

Brian Sandoval
Governor



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Acting Administrator
Division of Health Care Financing and
Policy

“One Medicaid for a Healthier Nevada”

2015 Annual Medicaid Conference

Reno/Sparks: Wednesday, October 7, 2015

Las Vegas: Thursday, October 22, 2015



The Changing Face of Nevada
Healthcare
NEW NEVADA



Governor Sandoval's Planning Framework

Vision

Nevada's best days are yet to come

Mission

Create a new promise of opportunity

Values

Action

Collaboration

Courage

Opportunity

Optimism

Pride

Strategic Priorities

Sustainable and Growing Economy

Educated and Healthy Citizenry

Safe and Livable Communities

Efficient and Responsive State Government

Core Functions of Government

Business Development and Services

Education and Workforce Development

Health Services

Human Services

Infrastructure and Communications

Public Safety

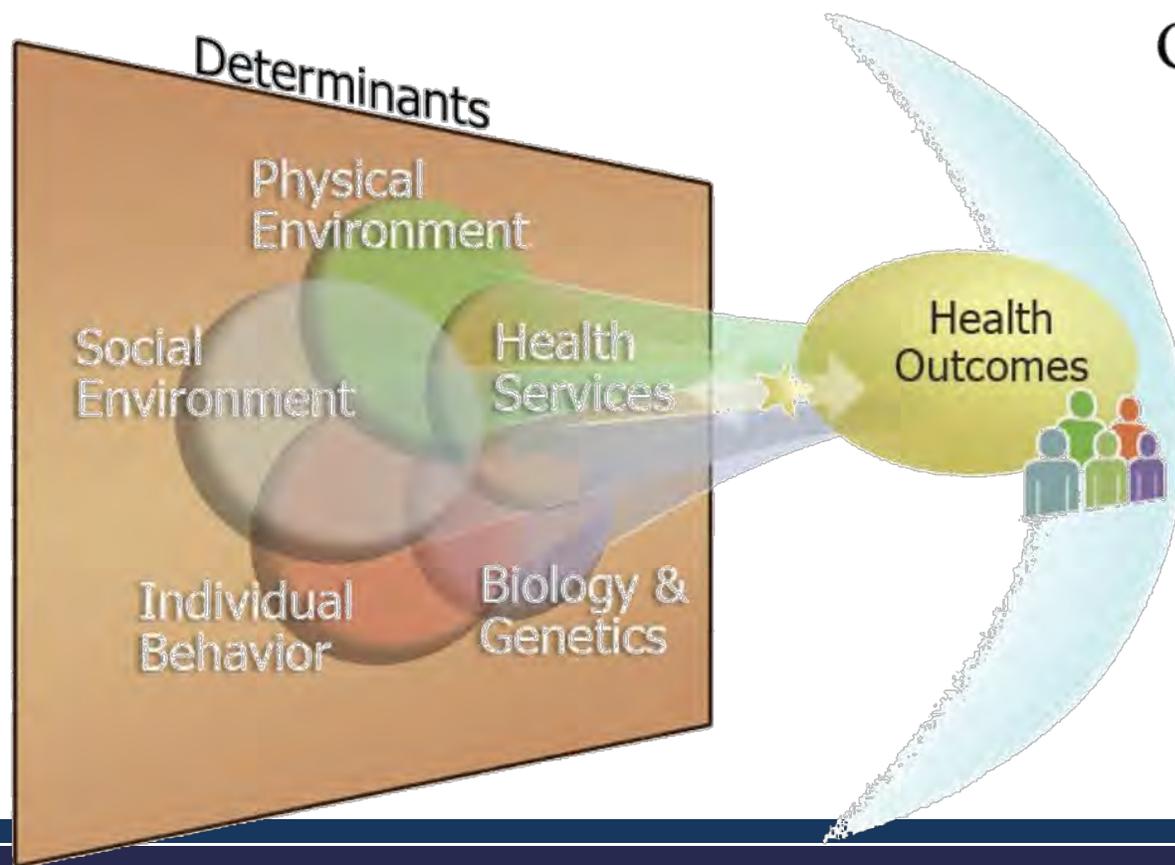
Resource Management

State Support Services



Healthy People 2020

A society in which all people live long, healthy lives

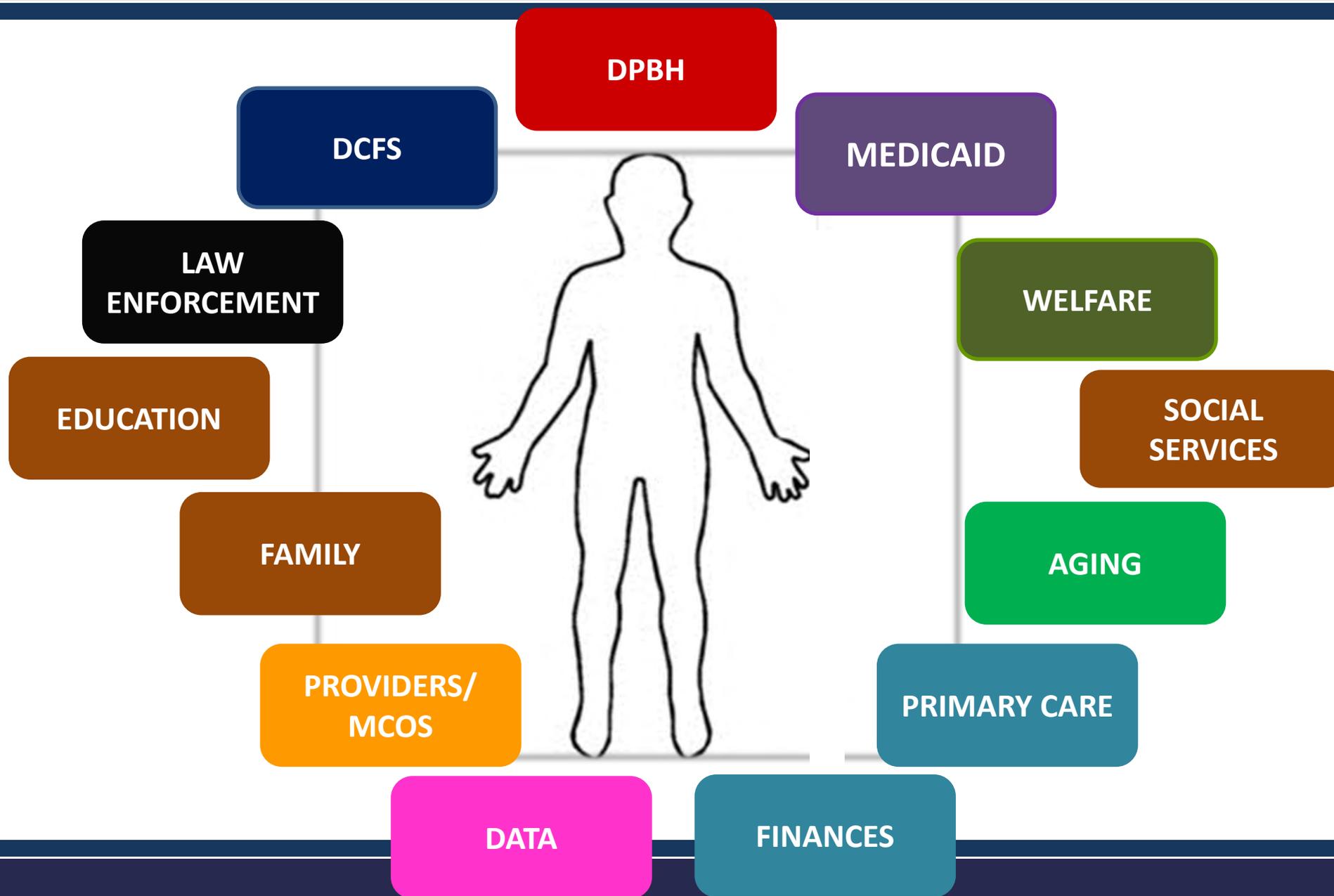


Overarching Goals:

- Attain high quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development and healthy behaviors across all life stages.



CARE COORDINATION





Moving from...
Crisis care

To...
***Prevention and early
intervention***



The Triple Quadruple Aim

1. To improve health care delivery
2. To improve population health
3. To lower costs -- improve efficiencies
4. Patient and provider satisfaction



1. Improving the experience of healthcare

➤ Patient Satisfaction-

- Informing patients of their healthcare determinants (home monitoring)
- Explaining the healthcare system
- Care management/Access
- Advocate, guide, interpret, educate
- Parity
- Cultural competency

➤ Provider satisfaction

- Reimbursement
- Care coordinators
- Provider extenders



2. Improving the health of populations

- Data collections
- Scorecards
- Measurable outcomes with baseline data

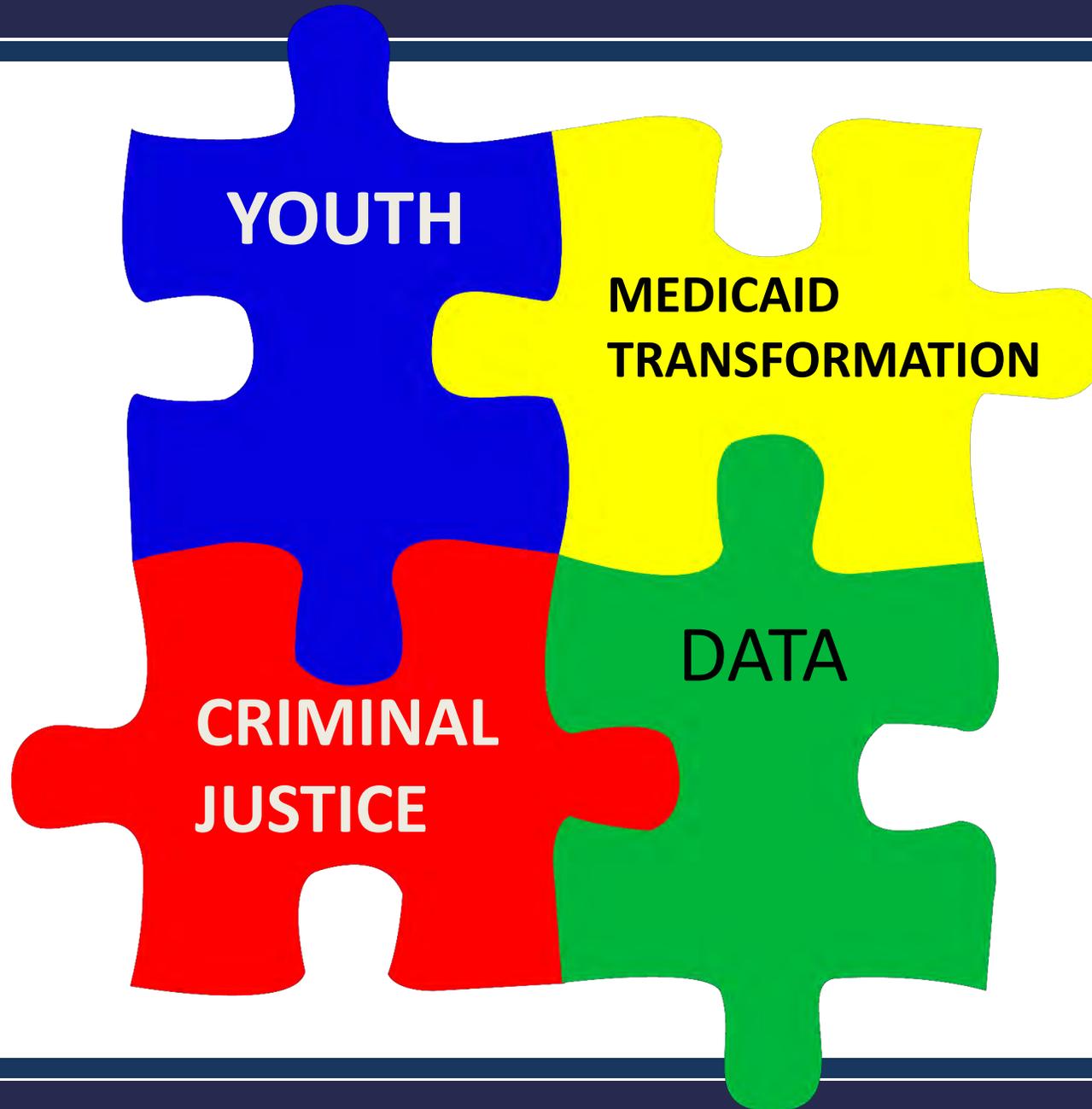
3. Lower cost

- Payment reform
- Maximizing federal dollars
- MCOs, Waivers, Carve outs



4. Improving quality

- Safety
- Effectiveness
- Patient centeredness
- Timeliness
- Efficiency
- Equity







Low Immunization Rates

Nevada and U.S. Average Immunization Rates
4:3:1:3:3:1 Series

Source: National Immunization Survey 2000 to Q2-2009





Children in Nevada... the data

1. Are less likely to be insured when compared to peers in other states.
2. Are less likely to access appropriate preventative care including immunizations.
3. Are more likely to suffer adverse health outcomes.



