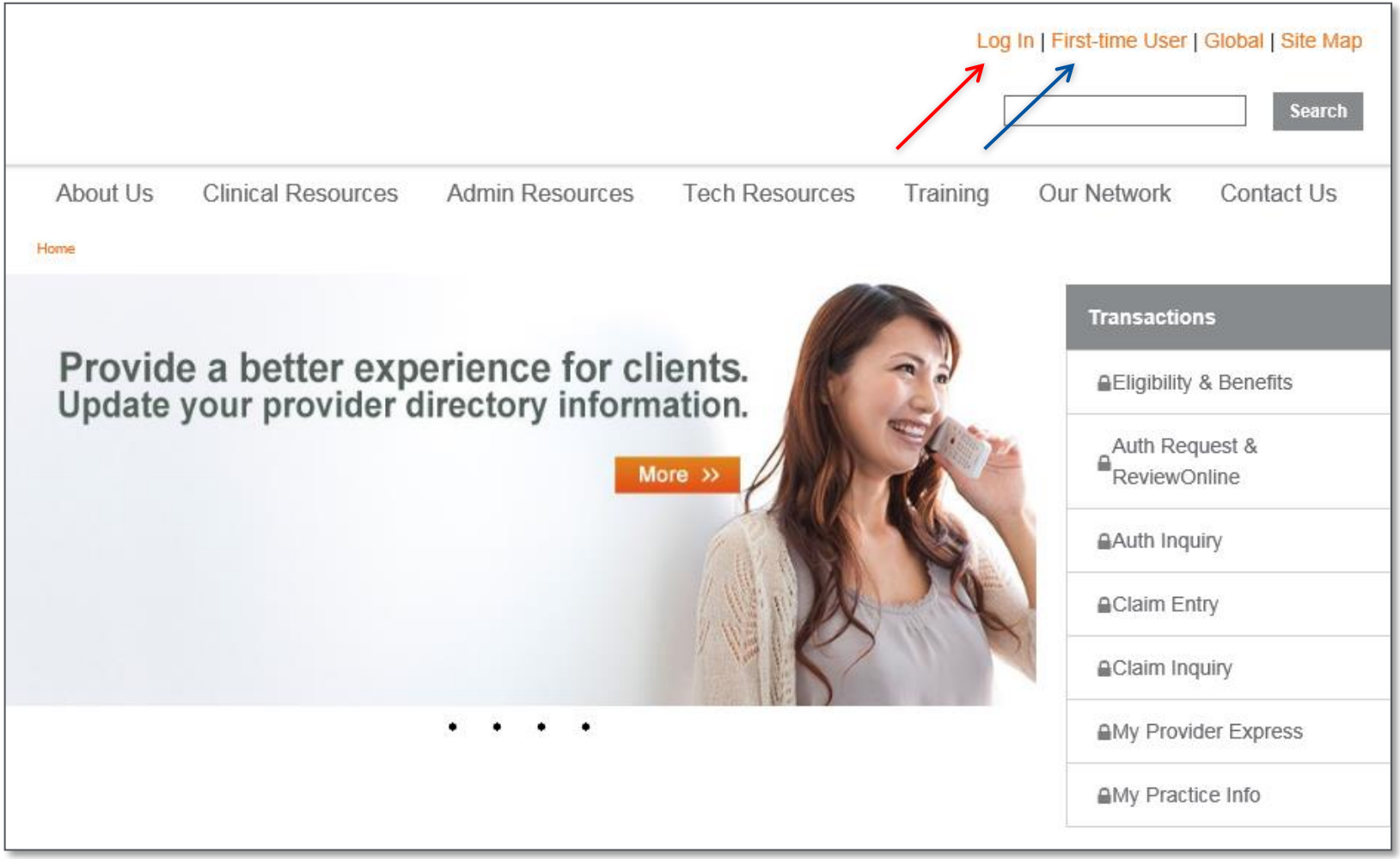
Public Pages include general updates and other useful information:

