



Health Care Guidance Program

Coordinating with you for better care!

Nevada Medicaid Partnering with Providers to Improve Patient Health

A Mandatory Health Program for Fee-for-Service (FFS) Medicaid Beneficiaries



Health Care Guidance Program

Coordinating with you for better care!



1-855-606-7875

<http://www.nvguidance.vitalplatform.com/providerportal/nev>

Secure fax line 1-800-542-8074



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Dear Colleague,

On June 1, 2014, the State of Nevada Division of Health Care Financing and Policy (DHCFP) launched the **Health Care Guidance Program (HCGP)**— a Care Management Organization (CMO) designed to assist Nevada's sickest and costliest Fee-for-Service (FFS) Medicaid beneficiaries.

Up to 41,500 Medicaid beneficiaries with one or more qualifying conditions are eligible to participate in the **HCGP**. The program is designed to help improve health outcomes for individuals who live with chronic health conditions by offering additional support to these beneficiaries and their providers. Participating in the HCGP does not affect Medicaid eligibility; the program does not determine FFS benefits, eligibility or coverage for services.

DHCFP and a third party administrator manage the HCGP and have the authority to access the personal health information of program participants through the contractual agreements in place with DHCFP.

As FFS Medicaid beneficiaries are enrolled, our staff may reach out to your office to request current beneficiary information to update participating beneficiary records. Staff may also provide HCGP recommendations or care alert notifications to alert you to any potential beneficiary care gaps or concerns that may need your attention. Please note that these assessments and care coordination activities are offered in the spirit of collaboration to improve care quality; your beneficiary-prescribed treatment plan will always take precedence.

Should you have questions regarding the **HCGP** eligible Medicaid Beneficiaries, or program staffs right for beneficiary information, please call us at **1-855-606-7875**. Additional information about the HCGP Program is available at <http://www.nvguidance.vitalplatform.com/providerportal/nev>.

Thank you.

Thomas McCrorey, MD

Medical Director

Nevada Medicaid Health Care Guidance Program

Nevada Medicaid – Health Care Guidance Program

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Welcome/Overview:

What is the Nevada Health Care Guidance Program?

The Health Care Guidance Program is a care management program that partners with local providers to help certain Fee-for-Service (FFS) Nevada Medicaid beneficiaries better manage their health. Launched on June 1, 2014, the program provides integrated physical and behavioral care management for up to 41,500 individuals across Nevada.

Program Goals

- Improve the quality of health and wellness for Nevada Medicaid beneficiaries
- Help providers coordinate care for their qualifying beneficiaries
- Promote beneficiary self-management skills through personalized interactions
- Provide comprehensive, efficient and cost-effective care management services

Benefits to Health Care Providers and Stakeholders

- Individualized beneficiary support at no cost, that encourages patient-centered care
- Access to regional care team resources: case managers, disease managers, social workers, behavioral health managers and community health workers
- Counseling and individualized support for your highest risk, Medicaid FFS beneficiaries
- Additional encouragement for beneficiaries to make and keep appointments
 - Help identifying and improving barriers to missed appointments, such as transportation
 - Appointment tracking and help placing reminder calls to beneficiaries
 - Ability to co-attend provider visits with beneficiaries to help facilitate tough conversations or assist with complex health information
- Assist beneficiaries with proper medication reconciliation and adherence
- Access to 24/7 nurse advice services
- Improve beneficiary self-management skills and health outcomes

Program Delivery

Beneficiary Participation

All FFS Nevada Medicaid beneficiaries are potentially eligible for this program. Enrollment and care management services are based upon the Centers for Medicare & Medicaid Services (CMS)-identified health conditions, risk level and impactability. The HCGP is free to all eligible Medicaid FFS beneficiaries; beneficiaries will continue to receive medical services through the current FFS payment system.

Additional information is available in section titled Beneficiary Eligibility and Identification (page 9).

Hours of Operation and Administrative Office Location

Toll-free number used for all programs: 1-855-606-7875

Health Care Guidance Program Hours:

Monday–Thursday: 8 a.m. to 8 p.m. (Pacific Time)

Friday: 8 a.m. to 5 p.m. (Pacific Time)

24-Hour Nurse Advice Line: 24 hours a day, 7 days a week

Administrative Office:

1000 East William Street

Suite 213

Carson City, NV 89706

The Administrative office hours are 8 a.m. to 5 p.m. Monday-Friday and is closed on state observed holidays.