More data: Children's Behavioral Health in Nevada

- 10% of Nevada youth, ages 12 to 17, suffer an episode of Major Depression over the course of a year
- Nevada has the 6th highest suicide rate in the nation for youth ages 11 to 18
- In Nevada, suicide is the 2nd leading cause of death for 15-19 year olds
- For Nevada high school students, within a 12-month period:
 - 26% feel sad and hopeless enough over a two-week period to affect their usual activity
 - 14% think seriously about suicide
 - 9% attempt suicide
 - 3% make a suicide attempt serious enough that it requires medical attention



YOUTH

- Public and Behavioral Health
 - De-stigmatization- Mandate Behavioral Health Screen
 - Integrated Mental Health and Substance abuse Block Grant
 - Focus on Behaviorally Complex
 - Access/ FFS and MCOs
 - Workforce
 - Prescription Drug
- Child and Family Services
 - Systems of care grant
 - Forensic and Civil Inpatient facilities
 - Child fatalities
 - Increasing EPSDT
 - Mobile Crisis
 - Children's 24 hour assessment centers



YOUTH

- Aging and Disability
 - Early Intervention
 - DD- Inpatient and Outpatient
- Medicaid
 - Primary Care payment increase
 - Increase EPSDT
 - Rising Risk Determinant
 - Patient Centered Medical Home
 - Applied Behavioral Analysis
- Welfare
 - Supplemental Nutrition Assistance Program (SNAP)
 - MEDICAID/Nevada Check Up
 - Child Care
 - Child Support

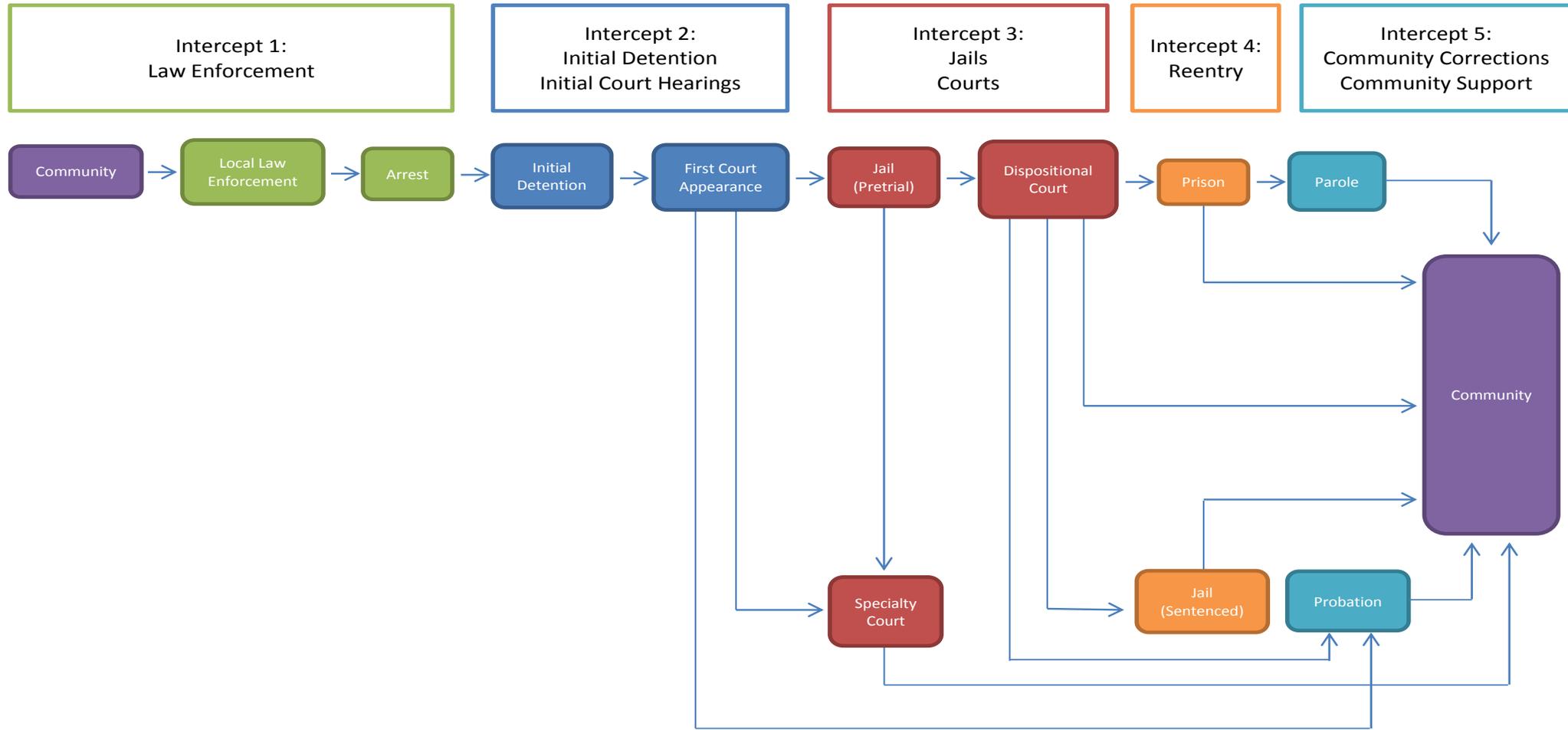


**CRIMINAL
JUSTICE**



People with Mental Illness Involved in the Criminal Justice System

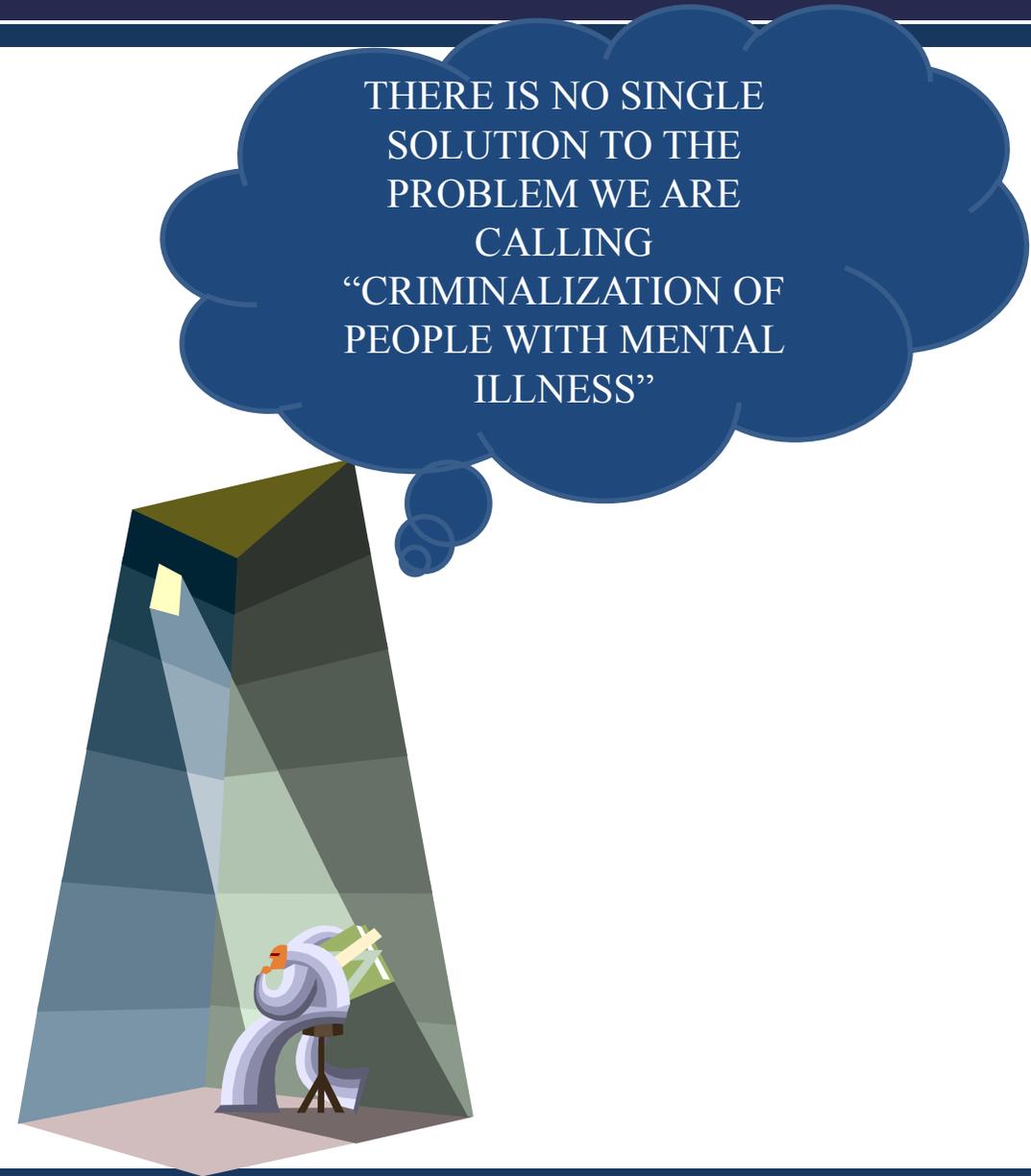
Criminal Justice Intercept Model





Criminal Justice

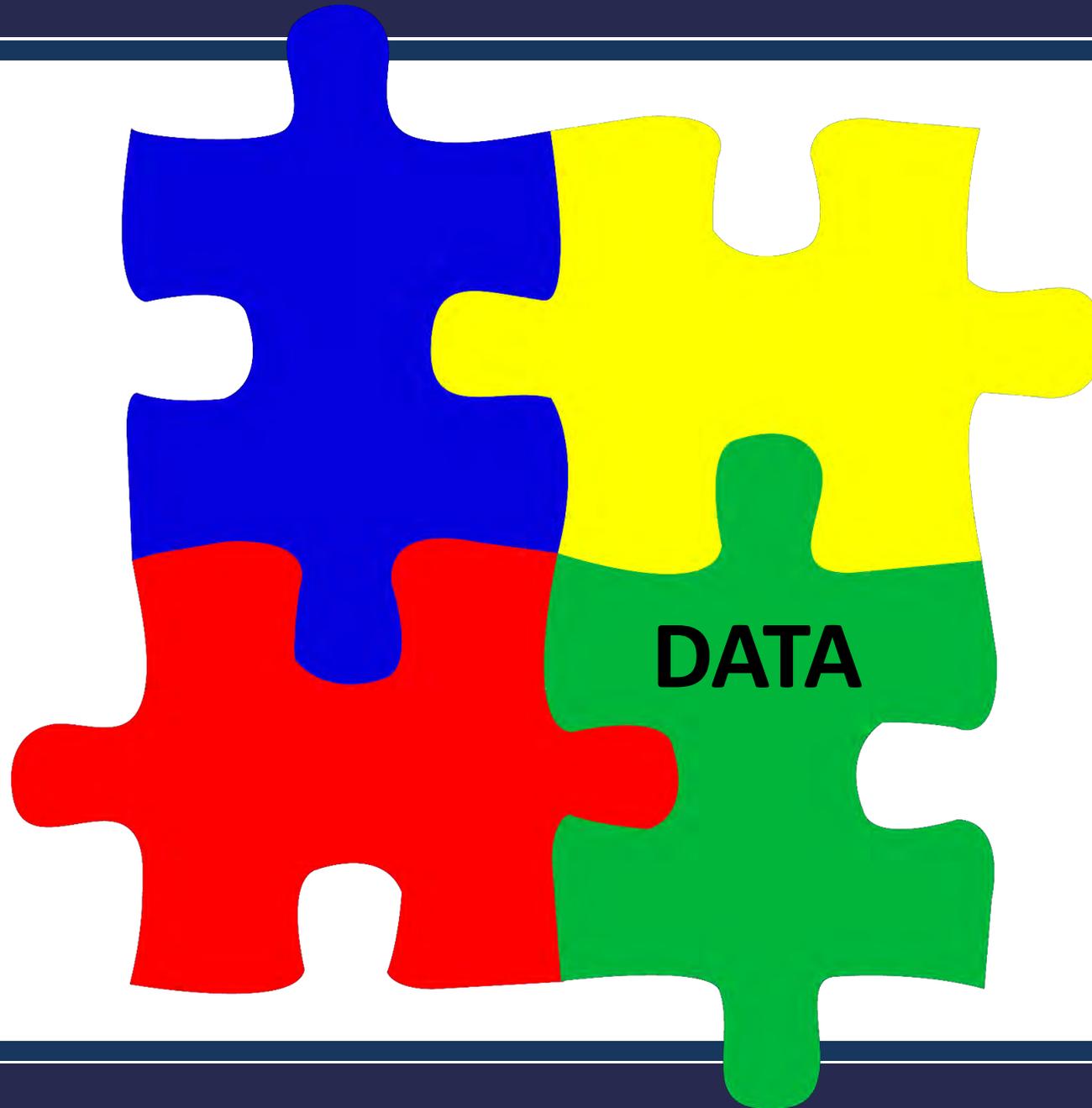
- Public and Behavioral Health
 - Substance abuse and MH Block Grant
 - Community Coordinators
 - Co-Occurring Model
 - MH Support to Community Jails
 - MOST
 - Forensic Hospital/Rawson Neal/Stein
 - Workforce
 - Crisis Centers
 - Behaviorally Complex
 - Legal 2000
- Welfare
 - Continuity of enrollment-rapid re-enrollment
 - Suspension while in jail





Criminal Justice

- Child and Family Services
 - Children's Correctional Facilities/ Summit View, NYTC, Caliente
 - Mobile Crisis
 - Juvenile Justice
 - Child Protective Services (CPS)
- Aging and Disability
 - Sr. Rx and accidental overdose
 - Adult Protective Services
- Medicaid
 - Inpatient 24+ hours
 - Expand prevention/early intervention





What is Data-Based Decision Making?

- The process of compiling, reviewing, sharing and using data to assist in improving health and particularly, targeting change and outcomes.
- Deciding what you want to know and why knowing that information is important.
- It is in simple terms: Collecting, Connecting, Creating and Confirming.



Why is Data-Based Decision Making Important?

- “What gets measured and monitored gets improved.”
- Without it all you have are hunches and opinions.



