Health Care Guidance Program
Coordinating with you for better care

Nevada Medicaid-Health Care Guidance Program (HCGP)

Understanding this Care Management Organization and how it partners with providers, hospitals, Federally Qualified Health Centers (HCGP), and Managed Care Organizations (MCOs) to improve patient health.

What is the Nevada Medicaid-Health Care Guidance Program?

The Health Care Guidance Program (HCGP) is a care management program that partners with local providers to support qualified Fee-For-Service Nevada Medicaid beneficiaries with assistive support and knowledge of resources; better managing their health. The program, which launched June 1, 2014, provides integrated physical and behavioral health care management for up to 41,500 beneficiaries across Nevada.

What are the goals of the Health Care Guidance Program?

The program is working to sustain the improvements in the quality of health and wellness for Nevada Medicaid beneficiaries; providing care in a more cost-efficient manner. The objectives to establish changes to find improvement and reach these goals include:

- The program seeks to help providers coordinate care for their highest risk, chronically ill patients that qualify.
- The program is designed to help improve the quality of health care that certain Fee-For-Service (FFS) Nevada Medicaid beneficiaries receive through care management services.
- Program beneficiaries will receive individualized care management services promoting increased self-management skills through one-on-one assistance.

Who Benefits from this Program and How?

Benefits to Providers

- Additional program resources offered at no additional cost to patients or providers
- Program staff support the Patient Centered Care Team model with the provider being at the center of the care team
- Direct collaboration with program resources on patient care plans
- Support for the highest risk, patients with the most need of physician time
- Decreases no-show rate
- Assists patients with follow up for transportation services
- Targets proper medication adherence
- Provides after hours clinical support for your patients
- Improves patient self-management skills and health outcomes

Benefits to Hospitals and Health Systems

- Care team works with hospital discharge planning whenever possible to ensure timely discharge, coordinating transition to next setting of care, and appropriate supports to avoid unnecessary return Emergency Department visits.
- Care transition and adherence interventions help decrease unnecessary readmissions that are often not covered.
- Program supports work to decrease inappropriate Emergency Department visits.
- Coordination with behavioral health and ambulatory specialists help enrollees get needed support.
- Evidence-based guidelines help increase quality and patient safety.

Benefits to Federally Qualified Health Centers (FQHCs)

- Care teams receive administrative and claims data, allowing them to share patient care plans, gaps in care, medication adherence, and information on other providers prescribing for the same patients.
- Program care teams promote FQHCs as patient centered care for beneficiaries, increasing FQHC enrollment of Medicaid members.
- Designated program staff visit FQHCs regularly to help coordinate patient services, decrease no shows, address patient transportation needs, and provide linguistically appropriate support.

Benefits to Managed Care Organizations (MCOs)

Program provides support for MCO beneficiaries in both urban and rural Nevada locations, who are transitioning to Fee For Service, ensuring continuity of care.

- Partnership with MCOs strengthens shared provider networks, Patient Centered Care model, closes gaps in care, and fosters patient-provider collaboration.
- Care team staff work with MCOs to share and transfer care plans and other care management information when program beneficiaries enroll back into the MCO.

Program Funding and Delivery

- This is a (5) year project and is funded under the umbrella of a 1115(a) Research & Demonstration waiver approved by the Center for Medicare and Medicaid Services (CMS).
- Axis Point HealthCare will conduct the program under contract to the Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP).
- Value Options is subcontracted by Axis Point to coordinate behavioral health components for enrollees.

Beneficiary Participation

- The Health Care Guidance Program is a free, enhanced medical benefit; beneficiaries will continue to receive medical services through the current Fee-For-Service payment system.
- Participation is mandatory for all qualifying Fee-For-Service Nevada Medicaid beneficiaries.
- Eligible Fee-For-Service beneficiaries are those with one or more of the demonstration-qualifying chronic conditions or a high cost/high utilization pattern who would benefit from additional support.
- Waitlist is prepared to be enacted if over 41,500 enrollees are identified, adding from this list those who are eligible when others are graduated or lose eligibility from program.

How are Participants Identified and Assessed?

- The CMS research and demonstration waiver defines the qualifying chronic physical and mental health conditions: Asthma, Cerebrovascular disease, COPD, Diabetes, ESRD, Heart Disease, HIV/AIDS, Mental Health, Musculoskeletal system, Obesity, Substance use disorder, Pregnancy and complex condition/high utilize.
- Predictive modeling tools will be used to assess all 41,500 potentially eligible beneficiaries and identify their risk level and presence of one or more of the qualifying conditions.
- Providers are also able to make real-time referrals (RTR) of Medicaid eligible beneficiaries into the program.

