Volunteer State Health Plan's BlueCare East & West Grand Regions Transitional Workshop

- *Disclosure Information*
- *Southeastrans, Inc.*
- *BlueCare/ValueOptions*
- *Emergency Room Over Utilization*

Disclosure of Ownership and Control Interest Statement Requirements

Federal Regulations require monitoring of payments of Medicaid funds to providers.

Presented by

Valeigh Osborne and Melissa Isbell

Why does BCBST/VSHP need disclosure information?

- Patient Safety – ensuring no one debarred from Medicare/Medicaid is providing care to our members or dealing with federal monies.
- Limit payment to fraudulent providers.
- Federal Regulations* and Contractor Risk Agreement with MCOs** require disclosure.
- GOAL: Ensure non-criminal or non-debarred individuals are working with BCBST/VSHP membership.

*Centers for Medicare & Medicaid Services (CMS)

**Managed Care Organizations

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Who is required to complete a disclosure statement?

- **ALL** network practitioners who provide care to BCBST/VSHP members (credentialed or non-credentialed)
- **ALL** groups of practitioners sharing square footage. If they share space or employees, the group must complete disclosure statement.
- **ALL** entities that provide services to members (i.e., hospitals, suppliers, labs, DMEs, etc.)
- GOAL: Complete disclosure statement one time and maintain copies for all MCOs requesting disclosure. (forms are valid for 3 years)

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Completing the disclosure statement

- Joe Brown, MD, PC or Joe Brown, MD & Associates or Joe Brown, MD, Inc. – without other practitioners within physical location
  - Complete four-page statement - entire statement including Board of Directors.
- Joe Brown, MD, PC or Joe Brown, MD & Associates or Joe Brown, MD, Inc. – with other practitioners in physical locations
  - Complete a statement for each practitioner and a statement for Joe Brown, MD, PC in its entirety.
- Joe Brown, MD
  - Complete for individual instructions.

Completing the disclosure statement for groups of 50 practitioners or more

- Must complete the one-page disclosure statement (groups over 50) per practitioner
  - Top half is completed by practitioner
  - Bottom half is completed by group

- Must complete one, four-page disclosure statement for the group.

- Example: Group with 55 practitioners
  - One-page statement per individual practitioner
  - One, four-page statement for large group
  - Total number of statements will be 56

Consequences for not completing a disclosure statement

- BCBST/VSHP is required to report non-compliance to the Bureau of TennCare who reports to CMS.
- Non-compliance is a “red” flag to government that debarred individuals may be working with federal funds.
- Non-compliance runs the risk of government requesting recoupment of federal funds.

EXAMPLE

- Five practitioners work in same office as Internists. They work independently of each other and bill separately. However, they share space and employees. On their door they are known as “The Doctor’s Group.” We will require all five to complete individual disclosure statements. Whoever is the managing practitioner (pays bills, oversees employees, etc.) will need to fill out a disclosure statement on “The Doctor’s Group.”

- We must have disclosure information about the individuals working within the office and having access to federal funds.

QUESTIONS?

Southeastrans, Inc.

Non-Emergency Transportation for BlueCare and TennCare*Select* Members

Presented by

Rich Eberle and Jeff Ward

BlueCare/ValueOptions

- Operations
- Clinical
  - Case, Disease and Utilization Management
- Behavioral Health

Presented by

Barry Condra and Rhonda Farriss

Operations - BlueCare Eligibility

Obtain eligibility and/or health care benefits information by:

- Using BlueAccess, bcbst.com or VSHPTN.com* online services
- Calling BlueCare Provider Service 1-800-468-9736
- Calling Family Assistance Service Center* 1-866-311-4287
- Faxing BlueCare Eligibility Form 1-866-504-6356
- Accessing the State's eligibility system, www.TennesseeAnytime.org

