NEW JERSEY HUMAN SERVICES

Provider MCO-led Integrated Care Management Training

NJ FamilyCare Behavioral Health Integration

JANUARY 28, 2025

Housekeeping

All attendees will enter the meeting on **mute**

This **meeting will be recorded** to act as an ongoing resource

You can **enable closed captions** at the bottom of the screen

Submit your **questions using the "Q&A" function** – direct them to State or specific MCO

(Note: we will aim to respond to all questions directly during or after the meeting. Responses to broadly-applicable questions may be shared publicly)

Materials and recording will be published and available on DMAHS website

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Learning goals for today

1. Understand **what MCO-led integrated care management is** and **how it benefits** members and providers
2. Learn **who is eligible** for MCO-led integrated care management and how you can **refer your patients**
3. Familiarize yourself with **State standards / minimum requirements** for MCO-led integrated care management
4. Discover strategies for **successfully working with** MCO care management teams
5. **Meet MCO care management teams** and identify key points of contact

Agenda

Introduction to MCO-led integrated care management Susan Pustay, Quality Assurance, DMAHS	10:35 – 10:45
State standards and eligibility for MCO-led integrated care management Shanique McGowan, BH Program Manager, DMAHS	10:45 – 11:00
Working successfully with MCO care management teams Shanique McGowan, BH Program Manager, DMAHS	11:00 – 11:05
MCO round robin Aetna, Fidelis Care, Horizon, UnitedHealthcare, Wellpoint	11:05 – 11:30
Q&A DMAHS and MCOs	11:30 – 12:00

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MCO-led integrated care management

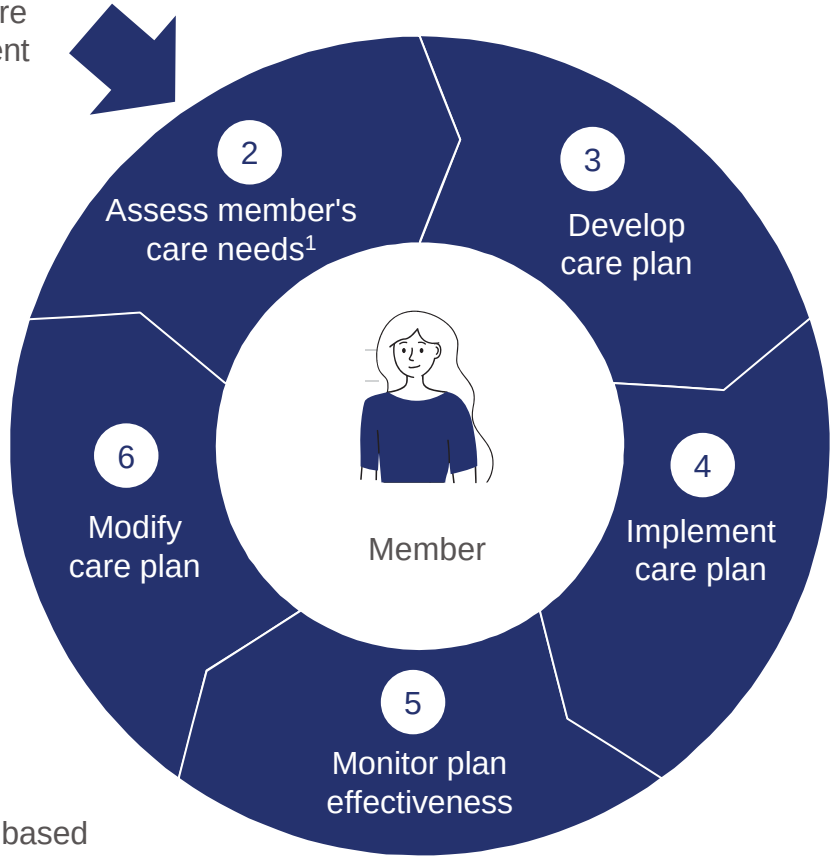
Structured approach used by managed care organizations to identify and support individuals with complex health needs

Goals

- **Whole-person care:** Integrate physical, behavioral, and social health needs to support comprehensive member well-being
- **Care coordination:** Ensure seamless collaboration among providers and services so members receive the right care at the right time
- **Improve health outcomes:** Promote better overall health by focusing on prevention, effective chronic condition management, and evidence-based treatments

What do MCO care managers do?

1 **Identify members** needing care management



7 **Measure** population-based **outcomes**

1. **Identify members** who have or may have complex needs early and **process referrals** from providers
2. **Assess members' medical, behavioral, and social needs** to identify risks and guide care planning
3. **Develop personalized care plans** tailored to each member's unique health goals and circumstances
4. **Implement care plan and coordinate care** actively linking members to providers, medical services, residential, social, behavioral, and other support services where needed
5. **Monitor member progress / plan effectiveness**, follow up and document updates, and review progress toward care plan goals
6. **Modify care plans** as needed to achieve stated goals and desired health outcomes and address evolving needs
7. **Measure population health outcomes** by using tools like the Care Management Member Experience Survey

1. Care manager responsible for re-assessing member's needs on ongoing basis

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Benefits of MCO-led integrated care management

