Healthy Connections

Primary Care For Idaho Medicaid Participants
Today’s Topics

❖ Coordinated Care Agreement & Re-contracting
  ❖ Fixed Enrollment
  ❖ Referral Policy Overview
  ❖ No Referral - Urgent Care
  ❖ Compliance Process
    ❖ Roster Changes
    ❖ MMCP/IMP
    ❖ HC Value Care
❖ Provider Performance Data
  ❖ Contact Information
HC Coordinated Care Agreement (CCA)

- HC will start re-contracting with updated CCA, later 2019
- Strengthening policy requirements & compliance on timely access to care, provider dismissals, member dis-enrollments, and provider maintenance (upkeeping demographics, renderings, etc.)
- 24/7 after hour coverage
  - HC expectations for 24/7 compliance are a member can reach an on call medical professional (MD, DO, NP, PA & RN or Nurse Hotline)
New Healthy Connections
Fixed Enrollment Process

❖ Annual Fixed Enrollment
  ❖ Aligns with the PCMH model of care in supporting long-term patient/provider relationships

❖ The key components:
  ❖ Enrollment to a new HC Service Location initiates a 90-day grace period to change PCP
  ❖ Thereafter- change allowed only during Annual Enrollment Period
  ❖ Members allowed to change PCP, outside of annual enrollment period, under special circumstances
  ❖ Providers only allowed to dis-enroll members as allowed per federal rules

❖ Enrollments will be effective the date the enrollment is approved
Fixed Enrollment

- Who can request a change in enrollment?
  - Member, HOH, Guardian, etc.
  - PCPs can only submit a request for change with a completed and signed enrollment form by member or an authorized representative.
- Some changes may require documentation from the member to be verified by the Department.
  - Special Circumstances
  - Closed panel clinics – clinics will need to authorize enrollment.
Fixed Enrollment

- When will changes in enrollment be effective?
  - All change requests must be approved by Healthy Connections staff based on change criteria and submitted documentation by member.
  - All changes in enrollment will be effective the date the enrollment is approved.

- IMPORTANT- ALWAYS VERIFY ELIGIBILITY AND OBTAIN A REFERRAL IF NOT THE PCP OF RECORD
  - Immediate processing to change a member’s enrollment will no longer be automatic as change requests may require research by the HC staff.
  - Submission of a change request is no guarantee of approval.
Fixed Enrollment & Auto Assigns

- If clinic accepts Auto Assignments (AA), member has not established care AND requesting referral to specialist, it is recommended to provide “one time” referral to ensure access to care.
  - Failure to provide one time referral may inhibit access to care.
    - To allow for continuity of care with specialist until care can be established with PCP.
  - Refer to roster to determine if member was a mandatory assignment.
  - HC Providers accepting AA have been receiving ongoing HC Case Management and are responsible to provide referrals for timely access to care per Coordinated Care Agreement.
Referral policy reminders

❖ Importance of checking members Medicaid Eligibility

❖ Services that do not require a Healthy Connections referral can be found in the provider handbook.

❖ Complete list of services can be found under section 2.5.4.5 Services not requiring an HC PCP Referral

❖ HC referrals can be provided by any of the following methods (Provider Handbook 2.5.4.3, Method of Referral):

❖ Electronic referral - Online via DXC Technology portal (preferred method)

❖ HC clinic Electronic Medical Record (EMR)

❖ Paper referral

❖ Verbal - PCP & Specialist to document verbal referral

❖ Admit Order (from PCP)
Referral policy reminders

- Appropriate follow up communication for services referred by a PCP are critical for effective care coordination and patient safety
  - General Provider and Participant Information- 2.5.4.1 General Guidelines
- Recommend referrals for members not established be furnished by PCP promptly and without compromise to quality of care and access to care
  - HC Coordinated Care Provider Agreement, Obligations of Provider (Section 2.1)
- Diagnose & Treat referrals can be passed on to another provider to treat the original condition
  - To include all core requirements
Referral Submissions
Urgent care- no referrals

- Effective July 1, 2019 Healthy Connection referrals will no longer be required for members to access Urgent Care centers.
- Urgent Care centers fill the gap between emergency rooms and primary care clinics by offering walk-in care and extended hours.
- Urgent Care centers can supplement a PCPs health care services by:
  - Accepting overflow volume when the practice is at capacity
  - Providing walk-in coverage when the Primary Care practice is closed
  - Providing services not typically offered at the Primary Care practice, such as x-rays, lab testing, and medical procedures such as suturing and casting
  - Referring patients with chronic illnesses to the Primary Care provider
Urgent Care Centers