Compliments, Complaints, or Concerns:

Use the same toll-free number listed above.



What Beneficiaries Experience

The HCGP staff complete the following steps:

- Mail an introductory package to all enrolled beneficiaries identified for the program
- Initiate contact with enrolled beneficiary by phone, or by home visit, to review the individualized support available through the HCGP, and to actively engage

Beneficiaries receive personalized support that include:

- Face-to-face or telephonic coaching sessions to help manage conditions or follow treatment plans
- Help selecting a primary care provider if beneficiaries do not have one
- Identification of medical and social barriers or any access issues that impact health, in a holistic approach
- Access to 24/7 nurse advice services
- Health education and guidance about community resources
- Help obtaining medical equipment and supplies or accessing available resources
- Assistance in organizing appointments or confirming transportation resources
- Support for care transitions between settings of care and providers

Beneficiary Grievances against the Health Care Guidance Program

Providers may submit grievances on behalf of their participating beneficiaries. Providers will need to submit written permission from their beneficiaries to do so. Grievances can be received by mail or submitted over the phone.

Phone Number: 1-855-606-7875

Mailing Address: PO Box 2127 Carson City, NV 89701

Written acknowledgment of the grievance will be mailed within two business days. It may take up to 30 days to receive a resolution response from the program administrator.

What Providers Experience

Care team staff will work closely with providers to improve beneficiary care quality and clinical outcomes:

- All interactions with beneficiaries are documented and reported back to the provider, including details of supplemental information given to the beneficiary to support care plan priorities
- Participating beneficiaries' medical, pharmacy and laboratory claims are evaluated for possible gaps in care; focusing on non-compliance with provider recommended therapies. This information will be made available to the treating provider
- Care team staff conduct active outreach in the community and may visit providers to discuss beneficiary care plans, coordination needs or other opportunities to support providers
- If the care manager notes that a beneficiary's condition is at high risk for deterioration and /or at risk for Emergency Department (ED) care or hospitalization, a clinical alert is generated and communicated to the provider immediately in order to assure beneficiary safety.

Descriptions of such correspondence are detailed in section titled Types of Correspondence (page 12).

What Care Teams Provide

Using evidence-based clinical guidelines, care managers coordinate with treating providers and other team members to help implement care plans and manage follow-up appointments and services.

- Care teams serve as an extension of the provider's practice through a patient-centered care approach to deliver program benefits
- Care teams are situated geographically within beneficiary and provider communities to reflect the diversity of Nevada
- Care teams are trained in listening skills and beneficiary engagement strategies
- Licensed mental health professionals have training and experience working with behavioral health and substance abuse issues
- Care teams are supported by in-state Medical Directors (primary care and behavioral health) who oversee quality, provide clinical case reviews and guide the program deliverables

Emphasizing Patient-Centered Care

The HCGP is based on the premise that a patient-centered care approach is key to improving the care quality, outcomes, and health of beneficiaries. The care team emphasizes the importance of beneficiaries selecting and maintaining a Primary Care Provider (PCP).

Care Team Staff:

- Confirm the beneficiary's primary care and/or behavioral health providers (BHP). If providers are not identified, the care team empowers the beneficiary in selecting a PCP or BHP as appropriate by offering a choice of providers in the beneficiary's geographic area.
- Communicate the list of beneficiaries that are linked to a provider to promote physician-beneficiary relationship and reinforce recommended treatment plans
- Work to address factors that may result in avoidable ED visits or hospitalization
- Assist high-risk beneficiaries in confirming follow-up visits after hospitalization, to facilitate timely transitions to ambulatory care
- Emphasize the importance of scheduling routine visits and completing recommended preventive services
- Support the provision of culturally and linguistically appropriate health care services



Benefits to Beneficiaries

The HCGP beneficiary goals are to:

- Help beneficiaries better manage their chronic conditions and help coordinate transitional care
- Provide beneficiaries with scheduled coaching calls and easy to understand written health education materials
- Help beneficiaries understand and follow their prescribed treatment plan
- Help coordinate follow-up appointments and services

