WELCOME

2019

PRESBYTERIAN
Provider Education Conference
&
Webinar Series

Presbyterian Health Plan

2019
Health Plan Updates

Taneil Tanuz
Relationship Executive
Provider Network Operations
• What’s new?
  • ePayment system
  • Laboratory partners

• What you need to remember?
  • Claim process
  • Centennial Care 2.0

• Training & Education

• Questions
Provider Network Management

Provider Network Operations
Department Operation Components

• Contracting

• Servicing
  • Long Term Care
  • Physical Health
Care Coordination

Stacey Hughes
Provider Representative
Provider Network Operations
Care Coordination

• **Program Enhancements** (Provider and Member Tools)
• Centennial Care 2.0 Highlights

• Building on Program Successes Centennial Care 2.0
• Centennial Care 2.0 FAQs
Centennial Care 2.0 FAQs

- **Centennial Care 2.0 MCOs:**
  - Blue Cross/Blue Shield of New Mexico (BCBS)
  - Presbyterian Health Plan (PHP)
  - Western Sky Community Care (WSCC)

- **Services will begin Jan 1, 2019** –
  - Members will stay with their current MCO through Dec 31, 2018
  - Basic Program Structure is the same as Centennial Care in 2014

- **Do members have to select a Centennial Care 2.0 MCO?**
  - PHP members who wish to remain with PHP do not have to actively select a 2.0 MCO. They will be automatically re-enrolled with PHP if they do not choose a different MCO.
Building on Program Successes  
Centennial Care 2.0

- **Target Care Coordination** by increasing care coordination at the provider level, improving transitions and leveraging partnerships.

- **Strengthen Physical and Behavioral Health Integration** and expanding capacity through telehealth.

- **Improve Long Term Services and Supports Programs** by increasing access to home and community based services and expanding Value Based Purchasing (VBP) arrangements.
Building on Program Successes
Centennial Care 2.0

- Expand Payment Reform Initiatives by increasing VBP arrangements and aligning the Safety net Care Pool with improved outcomes.

- Increase Member Engagement and Personal Responsibility through the Rewards program and cost sharing.

- Streamline Benefits and Eligibility through eligibility refinements and eliminating the three-month eligibility period.
Care Coordination Delegation: Transition more Care Coordination functions to the provider level:

- Full Delegation Model – MCO delegates full set of Care Coordination functions to the Provider/Health System
- Shared Functions Model – The MCO maintains some of the Care Coordination Activities and allows other Care Coordination activities to be done by the Provider or Partner.
Centennial Care 2.0 Highlights

- Care Coordination Delegation \textit{(continued)}
  Move Care Coordination to the point of service and align with Value Based Purchasing strategies
  - Improve and increase engagement of Members
  - Enhance outcomes and further gains achieved by MCO-based care coordination
  - Improve Member/Patient Experience
  - Increase natural touchpoints
  - Reduce Administrative costs and improve efficiencies
Community Benefit Changes

The community benefit provide home and community based services so members who meet a nursing facility level of care (NFLOC) can stay in their homes and communities instead of moving to a nursing home.

- Increase annual limit for Community Benefit Respite for people with long term care needs from 100 to 300 hours
- Nutritional Counseling added to Agency Based Community Benefit
Community Benefit Changes (continued)

- Start up goods, up to $2,000 for new Self-Directed Community Benefit (SDCB) members that may include a computer, printer or fax machine

- NFLOC Assessments
  - Community Benefit members who meet certain criteria and who are always expected to meet NFLOC will not be required to have an annual NFLOC assessment
Centennial Care 2.0 Highlights

- Home visiting pilot program, focuses on pre-natal, post-partum and early childhood development
  - Will be in up to four counties including Bernalillo
  - In collaboration with CYFD
    - Delivery Models: Nurse family Partnership and Parents as Teachers
    - Different sets of services depending on the type of visit
      - Prenatal visits
      - Post-Partum visits
      - Infant/Child visits
Centennial Care 2.0 Highlights

- Pre-Tenancy and Tenancy Services
  - New supportive housing services beginning 7/1/19 for member with Serious Mental Illness (SMI) to assist with acquiring, retaining and maintaining stable housing
    - Members eligible will access the program through a network of providers associated with the Linkages Supportive Housing Program
    - Certified Peer Support workers will be assisting with service delivery.