❖ The following parameters must be met to be considered an Urgent Care center with no Healthy Connections referral required:

❖ Evaluate and treat a broad spectrum of illness and injury
❖ Walk-in appointments are the primary scheduling model
❖ Posted hours of operation include: Open at least 1-hr daily outside the standard 8am-5pm weekdays & open a minimum 4-hours on weekends
❖ Primary healthcare delivery model is Urgent Care (not Primary Care)
❖ Clearly be identified as an Urgent Care center both physically and in marketing material
In addition, Urgent Care centers are required to:

- Communicate the visit summary directly to the patient’s HC PCP within three (3) days of the visit. At a minimum, this shall include:
  - Facts & Findings
  - Prescriptions and/or DME ordered
  - Other pertinent healthcare information
- Direct the patient to their HC PCP
  - For ongoing treatment or coordination of chronic/complex conditions
  - When secondary or specialty care is needed
  - For those seeking wellness services
- Educate patients when urgent care is appropriate
Compliance Process

- 24/7 coverage - Access to a medical professional for medical questions and/or referrals
- Provider Maintenance - must keep provider record current & notify DXC of any changes in their record, within 30 days of the date of change, including but not limited to:
  - The addition or removal of any providers
  - Address changes
  - Hours of operation for the primary care clinic
  - Clinic closures
- Referral compliance - Failure to communicate findings with the PCP may result in services considered non-covered and subject to recoupment. (provider handbook- General Guidelines 2.5.4.1 Medicaid Providers Receiving Referrals)
TIER III AND IV COMPLIANCE

- Quality Improvement and Quality Assurance efforts maintain forward progress
- No QA changes to Tier I & II clinics
- Tier III clinics
  - Complete the Healthy Connections PCMH Tracker bi-annually until recognized
  - Mirrors the NCQA recognition process
- Tier IV clinics
  - Bi-annual reporting on current PDSAs falling under one of the eight change concepts of PCMH
  - Selected by organization, based upon their own directives and priorities
Roster Changes

❖ **Dynamic Roster** - New fields added to the *exportable* online PCP roster
  ❖ Phone Number
  ❖ Address
  ❖ City
  ❖ State
  ❖ Zip
  ❖ Head of Household
  ❖ Enrollment Indicator (Mandatory or Voluntary)

❖ **Payment Roster** - Report has been modified to serve as the HC Case Management Payment report. Specific member demographic information has been removed & can now be found on the HC dynamic online PCP roster (exportable listing).

❖ To view changes, follow the directions in the *Trading Partner Account (TPA) User Guide*
Once enrolled with MMCP or IMP – members are dis-enrolled from HC
PCPs no longer responsible for HC referrals and will not receive a HC PMPM
Disenrollment from HC does not change Medicaid eligibility and benefits
More questions?
- Contact MMCP/IMP program or Blue Cross/Molina Healthcare
Healthy Connections Value Care Payment Reform

**Medicaid Fee For Service Payment Model Today**
- Current fee-for-service system pays providers when they do more - but there is little connections to quality and cost effectiveness
- Current payment model not sustainable - last year's Medicaid budget exceeded $2.4 billion and next year's is forecast to exceed $2.5 billion

**PAYMENT REFORM - Transition to Healthy Connections Value Care**
- HCVC is a value and risk based reimbursement model with a yearend settlement payment based on financial and quality performance
- Goal - Work together under a provider/led collaborative model to improve quality and control costs
Healthy Connections
Value Care Reform

❖ PAYMENT REFORM-Two Models

❖ Accountable Primary Care Organizations: Primary-care clinic providers who improve total cost of care and quality performance for their attributed Medicaid patients can earn shared savings, or are held accountable for a level of risk.

❖ Accountable Hospital Care Organizations: An integrated network of providers that includes an acute care hospital serving large numbers of Medicaid patients who improve total cost of care and quality performance can earn a portion of shared savings, or are held accountable for a level of risk.

❖ HCVC Program under development
Healthy Connections is implementing a Physician Performance Assessment (PPA) Portal designed to:

- Assist HC providers to move toward value based care by providing critical quality and cost data
- Displays cost and quality data for national measures based on HC provider claims
- Important for providers to keep DXC Provider Maintenance updated with organization information to receive accurate data on portal

Intend to launch in the near future

For providers interested in participating in HCVC Program, Quality and Cost data reports will be available through HC Representative in the future
## Contact Information

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