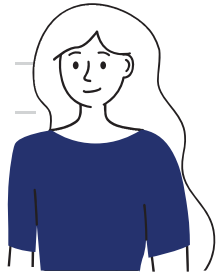
For members

- Integration of physical, behavioral and social needs
- Coordinated access to services across providers
- Improved adherence to treatment guidelines
- Reduced ER visits and readmissions
- Enhanced engagement and participation in one's own care journey
- Improved patient and family satisfaction

For providers

- Comprehensive understanding of member's needs
- Administrative assistance with care coordination
- Support in managing patients with complex needs
- Dedicated MCO resource to simplify and support timely referrals
- Greater ability to focus on clinical care
- Direct contact to MCOs to help navigate MCO system

Source: Buja A, Francesconi P, Bellini I, Barletta V, Girardi G, Braga M, Cosentino M, Marvulli M, Baldo V, Damiani G. Health and health service usage outcomes of case management for patients with long-term conditions: a review of reviews. Prim Health Care Res Dev. 2020

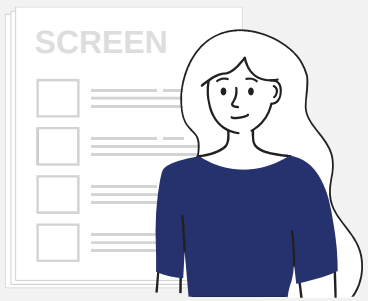


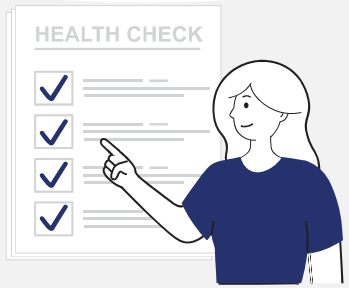
Amira

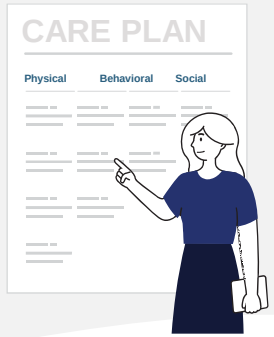
Her story

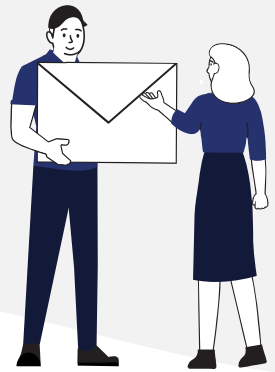
- 32 year old single mother
- Is a NJ FamilyCare member
- Struggles with depression and anxiety
- Recently lost her job
- Overwhelmed by her mental health challenges and stress of caring for children
- Began missing medical appointments
- Occasionally visits emergency room during panic attacks but receives little follow up

Amira's journey: How MCO care management improved her quality of life









MCO Initial health screening

- Identified as high risk for re-hospitalization
- Assigned a care manager (CM), Phil

Comprehensive needs assessment

- Determined her whole-person needs, including financial
- Checks-in with Phil quarterly to re-assess needs

Personalized care plan

- Plan prepared by integrated care team (Phil with input from Amira's PCP)
- Care plan reviewed at quarterly check-ins

Integrated care across providers

- Phil worked with PCP to address her physical health
- Connected to counselor and a local food assistance program

Ongoing health monitoring

- Care team monitoring progress and medication adherence
- Improved physical and mental health

Member outcomes

Fewer emergency visits | Improved MH | Overall, improved quality of life

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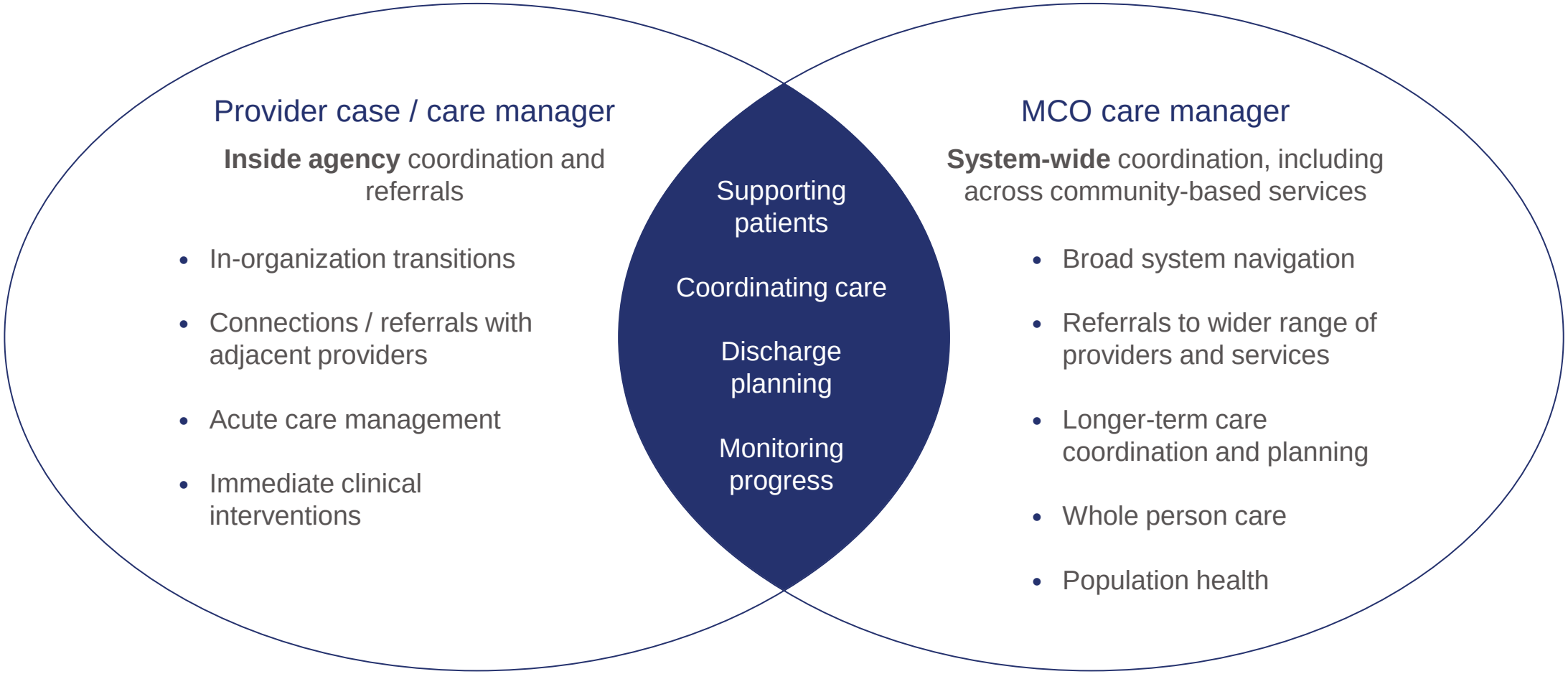
MCO care managers complement, not replace, provider care / case managers