- Once identified, beneficiaries are assigned to one of 8 care management programs based on their qualifying condition(s) and needs:
    1. *Disease Management Intervention*
    2. *Care Management Intervention*
    3. *Oncology Care Coordination*
    4. *Chronic Kidney Disease Management*
    5. *Mental Health Program*
    6. *Pregnancy Care Coordination*
    7. *Complex Condition Care Management*
    8. *Health Care Management*

How can Providers Validate and Refer Medicaid Eligible Patients?

Providers may validate the enrollment of patients and refer Fee-For-Service patients into the program by faxing a referral to 1-800-542-8074 or by calling the program directly at 1-855-606-7875 and selecting prompt "2". Providers may also download a referral form or, beginning in September 2014, validate patient enrollment by visiting our web site at https://nvguidance.axispointhealth.com/providerportal/nev.

Care Teams

- Serving as an extension of the provider's practice and the Patient Centered Care Team, the Health Care Guidance Program is delivered by regional care teams.
- By design, care team members are situated geographically within their clients' communities and reflect the diversity of Nevada.
- The care teams is led by a full-time, in-state Medical Director who oversees and provides guidance for the program and its delivery.

  Care teams will include:

    - Community-Based Primary Nurses
    - Care Team Supervisors
    - Social Workers
    - Community Health Workers/Peer Support
    - Complex Case Managers
- Using evidence-based clinical guidelines, care teams coordinate with the patient's providers and treatment team to work with the patient on implementing personalized care plans and managing follow-up appointments and services.

How is the Program Delivered?

- Patients receive targeted one-on-one support from their care team that may include:
    - Assistance with selection of a primary care provider for those patients without a primary physician.
    - Patient and caregiver coaching on their conditions and treatment plans conducted face to face or telephonically.
    - Identification of both medical and non-medical barriers that impact their health
    - Access to 24/7 nurse advice services.
    - Links to community resources and health education materials.
    - Help obtaining equipment, medications, and coordinating transportation.
    - Support for care transitions between settings of care and providers.
- Providers can access patients' care plans, receive clinical alerts, obtain monthly reports regarding gaps in patient care, and provide online feedback to the care team through the online provider portal.

Program Exclusions:

- All Medicaid Beneficiaries enrolled in a Managed Care Organization (MCO) Health Plan.
- Dual Eligible's – Excludes all beneficiaries dually eligible for Medicare.
- Home and community based service waivers/1915(c) Excludes individuals receiving case. management services through the state's 1915(c) Home and community based services waiver.
- Nevada Check-Up enrollees-(CHIP) *AKA SCHIP*
- Targeted Case Management (TCM) & Child Welfare beneficiaries are a case by case determination.
- Emergency only Medicaid
- Newly Eligible's/Childless Adults - Newly eligible's are defined as childless adults ages 19-64 and the expanded parent and caretakers ages 19-64 who are made eligible as part of the Patient Protection Affordable Care Act (PPACA) expansion population and receive the Alternative Benefit Plan.
- Intermediate Care Facilities- excluded are residents of intermediate care facilities that are intellectually disabled.

How easily accessible is communication and program learning opportunities for providers?
General and targeted communications are sent out to providers in Nevada, including:

- Medical director and staff visits to providers and facilities
- Direct mail announcements
- Newsletters
- Information on accessing the provider portal
- Post-Assessment follow-ups
- Clinical alerts for critical patient issues
- PharmaConnect gaps in care messaging for improved outcomes
- Provider advisory board consisting of local physicians

Health Care providers can access enrollees' care plans, receive clinical alerts, obtain monthly reports regarding gaps in patient care, and provide online feedback to the care team. Providers will be given education and practice support, including extra resources for the providers' care team.

How will providers know if recipient is eligible for, or already enrolled in HCGP?

Providers can find the indicator in the Electronic Verification System (EVS) that shows a Medicaid recipient is enrolled in the Health Care Guidance Program (HCGP). EVS currently reflects the acronym "HCGP-FFS" to indicate Care Management Organization. This indicator is informational only and there are no differences in benefits or billing procedures from any other Fee-For-Service (FFS) recipients.

If you have further Questions, who can you contact?

For a Fee-For-Service Nevada Medicaid beneficiary, please call the Nevada Medicaid Health Care Guidance Program at 1-855-606-7875 Option 1.

For providers and other questions about the Nevada Medicaid Health Care Guidance Program, (HCGP) organizations/providers may contact the Nevada Medicaid Health Care Guidance Program at 1-855-606-7875 Option 2.

For Providers with Clinical Questions contact Dr. Thomas McCrorey, Medical Director, at Thomas.McCrorey@axispointhealth.com or 775-434-1874.