- 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

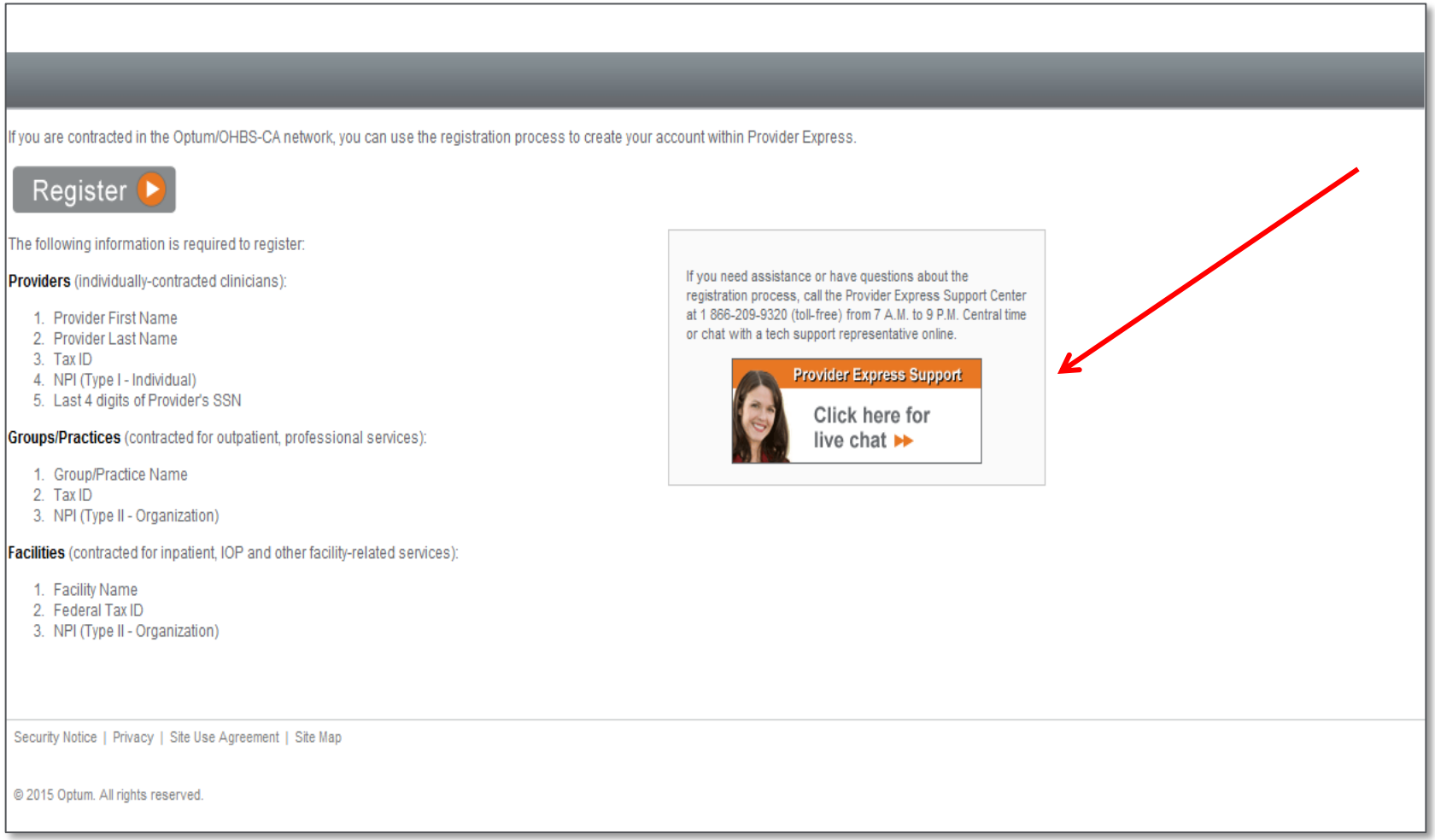
Provider Express, (continued)