*For TennCare members only

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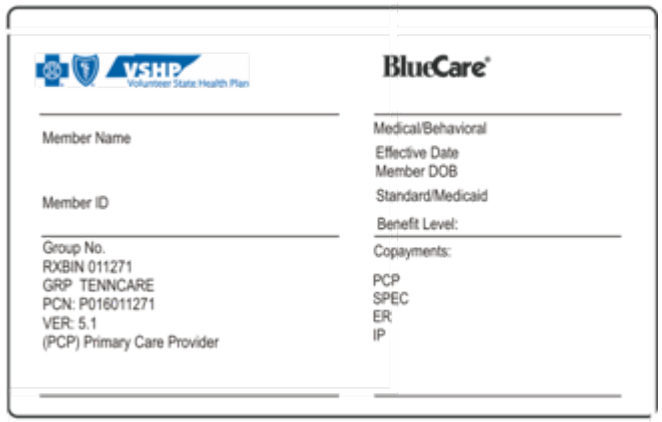
Operations - BlueCare ID Card

BlueCare Members will have one card for both medical and behavioral health care services.

- Mailing to **West Tennessee** members on/around October 13, 2008
- Mailing to **East Tennessee** members on/around December 15, 2008



Operations - BlueCare Program Changes

- Forty-five day (45) MCO change
- Member/PCP assignment
- Members should work with their assigned PCP to obtain referrals for other health care
- Integration of behavioral health
- Non-emergency transportation changes

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Operations - BlueCare Behavioral Health Changes

- Volunteer State Health Plan will administer behavioral health care services to BlueCare members only
  - West Grand Region — November 1, 2008
  - East Grand Region — January 1, 2009
- For prior authorization of all inpatient and higher level of care, call Monday through Friday, 8 a.m. to 6 p.m., ET
  - Phone 1-888-423-0131
- Mail request to:

  BlueCare
  Notification/Prior Authorization
  P O Box 182277
  Chattanooga, TN 37402-7277

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Operations - Non-Emergency Transportation Changes

- Contracted with Southeastrans, Inc. to provide non-emergency transportation
- Call Southeastrans on the member's behalf to arrange non-emergency transportation
  - East Region 1-866-473-7563
  - West Region 1-866-473-7564
  - TennCare*Select* – Statewide 1-866-473-7565
- File non-emergency transportation paper claims with date of service on or after September 1, 2008 to:

  Southeastrans, Inc.
  4751 Best Road, Suite 140
  Atlanta, GA 30337

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Operations – Transition of Care

- Authorization process
- Global authorizations
- Inpatient authorizations
- Continuation of care
- Member transition hotline available on October 1, 2008
- Call current Utilization Management
  - 1-888-423-0131

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Operations - Claims Filing

- **West:** File claims for date(s) of service Nov. 1, 2008, or after to BlueCare
- **East:** File claims for date(s) of service Jan. 1, 2009, or after to BlueCare
- Hospital reimbursement for member confinement on Nov. 1, 2008, or Jan. 1, 2009 will be reimbursed under transition rules
- For members hospitalized prior to November 1 and January 1, and continuing to be hospitalized after these dates, file a **split** bill
- Example: claims with date(s) of service prior to these dates should be filed with the member's current MCO. All claims with dates of service(s) after the contract effective date should be filed to BlueCare and will be paid on a Per Diem basis up to the maximum diagnostic related group (DRG) allowable.

Medical - Prior Authorizations

Prior Authorization is required for:

- Certain Specialty Pharmacy Medications
- All Out-of-Network services: (Hospital and Professional)
- Transplants and Transplant Evaluations (Effective 11/1/08)
- Chiropractic Services for children under the age of 21 years
- All Inpatient Medical (In Network)
- All Hysterectomies
- Orthotics and Prosthetics >$ $100 (Effective 11/1/08)
- All Home Health Services, which includes Private Duty Nursing
- DME >$100 for purchase or rental (Effective 11/1/08)
- All new requests for wheelchairs and accessories require prior authorization regardless of purchase or rental price (Effective 11/01/08)
- All Outpatient Therapies for members 21 years and older
- Hospice-Inpatient and Outpatient
- Global OB and High Risk OB (Effective 11/1/08)
- SNF-Skilled Nursing Facility (Effective 11/1/08
- All Bariatric Surgeries
- All food supplement and substitutes including formulas taken by mouth for adults 21 years of age and older

