

III. Enrollee Information



A. Enrollee Rights

Each enrollee in the Dallas Area NorthSTAR Program is a partner in his or her mental health or substance abuse care and each individual has certain rights. We feel that it is important that our Network Providers are aware of the rights *ValueOptions* guarantees to its enrollees while they are receiving services under the NorthSTAR program. Under the *ValueOptions* Program, enrollees have the right to the following:

1. Respect, dignity, privacy, confidentiality, and non-discrimination. This includes the right:
 - To be treated fairly and with respect
 - To know that their medical records and discussions with their providers will be kept private and confidential and not shared without their written permission.
2. A reasonable opportunity to choose a mental health or substance abuse provider from the ValueOptions NorthSTAR network of providers, and to change providers if they choose to do so. That includes the right to be informed about how to choose or change providers.
3. To ask questions and get answers about anything they don't understand. This includes the right:
 - To have their provider explain their behavioral healthcare needs to them and talk to them about the different ways their behavioral healthcare problems can be treated
 - To be told why care or services were denied and not given when requested by the member or their provider, or why services were modified from those requested by the member or their provider.
4. To consent or refuse treatment and actively participate in treatment decisions. This includes the right:
 - To be treated in the least restrictive, clinically appropriate setting
 - To give permission for their family members or guardians to be involved in the planning of their treatment
 - To work as part of a team with their provider in deciding what behavioral healthcare is best for them
 - To give consent to the care recommended by their provider
5. Utilization of each available complaint process through *ValueOptions* and through Medicaid and/or the State. Including receiving a timely response to complaints and Medicaid recipients receiving a fair hearing. This includes the right:
 - To make a complaint to *ValueOptions* or to the State about their behavioral healthcare, their behavioral health provider, or their behavioral health plan
 - To get a timely answer to their complaint
 - For Medicaid recipients to request and receive a Fair Hearing, or for non-Medicaid members to ask for a review by an Independent Review Organization (IRO).

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6. Timely access to care that does not have any communication or physical access barriers. This includes the right:

- To have telephone access to a behavioral health professional 24 hours a day 7 days a week in order to obtain any needed emergency or urgent care
- To get behavioral healthcare in a timely manner
- To be able to get in and out of a behavioral health provider's office, including barrier-free access for persons with disabilities or other conditions limiting mobility, in accordance with the Americans with Disabilities Act
- To have interpreters, if needed, during appointments with their providers and when talking about their plan. Interpreters include people who can speak in their native language, assist with a disability, or help them understand the information
- To be given an explanation they can understand about their behavioral health plan rules, including the services they can get and how to get them

B. Enrollee Responsibilities

Just as enrollees have rights, we also feel that they have responsibilities as partners in their recovery. In our Enrollee Handbook, and in the training sessions we hold with enrollees, we also help them to understand the responsibility they have to take part in meeting the goals they and their providers set. We acquaint them with the following tips that can help them, their provider, and everyone else involved in their care. We inform them that they have the following responsibilities:

1. To learn and understand each right they have under the NorthSTAR program. This includes the learn and understand their rights, to the best of their ability, under the NorthSTAR program
 - To ask questions if they don't understand their rights
 - To make any changes in their behavioral health provider in the ways established by *ValueOptions* and approved by the State
 - To keep their scheduled appointments
 - To cancel appointments in advance when they can't keep them
 - To use a NorthSTAR provider for all but emergency room care in an emergency or life threatening situation
 - To understand when it is appropriate to go to an emergency room and when it is not
 - To always contact their behavioral health provider first, or *ValueOptions* if they do not have a behavioral health provider assigned, to locate a NorthSTAR provider for their non-emergency behavioral health needs
 - To abide by the NorthSTAR policies and procedures, and obtain an explanation of these, if they are not understood, from their provider or ValueOptions.