- 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 Home Page – Log In

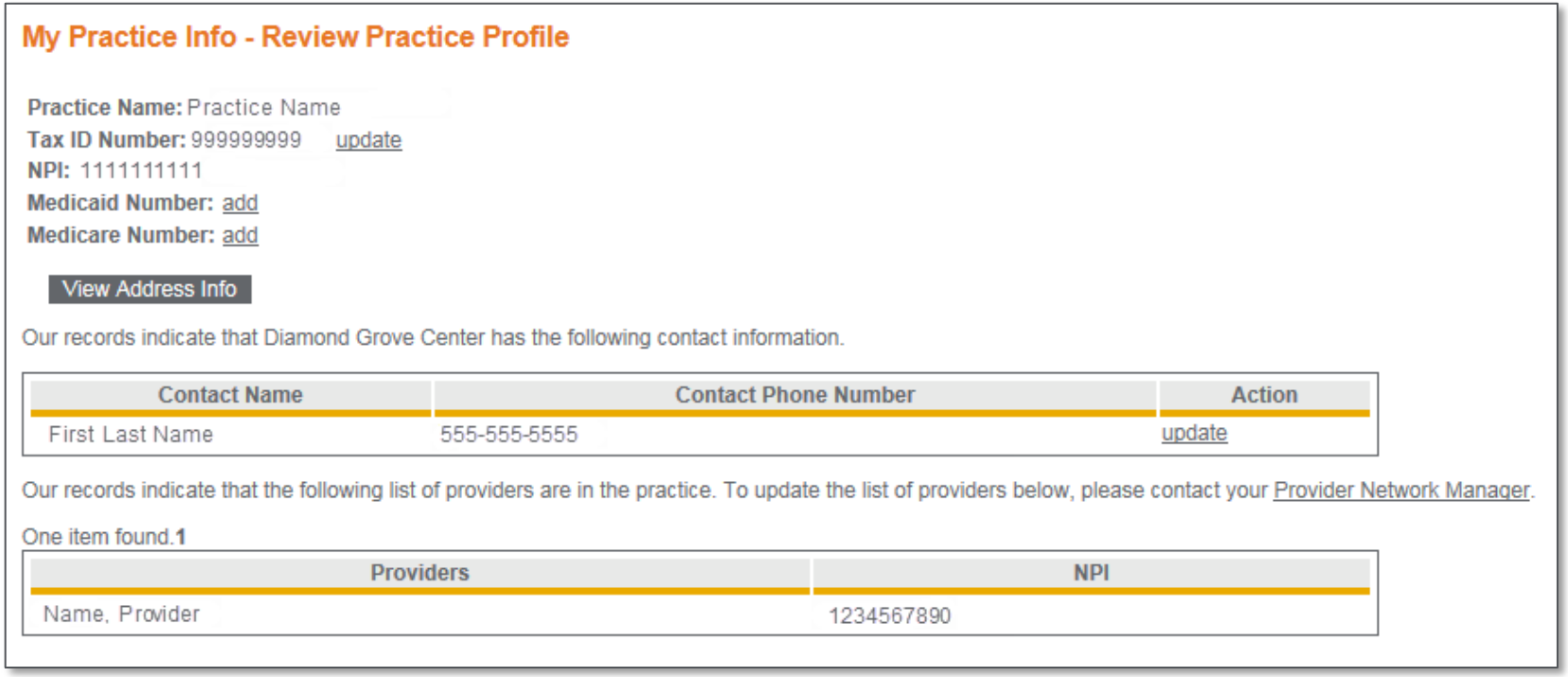


Provider Express – Tech Support Live Chat feature



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

Practice Name: Practice Name
Tax ID Number: 999999999 update
NPI: 1111111111
Medicaid Number: add
Medicare Number: add

View Address Info

Our records indicate that Diamond Grove Center has the following contact information.

Contact Name	Contact Phone Number	Action
First Last Name	555-555-5555	update

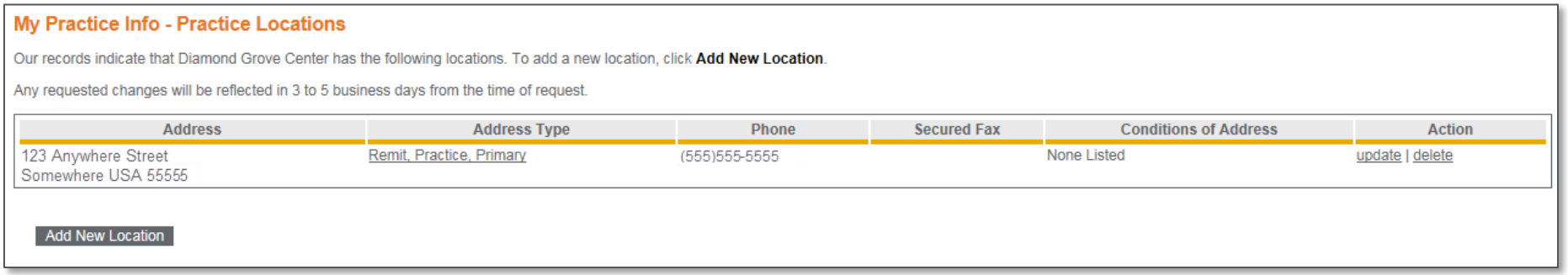
Our records indicate that the following list of providers are in the practice. To update the list of providers below, please contact your Provider Network Manager.

One item found.**1**

Providers	NPI
Name, Provider	1234567890

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



My Practice Info - Practice Locations

Our records indicate that Diamond Grove Center has the following locations. To add a new location, click **Add New Location**.

Any requested changes will be reflected in 3 to 5 business days from the time of request.