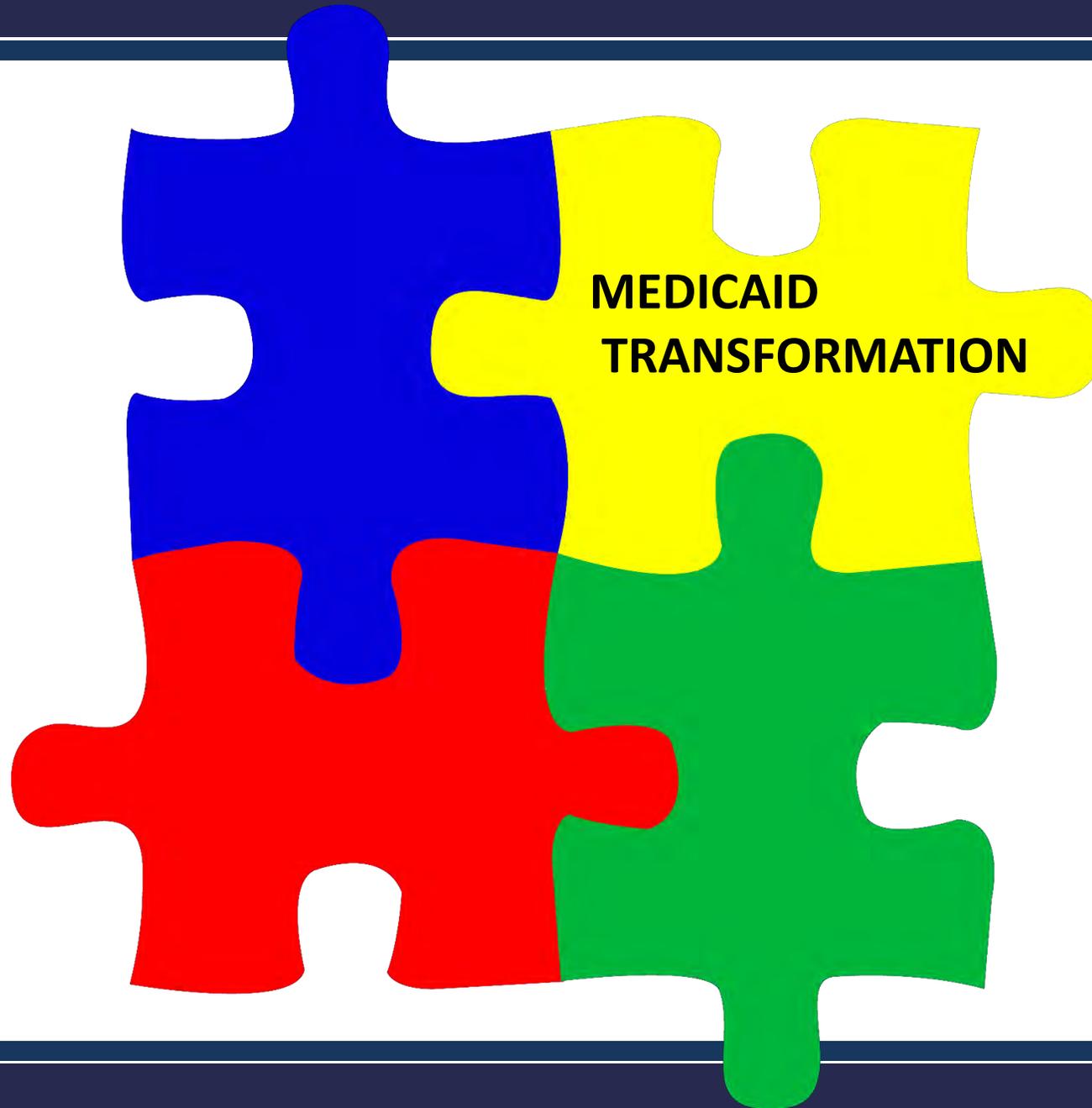
Asking the Right Questions

- Determine what you want to know and what you will do once the answer is determined.
- Determine what data will be needed in order to answer your questions. Assemble a body of evidence.
- Be aware of the different types of data available: Perception, Performance, Demographic and Process.



Data : Collecting, Connecting, Creating and Confirming.

- Public and Behavioral Health
 - Health Information Exchange
 - PDMP/Sr. RX/Claims Data
 - Regulatory
 - Avatar
 - Immunizations
- Child and Family Services
 - State Lab/ Renown Youth Project
 - Avatar
- Aging and Disability
 - Senior and Disability Rx
 - Early Intervention
 - Longitudinal data
- Welfare
 - Caseload
 - Enrollment
 - Demographics & Income
- Medicaid
 - MCO Contract
 - Claims data
 - Accountability Measures

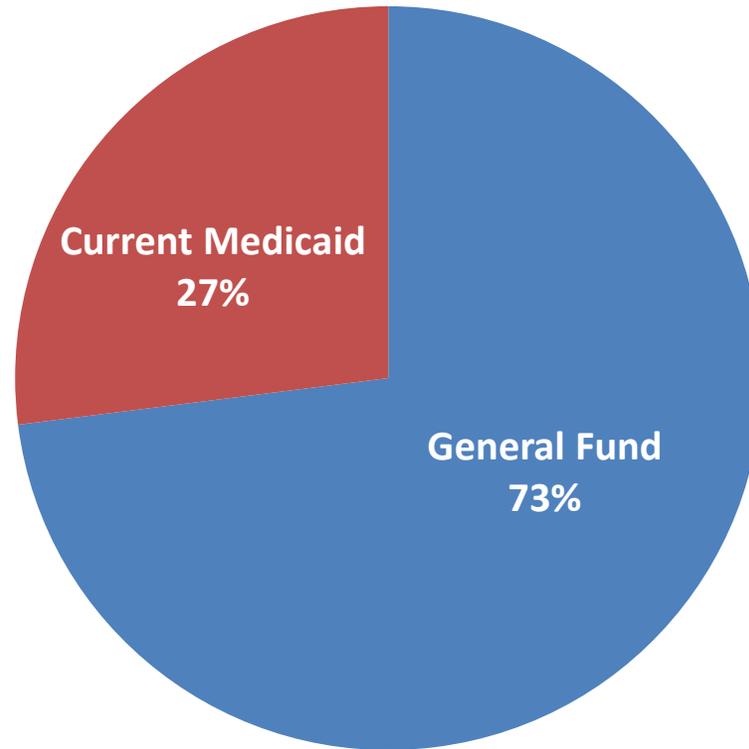


**MEDICAID
TRANSFORMATION**



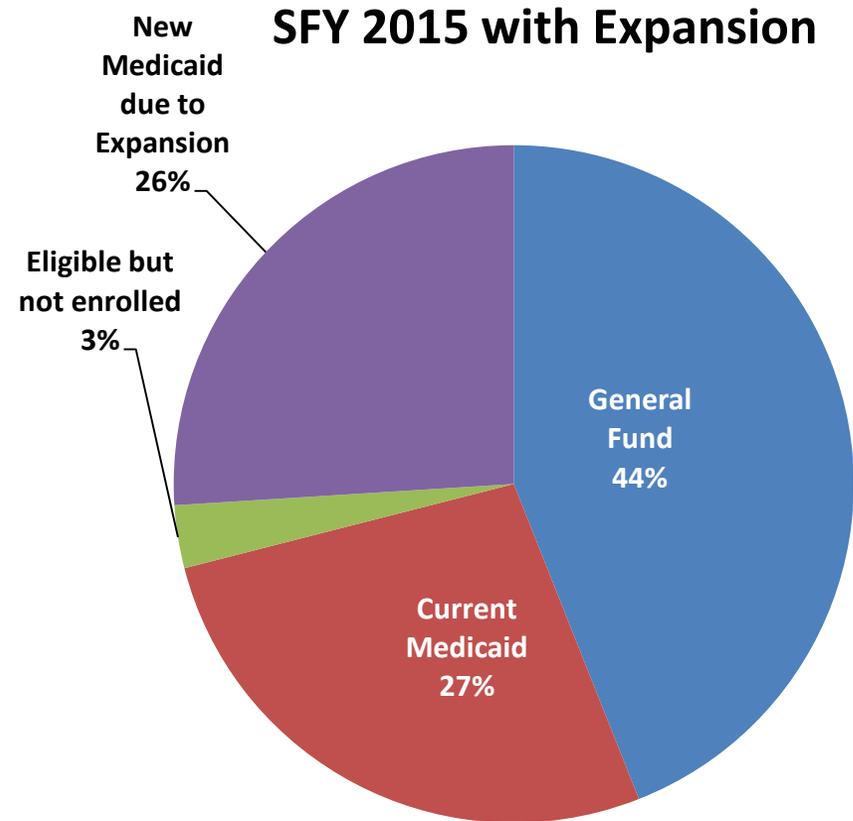
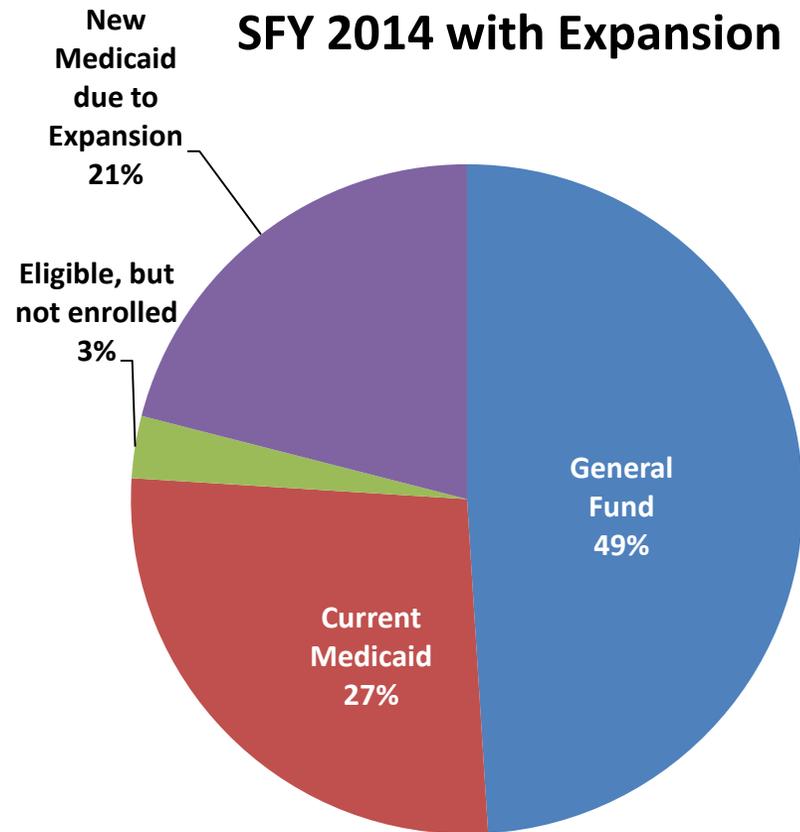
Pre-Affordable Care Act

SFY 2014/2015 before Expansion



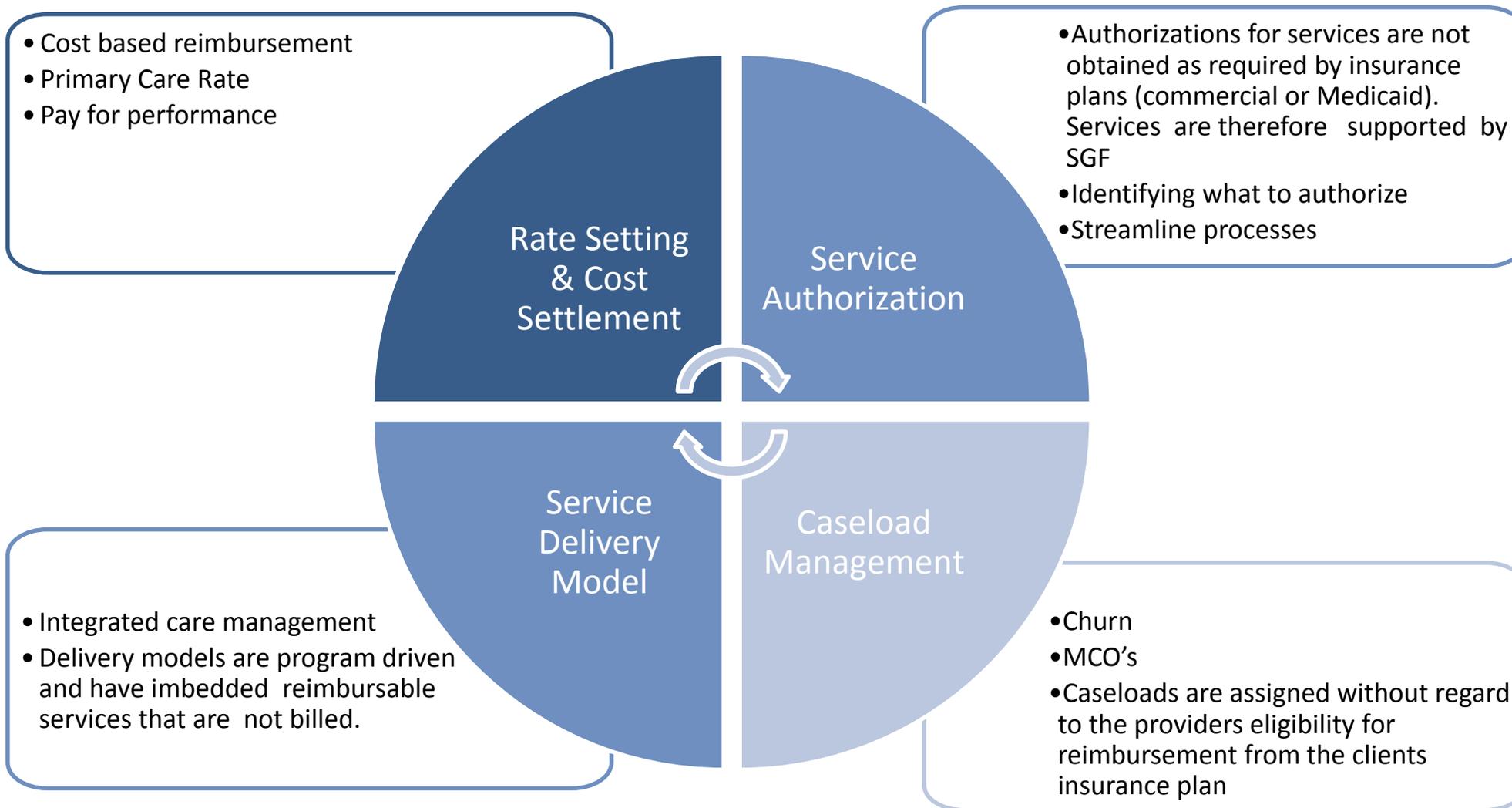


Affordable Care Act





Medicaid





Medicaid

- Provider relations
 - SIM
 - Workforce expansion: CHW, Community Paramedicine, Peers, Autism
 - Care Management Organization
 - Provider support/training
- Payment reform
 - Patient Centered Medical Home
 - CMO/Medical Homes
 - Waivers/Carve Outs
 - MCO Contracting
- Access
 - System integration
 - FQHC's
 - Telehealth
 - MCOs
 - New provider types



If not now, when?