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2. To share information relating to their behavioral health status with their behavioral health provider and become fully informed about behavioral health service and treatment options. This includes the responsibility:
 - To tell their behavioral health provider about their behavioral health
 - To talk to their behavioral health provider about their behavioral healthcare needs and ask questions about the different ways their behavioral healthcare problems can be treated
 - To help their behavioral health provider obtain their medical records
3. To actively participate in decisions relating to service and treatment options, make personal choices, and take action to maintain their behavioral health. This includes the responsibility:
 - To work as a team with their behavioral health provider in deciding what behavioral healthcare is best for them
 - To understand how the things they do can affect their behavioral health
 - To do the best they can to stay healthy
 - To treat behavioral health providers and staff with respect

C. Enrollee Access to Services

1. Emergency, Urgent, and Routine Appointment Standards

The State's standards for appointments for NorthSTAR enrollees are as follows:

Emergency: Immediately

Urgent: Within **24 hours** of request, including transfer between levels of care during a substance abuse episode

Routine: Within **14 calendar days** of request

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The State also requires *ValueOptions* to ensure that their Network Providers complete a behavioral health assessment and treatment plan within **three (3) days** of a routine outpatient visit and within **48 hours** of an emergency or urgent inpatient or residential placement. These treatment plans must be updated at least weekly for inpatient or residential treatment and **every ten (10) visits/units** for enrollees receiving outpatient services, but not less frequently than **every three (3) months**.

2. Schedule for Outpatient Appointments after Hospital Discharge

Per State requirements, outpatient services must be scheduled prior to a consumer's discharge from an inpatient (or other 24-hour) setting. Consumers must be seen within **seven (7) days** of discharge for mental health and within **five (5) days** for substance abuse/chemical dependency.

3. Appointments, Missed Appointments, and Follow-up

Providers are not permitted to bill patients for missed appointments. The State also requires follow-up for missed appointments by the providers. Providers must contact patients to reschedule missed appointments within 24 hours of the missed appointment.

D. Assessment Information

1. Eligibility Screening

All Medicaid consumers are eligible for the medically necessary Covered Services listed in Section II (Eligibility, Enrollment, and Covered Services). Consumers who are not Medicaid-eligible become eligible for services only when their clinical needs dictate. At the time of intake, providers must obtain sufficient information to establish the non-Medicaid consumer's clinical eligibility for services in the NorthSTAR Program. The following are the components of the eligibility determination process:

a. Steps for Providers to Assess Clinical Eligibility

The State requires the completion of assessment forms after a Provider conducts a comprehensive clinical assessment. Please see Section XIII (Required Forms) for a copy of these forms.

ValueOptions requires all network providers to ensure that the behavioral health assessment forms are completed within four (4) routine outpatient visits. Providers will not be able to request authorization for services until all required assessment data has been received by *ValueOptions*.

Assessment forms must be faxed to **1-877-888-6444**. Once an assessment form has been completed and sent to *ValueOptions*, please follow *ValueOptions* Authorization Policy outlined

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in Section IV (Clinical Policies and Procedures) of the manual. All emergency, urgent inpatient or residential placements require that assessment forms be submitted to *ValueOptions* within 48 hours.

b. Financial Eligibility Assessment

Individuals who are not currently Medicaid-eligible must be assessed for financial eligibility. A financial assessment must be completed and documented for each non-Medicaid person prior to enrollment, and **updated at least annually**, or whenever significant financial changes occur. All documentation supporting the information reported on the Financial Assessment Form must be submitted to *ValueOptions* prior to treatment. All emergency, urgent inpatient or residential placements require that assessment forms be submitted to *ValueOptions* prior to admission. A co-pay may be due from the Non-Medicaid eligible member to a provider. Please see Section XI (Claim and Billing Information) of this Manual for a copy of this Co-payment Schedule. See also attachment 7 for listed detail descriptions of eligibility processes.