State has collaborated with MCOs to update care management standards and tools across 3 key areas to better support members' BH needs

1 Identification of members

Expanded initial health screening questions and list of care management identification events to better address behavioral health

2 Assessment of members

Added serious mental illness (SMI) and other BH related questions into comprehensive needs assessment

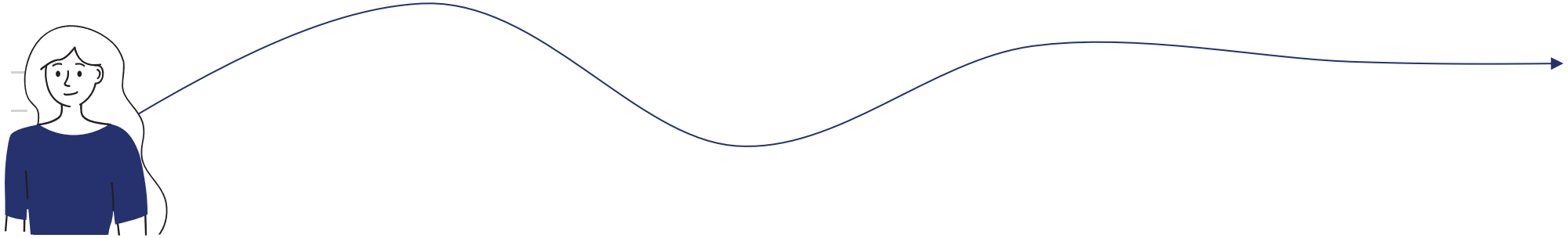
3 Care management delivery

Updated minimum requirements for MCO-led integrated care management to better address member's BH needs

MCO BH care managers are **required to have BH expertise** for members with behavioral health needs

Note: Care management is required by Federal Law to be provided for certain populations: MLTSS, DDD, DCP&P, etc. BH members can opt out

Members can qualify for MCO-led integrated care management at any time



Joins MCO

Entry pathway

Initial Health Screening (IHS) for new members	**Care Management Identification Event** (including provider and self-referral) which prompts re-screening

Note: MLTSS, DDD, DCP&P populations automatically qualify for care management, skip IHS, and undergo comprehensive needs assessment

New members receive initial health screen (IHS)

Question	Scoring
1 **Admitted to the hospital** in the past 6 months or **inpatient BH hospital / psychiatric hospital** in past 12 months?	1 admit = 1 pt 2 admits = 2 pts 3+ admits = 3 pts
2 **Emergency room** visit in past 6 months?	0-1 visit = 0 pts 2-4 visits = 1 pt 5+ visits = 2 pts
3 **Planned future hospital** admissions or surgeries?	1 pt
4 **Self-rating of health**: Excellent, Very Good, Good, Fair or Poor	Fair = 1 pt Poor = 2 pts
5 **Medical and mental health conditions** (serious mental illness and substance use disorder conditions added to list)	0 conditions = 0 pts 1-2 conditions = 1 pt 3+ conditions = 2 pts
6 Uses 4+ **prescribed medications** or 1+ **prescribed psychiatric medicine**[1]	1 pt
7 Use any **medical equipment** currently?	2 pts
8 Needs help with **activities of daily living**?	2 pts
9 What is your **living situation** today? • I have a safe and steady place to live • I am worried about safety of my home / losing my housing • I do not have a steady place to live	Safe = 0 pts Worried = 1 pt Do not have = 2 pts

Members with a **score of 5+** qualify for care management and undergo a comprehensive needs assessment (CNA)

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Members also qualify if a care management identification event occurs

Events include, but are not limited to:

2+ ER visits in 6 months	**Exacerbation** of chronic condition and / or disability	**Mental health** and / or **substance use hospitalization**
Provider referral[1]	**Self-referral**[2]	**MCO systems data update**[3]

MCOs must **reach out** to members that experience a CM identification event**:**

- **Offer CNA** to members not enrolled in care management
- Conduct **additional outreach** for already enrolled members

1. Including BH (MH / SUD) screening result, transitioning out of intensive BH service, homeless / at risk, and referral to housing support services, pregnant/postpartum, disengagement from mental health services - 3+ subsequent missing appointments; 2. Including death of a loved one, suicide attempt without hospitalization, or homeless / at risk, pregnant / postpartum; 3. Including new terminal illness diagnosis or BH diagnosis, pregnant/postpartum, 3+ address changes within past year

How can I refer my patients?