Address	Address Type	Phone	Secured Fax	Conditions of Address	Action
123 Anywhere Street Somewhere USA 55555	Remit, Practice, Primary	(555)555-5555		None Listed	update | delete

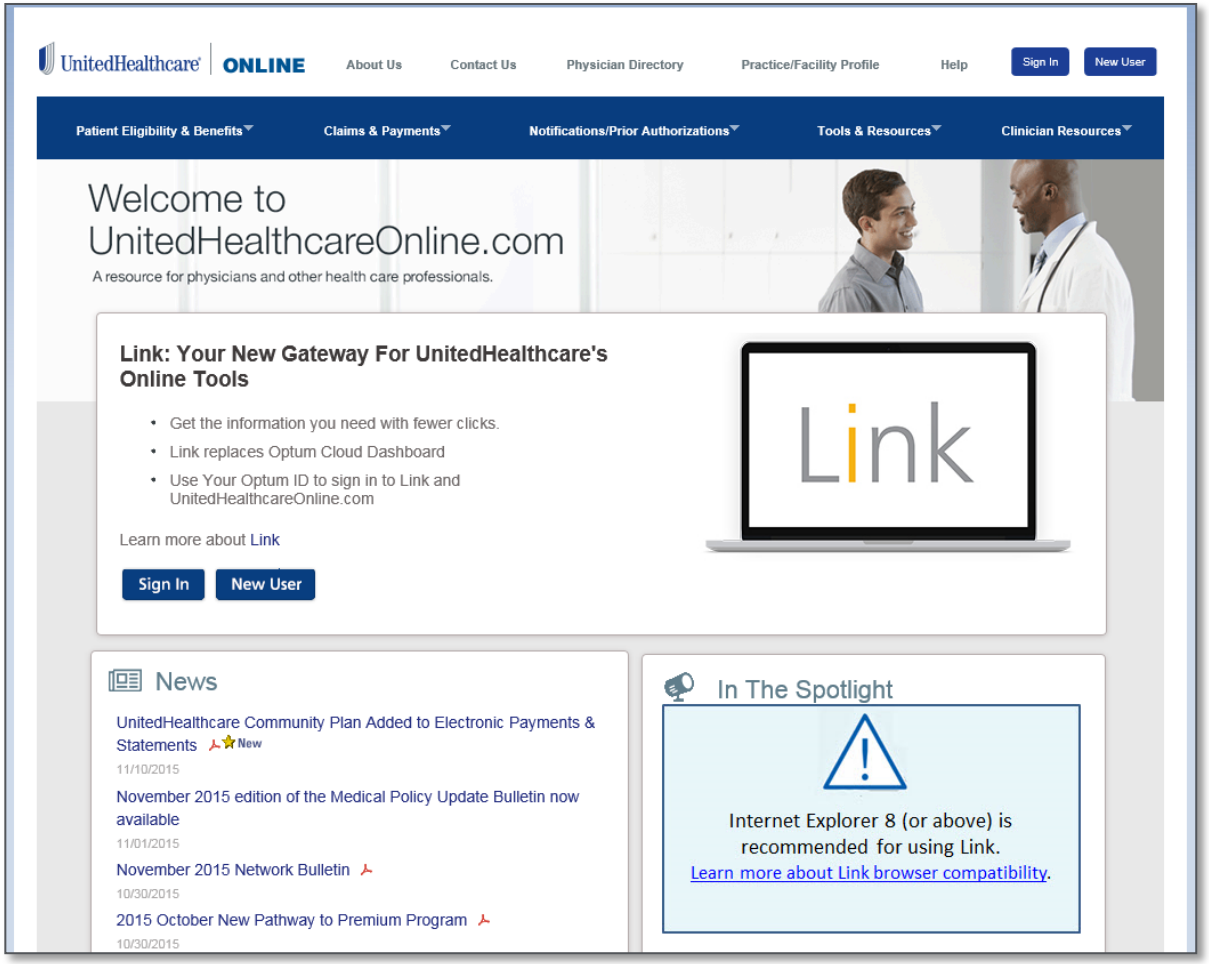
Add New Location

UnitedHealthcare provider website

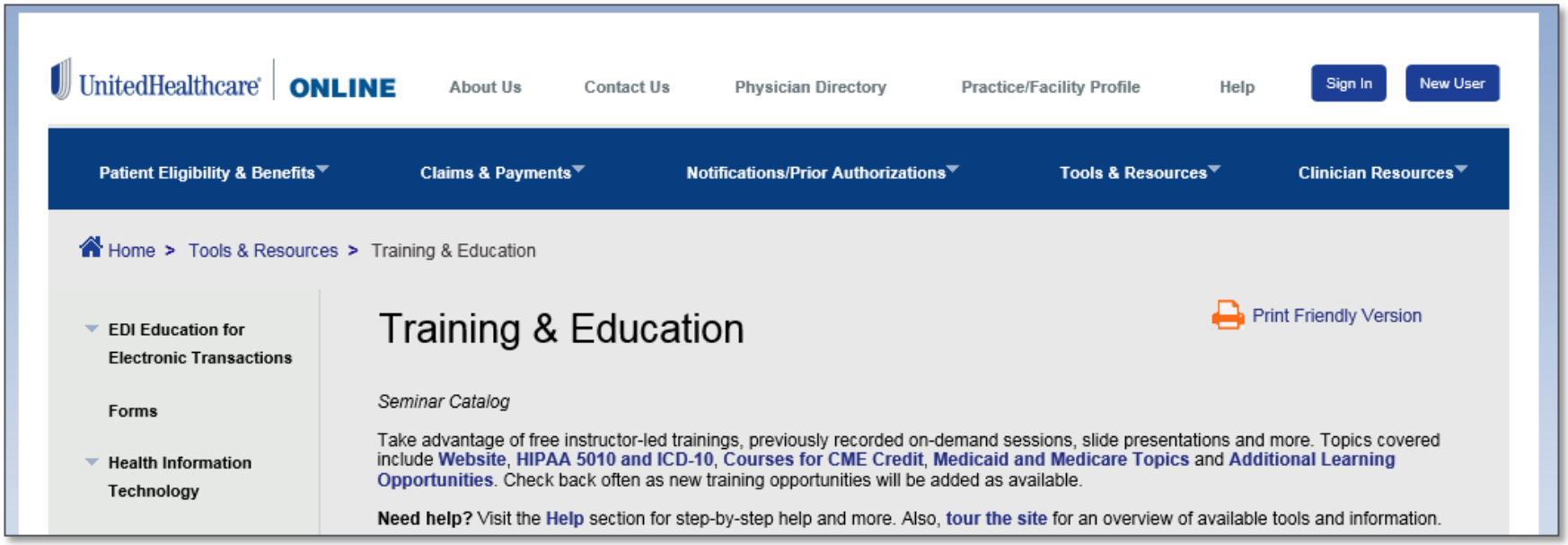
unitedhealthcareonline.com

- **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, 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 > Tools and Resources > UnitedHealthcare Community Plan Resources
- Customer Service for website support: 800-600-9007