- Expand Substance Use Disorder (SUD) Services
  - Extend Screening, Brief intervention, and Referral to Treatment (SBIRT) services through primary care, community health centers and urgent care facilities.
  - Provide SUD treatment for all adults in accredited residential treatment centers
Centennial Care 2.0 Highlights

- WDI/CHIP Working Disabled Individuals and Children’s Health Insurance Program – Copays sunsetting January 1, 2019

- Member Cost Sharing –
  - Copays:
    - Effective March 1, 2019
    - Exemptions:
      - Native American Members

<table>
<thead>
<tr>
<th>Copayment</th>
<th>Most Centennial Care Members</th>
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<tbody>
<tr>
<td>Non-preferred prescription drugs</td>
<td>$8 / prescription (certain exemptions will apply)</td>
</tr>
<tr>
<td>Psychotropic drugs and family planning drugs/supplies are excluded</td>
<td></td>
</tr>
<tr>
<td>Non-emergency ER visits</td>
<td>$8 / prescription (certain exclusions will apply)</td>
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Program Enhancements
Provider and Member Tools

Presbyterian is currently expanding telehealth services to include underrepresented specialties in rural, frontier and tribal areas. In addition, we plan to expand telehealth services to include the following:

- Suboxone prescribing and emergency department assessments and interventions through our Substance Use Disorder (SUD) and Community Collaborative Initiative.

- TalkSpace, a secure, confidential and anonymous text coaching platform that connects members with licensed New Mexico therapists via smartphone app or traditional telehealth video visits.

- Computerized Cognitive Behavioral Therapy with Smart Screener, which provides web-based therapy modules to members.
Program Enhancements

Provider and Member Tools

- Improving the Member Experience
  - Tools that allow members to have a more responsible and active participation in their healthcare.
  - Ease of navigation to assist the members on their way to better health

Member Portal Upgrade

- Experience and Availability
  - Enhanced mobile responsive website for phone, tablet, computer
  - New mobile app available to Android and IOS users

- New Features
  - Prepopulated forms for member inquiries on claims & eligibility
  - Pharmacies added to Provider Directory (Find a Doc)
  - Cleaner/easier navigation to important features
  - Enhanced Benefit Dashboard view
  - (Side by Side) Provider Comparison in Provider Directory
Program Enhancements
Provider and Member Tools

MyRide Non-Emergency Transportation
- Transportation smartphone app
- Automated scheduling
  - Booking trips to, from, and repeating
  - Canceling trips
- Viewing trip information
  - Seeing trip information
  - Where is my bus?
- In-vehicle technology
  - Arrive time and on schedule
Health Plan Updates

Taneil Tanuz
Relationship Executive
Provider Network Operations
Health Plan Updates

- NM Medicaid Enrollment
- TriCore
- ePayment System
- Claims Editing System
- Billing
- Provider Manuals
Provider Manuals

The provider manual is an extension of your contract and can be found on our website at www.phs.org/providermanual.
The following can be found in our provider manual:

- Overview
- Care Coordination
  - Including special needs populations
- Appeal and Grievances
- Credentialing Process
- Member Rights and Responsibilities
- Cultural Competency
- Prior Authorization
- Claims and Payments
Medical Policy

• Medical Policies
  • All services provided must be medically necessary as determined by the member's practitioner or provider in consultation with PHP. Benefit certification decisions are made on a case-by-case basis using the member's contract, the Medical Policies Manual, and the specific facts of the particular situation.

• Limitations and Exclusions
  • Benefits listed in the manual are subject to all the limitations and exclusions of the member's contract.