Effective 11/1/08:

- The following : Outpatient services require prior authorization, including, but not limited to:
  - Arthroscopy
  - Endoscopy
  - Laparoscopic Cholecystectomy
- All services performed by a plastic specialist, including, but not limited to:
  - Abdominoplasty/Panneculetomy
    - Belpharoplasty
    - Breast Reduction
    - Gynecomastia
    - Reconstructive Repair Pectus Excavatum
    - Reconstructive Breast
    - Vein Ligation
- High technology radiology to be reviewed by Med Solutions: CT, MRI, MRA, PET
- The following behavioral health levels of care require prior authorization for **BlueCare Only**:
  - Inpatient
    - Detoxification
    - Rehab
    - Crisis stabilization
    - Residential treatment facility
    - Partial hospitalization

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www.VSHPTN.com

Questions?

- Ask now
- Call BlueCare Provider Service **1-800-468-9736** for administrative issues
- Call Utilization Management **1-888-423-0131** for prior authorization or questions regarding continuation of care plans
- Claims filing address

  BlueCare
  P. O. Box 182277
  Chattanooga, TN 37422-7277
- Electronic billing

  eBusiness Service Center
  423-535-5717
  ecomm_techsupport@bcbst.com

VSHP Volunteer State Health Plan

VSHP
Case Management

Presented by

Angela Mitchell, Kati Becker and JoAnne Foster

Clinical – Case Management

Goal: A smooth transition for our members

- For Case Management Services call 1-800-225-8698
- Transition of members receiving Case Management Service
- Continuity of Care
- Members can call the hotline/command center number

Clinical – Case Management

- Call 1-800-225-8698, Monday through Friday, 8 a.m. to 6 p.m., ET for Case Management Services

- Transition process
  - Members currently receiving Case Management services
  - Referrals to Case Management
    - Predictive Modeling Screening
    - Assignment to Case Management
  - Case Management contact
    - Member
    - PCP
    - Servicing Provider

- Continuity of Care
  - No interruption of treatment
  - Non-Par providers

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Clinical – Case Management

- Coordinate member benefits
- Member assessment
- Identify member needs
- Evaluate members Plan of Care

- Integrated Care Management Team
  - Members, PCP's and Specialist
  - Utilization Management
  - Transition of Care
  - Complex Medical Case Management
  - Behavior Health Case Management
  - Disease Management
  - Medical Directors
  - Social Workers

Clinical – Case Management

Clinical Management Team for VSHP Case Management

- Managers
  - JoAnne Foster – East Tennessee
  - Angela Mitchell – West Tennessee
- Clinical Directors
  - Rafielle Freeman – East Tennessee
  - Jamie Patterson – West Tennessee
- Medical Directors
- West Tennessee
  - Dr. Clarence Davis
  - Dr. Phillip Smith
- East Tennessee
  - Dr. Pedro Cardona
  - Dr. Maria Lenaz

Clinical – Case Management

Questions?

VSHP
Disease Management

Presented by

Cheryl Murphy and Jamie Patterson

Clinical – Disease Management

- Goal: A smooth transition for our members
- For Disease Management Services call 1-800-416-3025
- Transition of members receiving Disease Case Management Service
- Continuity of Care

Clinical - What is Disease Management?

- ***Disease Management*** is a system of coordinated health care interventions and communications to populations with conditions in which patient self-care efforts significantly impact future health outcomes.

Source: Disease Management Association of America

Clinical - Disease Management Objectives

- Maximize opportunities to positively influence health status and health outcomes.
- Promote healthy lifestyles and reduce the impact of chronic disease and conditions.
- Support the physician or practitioner/patient relationship and plan of care.
- Encourage self-care management through education, intervention and Total Health Care Team Collaboration.
- Emphasize prevention of complications utilizing evidence-based practice guidelines and empowerment strategies
- Utilize innovative avenues for gaps in care resolution and improve HEDIS measurements for the target population.