- **Invest** in prevention, care coordination, expanded coverage, HIT, comparative effectiveness research
- **Test** new payment models and incentives
- **Support** community providers and fill gaps
- **Enhance** value-based decision making throughout the health care system to improve quality and outcomes



Your constituents. Our patients.
Let's work together on their health care costs.

The American Medical Association (AMA) and Congress serve the same people and share the same challenge — controlling rising health care costs. That's why the AMA supports investments in disease prevention and wellness programs, comparative effectiveness research, eliminating excessive administrative costs, and value-based decision-making throughout the health care system.

Keeping America healthy means making health care affordable and accessible for everyone. Together we can make that happen.

AMA
AMERICAN
MEDICAL
ASSOCIATION

Helping doctors help patients.





Legislative Updates



Key Legislation

- Assembly Bills
- Senate Bills
- Budget Approved Changes
- Operation Changes
- Program Changes
- Payment Rate Increases
- Delivery Model Changes



Key Legislation

- Assembly Bill 292 – Telehealth
- Assembly Bill 307 – Wraps Services for Children with Disabilities
- Assembly Bill 305 – Community Paramedicine
- Senate Bill 459 – Good Samaritan Overdose
- Senate Bill 489 – Peer Support Agency
- Senate Bill 498 – Community Health Worker



Assembly Bill 292 - Telehealth

- Expansion of Telehealth Coverage.
- Telehealth is defined as the delivery of service from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile or electronic mail.
- Expansion of Origination Site to the location where a patient is receiving telehealth services from a provider of health care located at a distant site.



Assembly Bill 292

- Service must be within a provider's scope of practice under state law and must be clinically appropriate and follow standards of practice.
- Services provided via telehealth have parity with face-to-face health care services. Health care professionals must follow the appropriate Medicaid Services Manual (MSM) policy for the specific service they are providing.



Assembly Bill 307 – Wrap-Around Services

- The DHCFP will work with Division of Aging and Disability Services Division (ADSD) to develop a cost neutral pilot program to provide wrap-around services to permit a child with intellectual disability to remain at home rather than in an institution.



Assembly Bill 305 - Paramedicine

- Endorsement on the permit of an ambulance or fire-fighting service to provide community paramedicine.
- Services provided by EMT, advanced EMT, or paramedic to patients who do not require emergency medical transportation and are provided in a manner that is integrated with the health care and social services resources available in the community.
- Evaluation as potential Medicaid covered service.



Senate Bill 459- Good Samaritan Overdose Act

- An opioid overdose prevention policy for Nevada.
- Medicaid policy update to support the change.



Senate Bill 489- Transition of Peer Support Svcs

- Transition of Peer Support Services to an Agency Model.
- DHCFP will work in conjunction with the Division of Public and Behavioral Health to implement the provider change as the regulations and processes are developed to support the service model.



Senate Bill 498 – Community Health Worker

- Licensure of Community Health Worker Pools.
- Defines Community Health Worker.
- Evaluation as potential Medicaid covered service.



Budget Approved Changes

- Addition of Autism Services – Applied Behavior Analysis.
- The DHCFP final budget includes funding to initiate an applied behavior analysis service package beginning January 2016.
- The DHCFP has worked extensively with stakeholders and CMS to develop this program.
- The policy and rate State Plan Amendments as well as the Medicaid Service Manual policy is at public hearing this month.



Operations Changes

- The operations of the Waiver for Persons with Physical Disabilities transitioned from DHCFP to ADSD, this is an operation agency change and not a program service change.
- This is to integrate all waiver and non-waiver state supported long term community based services into one state agency to support continuity of care and integrated quality systems.



Program Changes

- The Division of Welfare and Supportive Services is working with the DHCFP to expand eligibility for the Children's Health Insurance Program (CHIP), in Nevada called Nevada Check Up (NCU), to state employee's children who otherwise meet the eligibility criteria for NCU.



Payment Rate Increases/Updates

- Approved hospital rate increase (5% in FY16 and 5% in FY17).
- The state continuation of the Health Care Reform primary care physician rate bump to 100% of Medicare expired the end of June. The legislature approved changes in reimbursement to physicians, physician assistants, and certified nurse practitioners. Rates were rebased from a percent of 2002 Medicare rates to a percent of 2014 Medicare rates. Though some billing codes decreased in their rate, the change resulted in an overall rate increase of approximately 10%.



Payment Rate Increases/Updates

- Approved increase for IID waiver services.
- Approved home health nursing rate increase that averages to a 25% increase.



Delivery Model Changes

- The DHCFP, in Conjunction with other Department of Health and Human Services Divisions has been asked to complete an evaluation of the impact and processes that would be necessary to move LTSS into the managed care delivery model.



Break and Visit Vendor Booths

30 Minutes



Nevada's State Innovation Model (SIM)



Introduction to SIM

- The Center for Medicare and Medicaid Services (CMS) approved Nevada's State Innovation Model (SIM) Round Two application to improve population health in Nevada. The State was awarded \$2 million to design a State Innovation Model. The grant period began February 1, 2015 and run for twelve months
- The grant provides financial and technical support to DHCFP for the design of multi-payer health care payment and service delivery models that will accomplish the CMS triple aim of:
 - Strengthening Population Health
 - Improving Patient Experience of Care (Including Quality and Satisfaction)
 - Decreasing Per Capita Health Care Spending



State Innovation Model Design Goals

- Improve access to care
- Redesign the delivery system to align payments where possible to achieve cost savings
- Provide for robust Health Information Technology (HIT) and data infrastructure
- Improve patient experience



Topics

- Key Components of the State Health System Innovation Model (SHSIP)
- Multi-Payer Collaborative Concept
- Stakeholder Engagement Activities
- Youth-Focused Approach
- Upcoming Activities
- Initiatives To Be Leveraged



Key Components of the SHSIP

- Patient-Centered Medical Home (PCMH)
- Medical Health Home for superutilizers
- Paramedicine
- Community Health Workers
- Telemedicine
- Expansion and adoption of statewide Health Information Exchange (HIE) and Health Information Technology (HIT)
- Value-Based Purchasing (VBP)
- Multi-Payer Collaborative (MPC)



Patient Centered Medical Home (PCMH)

- PCMH has been discussed by the workgroups and included for consideration:
 - Use national recognition as the standard
 - Recognize practices committing to national recognition
 - Develop technical assistance capacity to help support practice transformation
 - Tier VBP payments based on level of national recognition



Medical Health Home

- Permissible Populations
 - 2 Chronic conditions
 - 1 Chronic condition and risk of a 2nd
 - Severe Persistent Mental Illness (SPMI)
- Suggestions
 - Begin with SPMI Population
 - Use opportunity to drive integration of physical and behavioral health
 - Add other groups in subsequent phases



Community Paramedicine

- Stakeholder endorsement of inclusion
- Paramedicine
 - Technical Assistance in expanding REMSA/Humboldt General Hospital models
 - Follow up care to patients with high readmission hospitalizations (ex. heart failure)
 - Reimbursement model and funding identification



Community Health Workers

- Stakeholders endorse inclusion
- Primary areas of focus
 - Medicaid expansion population
 - Minorities
 - Hard-to-reach populations
- Identify reimbursement mechanism and funding source



Telemedicine

- Stakeholder endorsement
 - Generally agree patient must be present for the encounter
 - Increase access to presentation sites
 - Concerns about affordability of equipment
- Uses
 - Behavioral health
 - Specialty access



Health Information Technology Plan

- General Plan
 - Rely on attested data from the payers involved
 - Expand claim types and data provided to Center for Health Information Analysis for Nevada (CHIA)
 - Procure analytics tool to sit on top of CHIA data to measure population health
 - Create a public facing dashboard on population health and related data
- Create centralized portals for Provider and Patient Information



Centralized Provider Portal

- Centralizes utilization from payer(s)
- Incorporates Admission/Discharge/Transfer (ADT) data from hospitals
- Creates a snapshot of the patient's health care encounters in a centralized patient profile
- Purpose: To meet providers' request to have more complete information available at point of care. Interim solution until statewide, robust HIE developed



Centralized Patient Portal

- Portable Personal Health Record
- Serves as a resource for lay individuals to research health conditions and how to manage health conditions (patient empowerment)
- Information regarding prevention and healthy behaviors
- Possible customization to send alerts to patients regarding gaps in care (ex. diabetic with no hemoglobin A1c in last 12 months)



Value-Based Purchasing (VBP) Model

- VBP has been discussed by the workgroups as being part of:
 - Patient Centered Medical Home reimbursement
 - Health Home/Superutilizer model
 - Episode-based bundled payments
 - Provider population health management performance
 - Introduction of VBP and Pay for Performance (P4P) concepts in public payer contracts



Multi-Payer Collaborative (MPC) Concept

- MPC

- Brings together payers and employers in the state invested in reaching consensus to develop goals, measures and a provider payment model component through the SIM project
- Goals of the MPC would be:
 1. Provide support on approach to provider practice transformation.
 2. Create a PCMH payment framework.
 3. Develop a standard, but flexible, Value-based purchasing (VBP) approach and support adoption.
 4. Establish pay-for-performance (P4P) improvement goals.
 5. Establish timelines for adoption of PCMH framework.
 6. Agree to established performance measurement parameters for simplified reporting and accountability.



Stakeholder Engagement Activities

- Activities to Date
 - 3 Kickoff meetings
 - 8 Community Meetings
 - 8 Taskforce Meeting
 - 12 Workgroup meetings
 - 3 Stakeholder update webinars
 - Numerous DHCFP presentations and individual stakeholder meetings
- Survey Tool Deployed
 - 93 responses
 - Responses: Survey remains open at:
https://www.surveymonkey.com/s/NV_SIM
- Website Content



Youth-Focused Approach

- Workgroup-Endorsed Areas of Focus
 - Prenatal services/Birth outcomes
 - Well-child visits and immunizations
 - Asthma services
 - Emergency Department utilization
 - Diabetes
 - Childhood obesity
 - Behavioral Health (BH) services
 - Dental care
 - Smoking prevention and cessation



Initiatives to be Leveraged

- Centers for Health Information and Analysis (CHIA) data
- HealthInsight Health Information Exchange (HIE)
- HealthInsight Regional Extension Center (REC) work
- MCO
- Health Care Guidance Program (HCGP)
- Balancing Incentive Payments (BIP)
- Medicaid Incentives for Prevention of Chronic Disease Grant (MIPCD)
- Certified Community Behavioral Health Center Grant (if awarded)
- Million Hearts



Initiatives to be Leveraged

- Project ECHO
- Tobacco Quitline
- Children's Heart Institute Pediatric Obesity Program
- Other Public and Behavioral Health Programs/Offices:
 - Nevada Birth Outcomes Monitoring System (NBOMS); Substance Abuse Prevention and Treatment Agency (SAPTA); Maternal and Child Health (MCH) Program; Obesity Prevention and School Health Program; Oral Health Initiative; CHW Program; Office of Suicide Prevention Diabetes Prevention and Control Program; Public Health and Clinical Services (PHCS)
- Other Initiatives?



Upcoming Activities

- CMS Quarterly Progress Reports
- Drafting components of the SHSIP for state and workgroup/taskforce validation
- Prepare for presentation of Nevada SIM Plan in January 2016.



Contacts

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<http://dhefp.nv.gov/Resources/Rates/SIMMain/>
- Email Address: Rates@dhefp.nv.gov
- Phone Number: 775-684-3156



Division of Welfare and Supportive Services Updates

The mission of the Division of Welfare and Supportive Services is to provide quality, timely and temporary services enabling Nevada families, the disabled, and elderly to achieve their highest levels of self-sufficiency.