• Plan Requirements
  • The manual assumes that all plan requirements have been followed, such as using in-plan providers, obtaining referrals, obtaining benefit certification as required, etc.
Provider Newsletter

2019 Practitioner and Provider Manuals Are Available Online

Presbyterian's provider manuals are great resources for providers to access essential information about our policies and procedures. Presbyterian’s Universal Practitioner and Provider Manual covers Presbyterian's programs, policies and guidelines for Commercial, Medicare and Medicaid products. Presbyterian also publishes a Centennial Care Practitioner and Provider Manual that provides detailed information specific to Presbyterian’s Centennial Care programs and requirements.

The manuals are an extension of a provider’s contract with Presbyterian, and they are updated quarterly and as needed. A key update made to the 2019 manual includes information regarding Centennial Care 2.0.

In the manuals, providers can find instructions for the following:
- Submitting medical and behavioral health prior authorization requests
- Submitting drug prior authorization and exception requests based on medical necessity
- Contacting Utilization Management, pharmacy, medical and behavioral health to discuss prior authorization
- Obtaining or requesting utilization management criteria
- Prior authorization criteria
- Medical policies
- Presbyterian's formularies and updates, including restrictions and preferences (e.g., quantity limits, step therapy and prior authorization criteria)
- Clinical Practice Guidelines
- Affirmative statement concerning utilization management decision-making and incentives
- Member rights and responsibilities

The manuals are available online at www.phs.org/ProviderManual. Providers may also request a printed copy of both manuals at no cost by contacting their Provider Network Management relationship executive. Providers can find his or her contact information at www.phs.org/ContactGuide.

UnitedHealthcare Centennial Care Members Transition to Presbyterian

Presbyterian is honored to continue our tradition of service and innovation with the Centennial Care program. On Sept. 1, 2018, we expanded our commitment to the Centennial Care program and partnered with UnitedHealthcare (UHC) to transition nearly 85,000 Medicaid members to Presbyterian.

Many of these members are already served by Presbyterian’s contracted providers as well as other group and independent practices. Presbyterian hired a majority of UHC’s care coordinators in an effort to preserve the providers-patient relationship and help ease the transition for these new members.

To ensure members continue to receive the procedures, services and medication they need, providers should verify the prior authorization process. For a complete guide to prior authorizations, please visit www.phs.org/Providers/Authorizations.

We want to thank all our providers for the work they do every day to improve the health of New Mexicans. We are excited to meet the needs of our new members and to do our part to improve the health of the patients, members and communities we serve.

Presbyterian exists to improve the health of the patients, members and communities we serve.
Centennial Care 2.0 Copays

New copayment requirements start March 1, 2019.

A provider may be required to take copayments for the following services:

- Non-preferred prescription drugs per encounter
  - Note: Psychotropic drugs and family planning drugs are exempt
- Non-emergent use of the Emergency Department

To verify if a copayment applies, providers must confirm the member’s eligibility information. They can do this by checking the member’s Presbyterian ID card and logging into Presbyterian’s myPRES Provider Portal. Please see the provider manual for details.
New Mexico Medicaid Enrollment
Why NM Medicaid Enrollment Is Important

Centennial Care Encounter Reporting

Presbyterian is required by the Human Services Department (HSD) to report all services rendered to Presbyterian Centennial Care members.

Providers must submit claims to Presbyterian within 90 days from the date of service.

If the provider is not enrolled with HSD, the claim will be denied.

Additional information regarding encounter data reporting can be found in the Claims chapter of the Provider Manual.
NM Medicaid Enrollment Requirement

New Mexico Medicaid Portal:
https://nmmedicaid.portal.conduent.com/webportal/enrollOnline
Effective Feb. 1, 2018, the Centers for Medicare & Medicaid Services (CMS) require the following providers to also enroll with NM Medicaid:

- Attending
- Ordering
- Prescribing
- Referring
- Rendering

**Note:** These providers must be reported on claims.

http://www.hsd.state.nm.us/providers/Registers_and_Supplements.aspx
Tricore Update
Presbyterian’s preferred reference laboratory is TriCore Reference Laboratories (TriCore) within 5 county area.