UnitedHealthcare Online – login page

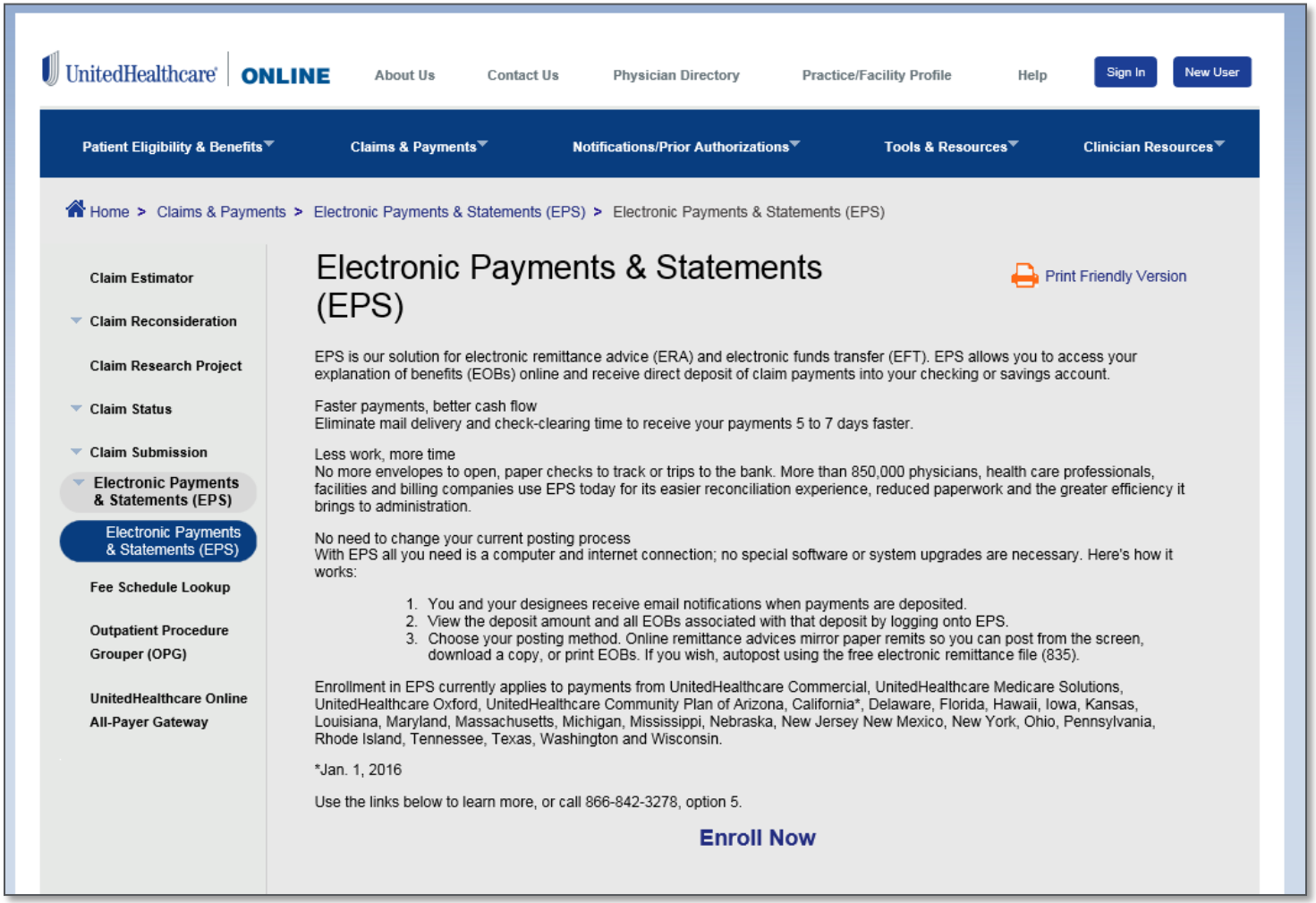


Training

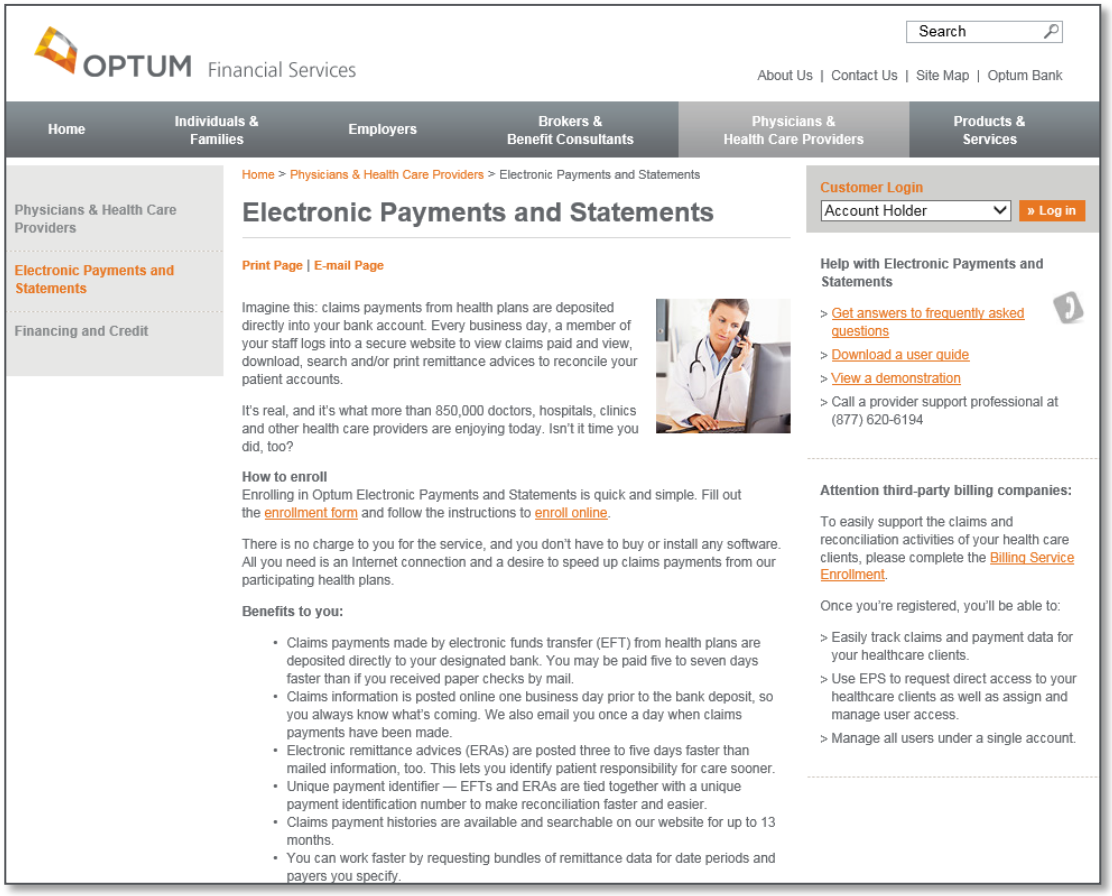


Training Opportunities:
Unitedhealthcareonline.com Overview
EPS Introduction
EDI 101: Basics and Beyond

Electronic Payments & Statements (EPS)