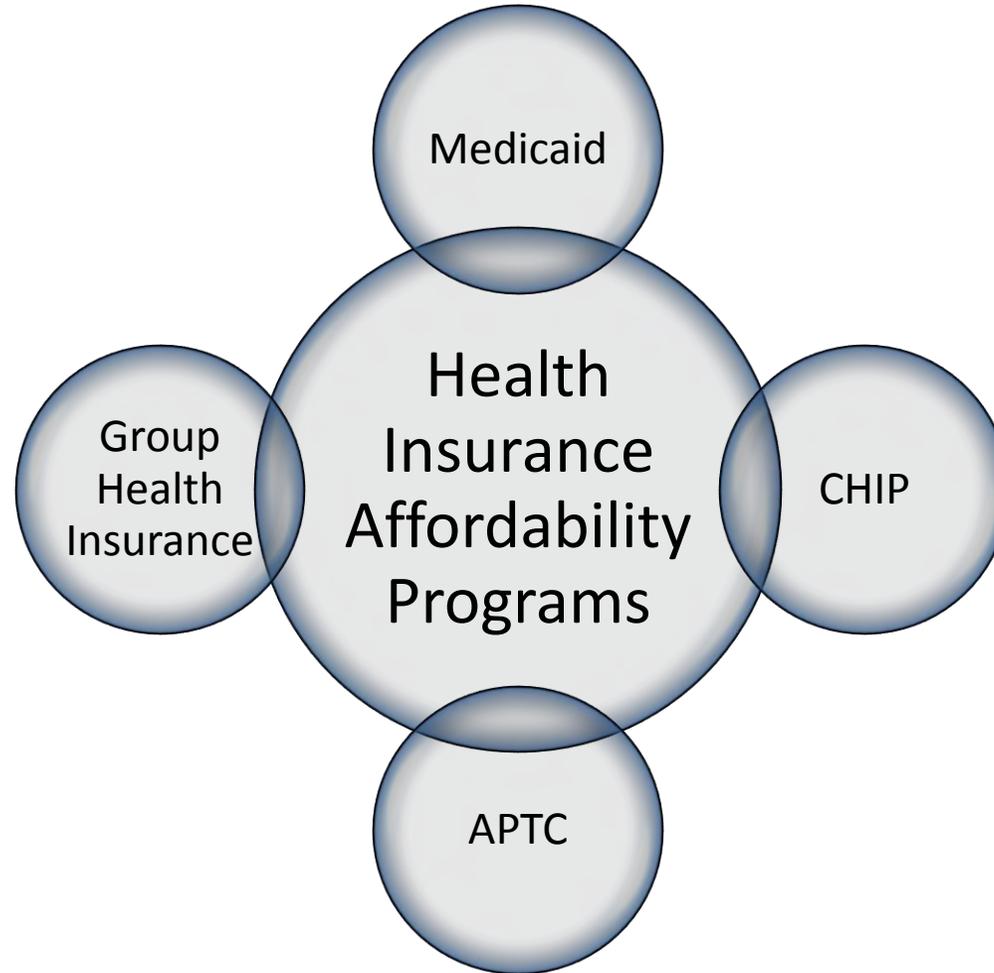


Application/Access

- The ACA expands access to health insurance through improvements in Medicaid, the establishment of Affordable Insurance Exchanges, and coordination between Medicaid, the Children's Health Insurance Program (CHIP), and Exchanges.
- The alignment of the methods for determining eligibility is one part of an overall system established by the Affordable Care Act that allows for prompt eligibility determinations and allows for prompt enrollment of individuals in the “insurance affordability program” for which they qualify. Insurance affordability programs include Medicaid, CHIP, advance payments of premium tax credits and cost-sharing reductions through the Exchange.



Single Application





Presumptive Eligibility

- Qualified Entity
 - Hospital (Provider type 11)
 - Critical Access Hospital (Provider type 75)
- Qualified Employees
 - Academy certified
 - FBI background check



Presumptive Eligibility

- Requirements
 - Only one presumptive period allowed within 2 calendar years
 - Entity must assist 90% of presumptively eligible persons submit formal application for Medicaid
 - State requires 94% accuracy rate on presumptive determinations
 - Must notify DWSS of determination within 5 days
 - Entity cannot use Third Party Contractors for eligibility determinations
- Eligibility
 - Begins the day the presumptive eligibility determination is made
 - From date of eligibility determination through end of next month



Safety Net Programs - Nevada's Needy Populations

- SNAP – to supplement food and nutrition needs and authorize children for school lunch program
- TANF – to provide for items not covered by other programs – for example toiletries, toothpaste, clothes, school supplies.
- Employment and Training (NEON) employment focused program to assist parents in overcoming barriers to gaining long term and stable employment. Includes possible education, domestic violence, daycare, transportation, life skills, and mental health barriers.

- Medicaid/Nevada Check-up – to provide medical support to our lowest income households and includes coverage for:
 - Pregnant Women
 - Children
 - Disabled
 - Elderly
 - Parent and Relative Caretakers
 - Institutional
- Other support programs offered:
 - Child care
 - Energy Assistance Program
 - And Child Support Enforcement



Click In - Come In - Call In

- Individuals applying for assistance are provided service options via:
 - Access Nevada – the DWSS online application system
 - Mail/Fax in applications
 - Call Center (CCT) – includes Automated Voice Response system for routine queries
 - Visit one of the local area offices
- SNAP Outreach partners also accept applications at local food banks and community sites



Customer Service Improvements

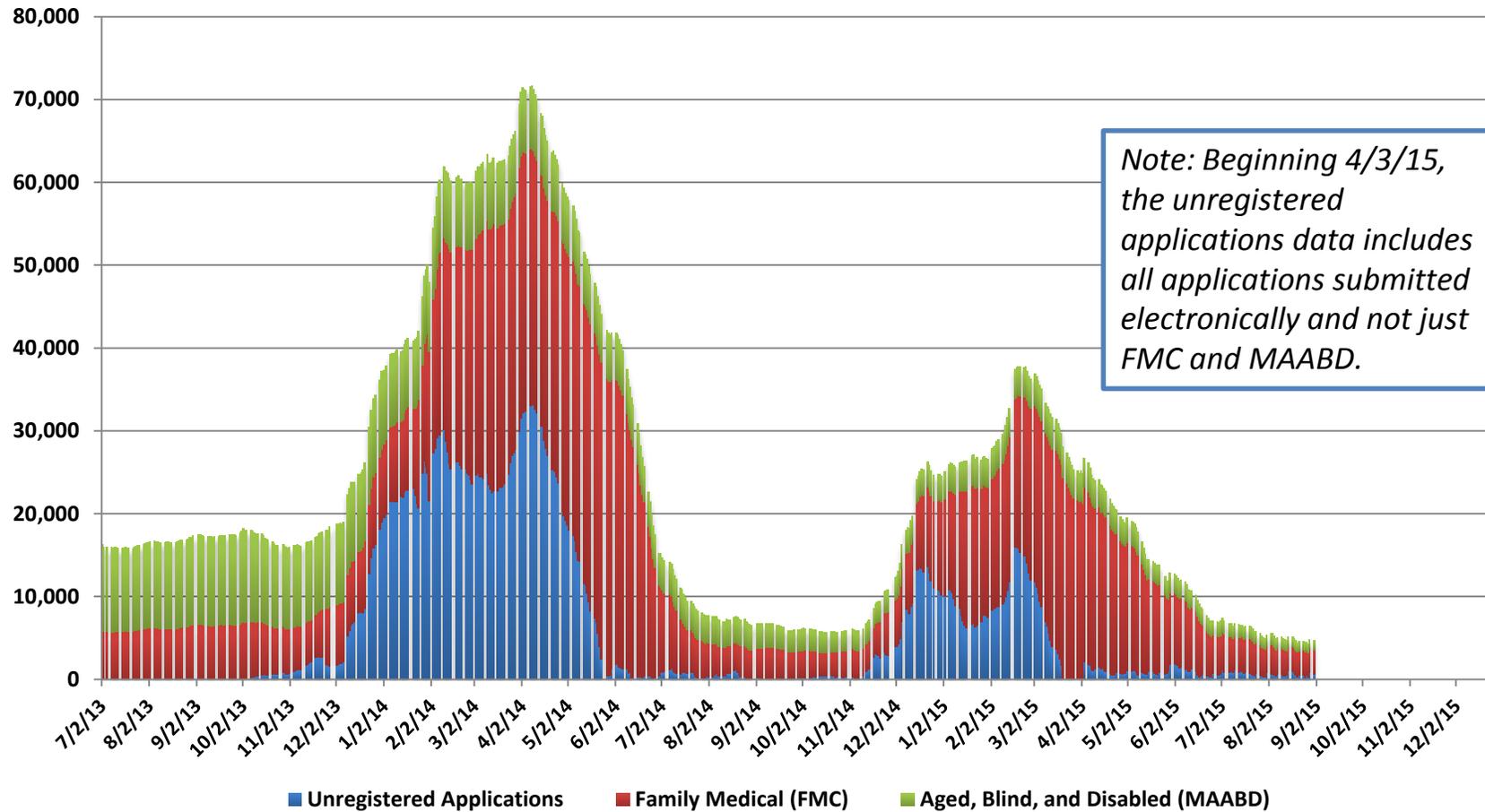
	Average Call Time FSS	Average Call Time AA	Average Call Wait Time FSS	Average Call Wait Time AA	Longest Wait Time FSS	Longest Wait Time AA	Total Number of Calls Rcvd	Total Dropped Calls
Apr-14	N/A	0:05:03		0:23:40		1:01:28	36,814	35,544
May-14	N/A	0:04:45		0:27:20		1:15:07	29,748	29,767
Dec-14	0:06:59	0:03:40	0:01:27	0:01:23	0:07:41	0:10:48	52,775	3,622
Jan-15	0:08:12	0:03:56	0:00:38	0:03:26	0:10:22	0:27:28	71,742	5,720
Feb-15	0:08:53	0:03:46	0:00:57	0:03:06	0:10:39	0:29:48	59,152	5,237
Mar-15	0:07:16	0:03:54	0:00:47	0:03:40	0:10:29	0:23:22	54,995	3,271
Apr-15	0:08:34	0:03:39	0:02:21	0:02:59	0:13:48	0:23:34	57,136	1,663
May-15	0:08:30	0:03:47	0:02:02	0:02:41	0:14:51	0:20:40	61,722	2,775
Jun-15	0:08:41	0:03:53	0:01:33	0:02:16	0:13:19	0:22:47	45,087	1,798
Jul-15	0:08:33	0:03:53	0:01:15	0:02:30	0:11:18	0:18:52	60,110	3,916
15-Aug	0:08:09	0:03:52	0:02:31	0:01:19	0:14:40	0:19:09	51,840	1,574

Call center improvements include increasing staffing and scope of work.

- Less than 10 minute wait
- Transfer less then 50% of the time
- Process at first touch