Clinical - Disease Management Programs

- CaringStart® Pregnancy Program

- CareSmart®
  - Asthma
  - Bipolar Disorder
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Coronary Artery Disease (CAD)
  - Diabetes
  - Heart Failure
  - Major Depression
  - Obesity
  - Schizophrenia

Clinical – Disease Management

Clinical Management Team for VSHP Disease Management

- Director
  - Renee Trammell
- Manager
  - Cheryl Murphy
- Medical Directors
  - West Tennessee
    - Dr. Clarence Davis
  - East Tennessee
    - Dr. Pedro Cardona
    - Dr. Maria Lenaz

Clinical – Disease Management

Questions?

Behavioral Health

Presented by

Janice Maurizio and Deb Dukes

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Behavioral Health Integration - Transitional benefits

- Continuation of care: Members will be able to receive services from their treating provider for up to 30 days
- VSHP will outreach to providers based on authorizations received from previous vendor
- Providers call 1-888-423-0131 for registration of care
- Members with SED[1], SPMI[2], Addictive disorders, Co-occurring disorders (MH/SA[3]) and Dually Diagnosed (MH/DD[4]) seeing out-of-network providers allowed special time frames for transition

  - MH Case Management 3-months
  - Psychiatrist 3-months
  - Outpatient behavioral health therapy 3-months
  - Psych rehab and supportive employment 3-months
  - Psychiatric inpatient or residential treatment and supportive housing 6-months

1 – Serious Emotional Disturbance
2 – Serious and Persistent Mental Illness

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3 – Mental Health/Substance Abuse
4 – Mental Health/Developmental Disability

Behavioral Health - Services/ Utilization Management

- Call 1-800-468-9736 Monday through Friday 8 a.m. to 6 p.m., ET for claims, benefit, eligibility and referral information
- Call 1-888-423-0131 for routine utilization management review
- PCP referrals are not required for Behavioral Health Services
- Staff available 24 hours a day for:
  - member referral requests
  - authorization of inpatient level of care, detox, crisis respite and crisis stabilization services
- Behavioral Health Criteria and Treatment Practice Guidelines available on line at VSHPTN.com
- ASAM[1] criteria used for Substance Abuse review

1 – American Society of Addiction Medicine

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Behavioral Health - Prior Authorization

Prior Authorization is required for:

- Inpatient
- Residential
- Rehab
- Detox
- PHP
- IOP
- Day Treatment
- ABA
- Supported Employment
- Supportive Housing
- Crisis Respite
- Crisis Stabilization
- Psychiatric Rehabilitation
- Psychiatric Testing
- 23-hour bed

- Emergency Services / Admissions are allowed 24 hours to authorize care
- Reviews are completed telephonically
- Use Inpatient Treatment Request (ITR) forms available on line at VSHPTN.com as a guide for Telephonic Review process
- Submit ITR's via the Web

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Behavioral Health - Priority members

Priority members

- First 10 visits each month do not require authorization
- Authorization is required by visit 11
- Visits include: Medication, Case Management, Therapy
- Multiple services are allowed on the same day

No authorization required for

- CRG[1]/TPG[2] assessments
- Crisis Services (mobile crisis, walk in crisis, telephonic)
- Emergency Room Services
- Peer Support

1 – Clinically Related Group

2 – Target Population Group

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Billing Using Modifiers To Denote Licensure Levels

In order to be reimbursed appropriately, it is required that practitioners bill using the appropriate modifier to denote their licensure level. Per the existing ValueOptions of Tennessee, Inc. Tennessee Managed Medicaid Reimbursement Schedule, the following modifiers must be used:

Modifier Code	Modifier Description
UA	MD Level
HP	Doctoral Level
HO	Masters Level
SA	Nurse practitioner rendering service in collaboration with a physician

If the appropriate modifier is not submitted, your claims may be denied.