Providers can refer patients for MCO-led integrated care management **at any time**

We encourage providers to **proactively refer patients** who you think would benefit from MCO care management

To refer your patients, submit a request to member's MCO care management team by **phone, portal or email** *(detail follows)*

Reminder:
Dental referrals

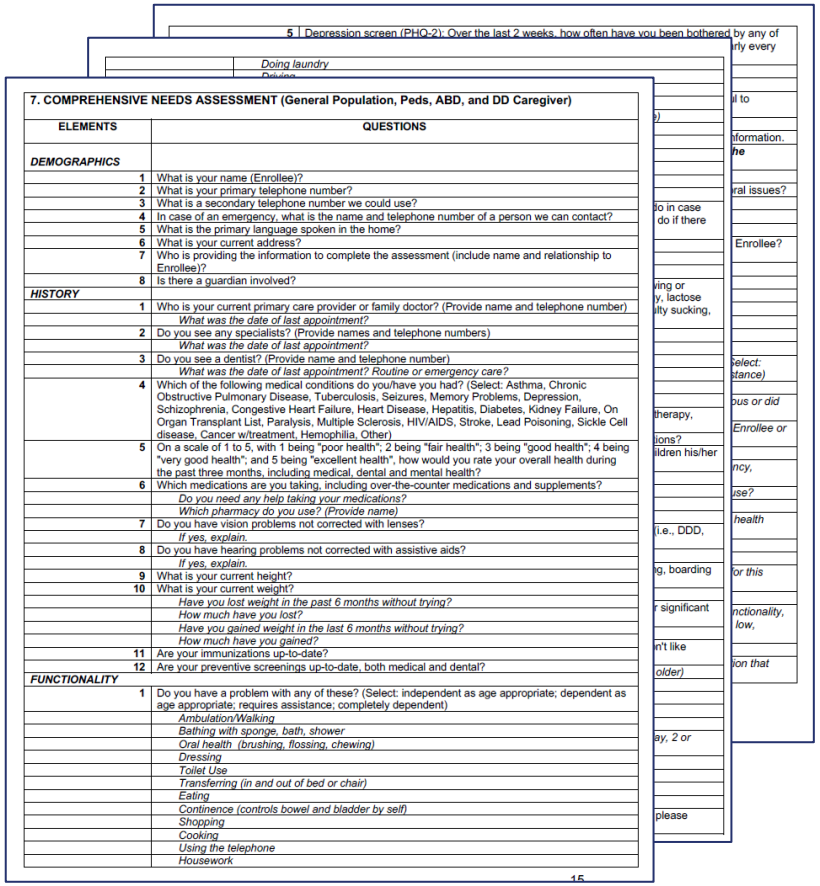
Good oral health is necessary for good overall health!

- All NJ FamilyCare MCOs offer an identical dental benefit package:
  - Dual-eligible FIDE-SNP members are included
  - MCO provider panels may differ
- NJ FamilyCare offers a **comprehensive** dental benefit
- Dental benefits include (but are not limited to):
  - Diagnostic and preventive services (2 preventive visits/12 months)
  - Restorations (fillings, crowns)
  - Endodontic services (root canals)
  - Periodontal services (gum treatment)
  - Dentures (partial and complete)
  - Extractions and oral surgery
- Some services may require prior authorization – check with MCO
- Listings of included dental services may be found at: www.njmmis.com (see: Rate and Code Information)

Clients receiving BH care may require additional assistance and/or treatment

- More frequent preventive services are available for members with special health care needs
- Substance use disorder can intensify the need for dental care
  - Meth mouth
  - Oral buprenorphine patches
- Regular dental care should be encouraged to prevent non-traumatic dental visits to hospital emergency departments
- Dental care in a hospital operating room or ambulatory surgical center is benefited with documentation of medical necessity; Care Managers are required to assist in scheduling
- Bi-directional referral is encouraged among providers; authorization for referrals not needed for in-network providers (PCD base line physical within 180 days of enrollment)
- NJFC Contract dental appointment time requirements:
  - Emergent: immediate upon presentation
  - Urgent: 24 hours
  - Routine: 28 days

Eligible members undergo a Comprehensive Needs Assessment (CNA)