The HCGP is designed to help beneficiaries:

- Learn more about their health and/or a specific health situation
- Get answers to any health-related questions and help between provider visits
- Better understand the prescribed treatment plan
- Choose the best care based on symptoms or condition
- Assist in arranging transportation to medical appointments

Behavioral Health and Substance Abuse focused programming encompasses:

- Behavioral Health/Substance Abuse specific and focused assessments
- Peer coaching from individuals who understand Behavioral Health and Substance Abuse
- Support from individuals who understand the provider community and can assist with advocating for client needs
- Knowledge of specific Behavioral Health and Substance Abuse providers within Nevada

Meeting the beneficiaries individual needs

The HCGP will work with beneficiaries on a one-to-one basis. Beneficiaries receive personal attention and help with specific health needs. Program Care Managers and care team members:

- Help the beneficiary work with their provider, or care team, to follow their prescribed treatment plan
- Call or visit the beneficiary at a convenient time
- Answer beneficiary health questions
- Provide health information and resources

- Assist in managing chronic health conditions, such as asthma, diabetes, or heart disease
- Help beneficiaries manage their recovery after an injury, surgery or hospitalization
- Provide community resources to assist in ongoing care

24/7 Nurse Advice Line: 1-855-606-7875

Participating beneficiaries will be encouraged to call the 24/7 Nurse Advice Line for non-emergent situations, to re-direct inappropriate emergency department utilization. Based on the end point of the call, beneficiaries may be instructed to call the provider's office within a specified period of time. For non-English speaking beneficiaries—translators are available. The program offers support in several languages and dialects.

The HCGP nurses have over 15 years of medical experience and are friendly, caring people that will help with any health question or concern. The nurses are supported by medical personnel; providing beneficiaries with information you can trust.

Provider Advisory Board (PAB)

As part of the program's ongoing relationship with the provider community, the HCGP has established a PAB. The PAB serves two key roles:

- A forum for health professionals within medical communities to share insight and feedback between peers and the HCGP
- A mechanism to disseminate up-to-date information on the HCGP's initiatives and effectiveness

In addition to the two main goals for utilizing the PAB as part of the CMO service delivery process, other purposes of the PAB are to:

- Provide a forum for discussion and critique of the CMO program
- Identify opportunities and barriers for engaging beneficiaries and providers
- Identify opportunities for collaboration with providers and advocates
- Review and assess program design and results as they become available

The PAB is meant to reflect the diversity of the Nevada health care delivery system. The PAB will include a varied mix of Nevada Medicaid provider offices, clinics and specialties including high- and low-volume clinics; federally qualified health clinics; rural health clinics; health care advocacy organizations; and key opinion leaders.

The PAB will meet four times per year. Two meetings will be face-to-face, and two will be telephonic.

Quality Provider Improvement and Advisory Board

Quality Improvement

The HCGP's quality assurance committee provides ongoing quality assessments, monitors program performance and overall quality of the program. These quality reviews include data analysis and evaluation of program outcomes. Performance improvement experts consult with both internal and external stakeholders in the development of:

- Clinical competencies
- Program compliance standards
- Tools and processes to monitor administrative and clinical performance
- Management training (monitoring, auditing, and process improvement)
- Process improvement recommendations that support clinical outcomes, which involves notifying beneficiaries of gaps in care, such as necessary tests and labs, assisting beneficiaries with transportation and appointment arrangements
- Assessment of aggregate program outcomes; beneficiary or provider complaints; service level standards; and discussions that affect policy or benefit determination change that impact beneficiary care management
- Measurement of provider and beneficiary satisfaction through a 3rd party satisfaction survey

Quality Committee findings will be discussed at Provider Advisory Board (PAB) meetings and then tied to DHCFP's Nevada Comprehensive Care Waiver (NCCW) Quality Strategy. A detailed description of the medical community representation and purpose within the Provider Advisory Board is outlined in the section below.

The HCGP's quality improvement description is available on the provider portal under the program information tab:
<http://www.nvguidance.vitalplatform.com/providerportal/nev/>

The NCCW Quality Strategy can be found at: <http://dhcfp.nv.gov>.