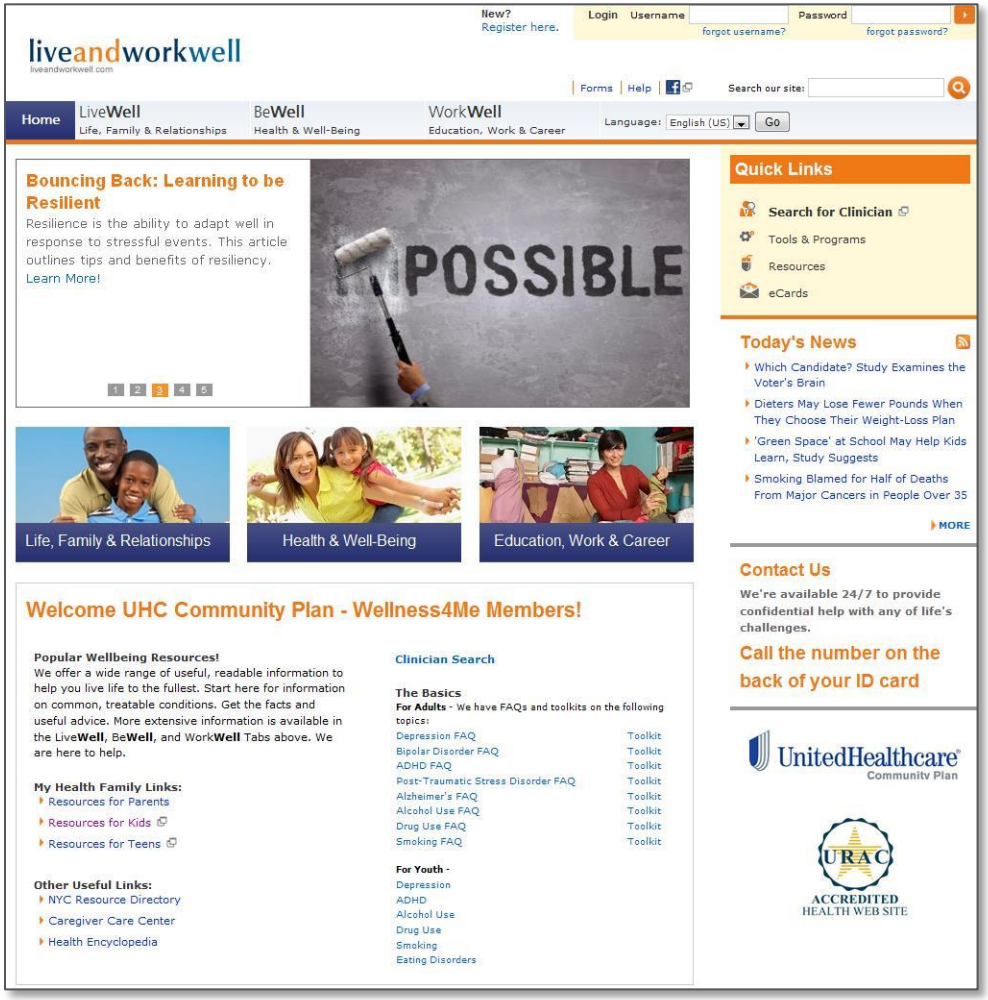


Viewing Electronic Remittance Advice (ERA), 835



http://www.optumhealthfinancial.com/

Live and Work Well



Planning resources: https://www.liveandworkwell.com/public/

liveandworkwell
liveandworkwell.com

Home | Site Tour | Forms | Help | Español

Home | Personal Empowerment Kits

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

Member Services

- Register or login to access benefits & manage claims
- Search for Clinician
- Get care and services
- Contact us