7. COMPREHENSIVE NEEDS ASSESSMENT (General Population, Peds, ABD, and DD Caregiver)

ELEMENTS	QUESTIONS
DEMOGRAPHICS	
1	What is your name (Enrollee)?
2	What is your primary telephone number?
3	What is a secondary telephone number we could use?
4	In case of an emergency, what is the name and telephone number of a person we can contact?
5	What is the primary language spoken in the home?
6	What is your current address?
7	Who is providing the information to complete the assessment (include name and relationship to Enrollee)?
8	Is there a guardian involved?
HISTORY	
1	Who is your current primary care provider or family doctor? (Provide name and telephone number)
	What was the date of last appointment?
2	Do you see any specialists? (Provide names and telephone numbers)
	What was the date of last appointment?
3	Do you see a dentist? (Provide name and telephone number)
	What was the date of last appointment? Routine or emergency care?
4	Which of the following medical conditions do you/have you had? (Select: Asthma, Chronic Obstructive Pulmonary Disease, Tuberculosis, Seizures, Memory Problems, Depression, Schizophrenia, Congestive Heart Failure, Heart Disease, Hepatitis, Diabetes, Kidney Failure, On Organ Transplant List, Paralysis, Multiple Sclerosis, HIV/AIDS, Stroke, Lead Poisoning, Sickle Cell disease, Cancer w/treatment, Hemophilia, Other)
5	On a scale of 1 to 5, with 1 being "poor health"; 2 being "fair health"; 3 being "good health"; 4 being "very good health"; and 5 being "excellent health", how would you rate your overall health during the past three months, including medical, dental and mental health?
6	Which medications are you taking, including over-the-counter medications and supplements?
	Do you need any help taking your medications?
	Which pharmacy do you use? (Provide name)
7	Do you have vision problems not corrected with lenses?
	If yes, explain.
8	Do you have hearing problems not corrected with assistive aids?
	If yes, explain.
9	What is your current height?
10	What is your current weight?
	Have you lost weight in the past 6 months without trying?
	How much have you lost?
	Have you gained weight in the last 6 months without trying?
	How much have you gained?
11	Are your immunizations up-to-date?
12	Are your preventive screenings up-to-date, both medical and dental?
FUNCTIONALITY	
1	Do you have a problem with any of these? (Select: independent as age appropriate; dependent as age appropriate; requires assistance; completely dependent)
	Ambulation/Walking
	Bathing with sponge, bath, shower
	Oral health (brushing, flossing, chewing)
	Dressing
	Toilet Use
	Transferring (in and out of bed or chair)
	Eating
	Continence (controls bowel and bladder by self)
	Shopping
	Cooking
	Using the telephone
	Housework

Comprehensive Needs Assessment (CNA)

Questionnaire → Assessment → Care Plan

Questions across several elements:

- Demographics
- History
- Functionality
- Nutrition
- Developmental concerns
- Support/community resources
- Psychosocial history

Care manager **assesses member** across:

- Cognitive function
- BH (e.g., drug and alcohol use, existing supports and resources, and BH diagnoses)
- Risk
- Health literacy
- Long-term needs

State has introduced three minimum levels of care for MCO-led care management for members with a BH diagnosis

	Low intensity	Moderate intensity	High intensity
Illustrative population criteria (in addition to BH diagnosis or screening result & score 5+ on IHS required for all)	• **Under 26** with **Department of Children & Families (DCF) history** • In MH / SUD **outpatient counseling** • In **medication management only** with SMI diagnosis	• **Hospitalized in past 12 months** • Receiving **outpatient services other than counseling** (e.g., partial care) • In **provider care management** • **Comorbid physical health diagnosis** and SMI	• **Homeless** • **High utilizers** (i.e., 2+ hospitalizations or ER visits within 6 months)

Criteria serves as guidance, MCO care managers can use discretion to ensure members get level of support they need

MCO care managers must maintain caseload limits, meet member outreach requirements, and possess BH expertise across all three levels

	Low intensity	Moderate intensity	High intensity
Caseload	• MCOs must maintain specific **care manager-to-member ratios**, adjusted for complexity / care level • If ratios exceed limits, additional care managers must be hired		
Outreach	• Min **2x per year** • Telephonic, virtual, or in-person	• Min **1x per quarter** to member • **Mandatory annual face-to-face** assessment (virtual or in-person)	• Min **1x per month** • **Mandatory annual face-to-face** assessment **in person**
Care management integration model	• **Any of 3 models,** so long as all member needs are covered, with clear mechanisms for BH/PH coordination**:** - **Fully integrated:** One care manager, with BH and PH expertise, handles all member needs - **Co-managed:** Two care managers – one specializing in BH and the other in PH – who collaborate closely to ensure member needs are met - **Individually managed:** Separate care managers for BH and PH, working independently. While they do not collaborate directly, mechanisms are required to ensure member needs are met, without duplication or gaps		
BH expertise	• **"Primary"** care manager must have **BH expertise / background**		

DMAHS will **continuously monitor** these requirements and adjust them if needed

Best practices for working with MCO care managers

1. **Refer members** to MCO-led integrated care management if additional support is necessary
2. **Identify a member's care manager and respond to MCO outreach** to give input into member's care plan
3. Proactively outreach to MCO care managers with **updated information** on enrolled members, including care / health updates and contact information
4. **Remind and encourage enrolled members** to connect with their MCO care managers for care coordination support, building member trust in MCO CM

Need Help? Contact the DMAHS BH Integration Unit or member's MCO

DMAHS BH Integration Unit

For general MCO-led care management questions, policies or concerns

Dmahs.behavioralhealth@dhs.nj.gov

Behavioral Health Integration Stakeholder Information Website[1]