Beneficiary Eligibility and Identification

The HCGP is provided to individuals across the state in FFS Medicaid who meet certain qualifying chronic or complex conditions or who show high utilization patterns.

The CMS and DHCFP have confirmed the following qualifying conditions:

- Cerebrovascular Disease, aneurysm, and epilepsy
- Heart disease and coronary artery disease
- Asthma
- Chronic obstructive pulmonary disease , chronic bronchitis, and emphysema
- Diabetes mellitus
- End stage renal disease and chronic kidney disease
- Mental Health conditions—includes (but not limited to) psychotic disorders (such as dementia, paranoia, schizophrenia, delirium and psychosis) mood disorders (such as bi-polar disorder, anxiety disorder and depression) and other mental health disorders
- Musculoskeletal system conditions—osteoarthritis, spondylosis, disc displacement, Schmorl's Nodes, disc degeneration, disc disorder +/- myelopathy, postlaminectomy syndrome, cervical disorders, spinal stenosis, spondylolisthesis, nonalopathic spinal lesions, femur fracture and spinal sprain
- Obesity
- Pregnancy
- Substance use disorder
- HIV/AIDS
- Complex Condition/High Utilizer: Individuals with complex conditions incurring high treatment costs exceeding \$100,000 in claims

Participation is mandatory for those who qualify (eligible beneficiaries may only opt out of the program through a formal Opt-out process)*

* Native Americans and Alaskan Natives have voluntary enrollment.

Medicaid beneficiaries who are not eligible to participate in the HCGP:

- Those currently enrolled in Managed Care Organizations (MCOs)
- Dual Eligibles
- Those enrolled in Home Community Based Services waivers (section 1915c)
- Residents of Long-Term Care Facilities/Skilled Nursing Facilities (SNF)
- Nevada Check-Up beneficiaries who are part of the Children’s Health Insurance Program (CHIP)
- Those in the child welfare system (juvenile justice or foster care programs)
- Emergency Medicaid
- Individuals receiving Targeted Case Management (TCM)
- Intermediate Care Facility residents whom have intellectual disabilities (ID)

Beneficiary Identification

Eligible beneficiaries are identified, assessed and stratified by risk level using historical claims data and clinical information using state-of-the-art predictive modeling tools.

Predictive modeling tools are used to assess up to 41,500 eligible beneficiaries and identify their risk level and presence of one or more of the qualifying conditions.

Based upon the identified conditions and predicted risks, each beneficiary is assigned to one of eight programs:

1. Complex Condition Care Management
2. Mental Health Program
3. Oncology Care Coordination
4. Chronic Kidney Disease Management
5. Pregnancy Care Coordination
6. Chronic Disease Management Intervention
7. Care Management Intervention
8. Health Care Management

Clinical Guidelines

The HCGP is designed using current, nationally recognized evidence-based clinical guidelines. Clinical guidelines are reviewed annually and semi-annually as required.

Providers are encouraged to provide feedback on the clinical guidelines, as well as all other aspects of the program.

Access the current guidelines at:

<http://www.nvguidance.vitalplatform.com/providerportal/nev>

Provider Manual Updates

The HCGP Provider Manual will be revised and mailed to reflect any updated information based on adjusted programming or State mandates. The most current Provider Manual and additional tools and resources are available online and are accessible at

<http://www.nvguidance.vitalplatform.com/providerportal/nev>

Provider Reporting Requirements to the DHCFP

Medicaid providers are required to report, in writing within five working days, any change in ownership, address or any other information pertinent to the receipt of Medicaid funds. Failure to do so may result in termination of the contract at the time of discovery.



Types of Correspondence

As part of the HCGP, providers will receive various written communication materials with a clear call to action. **Samples of all materials are posted on the Provider Portal, under the Sample Materials tab (<http://www.nvguidance.vitalplatform.com/providerportal/nev>).**

Sensitive Patient Information: The HCGP will not be able to share Mental/Behavioral Health information or HIV/AIDS and Substance Abuse information.

1. Introductory Letter Package

Providers will receive an introductory letter that explains the program. A program overview is included in the letter package every six months and serves as a guide to address potential questions about the program.