If needing services outside of the 5 county area please contact your Provider Representative Team.
Presbyterian ePayment
Presbyterian ePayment - ERA/EFT Update

• Effective November 15, 2018

• To take advantage of these new services, providers can register at the website link provided in your packet.
National Drug Code Requirement
Providers are required to bill with the National Drug Code (NDC) and the Healthcare Common Procedure Coding System (HCPCS) code combination on all claims for all product lines.

- NDC number can be up to 11 digits
- NDC quantity (gm, ml, unit)
- HCPCS Code

Claims will deny if this information is not provided.
Health Plan Reminders

- Appeals and Grievances
- Prior Authorizations & Inpatient Notifications
- Fraud, Waste & Abuse
- Presbyterian Members
- Cultural Sensitivity
- Centennial Care Overview
- Critical Incident Management and Reporting
- Care Coordination
Provider and Member Appeals & Grievances
Provider & Member Appeals

• First Level Appeals must be filed within 12 months from date of service.

• Second Level Appeals must be filed within 20 days from date of appeal decision.

Reminder: Providers and members no longer have the right to a Level II appeal for Centennial Care
For ease of use, you can now submit appeals and grievances online at [www.phs.org/appeals](http://www.phs.org/appeals)
Provider Grievances

Providers may file a grievance if he or she is dissatisfied or disagrees with the following:

• Presbyterian’s decision to terminate

• Presbyterian’s decision to suspend

• Presbyterian’s general operations
Member Appeals & Grievances

All members have the right to voice their concerns or problems related to their coverage or care by filing one of the following:

1. **Grievance** – to voice a concern about their experience

2. **Appeal** – to voice a concern about a decision
Filing an urgent appeal

Urgent Verbal Appeal

• Presbyterian Customer Service Center will page the Appeals and Grievance staff if an urgent issue is identified on a call

• Coverage includes after-hours and weekends

REMIINDER: Unless the Member or the provider requests an urgent appeal, a verbal appeal must be followed by a written appeal that is signed by the Member within 13 calendar days; failure to file the written appeal will be considered a withdrawal.
Member Second Opinions

Members have the right to seek a second opinion. Presbyterian will assist members in locating a provider within their network their ID card.

Members should contact Presbyterian by using the number on the back of their ID card.
Member Advocates

What they can do for providers and members
Member Rights & Responsibilities

Presbyterian members are free to exercise their rights and, by doing so, should not affect the care they receive from Presbyterian or its network of providers.

Member Rights and Responsibilities: https://www.phs.org/memberrights
Medicare Advantage Member Reminders

As required by the Centers for Medicare & Medicaid Services (CMS), providers cannot request a Medicare Advantage member to sign an Advanced Beneficiary Notice (ABN) to assume financial responsibility, because they are part of a Medicare Advantage plan.

Prior to referring Medicare Advantage members for services, such as lab tests and advanced diagnostic imaging services, providers must verify that the service is covered by Medicare.

• If the service is not covered by Medicare, providers should inform members that they will be held financially responsible for that service.

Note: All Presbyterian Medicare plans are considered Medicare Advantage plans.
Credentialing & Recredentialing
Credentialing and Recredentialing

• Credentialing is required for all contracted providers
• Credentialing can take up to 30-45 days
• Provider recredentialing occurs every three years
• Providers should not render care to members until approved by the credentialing board
• Failure to complete credentialing may result in claim denials
Examples of a High-Volume Provider?

Examples of high-volume providers include but are not limited to the following:

- Cardiology
- Cardiovascular Surgery
- Dermatology
- Gastroenterology
- General Surgery
- Endocrinology
- Orthopedics
- Neurology
- OB/GYN
- Oncology
- Ophthalmology
Claims & Corrected Claims
Submitting Claims to Presbyterian

Providers can submit claims to Presbyterian electronically or by paper.

Note: For behavioral health electronic claims submissions (ECT), please notify your clearinghouse to update the Payer ID for ECT submissions to add Magellan Payer ID – 01260 (Magellan Payer ID for Change Healthcare, which was formally known as Emdeon).
Submitting Corrected Claims

Claim resubmissions, corrections and adjustment requests must be submitted within 12 months of the date of service.

CMS 1500

UB 04
Providers can submit corrected CMS-1500 claims.