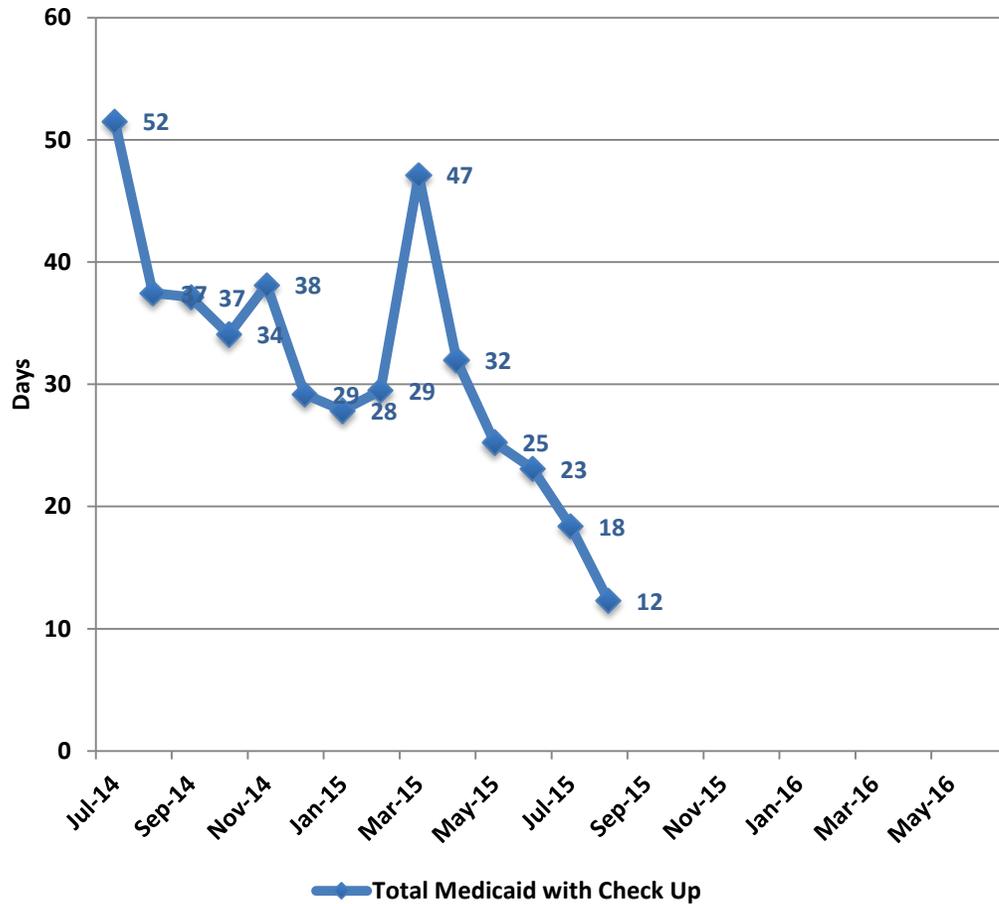


Pending Applications





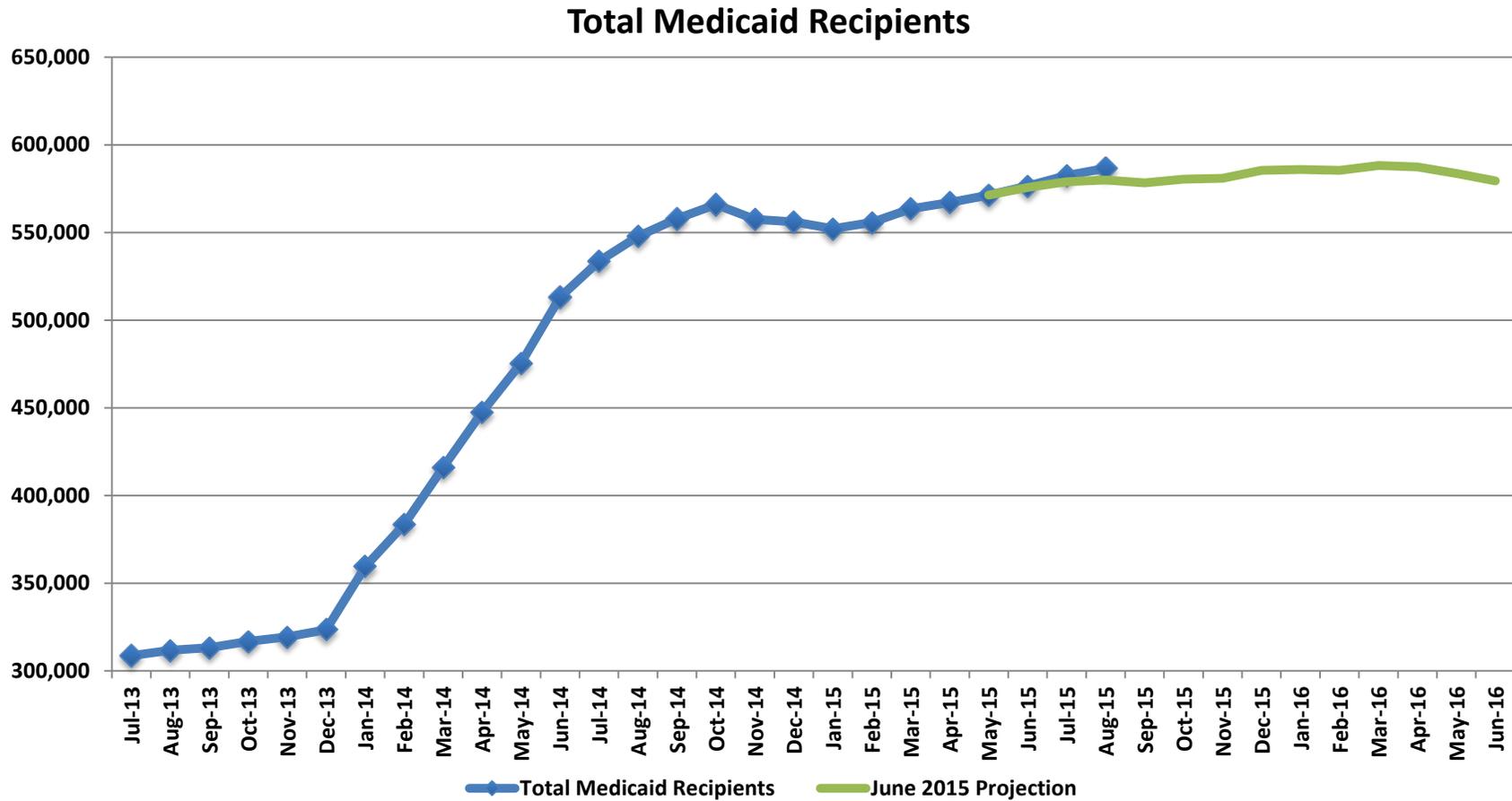
Average Processing Times (Days)



Month	Total Medicaid with Check Up	FMC	MAABD Institutional	MAABD Non-Institutional
Jul-14	52	32	77	57
Aug-14	37	20	33	51
Sep-14	37	17	45	47
Oct-14	34	19	33	41
Nov-14	38	18	163	61
Dec-14	29	20	67	40
Jan-15	28	23	32	35
Feb-15	29	21	27	38
Mar-15	47	28	55	70
Apr-15	32	29	23	34
May-15	25	21	184	25
Jun-15	23	18	86	47
Jul-15	18	11	86	49
Aug-15	12	8	53	28

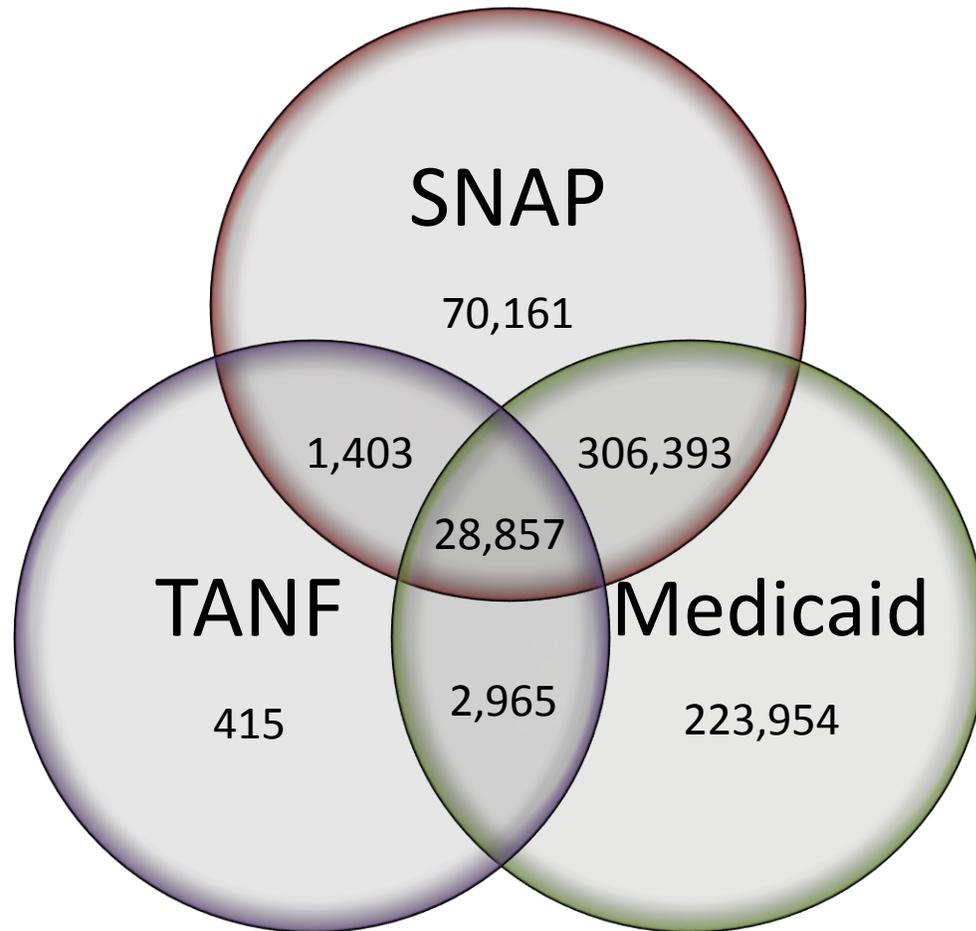


Caseload Growth





Recipients by Program



Program	Recipients
TANF	33,640
Medicaid	562,169
SNAP	406,814

Note: November 2014 data is used in the diagram. 634,148 unique individuals are in at least one of the three programs.



Populations Served

- DWSS provides vital support programs for Nevadan's:
 - Children
 - Pregnant Women
 - Nursing home/Institutional coverage
 - Homeless
 - Temporarily Disabled
 - Permanently Disabled
 - Unemployed
 - Children in the custody of a Public Agency
 - Working Poor
 - Elderly and Retired



Population Health Approach

DHHS Interoperability Alliance for Unified Health Strategy our the common populations:

Breaking out of the silos:

- Public Health agencies
- Behavior health
- Social services
- Health Delivery Systems
- Share data
- Social Determinants of poor health
- Groups of individuals
- Geographical Areas
- Type of health services

Innovative prevention:

- Telephone prompts
- Home visits
- Promoting community or public health
- Nutrition education
- Swimming lessons



The future: Challenging, Creative, and Collective Client Centered Focus.



Medicaid Partner Introductions

Hewlett Packard



Provider Relations Team

Provider Relations Manager

- Marissa Fernandez

Provider Representatives

- Ismael Lopez-Ferratt
- Jassamine Haughton
- Jennifer Shaffer
- Kim Teixeira



Provider Web Portal



The screenshot shows the top section of a web portal. On the left is the Nevada state seal. To its right is the text "Nevada Department of Health and Human Services" and "Division of Health Care Financing and Policy Provider Portal". In the center is a photograph of a diverse group of healthcare professionals. On the right are links for "Transition Info" and "Site Map". Below the header is a notification for "Preferred Drug List Announcements" with a "Review" link. A dark blue navigation bar contains buttons for "Home", "Providers", "EVS", "Pharmacy", "Prior Authorization", "Quick Links", and "Contact Us". A light blue secondary navigation bar lists various services: "Announcements/Newsletters", "Billing Information", "Electronic Claims/EDI", "E-Prescribing", "Forms", "NDC", "Provider Enrollment", and "Provider Training".



Provider Web Portal



Nevada Department of Health and Human Services
Division of Health Care Financing and Policy Provider Portal

[Contact Us](#) | [Login](#)



Home

Home

Provider Login 

***User ID**

Log In

[Forgot User ID?](#)
[Register Now](#)
[Where do I enter my password?](#)

What can you do in the Provider Portal

Through this secure and easy to use internet portal, healthcare providers can inquire on the status of their claims and payments, inquire on a patient's eligibility, process prior authorization requests and access Remittance Advices. In addition, healthcare providers can use this site for further access to contact information for services provided under the Nevada Medicaid program.



Protect Your Privacy!
Always log off and close all of your browser windows

Resources
[Authorization Criteria](#)
[Search Fee Schedule](#)

Looking for a provider near you?
[Search Providers](#)

Website Requirements
Prior Authorization Quick Reference Guide [[Review](#)]
Provider Web Portal Quick Reference Guide [[Review](#)]



Claims and Payments Through August 2015

- 7,472,842 Electronic claims received
- 612,789 Paper claims received
- Total claim payments: \$902,603,499.05



New and On the Horizon

- ICD-10 implemented on 10/1/2015
- Third quarter newsletter published on 10/19/2015
- 2016 Provider Training Calendar coming soon



Hewlett Packard Enterprise



**Hewlett Packard
Enterprise**





Nevada Medicaid Conference

The Amerigroup Family



Amerigroup Innovations



- IHD
- Bedside Delivery
- Patient 360

Translation Services



- 24 hours a day
- 7 days a week
- Over 170 languages

Questions?

Please contact:

Amerigroup Community Care
9133 W. Russell Rd
Las Vegas, NV 89148

Amerigroup Provider Services: 1-800-454-3730
Member services: 1-800-600-4441

www.amerigroup.com/providers

Thank you for partnering with



Amerigroup
RealSolutions[®]
in healthcare



Health Plan of Nevada Inc.

SmartChoice and Nevada Checkup 2015



HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

New Prior Authorization Guidelines

New Prior Authorization Guidelines for Health Plan of Nevada (Eff. 8/2015)

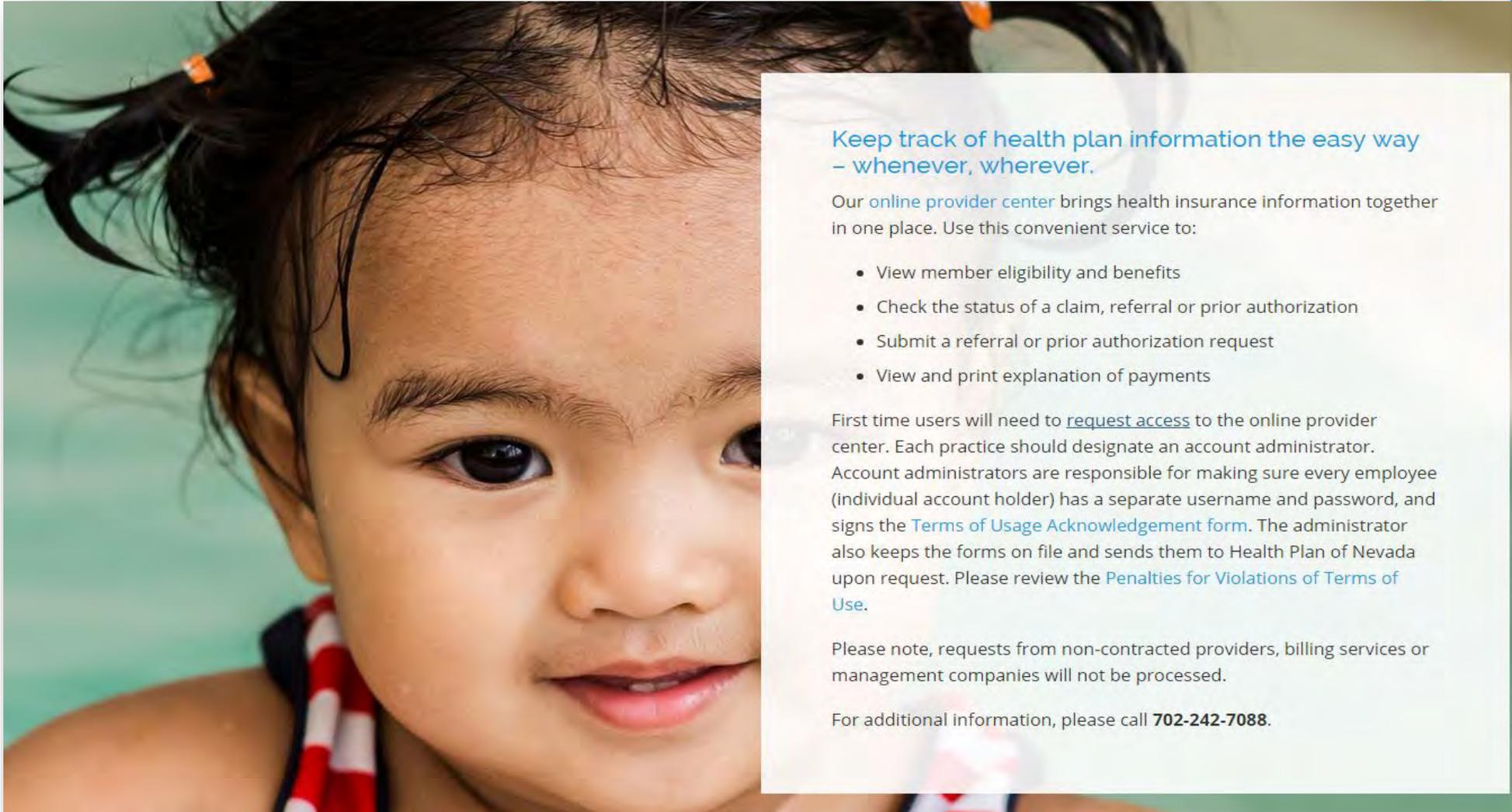
- ***Prior Authorization Will No Longer Be Required***
 - Must meet both criteria:
 1. Professional services provided in an office setting (place of service 11)
 2. Billed charges less than \$750 (per line item)
- APPLIES TO: (In-Network Providers only)
 - ✓ SmartChoice
 - ✓ Nevada Check Up