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Behavioral Health - Non priority members

- 20 visits allowed per member per year
- Visits include medication management and therapy, both mental health and substance abuse
- Complete required Outpatient Request Form (ORF) at the end of these sessions
- ORF's may be submitted directly to VSHP by:

  - Fax at 1-800-292-5311
  - Web site, VSHPTN.com

Behavioral Health - Benefits for Standard Medicaid

- Mental Health covered as Medically Necessary
- Age 21 and older:
  - Substance Abuse limited to 10-day detox
  - $30,000 in Medically Necessary lifetime benefits
- Substance Abuse under age 21 years covered as Medically Necessary

Behavioral Health - Coordination of Care / Treatment Planning

- 3M[1], PHQ9[2], CAGE[3], Release of Information forms available on line at VSHPTN.com
- Treatment plans need to be completed within 30 days of admission to an outpatient program
- Treatment plans need to be updated every 90 days
- Goals should reflect each service a member is receiving
- Treatment plans should reflect member, family involvement

1 – Medical Management Monitoring
2 – Patient Health Questionnaire 9-Item
3 – Cut Annoyed Guilty Eye-opener Screening for Substance Abuse Problems

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Behavioral Health Discharge planning / Ambulatory follow up

- All members admitted to an inpatient program need to be assessed for case management services
- All inpatient program case managers need to contact all outpatient providers involved with members care
- Case management appointments need to be scheduled within 7 days of discharge
- Other behavioral health appointments should be scheduled within 7 days of discharge
- Behavioral health case management staff available to assist with finding appointments
- Behavioral health case management staff will follow up with both members and providers regarding appointment compliance

Behavioral Health - Mental Health Case and Disease Management Educational Services

- Behavioral health disease management programs on Schizophrenia, Bipolar and Depression
- Providers should provide education on:
  - medications and their side effects
  - behavioral health disorders and treatment options
  - self-help groups, peer support
  - other community support services available for members and families
- Behavioral health case management services available as an additional level of support at 1-888-423-0131
- PCP Consultation line available at 1-877-241-5575

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Behavioral Health - Recovery and Resiliency

- A philosophy of Recovery and Resiliency is embraced throughout the continuum of care
- Care management personnel who are knowledgeable and competent in recovery principles
- Treatment planning is conducted with member involvement focusing on member goals, values and beliefs
- Education of family members and others identified by the member as significant in their support structure will be offered
- Empowerment of consumers and family members to engage in mutual support and self-help is encouraged among all providers

Behavioral Health - Your Tennessee Clinical Team

- Dr. Kelly Askins, Medical Director
- Deb Dukes, Clinical Director
- La Tisha Reid, Manager Disease Management / Case Management

Behavioral Health

Questions?

ED Diversion / Medical Home Program

Presented by
Jamie Patterson and Cheryl Murphy

ED Diversion / Medical Home Program

- Provides 24/7/365 nurse triage access through NurseLine call center
- Coordinates care of non-emergent patients inappropriately utilizing the Emergency Department (ED) with expedited PCP follow-up care
- PCP appointments are scheduled within 24 to 48 hours after being seen in the ED
- Patient is tracked and monitored from initial ED point-of-access through PCP follow-up. The purpose of this process is to solidify a “Medical Home” for the member as well as identify additional clinical needs including, but not limited to Case Management, Disease Management, and Behavioral Health concerns.

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ED Diversion / Medical Home Program

- Transportation is arranged as needed for ED members from the hospital, to the PCP, and home

- NurseLine is available anytime to assist members with additional health care concerns or questions

  - BlueCare 1-800-468-9736
  - TennCare*Select* 1-800-276-1978
  - Direct Line 1-800-262-2873

Benefits to Members

- Provides expedited access to Primary Care
- Assists member in establishing a “Medical Home” and in navigating through the health care delivery system
- Access to a nurse for triage assessment, health advice and education through NurseLine
- Coordinates member clinical needs including case management, disease management, specialty referrals and transportation