A corrected claim must include all previously submitted claim information as well as the corrected information.

A corrected electronic claim is identified only when field 22 on the claim has a “Resubmission Code” of seven or eight and the “Original Ref No” field contains a claim number.
Third Party Liability (TPL)

As a reminder, Centennial Care is the payer of last resort.

Third party payers can include:

- Group health insurance
- Auto liability insurance
- Worker’s compensation
- Court-ordered health coverage
- Medicare

Providers are responsible to verify if patient has other insurance coverage prior to services being rendered.
Demographic Updates / CMS Audit
**Demographic Audit**

**The Centers for Medicaid & Medicare Services**

- CMS began auditing provider demographic data for all managed care organizations.
- The review is aimed at determining whether the information contained in the online directory is accurate.
- Presbyterian is required at a minimum to audit provider data quarterly.
- Provider non-compliance may result in a potential removal from the Presbyterian directory listing.
- CMS may take compliance and/or enforcement actions against Presbyterian by having a potential loss of Medicare membership.
We Need Your Help to Verify Your Data!

Your name should reflect how the phone is answered and name on the building.

Providers panel status should be current and indicate whether their panel is open or closed (i.e., Are they accepting new patients?).
We Need Your Help to Verify Your Data!

- Office staff should be knowledgeable on which Presbyterian plans are accepted.
- Provider offices must notify Presbyterian any time a provider leaves its practice.
- **Only** list providers at locations that appointments can be made by member.
- **Only** current providers should be listed.
Provider Demographic Real-Time Updates

Update Your Provider Directory Information

Keep your Provider Directory profile information current by making updates through your myPRES account. You can update your office hours, address, accepting new patient status, and more.

Update Now »

Become a Presbyterian Health Plan Contracted Provider

Join Presbyterian as a contracted Presbyterian Health Plan provider. We want to partner with you for efficient and effective healthcare. We are dedicated to superior service and quality care.

Apply Now »

Apply to Treat Patients in our New Mexico Hospitals and Clinics

Use our online application process to apply for privileges within our Presbyterian Delivery System of night hospitals and many clinics throughout New Mexico.

Apply Now »
Attestation

In an effort to improve provider data accuracy, Presbyterian is requesting that providers attest every 90 days that their directory information is true and correct.

Days left to attest: 90

Please review your directory information and attest by clicking the following link: Update Provider Dashboard

Remind me later
Provider Services

Behavioral Health - Magellan Portal

Clear Claims Connection

Cultural Sensitivity Competencies

ePayments Contracted Providers

ePayments non-Contractor Providers

myPRES Provider Portal

National Imaging Associates Provider Portal

Update Provider Demographic Information

View Less...
UPDATE PROVIDER INFORMATION

Updating information for Taxonomy #

- **Directory Address & Office Hours**
  - UPDATE, ADD OR VIEW

- **Physical Address**
  - UPDATE OR VIEW

- **Mailing & Remittance Address**
  - UPDATE OR VIEW

- **Panel Status & Spoken Languages**
  - UPDATE
  - Go to myPRES Menu of Services
  - Attest
By clicking “attest,” I am certifying that the following demographic information is correct:

1. Office hours
2. Phone and fax
3. Provider names and languages spoken
4. Accepting new patients

Submitted By:
Enter Name

[Buttons: I Attest, Cancel]
Success

Your attestation was recorded,
Thank you.
myPRES Portal Overview
Welcome to the Provider Portal

Introducing the Presbyterian ePayment Center

Presbyterian recently migrated to a new electronic payment platform called the Presbyterian ePayment Center. To accelerate payment and increase payment accuracy, contracted providers are encouraged to enroll in our new platform by visiting [Presbyterian ePayment Center registration link]. Should you require assistance in the enrollment process, please email Help@ePayments.Center or call the Presbyterian ePayment Center Customer Service Team at 1-888-774-4392.

Note: Behavioral health providers may disregard this notification. There will not be any changes to the electronic payment platform that behavioral providers use.