2. Reassessment of Financial and Clinical Eligibility

a. Clinical

Providers are required to reassess each consumer's clinical eligibility during treatment and also after discharge from any inpatient or residential setting. Initial and reassessment data must be submitted to *ValueOptions* in the manner prescribed by *ValueOptions*.

b. Financial

A financial assessment must be completed and documented for each non-Medicaid person prior to enrollment, and **updated at least annually**, or whenever significant financial changes occur. All documentation supporting the information reported on the Financial Assessment Form must be submitted to *ValueOptions* within 30 days from the onset of treatment. All emergency, urgent inpatient or residential placements require that assessment forms be submitted to *ValueOptions* within 48 hours.

E. Enrollee Special Needs Affecting Access to and Delivery of Services

1. Cultural and Linguistic Sensitivity, Including Use of Interpreters

In its NorthSTAR Program, the State is particularly concerned that the selected Behavioral Health Organization make certain that each Enrollee who needs culturally appropriate services may receive services from a provider who shares his/her cultural background, values and perspective. Because of this, *ValueOptions* will:

- Coordinate services with community advocates and agencies that assist non-English and limited-English speaking individuals and/or provide other culturally appropriate services.

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- Ensure that all of our marketing and enrollment materials are written at the 4th through 6th grade reading levels and are available in alternative formats for the blind and disabled and in the language of any population group that comprises more than ten percent of the covered lives.
- Provide 24-hour access to interpreter services for Enrollees to access emergency behavioral health services within our network either through telephone language services or interpreters.

In keeping with both the State's requirements and its own mission, *ValueOptions* must also make certain that its Provider Network take the following steps:

- Provide interpreter services for Enrollees as necessary to ensure effective communication – including translated written/video materials, e.g., documents, forms and information pamphlets regarding behavioral health prevention services (assessment, treatment or education)
- Use trained professional interpreters when behavioral health treatment information is to be discussed. Family members or friends are discouraged from being used as interpreters in behavioral health treatment.
- Have an identified staff member to assist Enrollees who are deaf or hard-of-hearing.
- Maintain a current list of interpreters who are "on-call" to provide interpreter services and make a copy of the list readily available to *ValueOptions* (for submission to the State) upon request. This list will include individuals that can competently translate Spanish and provide Level III interpretive sign language services.
- Comply with the Title III of the Americans with Disabilities Act and have TDDs in offices where the primary means of offering goods and services is by telephone.

If you have any difficulty in understanding the above requirements, or if you need further information, please contact one of our Enrollee and Provider Service Representatives at **1-888800-6799**.

2. Transportation Needs

Emergency transportation for all Medicaid Enrollees is available through either the STAR or fee-for-service Medicaid programs.

Non-emergency transportation for Medicaid Enrollees is provided under the Medicaid Transportation Program administered by DSHS. In order to access these services for enrollees under your care, please take the following steps:

- Call the Medicaid Transportation Program (MTP) with at least one (1) workdays' notice, whenever possible.

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- Call between 8:00 a.m. and 5:00 p.m. Central Standard Time, weekdays
- Please have the following information available:
 - Consumer's Medicaid Number
 - Provider's name, address, phone number
 - Date, time and purpose of appointment

The Medicaid Transportation Program can be reached at the following number:

1-877-633-8747

ValueOptions is required to provide non-emergency transportation services for non-Medicaid Enrollees through its Specialty Provider Network (SPN). We are required by the State to maintain the existing level of transportation services through the SPN and as outlined in 42 TAC §144.541 pertaining to services provided in Specialized Female Programs and to non-Medicaid Enrollees who do not have transportation to Covered Services.

Transportation currently provided by SPN's includes:

- Transportation provided by agency staff in agency vehicles to and from SMI day treatment programs
- Transportation of consumers in conjunction with community support activities (e.g., application for benefits, assistance with community living skills training)
- Limited transportation assistance to and from treatment for consumers with no alternative transportation available

Transportation benefits are provided by *ValueOptions* in the following ways:

- The cost of routine transportation to and from structured day treatment programs will be built into the per diem reimbursement rate for day treatment
- Transportation for consumers receiving Specialized Female substance abuse/chemical dependency services will be built into the reimbursement rate for those services.