If you have any questions regarding this notification, please contact your Provider Advocate or Provider Services at **(702) 242-7088 or (800) 745-7065**

Online Provider Center

The screenshot displays the 'Online Provider Center' website. At the top left is the '@YOURSERVICESM' logo. To the right are logos for 'HEALTH PLAN OF NEVADA' and 'SIERRA HEALTH AND LIFE', both noted as 'A UnitedHealthcare Company'. A navigation bar contains links for 'Contact Us', 'News', 'Help', and 'Login'. The main content area is divided into two primary sections: 'Log In' and 'Information Center'. The 'Log In' section includes a form with 'User Name' and 'Password' fields, a 'Log In' button, and links for 'Create an Account', 'Forgot Your Password', 'Need Help? Read our FAQ', and 'Forgot Your Username'. The 'Information Center' section features 'News Headlines' with a date 'Jan 01' and a headline about 'Stat Prior Authorization case submission only available M-F 7-4 PST', and 'Related Links' such as 'Health Plan of Nevada', 'Senior Dimensions', 'Sierra Health and Life', 'Southwest Medical Associates', and 'Behavioral Healthcare Options'. Below the 'Log In' section is a 'First Time Visitor?' section with text about finding missing benefit information and a link to 'Take tour of the site!'. On the right side of the page, there is a photograph of a man in a white shirt and blue tie looking at his smartphone. At the bottom right, the 'HEALTH PLAN OF NEVADA' logo is repeated.

Online Provider Center



Keep track of health plan information the easy way
– whenever, wherever.

Our [online provider center](#) brings health insurance information together in one place. Use this convenient service to:

- View member eligibility and benefits
- Check the status of a claim, referral or prior authorization
- Submit a referral or prior authorization request
- View and print explanation of payments

First time users will need to [request access](#) to the online provider center. Each practice should designate an account administrator. Account administrators are responsible for making sure every employee (individual account holder) has a separate username and password, and signs the [Terms of Usage Acknowledgement form](#). The administrator also keeps the forms on file and sends them to Health Plan of Nevada upon request. Please review the [Penalties for Violations of Terms of Use](#).

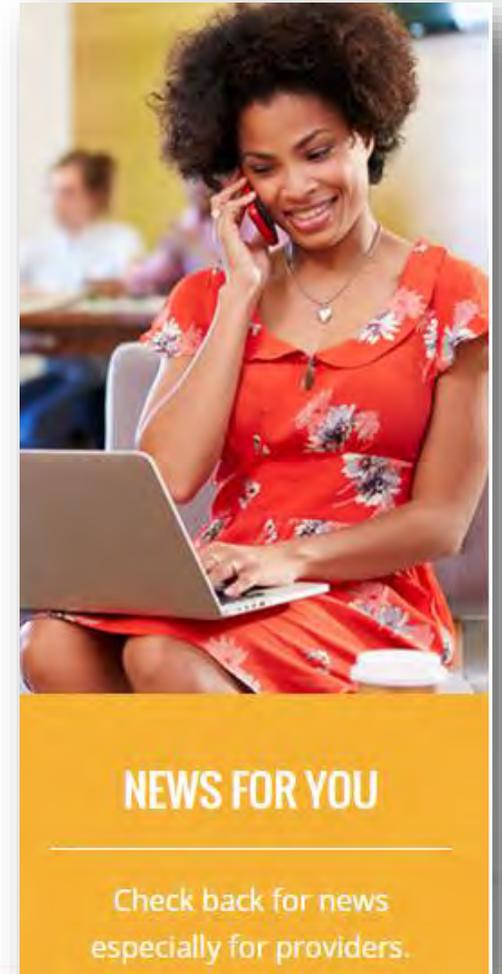
Please note, requests from non-contracted providers, billing services or management companies will not be processed.

For additional information, please call **702-242-7088**.

Provider News

<http://www.myhpnmedicaid.com/Provider.htm>

- Review the latest policy changes
- Examples of Updates:
 - Changes to Preferred Drug List
 - Prior Authorizations
 - Benefits
 - ...to name a few. 😊
- Simply click on the topic to view the document.
- We encourage you to visit the website often, to see what's new.



YOUR BABY SLEEPS SAFEST

A Alone
B on the back
C in the crib.

Now you know the ABCs of safe sleep!



GOT A CRIB?

You may qualify for a free portable crib.

Together with the Cribs for Kids® program, Health Plan of Nevada is working to provide Graco® Pack'n Play® portable cribs to those who qualify.*

Who Qualifies?

Are you pregnant?

Are you a Health Plan of Nevada Medicaid member?

If you can answer yes to both questions, congratulations you may be eligible!



Here's how to join:

1. Call Health Plan of Nevada at **1-800-486-1092**, Monday through Friday, 8 a.m. to 6 p.m. local time.
2. Complete the recommended number of prenatal care visits during your pregnancy (*Your number of visits will be discussed during the call.***)
3. After your baby is born, call Health Plan of Nevada at **1-800-486-1092** to get your Graco® Pack'n Play® crib within three business days.



Color and style may vary



Why is safe sleep important?

More than 4,000 sudden and unexpected baby deaths happen each year. Studies show up to 90 percent of these deaths happen because the baby is placed to sleep in an unsafe way. **THESE DEATHS ARE PREVENTABLE.**

The safest way for your baby to sleep is alone, on the back, and in a safety-approved crib without pillows, bumper pads, stuffed animals, or comforters.

**Even if you have a crib you can still qualify, call us for details and available options.*

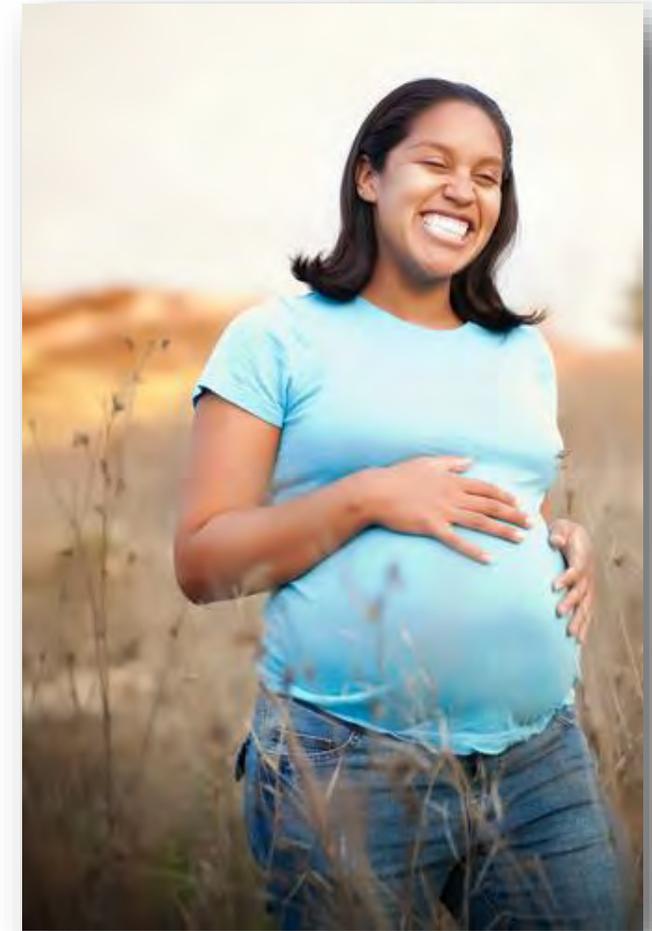
***This information is a guideline only. Please follow your doctor's advice on the number of prenatal visits you need.*

Post Partum Incentive

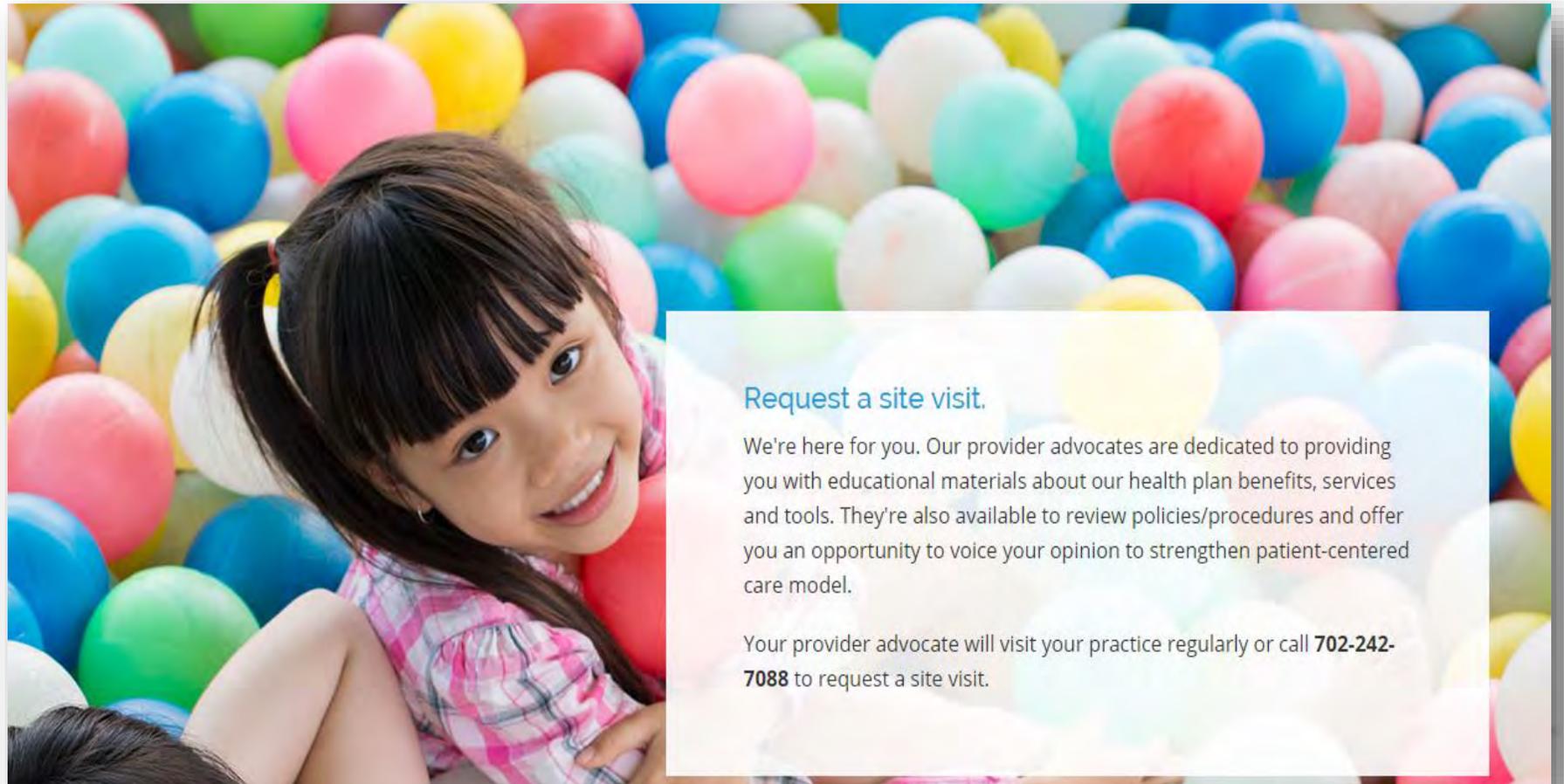
Health Plan of Nevada (HPN) is offering a bonus payment to our providers for each post-partum visit completed for our Medicaid members, who are your patients.

The bonus payments will be paid in the first quarter of each year for post-partum visits completed the prior year.

Please contact your Provider Advocate for details on this exciting incentive!



Need Help?
Contact Your Advocate or Request a Site Visit!
Provider Relations 702-242-7088



Request a site visit.

We're here for you. Our provider advocates are dedicated to providing you with educational materials about our health plan benefits, services and tools. They're also available to review policies/procedures and offer you an opportunity to voice your opinion to strengthen patient-centered care model.

Your provider advocate will visit your practice regularly or call **702-242-7088** to request a site visit.



Health Care Guidance Program



Supporting Providers Serving Qualified,
“Fee For Service”, Medicaid Patients

Presented by:

Cheri Glockner, Executive Director,

Cheri.glockner@axispointhealth.com



What is the Health Care Guidance Program (HCGP):

- Nevada's Care Management Organization working with Fee-for Service Medicaid Recipients around the State.
- Funded by CMS demonstration waiver for up to 5 years
- Program goals: Improve Quality, Improve Health Outcomes, Improve Patient Satisfaction, Improve value/reduce avoidable costs
- AxisPoint Health (formerly McKesson) contracted to provide services



**Toll Free Number:
1-855-606-7875**



Who is Eligible to Participate

The Health Care Guidance Program Serves...