Benefits to ED Physicians and Hospital

- Provides a coordinated system to assist members being redirected from the ED to primary care or urgent care
- Documents member activity from the ED to PCP follow-up visit, also includes member clinical assessment
- Provides monthly member tracking report to appropriate ED leadership
- Provides an integrated behavioral, physical, and social care coordination model

Benefits to ED Physicians and Hospital

- ED staff training is provided on an ongoing basis to both providers and ED clinical support teams
- ED is provided with a unique telephone number to reach the NurseLine team for patient care coordination (“One number to call, that’s all.”)
- Mitigates risk to the hospital system by utilizing NurseLine as a safety net for post-visit tracking and outreach
- Decreases unnecessary treatment and cost of non-emergent visits
- Decreases overcrowding in ED by appropriately directing members to a Medical Home

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Benefits to PCP / FQHC

- Enhances the “Medical Home” model and strengthens the relationship between the PCP and the member
- Increases patient volume and referrals to PCP
- Improved coordination of patient clinical activities and/or treatment in other care settings
- Minimizes duplication of unnecessary tests and procedures

Benefits to Health Plan

- Decreases inappropriate ED utilization and cost
- Helps to fulfill mission by ensuring access to quality health care in appropriate care settings
- Serves as a preferred safety model for the community and hospital systems

Phase 1 ~ Network Assessment Development

- Emergency Department Utilization Assessment to determine appropriate and inappropriate care rendered and to establish benchmarks and targets for improvement, year 1, year 2, and year 3

- Emergency Department Physician Assessment to determine physician, other clinical and administrative support for the redirect program, by hospital

- Community Provider Assessment establishing primary care physicians willingness to receive referrals same day or next day for patient follow-up after initial ED medical screening

Phase 2 ~ Implementation

- Begin ED educational process with ED physicians, nursing staff, other clinical staff, clinical support staff, and hospital administration

- Engage NurseLine team for “new client” set up with centralized provider and patient communication, centralized patient appointments and daily tracking reports

- Establish referral provider network including private PCP offices, FQHC and urgent care clinics

Phase 2 ~ Implementation

- Improvement targets should be finalized and rewards to providers (if applicable) determined in order to engage physician participation and cooperation

- Timelines should be agreed upon to measure performance and payout financial rewards for increased efficiency and more appropriate utilization of the delivery system. (A different payment rate could be established for ED doctors who participate in the triage out process and incentives or rewards could be established for physicians who accept patients under a “same day next day” scenario to make the incentives less complicated. This is optional per payer).

Phase 3, Part 1 ~ Patient Referral Process

- Patient presents at a participating ED
- Patient is triaged and assessed by a physician to comply with Federal EMTALA guidelines
- Patient is determined non-emergent
- Patient payment method is identified
- Patient is placed on the telephone with NurseLine for coordination of care to a primary care physician, FQHC or urgent care clinic (UCC)

Phase 3, Part 1 ~ Patient Referral Process

- Appointment is made and communicated with the hospital ED team and the patient
- Patient is given an appointment slip to be presented at the PCP office, FQHC or UCC
- NurseLine informs PCP office of upcoming patient visit
- NurseLine provides a follow-up call to the patient after the visit to verify member received the help needed and satisfaction of care

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Phase 3, Part 2 ~ Patient Referral Process

- Through the NurseLine, questions are asked to determine why the member chose the ED verses the physicians' office and to see if a new PCP assignment is needed. All of this information is tracked in a database at NurseLine and sent to the Emergency Services Management (ESM) Team at VSHP.

- NurseLine provides weekly updates of patient/referral tracking report given to ED physicians and payer to ensure patient tracking and follow up is occurring.

- NurseLine provides monthly summary reports for payers to measure improvements in appropriate utilization.

Phase 3, Part 2 ~ Patient Referral Process

- ESM team assists members in establishment of a “Medical Home” with a primary care physician.

- ESM team educates members about calling the NurseLine for future medical questions and assistance in scheduling physician appointments as well as determining more appropriate use of the ED.

- NurseLine sends to the ESM team daily reports indicating additional services needed for the member. ESM then leads the member through a smooth transition to disease management or case management.