1-609-281-8028

Member's Managed Care Organization

For specific member care management inquiries and MCO-related questions

Aetna

Horizon

Wellpoint

Fidelis Care

United

Refer to key MCO points of contact in upcoming slides

1. https://www.nj.gov/humanservices/dmhas/information/stakeholder/index.html

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MCO Round Robin

5 mins x 5 MCOs

- Introduce care management teams
- Overview of MCO specific care management processes
- Tips for working successfully with your team
- Key points of contact

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Aetna Better Health of NJ (ABHNJ)

Presenter

Melissa Pinney-Campbell, RN

Associate Manager, Clinical Health Services

Aetna | Meet our care management team

Amy Klassen, RN
Senior Manager, Clinical Health Services

- Responsible for program outcomes
- Email: klassena@aetna.com

Melissa Pinney-Campbell, RN
Associate Manager Clinical Health Services

- Oversight of daily operations of Integrated Care Management team
- Email: campbellm5@aetna.com

Angela Guedes, LCSW
Associate Manager-Behavioral Health Clinical Health Services

- Oversight of daily operations of Integrated Care Management Team
- Email: angela.guedes@aetna.com

Aetna | Overview of our care management process

- Aetna has an Integrated Care Management program. Primary Care Managers have behavioral health experience.

- MLTSS continues to manage membership that meets Nursing Facility Level of Care, this criteria may include members with Behavioral Health Needs. Integrated Care Management (ICM), focuses on both Physical and Behavioral Health needs, members in this care management program, often do not meet Nursing Facility Level of Care, however, need assistance with episodic health care needs.

- Clinical Case Managers and Care Coordinators have varying frequency of contact with members based on the members intensity of care need and member preferences. Some members engage very actively with their care team and all are encouraged to call their care managers with any updates or concerns as needed.
  - When a member agrees and joins Integrated Care Management a clinician will complete additional assessments and create a care plan. At the time a care plan is created the member along with their primary care provider receive a welcome letter which includes contact information and the name of their assigned ICM staff.
  - It is encouraged for ICM and primary providers to share care plans, participant in interdisciplinary care team meetings and share updates.

- Calling member services is the best way to reach the assigned care manager. In between the referral and development and sharing the care plan/welcome letter delivery, providers may call members services or send an email to request an update.
- Referrals are accepted via phone or by emailing our referral mailbox

- Standard business hours are 8:00 AM- 5:00 PM.

Aetna | How to work successfully with us

How to collaborate with our team

- Reach us **the way you prefer** via phone or email!
- We look forward to care coordination with you to provide optimal outcomes.

Contact us

Phone number **Website**	855-232-3596 https://www.aetnabetterhealth.com/newjersey/providers/index.html
Referral email	AetnaBetterHealthNJCMReferral@AETNA.com

Aetna | Upcoming trainings

When	Training Topic	Link
Feb 5 12 pm	BH Integration Provider Training Integration Overview for BH providers new to ABHNJ	https://www.aetnabetterhealth.com/newjersey/providers/training-orientation.html
Feb 19 12 pm	BH Integration Provider Training Integration Overview for BH providers new to ABHNJ	
Mar 5 12 pm	BH Integration Provider Training Integration Overview for BH providers new to ABHNJ	
Mar 26 12 pm	BH Integration Provider Training Integration Overview for BH providers new to ABHNJ	

Fidelis Care New Jersey

Presenter

David Houston, LCSW

Manager, Behavioral Health
Fidelis Care New Jersey

Fidelis Care NJ | Meet our care management team

Lisa Dolmatz, LCSW

Senior Director, Population Health Strategy
Behavioral Health Administrator

- Provide leadership and inform strategy for population health and clinical operations internally.
- Oversee all MCO functional areas including quality management, utilization management, network development and management

David Houston, LCSW

Manager, Behavioral Health

- Manages CM team and care coordination of behavioral health members
- Manages escalations and care management issues related to members or providers
- Develop and assess healthcare outcomes related to mental and behavioral health needs of members

Amanda Bassimakopolos, LCSW

Supervisor, Behavioral Health

- Supervises the day- to-day activities of the BH CM team and assures proactive identification of members at risk and in need of BH CM.
- Supervises the assessment of behavioral health members' situations and functioning, assuring identification of individual needs.

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Fidelis Care NJ | Overview of our care management process

- Our Behavioral Health CM Team manages the whole member. These members have a primary behavioral health diagnoses and physical health needs that are all managed under one assigned BH CM.
- The behavioral health care management team at Fidelis Care NJ is highly experienced and has been in place for over 10 years. We currently have 28 behavioral health care managers. 25 BH CMs are with the MLTSS program and 3 BH CMs are with our CORE Medicaid program. All BH CMs are Masters Level Licensed Clinicians with a wide array of experience in the behavioral health field. Additionally, the current behavioral health team is vastly diverse through gender, ethnicity and language and we always celebrate diversity.
- We believe that having strong partnerships with community providers is essential in ensuring best outcomes for members with behavioral health needs. Throughout the years, our BH CMs have worked closely with many different community partners i.e. ICMS, PACT, etc.
- Providers can refer members by sending an email to David Houston- Manager, Behavioral Health david.houston@fideliscarenj.com or by calling 973-856-1151. Providers can also call our customer service line at 888-453-2534 and request CM referral. We are always willing to discuss and conference members.
- MCO care managers are available for contact during normal business hours 9-5, Monday-Friday. Additionally, members can utilize our 24-hour BH Crisis Line 800-411-6485 to address any behavioral health needs.
- Providers can contact assigned care managers via phone or email, and this information can be available by request.
- BH Care Managers take pride in being extremely responsive to all calls and e-mails from members, providers and other community partners. All calls or emails are returned within one business day at the latest. If a CM is unavailable and the call requires immediate attention, please call the customer service line 888-453-2534 and request to speak with a representative from the BH CM Team.