Geographic Distribution of HCGP Enrollment:

- South 62%
- North 27%
- Rural 12%

Total NV Medicaid
Enrollment 574,302
(100%)*

Medicaid Fee for
Service Enrollment
179,437 (31%)



HCGP Enrollees with
qualifying conditions
capped at 41,500 (7%)

*As of Jan 2015

Participation is mandatory



Qualifying Conditions Among Enrollees

- Cerebrovascular disease, epilepsy
- Diabetes mellitus
- ESRD, chronic kidney disease
- CAD
- Asthma, COPD, chronic bronchitis
- HIV/AIDS
- Mental health disorders
- Musculoskeletal system diseases
- Neoplasm/tumor
- Obesity
- Pregnancy
- Substance use disorder
- Complex high cost conditions

Excluded Populations:

- Dual-Eligibles
- Adoption assistance, foster care
- Home and Community Based service Waivers (Section 1915c)
- Targeted Case Management (TCM) recipients
- MCO enrollees
- Nevada Check-Up enrollees (CHIP)
- Emergency Medicaid
- Long-Term Care/SNF residents



Core Program Components

The Health Care Guidance Program Provides...

Enrollee Services

- Mailed materials, surveys, enrollee handbook
- Face to Face interaction
- Real time Referrals
- Health Education and Coaching
- 24x7 Nurse Advice Line Support
- Engaged in one of 8 Care Management Programs
- Online Health Resources
- Assistance securing transportation, making appointments, etc.

Provider Services

- Link Enrollee to Provider
- Navigation assistance
- 24/7 Nurse Advice Line to support providers
- Provider Outreach
- Provider Portal
- Provider Profiling
- Practice improvement support through Clinical Care Alerts and Gaps in Care information
- Clinical Guideline Info
- Decrease readmissions

Administrative Services

- Population Profiling
- Enrollment and Disenrollment
- Medical records
- Quality Assurance
- Grievances
- Technical Infrastructure
- Reporting



Program Delivery Model





Program Supports Clinical Effectiveness

- Local leadership team
- Geographically distributed staff
- Familiar with medical and community resources
- Includes MDs, RNs, LCSW, and community health workers
- Nurse advice line available 24/7
- Engages recipients and providers
- Improves follow up visit compliance
- Supports medications and care plan adherence



Checking Eligibility in Eligibility Verification System (EVS)

Eligibility - Windows Internet Explorer
https://www.medicaid.nv.gov/hcp/provider/VerifyEligibility/tabid/548/Default.aspx?35=Y&07=Y&53=ms23sv55oukpwg55ks5vul558s19=0EG5tJnqO6m0yLCypyEuerbFBt

Eligibility Tuesday 10/28/2014 08:26 AM PST

Delegate for MCKESSON HEALTH SOLUTIONS A DIVISION OF **Role IDs** Provider - In Network - 1457779787 **Location** 995 - 11000 WESTMOOR CIR STE 125, WESTMINSTER, CO, 800212724

Eligibility Verification Request

* Indicates a required field.
Enter the recipient information. If Recipient ID is not known, enter SSN and Birth Date or Last Name, First Name and Birth Date. Please verify response below as not all information is currently used during search.

Recipient ID **Last Name** **First Name**
SSN **Birth Date**
*** Effective From** 10/28/2014 **Effective To** 10/28/2014

Service Type Code Search

Service Type Code 30-Health Benefit Plan Coverage

Submit **Reset**

Eligibility Verification Information for ALEC BACA from 10/28/2014 to 10/28/2014

Coverage	Effective Date	End Date	Primary Care Provider
MEDICAID FFS	10/28/2014	11/30/2014	0000000000
CMO CAREMGMT	10/28/2014	11/30/2014	0000000000

[Other Insurance Detail Information](#)



Real Time Referral Process



**Health Care
Guidance Program**
Coordinating with you for better care!

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: M F 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: _____

NEV_RTR_0615



Communication & Contact

- **Toll free number: 1-855-606-7875**
 - Option #1 for members
 - Option #2 for providers
- **Secure fax number: 1-800-542-8074**
 - Real Time Referral Form (download at NV Medicaid/DHCFP website under Care Management Organization & 1115 Waiver tab)
 - Include clinical information or updates as appropriate
- **Provider portal:**
 - www.nv.guidance.vitalplatform.com/providerportal/nev
 - Call 1-855-606-7875, option #5 to confirm log in details
 - Access program resources and information on your enrolled patients



Policy Updates from the Division of Health Care Financing and Policy



ICD10 2015

- Effective October 1, 2015 ICD10 implementation
- There is no dual processing of ICD9 & ICD10
- Centers for Medicare and Medicaid Services (CMS) website for training resources <https://www.cms.gov/Medicare/Coding/ICD10/index.html>
- CMS 1500 claims and Pharmacy based upon date of service
- Institutional claims which date span over October 1, 2015 implementation date are based upon date of discharge



Applied Behavioral Analysis

- Proposed effective date January 1, 2016
- Public hearing tentatively scheduled for October 2015
- Based upon CMS guidance for Behavioral Intervention coverage under EPSDT.
- Policy based upon Behavior Certification Board, Center for Disease Control and Prevention, and the American Academy of Pediatrics.
- Provider qualifications based upon National Certification and State Licensure requirements.
- ABA is to compliment existing state plan services such as screening, assessment, physical therapy, speech therapy, occupational therapy and behavioral health services.



EPSDT Healthy Kids Policy

- Early- Child's health is assessed as early as possible in the child's life, in order to prevent or find potential diseases and disabilities in their early stages when they are most effectively treated.
- Periodic- based upon national periodicity schedules for vision, hearing, immunization, and dental services.
- Screening- designed to evaluate the general physical and mental health, growth, developmental and nutritional status of infants, children and adolescents.



EPSDT Healthy Kids Policy

- Diagnostic- Any condition discovered during a screening should be followed up for a diagnosis.
- Treatment- Health care treatment is available to correct or improve defects and physical and mental illnesses or conditions by Healthy Kids screening and diagnostic services. Includes all medically necessary services, regardless of state plan coverage.



EPSDT Healthy Kids Policy

- Covers children under the age of 21
- Reimburse Primary Care Providers (including extenders)
- Components of an EPSDT exam include:
 - Comprehensive history
 - Unclothed physical exam (vision, hearing, dental)
 - Developmental/behavioral assessment
 - Appropriate immunizations/lab
 - Health education (anticipatory guidance)



Behaviorally Complex Care Program

- Established with the intention of providing care in Nevada
- Supports facilities to care for individuals with medically-based behavior disorders resulting in the Medicaid recipient posing a danger to self and/or others
- The rate is tiered to accommodate a range of behaviors



Behaviorally Complex Care Program

- What is Considered Behaviorally Complex?
 - Injures Self
 - Physical/Physical Aggression
 - Regressive/Sexual Behaviors
 - Brain Injury and Related Conditions
- Includes Individualized Treatment Plan
- Various Approaches (not all inclusive)
 - Staff Training
 - Sensory Stimulation
 - Behavior Management
 - Cognitive/Emotion Oriented Therapy
 - Environmental Modification
 - Clinically-Oriented Therapy



Community Based Providers

- New Home and Community Based Services (HCBS) Regulations as of March 2014
- Intended to:
 - Maximize opportunities for individuals to access the benefits of community living
 - Ensure recipients receive services in the most integrated settings
 - Promote Person Centered Planning
 - Provide individuals opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources



Long Term Support Services No Wrong Door/Single Entry Point

- Nevada 211 as the 1-800#
- NWD Website in development within DHCFP
- All Health and Human Services locations are NWD/SEP locations:
 - The BIP team has visited all DHHS and ADRC locations throughout the state in July and August 2015 to socialize, get feedback and gain support of the Nevada NWD methodology and concept
- Formal roll-out and training to all locations and personnel to begin October 2015



Program Integrity



What Is Program Integrity?

Safeguarding the Medicaid program through the detection and prevention of provider and recipient fraud, waste and abuse.

- a. CMS mandated
- b. Protects program and taxpayer's money

The DHCFP utilizes both the Provider Support Unit and the Surveillance & Utilization Review Unit (SUR) to oversee Medicaid program integrity activities.

GOAL: Right Recipient/Right Service/Right Provider/Right Amount of Time/Right Amount of Money



What Is Fraud, Waste & Abuse?

Fraud - intentional misrepresentation

Submitting false claims; billing but not providing goods or services; Medicaid sanctioned in another state.

Waste - services provided unnecessarily

Ordering a deluxe power Wheelchair when only a manual one needed; ordering/billing for unnecessary tests, equipment or supplies.

Abuse - billing inappropriately for services

Unbundled services billed as all-inclusive; billing for duplicate services.

Improper Payments - simple errors

Using incorrect codes or modifiers; billing using wrong unit/time increments.



Program Integrity Activities – Provider Support

- Provider Enrollment - First step in preventing fraud, waste or abuse. Enhanced screening measures to ensure only qualified individuals and organizations are enrolled.
- Contract Suspensions, Terminations & Denials – Medicare, Medicaid or CHIP criminal conviction in the past 10 years OR terminated after January 1, 2011 in another state.
- MSM Chapter 100 Policy Development/Maintenance – Provider rules, requirements and conditions of participation. All Medicaid providers responsible to read, follow and be familiar with this chapter.
- Affordable Care Act (ACA) Initiatives
 1. Provider screenings – screened according to risk level.
 2. Assigned risk levels – based on provider type (high, moderate, limited).
 3. On-Site Visits – CMS requires pre-enrollment and post-enrollment on-site visits for high and moderate risk providers. State may conduct unannounced site visits during enrollment/revalidation.
 4. Revalidation – states must revalidate the enrollment of providers at least every five years.



SUR Unit – Program Integrity Activities

- Conducts Improper Billing Education – Primary goal is to educate providers on how to appropriately bill services.
- Waste/Abuse Discovery & Overpayment Recovery – Identification, prevention and recovery of overpayments. Identified overpayments must be recovered per CMS.
- Pharmacy Lock-in Program – Used when patterns of recipient abuse/misuse of controlled substances identified. Locked into one pharmacy for all controlled substances.
- Recovery Audit Contractor (RAC) and Medicaid Integrity Contractor (MIC) Collaboration – State contracted RAC vendor identifies and recovers overpayments. CMS assigned MIC identifies overpayments and SUR recovers.
- Suspected provider and recipient fraud referrals made to the Medicaid Fraud and Control Unit (MFCU); DWSS; and medical, dental and pharmacy boards as appropriate.



What's New?

- ACA mandated all enrolled Medicaid providers revalidate and/or update all enrollment information currently on file. Revalidation was known as re-enrollment.
- Durable Medical Equipment Suppliers (Prosthetics, Orthopedics, Supplies) must be revalidated every 3 years.
- All other providers must be revalidated every 5 years – includes all FFS and MCO providers.
- HPES notifies providers on revalidation timeframes - current revalidation project started in June 2012 and ended in June 2015. **Non-revalidated providers have a grace period until March 25, 2016.**
- Re-enrollment – a term used for a provider previously enrolled in NV Medicaid, was terminated or deactivated for any reason and is now eligible to re-enroll as a provider in the Medicaid program,
- Revalidation – a term used for active providers who need to revalidate their current information to extend their current NV Medicaid agreement.



Ordering, Prescribing and Referring Project

- Another ACA initiative recently rolled out by NV Medicaid.
- Eligible physicians/practitioners who order, prescribe or refer for NV Medicaid recipients must be enrolled in Medicaid even if they don't submit claims.
- If submitting claims – must be fully enrolled.
- If ordering, prescribing or referring only – must be OPR enrolled.
- **Note:** The OPR's NPI is required on the servicing provider's claims.

Consequences: If a provider uses a OPR that isn't enrolled as a NV Medicaid OPR, then the servicing provider's claims won't be paid.



Web Based On-line Enrollment – Three Phase Project

- Phase I projected to roll out within the next few months.
- Web based system that allows providers to enter their information and secure access to their application data.
- Geared to improve the overall provider enrollment experience.
- Benefits of the system are accurate and legible applications as well as complete applications prior to submission.
- Prompts to attach all required documentation with application.
- Pre-populates with provider data.
- Can update existing information and make necessary changes as needed.
- Improves, streamlines and expedites the provider enrollment process.



Managed Care Encounter Data – New Initiative

- What is encounter data? Health care service records for which an MCO pays. Traditionally SUR has focused on FFS providers as have had access to claims and payment information. SUR is now receiving MCO encounter data.
- Why do we use it? To measure and monitor rates of care, service utilization, program trends and quality.
- Encounter data is equivalent to paid claims for Fee-For-Service (FFS) providers. HP processes and pays FFS claims and SUR is able to run reports to identify areas of concern. Likewise, the MCOs process and pay their own claims referred to as encounters and currently complete their own program integrity activities.
- Importance of Encounter Data: SUR will now be able to look at both FFS and MCO claim data and be able to run reports for areas of concern. MCOs will still process and pay their own claims and complete their own program integrity activities.



What is the SUR Role With Encounter Data?

Why should you, as a Medicaid Provider, care about encounter data?

- You may be providing services to FFS recipients and/or be credentialed by one or both of the MCOs and providing services to their recipients.
- You may have three different payers for the services you provide.
- SUR will now be able to look at both FFS and MCO claims as a combined dataset.
- SUR will now be able to identify problem areas across all three payer sources (FFS, Amerigroup, and HPN).
- SUR will now be able to leverage the strengths of each plan as well as identify weaknesses in any of the payment methodologies.



What Changes Can you Expect?

When you are subject to a Program Integrity review in the future, SUR will look at all services for which you have been paid, and may select a sample which includes FFS claims and MCO encounters under both MCO plans.

- The goal will be more coordination between SUR and MCO program integrity to minimize any unnecessary inconvenience to you, our valued provider.



Thank you for attending.

Division of Health Care Financing and Policy