To view any previous communications regarding Presbyterian's new electronic payment platform, please visit our News & Communications page located on the provider website at [https://www.pni.org/providers/contact-us/news-and-communications](https://www.pni.org/providers/contact-us/news-and-communications).

United Healthcare Centennial Care Members Will Transition to Presbyterian Health Plan, Inc.

Beginning Sept. 1, 2018, all current UnitedHealthcare (UHC) Centennial Care Members will transition to Presbyterian Health Plan, Inc. (PHP). Click [Here](https://www.pni.org/providers/contact-us/news-and-communications) to find out how this transition will affect your practice. Click [Here](https://www.pni.org/providers/contact-us/news-and-communications) to find out how this will affect our members.

Medicaid Enrollment Guidelines

As of February 1, 2018, the Centers for Medicare & Medicaid Services (CMS) require attesting, ordering, referring, rendering, and prescribing providers to enroll in New Mexico Medicaid. [Click here](https://www.pni.org/providers/contact-us/news-and-communications) to review the Medicaid enrollment guidelines.

Gaps in Care

Verify Eligibility

Verify Claims

Inquiries

Payment Tracking

Member Roster

Fast Claim
Prior Authorizations and Inpatient Notifications
Prior Authorizations

Certain specialized services and prescription drugs require a prior authorization or inpatient notification before being rendered to patients and members. Prior authorizations and inpatient notifications ensure that patients are receiving the right amount of medically necessary care in the right setting for the insurance plan for which they're enrolled.

Medical

Prior Authorization Guide

Intel Connected Care Prior Authorization Grid

Prior Authorization Request Form

Centennial Care Prior Authorization Request Form

Durable Medical Equipment (DME) Prior Authorization Request Form
Inpatient Notifications

Search existing authorization requests

Search authorization requests by Type, Status, Dates of service, Request date, Authorization ID, or Member ID or Medicaid ID or SSN. To view all authorizations, please select Request Date.

ICD10 NOTICE:
All authorizations that span the following effective dates will need to be submitted as two separate requests:
Services on or after October 1, 2015, submit authorization requests with appropriate ICD-10 diagnosis codes.

Submit a new authorization

Select the service type for the authorization you are requesting.

- Outpatient Prior Authorization
- DME/O&P Prior Authorization
- Inpatient Prior Authorization

Inpatient Admission

For all requests for Advanced Imaging and Cardiac Imaging, please contact NIA at RadMD.com or 1-866-236-8717.

Effective for dates of service on or after October 15, 2014, all Commercial, Medicare, and ASO behavioral health prior authorization requests must be completed telephonically through Magellan Healthcare by calling 1-800-424-4657. If you have additional questions, please contact your Behavioral Health Provider Liaison or the Behavioral Health Provider Relations Department at 1-800-424-6935.
Fraud, Waste and Abuse
Presbyterian Health Plan’s Program Integrity Department (PID)

We are required to cooperate with regulatory and law enforcement agencies in reporting any activity that appears to be suspicious in nature.

PID assists in detecting, investigating and reporting potential fraud, waste and abuse cases.
Fraud, Waste and Abuse - Provider

Types of Provider Fraud, Waste and Abuse:

• Billing for services never provided
• Misuse of modifiers to increase payment
• Upcoding, unbundling and split-billing
• Excessive and/or unnecessary prescribing, testing, office visits and procedures
• Altering medical records or claims submissions
Fraud, Waste and Abuse - Member

Types of Member Fraud, Waste and Abuse:

- Use of another’s insurance card for medical care
- Falsifying information on an insurance application
- Not paying copayments or deductibles
- Forging prescriptions to obtain drugs for use or sale
Reporting Fraud Activity to Presbyterian

You can report fraud activity to Presbyterian by:

• Calling Presbyterian’s 24-hour fraud and abuse hotline at (505) 923-5959

• Online at the following web address:
  https://www.phs.org/health-plans/understanding-health-insurance/fraud-and-abuse/Pages/form.aspx

• Calling the State of New Mexico hotline at 800-239-3147

• Writing to Presbyterian's Program Integrity Department (PID)
  Presbyterian Health Plan
  Program Integrity Department (PID)
  P.O. Box 27489
  Albuquerque, NM 87125-7489
Cultural Sensitivity
Cultural Competency

What does it mean?