Fidelis Care NJ | How to work successfully with us

How to collaborate with our team

- We at Fidelis Care are always happy to arrange meet-and-greet sessions with providers to talk about our care management programs and explore the benefits of working together.

Contact us

Phone number (In Network)	**David Houston, LCSW** Manager, Behavioral Health 973-856-1151 **Amanda Bassimakopolos, LCSW** Supervisor, Behavioral Health 862-229-3062
Referral email	David.Houston@fideliscarenj.com Amanda.Bassimakopolos@fideliscarenj.com

Fidelis Care NJ | Upcoming trainings

When	Training Topic	Target audience	Link
Jan 30 3:30pm-4:30pm	Behavioral Health Integration Overview	FFS BH providers joining managed care	Register
Feb 4 10:30am- 11:30am	Behavioral Health Integration Overview	FFS BH providers joining managed care	Register
Feb 27 3:30pm-4:30pm	Behavioral Health Integration Overview	FFS BH providers joining managed care	Register
Mar 4 10:30am-11:30am	Behavioral Health Integration Overview	FFS BH providers joining managed care	Register
Mar 27 3:30pm-4:30pm	Behavioral Health Integration Overview	FFS BH providers joining managed care	Register
Apr 1 10:30am-11:30am	Behavioral Health Integration Overview	FFS BH providers joining managed care	Register

Horizon Blue Cross Blue Shield of New Jersey

Presenter:

Nicole Ladson, LPC

Manager, Medicaid Clinical Operations

Horizon | Meet our Care Management Team

Carol Cianfrone, BSN. RN
Senior Programs Director
Medicaid Care Management Programs

Nicole Ladson, LPC
Manager
Medicaid Clinical Operations

Jamie Lewis, MSM, MSN, RN
Manager
Clinical Operations

Sara Holmlund, BSN, RN BC
Supervisor
Clinical Operations

Horizon | Overview of our Care Management Process

- Our care management model reflects a combination of fully integrated and co-managed enrollment. In most cases, members will be assigned a Behavioral Health Care Manager to coordinate all (physical and behavioral health) needs. We recognize the importance of consistency, so in those instances where it is most beneficial to maintain an existing member-CM relationship; and the primary CM does not posses behavioral health expertise, a Behavioral Health Care Manager will be assigned as secondary, to help ensure all integrated coordination of the member's behavioral health concerns/needs.

- MLTSS employs a fully integrated care management model. The assigned MLTSS Care Manager, who has experience working with behavioral health needs, assumes primary responsibility for coordination of all of the member's physical health, behavioral health, and long-term care needs.

- In partnership with the member, PCP, specialists, and/or BH providers; the Care Manager will develop and implement a care plan upon enrollment into Care Management, a copy of which is provided to the member's PCP. Assessment of the member progress toward goals (or identification/analysis of barriers) is documented at each scheduled outreach with the member/care team. Our Care Managers collaborate with the members/the care team via various methods including telephone, email, and during interdisciplinary team meetings.

- Our Care Management Team is available Monday through Friday, from 8 a.m. to 5 p.m., ET. By calling 1-800-682-9094 and selecting the appropriate extension (our general line or the Care Manager's direct extension). Return calls are completed within 48-business hours.

- Providers interested in referring members can outreach our Care Management Team (as noted above) or can visit our website at: https://www.horizonnjhealth.com/for-providers/programs/care-management to complete the **Care/Case Management Referral Form**.

Horizon | How to work successfully with us

How to Collaborate with Our Team

Name	Phone	Email Address
Care Management Team	1-800-682-9094, Ext. 89634 or 89385	Medicaid_Referrals@HorizonBlue.com

For escalations

Name	Title	Phone	Email Address
Carol Cianfrone, BSN, RN	Sr. Director – Medicaid Care Management	609-537-3125	Carol_Cianfrone@horizonblue.com
Nicole Ladson, LPC	Manager – Medicaid Clinical Operations	609-455-4266	Nicole_Ladson@horizonblue.com
Jamie Lewis, MSM, MSN, RN	Manager – RN, Clinical Operations	609-802-5047	Jamie_Lewis@horizonblue.com

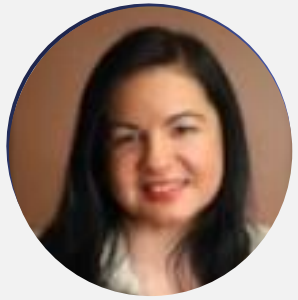
Horizon | Upcoming trainings

When	Training Topic	Target Audience	Link
Feb 13 11:00am	BH Medicaid Integration Training	Ancillary	Register
Feb 18 3:00pm	BH Medicaid Integration Training	Professional	Register
Mar 4 12:00pm	BH Medicaid Integration Training	Professional	Register
Mar 6 1:00pm	BH Medicaid Integration Training	Ancillary	Register