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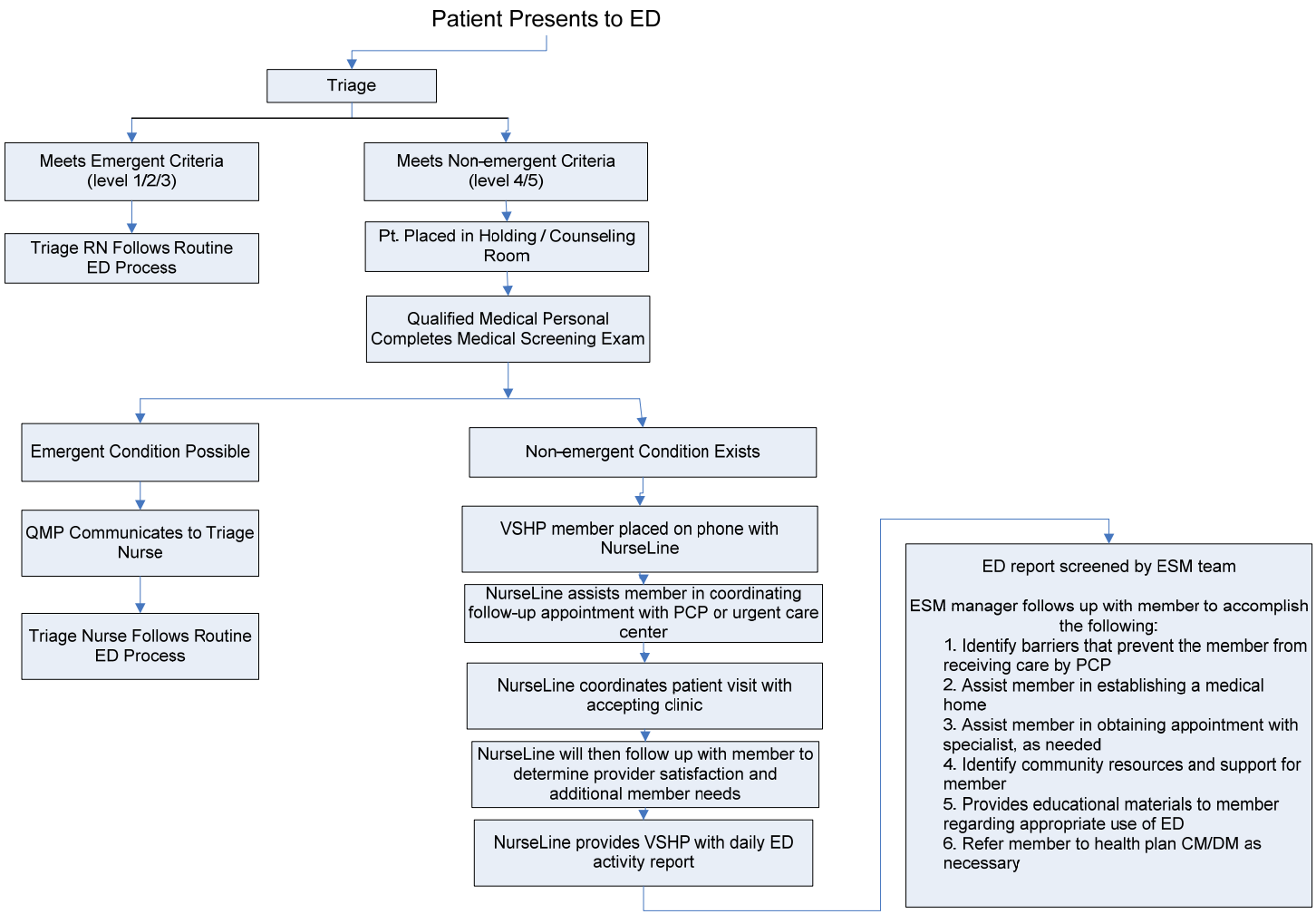
Patient Referral Flowchart



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ED Diversion / Medical Home Program

Questions?