2. Monthly Provider Post-assessment Reports

Providers will receive post-assessment reports for all beneficiaries assessed within the month. These reports contain information covered during the Care Manager's beneficiary assessment. The provider is encouraged to comment and make recommendations to the reports to promote improved care plan outcomes.

Providers are supplied the program contact information for easy collaboration:

- Call the program to speak to member of the care team at 1-855-606-7875
- Send a secure fax to 1-800-542-8074

3. Monthly Gaps in Care Notification Letters

Providers with claims related to beneficiaries with identified gaps in care will receive monthly clinical care notifications that help prescribers determine variations from guideline-based care and provide recommendations for resolution. Examples of gaps in care include missed screenings, sub-optimal therapy, medication issues and forgotten lab tests. This information provides a comprehensive picture of beneficiary compliance with their prescribed treatment plan. Feedback from providers regarding actions taken toward closing beneficiary gaps in care is welcome, but not required.

4. Physician Clinical Alerts

Clinical alerts are triggered when beneficiary-reported information exceeds specific measurement criteria. These criteria indicate that a beneficiary's condition is at higher risk for deterioration, and/or at risk for ED care or hospitalization. In the event a beneficiary reports an issue, you will receive a call from the Care Manager and/or a faxed alert, depending on the severity of the situation.

Clinical alerts include beneficiary demographic information and the main clinical complaint reported by the beneficiary, as well as a physician response page to capture provider comments. We request that providers communicate any beneficiary updates or concerns with the HCGP Care Manager by faxing this information to the secure fax line that is included on the alert form.

After a clinical alert is generated for a symptomatic beneficiary, the Care Manager will follow up with the beneficiary to understand their status and record any steps that the beneficiary may have taken to manage their situation. If the beneficiary has not contacted their provider, the Care Manager will encourage them to do so.

Sample events that trigger clinical alerts:

- Asthma control: beneficiary has had ongoing symptoms daily over the course of a month
- Beneficiary reports a systolic blood pressure higher than 180 in the last two days
- Contraindication: beneficiary with heart failure takes NSAID

Note: All clinical content for this program, including alert criteria, are reviewed and approved by physician specialists for the health care condition.

5. Beneficiary PCP Selection Notification

We are able to assist beneficiaries in the selection of a PCP. Should a beneficiary select you as a provider, you'll receive mailed correspondence notifying you of the PCP selection.



Online Information and Provider Portal

There is helpful general program information available in two locations.

The CMO section of the DHCFP website contains quick links to informative HCGP documents including the Real Time Referral (RTR) Form and program summaries: <https://dhcfp.nv.gov/caremgmt.htm>

For now, the HCGP's Provider Portal is password protected to meet HIPAA security and confidentiality regulations. Eligible providers, meeting HIPAA requirements, will be supplied with access instructions (user name and password information) either via a mailed letter or via a HCGP staff member. The site URL is: <http://www.nvguidance.vitalplatform.com/providerportal/nev>.

A user guide is also posted in the resources section of the portal. We encourage you to review this tool if you have active beneficiaries.

If you have questions regarding log-in credentials, call the HCGP, between the hours noted, at **1-855-606-7875** and follow the phone prompts for website help. Hours: Call between 8 a.m. to 8 p.m. Monday through Thursday, and 8 a.m. to 5 p.m., Friday Pacific time.

The HCGP Provider Portal supplies key program information including:

- Beneficiary list and individual beneficiary data
- Provider bill of rights
- Evidence-based clinical guideline information
- Beneficiary advance directives educational information
- Samples of program materials and educational fulfillment
- Announcements, notices, and newsletters
- Most current Provider Manual



Collaboration and Coordination with Providers—Community Outreach Program

To deliver the best program possible, provider participation is imperative. The Nevada Medicaid and HCGP offers a collaborative Community Outreach Program that is designed to promote and build awareness around the benefits of participation in the program. The Community Outreach Program interacts with both providers and community-based organizations who serve Nevada Medicaid beneficiaries.