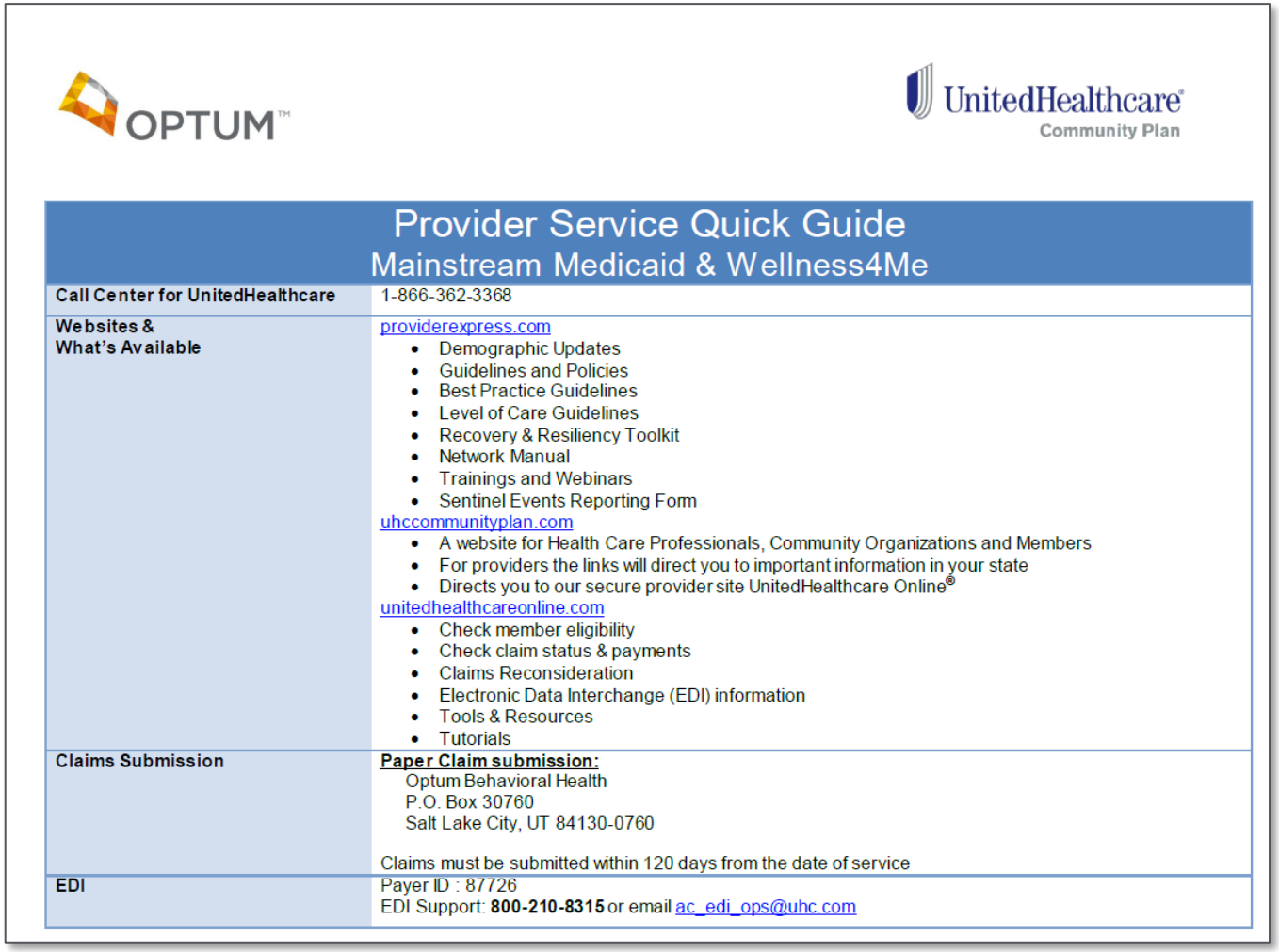
Hot Topics

- Just Diagnosed: Mental Health
- Just Diagnosed: Substance Use Disorder
- Federal Mental Health Parity
- Mental Health
- Drinking, Drugs and Addictions
- Personal Empowerment Kits
- Building Your Way to Wellness
- Self-Help Programs
- WorkLife Balance
- Video Voices of Hope
- Important Notice on Payment of Out-of-Network Benefits
- Aviso Importante sobre el Pago de Beneficios Fuera de la Red

Network Services

Ilana Adler, LMSW, Government Liaison for NY

Provider Service Quick Guide, page 1



OPTUM™

UnitedHealthcare® Community Plan

Provider Service Quick Guide
Mainstream Medicaid & Wellness4Me

Call Center for UnitedHealthcare	1-866-362-3368
Websites & What's Available	providerexpress.com • Demographic Updates • Guidelines and Policies • Best Practice Guidelines • Level of Care Guidelines • Recovery & Resiliency Toolkit • Network Manual • Trainings and Webinars • Sentinel Events Reporting Form uhccommunityplan.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® unitedhealthcareonline.com • Check member eligibility • Check claim status & payments • Claims Reconsideration • Electronic Data Interchange (EDI) information • Tools & Resources • Tutorials
Claims Submission	**Paper Claim submission:** Optum Behavioral Health P.O. Box 30760 Salt Lake City, UT 84130-0760 Claims must be submitted within 120 days from the date of service
EDI	Payer ID : 87726 EDI Support: **800-210-8315** or email ac_edi_ops@uhc.com

Provider Service Quick Guide, page 2

Electronic Payments & Statements (EPS)	It's quick and easy, go to UnitedHealthcare Electronic Payments & Statements (www.unitedhealthcareonline.com) > Claims & Payments > Electronic Payments & Statements Questions - 866-842-3278, option 5
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 (MH IOP) • 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

Contact us

Svetlana (Lana) Kats – Director of Network Management for NY Public Sector

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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

Contact us, continued

If you have questions please, feel free to send an email to:

The Network mailbox: NYHarp_ProvServices@optum.com

All questions will be directed to the appropriate network manager.

*** Please note: We are in the process of reassigning regions and updates will be available at a later date.

Contact us, continued

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Thank You
We Appreciate Your Attendance Today