Nellie Stewart

Manager Care Advocacy

UnitedHealthcare | Meet our care management team



Yesenia Gutierrez

Associate Director Care Advocacy

Nellie Stewart

Manager Care Advocacy

UnitedHealthcare | Overview of our care management process

- What is your MCO model for care management? **Co-managed**
- Are there any differences between your existing CM offering (for MLTSS, etc.) and BH care management? **UHCCP has Care Management programs for specialty populations as follows: DDD, MLTSS, Foster Care, immunocompromised and ABD. We offer BH Care Management for members identified with BH and SUD needs.**
- What can providers expect from [MCO] care managers? **Collaboration opportunities around identification of member needs and ensuring said needs are met.**
  - How do they seek input from providers? **Email or phone**
  - How and when will they share a care plan? **Throughout the care management process, starting with member identification.**
  - How often do they communicate with members and providers? **Varies based on member needs**
- How can providers find out if a member has a care manager? **Email necsbhcca@uhc.com or phone 1-877-704-8871**
- How do providers refer members? **Email necsbhcca@uhc.com or phone1-877-704-8871**
- When are MCO care managers available for contact? **Monday – Friday 8:00 am – 5:00 pm**
- How do providers contact CMs (e.g., phone/email)? **Email necsbhcca@uhc.com or phone 1-877-704-8871**
- How quickly should providers expect a response? **1 business day**

UnitedHealthcare | How to work successfully with us

How to collaborate with our team

- The most direct way for **provider staff** to reach Behavioral Health Care Management is through direct email: NECSBHCCA@UHC.com
- **Reminder:** This is a **provider facing email only and** should not be given to members as there would then be a risk of member crisis issues waiting in an email inbox.
- If staff are **sitting with a Member/wanting Member facing referral/care coordination**, they should use: **Special Needs Hotline 1-877-704-8871**
- The Hotline is **available to all members and providers.** All calls are routed to Behavioral Health **and** Medical Care Management for care coordination activities.

Contact us

Phone number (In Network)	**1-888-362-3368**
Referral email	NECSBHCCA@UHC.com

UnitedHealthcare | Upcoming trainings

Available upon request email NJNetworkmanagement@optum.com with subject line "Provider Training Request"

Presenter

Ann Basil, LCSW

Director of Behavioral Health Services

Ann.Basil@Wellpoint.com

Wellpoint | Meet our BH Case Management team

Ann Basil, LCSW

Director of Behavioral Health

- Director over NJ Behavioral Health Services,, including member-facing Case Management and provider-facing Utilization Management.

Paige King, LCSW

Manager of BH Case Management

- Manager over NJ BH member-facing Case Management team for Core Medicaid, LTSS, and DDD members.

Troy Turner, RN

- Team Lead for NJ BH member-facing Case Management team for Core Medicaid, LTSS, and DDD members.
- Manages a small caseload of LTSS members for BH

Wellpoint | Overview of BH Case Management

- Wellpoint is following a new BH Case Management design for Core Medicaid based on the updated contractual requirements
- We are continuing to hire and build the BH Case Management team
- MLTSS and DDD members have a primary (non-BH) Case Manager. When BH needs are identified, a BH Case Manager is assigned as secondary to triage and case manage the specific BH needs and work as a partner to the primary CM
- Wellpoint BH Case Managers are available Monday through Friday 8am – 5pm by phone or email.
- If you are trying to determine if a member is assigned a BH Case Manager, you can reach out to NJBehavioralHealth@Wellpoint.com to inquire
- Members may be assigned a BH Case Manager based on a trigger event for example, 2+ BH ER visits in 6 months, but anyone can refer a member to BH Case Management.

Wellpoint | How to work successfully with us

Contact Member / Provider Services

Member Services	833-731-2147
Provider Services	833-731-2149
Provider QRG Link	NJ_WLP_CAID_ProviderQRG.pdf

Contact BH Case Management

Phone number (In Network)	**Paige King, LCSW** BH CM Manager Paige.King@Wellpoint.com **Troy Turner, RN** BH CM Team Lead Troy.Turner@Wellpoint.com
Referral email	NJBehavioralHealth@Wellpoint.com

WellPoint | Upcoming trainings

- Wellpoint hosts ongoing provider education and trainings
- Topics include education items such as new provider orientation and claims, but also educational topics
- Recording of Phase One BH Integration provider training is posted online
- Use (2) links below to review topics and dates and register for all provider education and training sessions

Training academy | Wellpoint New Jersey, Inc.

https://www.carelonbehavioralhealth.com/providers/resources/trainings

Q&A

Please direct your questions to the State or a specific MCO

Appendix – Quick Reference Guide Contact Information

Key contact information by MCO in quick reference guide (QRG)

	Aetna	Fidelis	Horizon	United	Wellpoint
Phone	**Angela Guedes:** BH CM Supervisor 959-299-3163 **Melissa Campbell-Pinney:** ICM Assoc Manager 959-299-3277	**General CM:** 1-855-642-6185 (TTY: 711)	**General CM:** 1-800-682-9094 Ext. 89634 or 89385	**Members and Providers:** 1-888-362-3368	**Medicaid Providers:** 833-731-2149 (TTY 711) **FIDE SNP Providers:** 866-805-4589 (TTY 711)
Email	**Referrals:** **AetnaBetterHealthNJ CMReferral@AETNA.com**				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