The primary goals of the Community Outreach Program are to:

- Establish key relationships with physicians, clinics, hospitals and other primary centers of care for Medicaid beneficiaries
- Create a state medical/Medicaid community/Care Management Organization partnership that is both proactive and collaborative. This partnership will facilitate constructive program feedback and acceptance of the new program
- Quickly optimize enrollment through maximum provider exposure and create a real time referral process in the state for Medicaid providers and agencies
- Promote the importance of establishing and retaining a medical home for Medicaid beneficiaries
- Identify key community resources to support the beneficiary in the management of their condition



Patient Real Time Referrals

Patient RTR Process

Patients' eligibility is based on established identification and stratification process using historical claims data.

If you have a patient who has not yet been identified but you think could benefit from the HCGP*, you may refer that patient by calling **1-855-606-7875 (toll-free)**, or by completing the RTR form located adjacent to this page and faxing it to **1-800-542-8074** (secure fax line).

When a RTR is received, a program coordinator will confirm its receipt. Patient eligibility* will be verified, and if confirmed as eligible, the HCGP will initiate contact with the patient.

Should the patient be found as ineligible, the program will not provide outreach nor will it initiate any further interventions. If the patient qualifies and the number of patients managed has not reached the program cap of 41,500, a Care Manager will reach out to the patient and will initiate the standard program mailings.

RTR Form Instructions

1. Please specify the primary condition for your patient. If you are requesting complex case management support, please include additional information so we may better address your patient's needs.
2. Please include as much information as possible for your patient so they can be contacted by the care management staff.
3. Please include your complete contact information, including the name of the person submitting the form, so we may contact your team with any questions.

Please make a copy of the blank form so you may continue to refer patients, as you deem appropriate. Once complete, please fax the form to **1-800-542-8074** (secure fax line). No cover page is needed.

RTRs may be made by the following:

- Physical and mental health providers
- Community resources
- Nurse Advice Line
- Nevada Medicaid

*The HCGP's comprehensive eligibility review process ensures the patient is:

1. Eligible per the identification and stratification process.
2. In the active pool of managed patients or is on a waitlist due to the program cap of 41,500.



Health Care Guidance Program

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Patient Real Time Referral

Please fax to:

Attn: Health Care Guidance Program Coordinator

Fax Number (secure): 1-800-542-8074

Should you have a question, please call 1-855-606-7875.

Date being sent: ____/____/____

Patient Information:

First Name: _____ Last Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ DOB: _____

Telephone Number (s) Home: _____

Cell: _____

Gender: F M Medicaid ID#: _____

Health reason for referral: _____

Referring Provider's Information:

Provider First Name: _____ Provider Last Name: _____

NPI ID #: _____

Clinic Name (if applicable): _____

Provider Address: _____

Provider City: _____ Provider State: _____ Provider Zip Code: _____

Phone Number: _____

Fax Number: _____

Provider Bill of Rights

As the primary caregiver for your patients, you, the practitioner, direct and coordinate the plan of care.

The Nevada Medicaid HCGP Care Manager assists you in your delivery of care to patients by using in-person contact, the telephone, the internet and printed materials to reinforce your recommendations and motivate adherence to the plan of care. This process is designed to enhance cooperation and communication among all parts of the care team.

We also want to communicate your rights as we work together in providing optimal care for your patients.

You have the right to:

- Receive information about the HCGP including information about the program administrator, details around the program services that are offered in conjunction with your practice, as well as information about our staff, their qualifications and any contractual relationships
- Be informed of how we coordinate our interventions with treatment plans for individual patients
- Contact the HCGP employees and the program administrator responsible for managing and communicating with your patients
- Be supported by the HCGP in your decisions with patients regarding their health care
- Receive courteous and respectful treatment from our staff
- Communicate any complaints or concerns to the HCGP Provider Service Line, 1-855-606-7875, Monday through Thursday 8 a.m. to 8 p.m., and Friday 8 a.m. to 5 p.m. (Pacific Time)
- While we believe the key to success of the HCGP is provider participation and support, you do have the right to choose to not be part of our program. Decline to participate in or work with our programs and services for your patients

The practitioner rights are often determined in part by contract with each state. Where this is the case, some factors, for instance, declining to participate may not be applicable.

As a participant in the Nevada Medicaid HCGP you have a responsibility to:

- Communicate with HCGP Provider Service Line as appropriate
- Support the program and encourage patient participation