Presbyterian requires all staff to complete annual cultural competency training,

Cultural competency enhances communication and treatment effectiveness.

Being culturally competent includes awareness of the existence of culturally diverse populations and the potential for racial and ethnic healthcare disparities.

All cultures have unique views and practices in regard to illness and well-being that affect the healthcare decisions they make.
Cultural Sensitivity

- Language
- Ethnicity/race
- Age
- Gender
- Religious beliefs
- Values
- Traditions
- Diverse culture
- Ethnic backgrounds
- Limitations with English proficiency or reading skills
- Physical or mental disabilities
- State of homelessness
If a provider does not offer translation services, the Presbyterian Customer Service Center can be contacted to help coordinate these services.
Care Coordination

Stacey Hughes
Provider Representative
Provider Network Operations
Centennial Care Overview
Presbyterian has Centennial Care policies and procedures in place that focus on integrated care coordination, which combines physical, behavioral and long-term care services.

All providers types are encouraged to work together to ensure that patients and members receive the right amount of care, at the right time, in the right setting.
Centennial Care Covered Services

- Preventive services
- Laboratory tests
- Hospital care
- Urgent care and emergent care
- Prescription drugs
- Behavioral healthcare related services
- Long-term care services and support, which are called community benefit services
- Dental services
- Vision services
- Transportation services
Value Added Services

• Adult routine physicals
• Dental varnish for children
• Enhanced Care Coordination services
• Expansion of category 301/035 benefits – pregnancy related services
• Medisafe medication reminder
• Traditional Healing Benefit
• Baby Benefits Program
• School sports physicals
• Tabtime Vibe Vibrating Pill Timer reminder
Care Coordination
What is Care Coordination?

Maximizes health and functionality for members with chronic conditions

Assists with coordinating complex care needs

Facilitates appropriate and cost-effective care

Available for all Centennial Care members, including people with special health care needs

Promotes integration among providers including but not limited to behavioral health and long-term care
Care Coordination – Member Centric Model

The “Heart and Soul” of Centennial Care

With this model, the member is:

• The center of the care model

• An active participant

• Matched with the appropriate care coordinator

• Receives a holistic, multi-disciplinary approach to care coordination
The Care Coordination process starts by identifying a member’s needs at the time of enrollment with a health risk assessment (HRA).

If a need is indicated, a care coordinator will perform a face-to-face comprehensive needs assessment (CNA) to clearly identify all needs, risks and intensity of care coordination. The Care Coordinator develops a care plan with the member, caregivers, providers and family members, if appropriate.

Finally, the care coordinator’s goal is to assist high-risk members to prevent complications that may result in hospital and emergency room visits.
Members with Special Circumstances

Members with special circumstances are those who are under the care of one of the following:

- New Mexico’s Children Youth and Families Department (CYFD)
- New Mexico Corrections Department (NMCD)
- Tribal Custody

We support high-risk members using the following strategies:

- Behavioral health screening within 24 hours of referral
- Correctional facility-to-community transition planning
Critical Incident Management and Reporting/Training

Behavioral Health and Personal Care Service Providers
Who must report incidents?

- Personal care services (PCS) providers
- Support brokers
- Behavioral health providers
- How do I report incidents?

- Online at the following web address: [http://www.hsd.state.nm.us/providers/critical-incident-reporting.aspx](http://www.hsd.state.nm.us/providers/critical-incident-reporting.aspx)
Critical Incident Management & Reporting
Behavioral Health and Personal Care Service Providers

What qualifies as a critical incident?

• Abuse, neglect and/or exploitation
• Incidents that involve the following:
  o Emergency services
  o Death of a member
  o Involvement of law enforcement
  o Environmental hazards that compromise the health/safety of a member
  o Any elopement or missing member

Note: Incidents must be reported within 24 hours of knowledge of the incident.
Critical Incident Management Training

The following provider types and their staff must receive initial and ongoing training:

- Long-term Care Providers
  - Home and Community-Based Providers
  - Nursing Home Facility
- Behavioral Health Providers

Each agency is responsible to train all staff who work with Centennial Care members on the Critical Incident reporting requirements.

If training is not completed, agencies may be sanctioned up to and including termination of their provider contract with Presbyterian.
Presbyterian Quality Initiatives

Orlando Gonzalez
VBP Implementation Manager
Provider Network Operations
Presbyterian Quality Initiatives
Provider Quality Incentive Program (PQIP)

- PQIP, the entry level Quality Incentive program, is designed to encourage providers to focus on HEDIS® Quality Measures.
- Presbyterian provides quarterly updates on provider progress and gaps in care.
- Tiered reimbursement is based on percentage completed.

PQIP II Introduction

- PQIP II will differ from PQIP in that it will include additional, more rigorous targets, such as those seen under the PCMH program, while also including the base targets for PQIP.
- PQIP II is intended for more advanced PCPs and groups that are interested in advancing their model of care to the PCMH stage in the future.
- Participation in PQIP II will require at least two years of experience in the PQIP program.
Patient Centered Medical Homes - Small Group

The Presbyterian PCMH Value-based model for small group providers is approximately 1000 members.

- Must agree to pursue national recognition as a PCMH
- Assigned members in Centennial Care, Commercial HMO, Medicare HMO.
- Will receive payment per member, per month with opportunity for performance-based bonus.
  - Bonus is based on percent of completed utilization and quality targets.
Patient Centered Medical Homes
The PHP PCMH Value Based Model

- Assigned members in Centennial Care, Commercial HMO, Medicare HMO
- $2 payment per member, per month
  - Monthly payments range from $3,974 to $49,934
- Opportunity for shared savings
  - Based on a total cost of care reduction
  - Meeting two utilization and 10 quality targets

Value-based Purchasing- Provider Assistance

All value-based purchasing (VBP) arrangements provide the following:

- Gaps In Care Member Detailed Report
- Regular Scorecards:
  - PQIP - Quarterly
  - PCMH - Monthly
## Value Based Models

### PHP Glide Path: PQIP → PCMH

<table>
<thead>
<tr>
<th></th>
<th>PQIP</th>
<th>Advanced PQIP2</th>
<th>PCMH for Small Providers</th>
<th>PCMH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panel Size</td>
<td>No minimum No maximum</td>
<td>No minimum No maximum</td>
<td>Minimum 1000</td>
<td>Minimum 2000</td>
</tr>
<tr>
<td># of QA Measures</td>
<td>10</td>
<td>10</td>
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<tr>
<td># of UM Measures</td>
<td>N/A</td>
<td>IP Admits &amp; ED Visits</td>
<td>IP Admits &amp; ED Visits</td>
<td>IP Admits &amp; ED Visits</td>
</tr>
<tr>
<td>Patient Source</td>
<td>Imputed Only</td>
<td>Imputed Only</td>
<td>Assigned</td>
<td>Assigned</td>
</tr>
<tr>
<td>Compensation Methodology</td>
<td>Quarterly based on numerators</td>
<td>Quarterly based on numerators with annual quality performance bonus</td>
<td>PMPM w/ program annual utilization and quality bonus</td>
<td>PMPM w/ shared savings opportunities at end of year</td>
</tr>
<tr>
<td>Practice Administrative Involvement</td>
<td>Low Opt-In</td>
<td>Low Opt-In</td>
<td>Monthly follow up report, Member outreach, monthly meetings</td>
<td>High monthly report follow-ups, Member outreach, monthly meetings</td>
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<td>2017 Payout</td>
<td>$343,566</td>
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<td>TBD</td>
<td>$917,571</td>
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<tr>
<td>NCQA PCMH Criteria</td>
<td>None</td>
<td>2 standards / 1-2 elements</td>
<td>4 standards / 1-2 elements</td>
<td>6 standards / 1-2 elements</td>
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</tbody>
</table>
More Information on Quality, Medical Record Review or Guidelines:

For more information on Value Based Purchasing contact:

**Orlando Gonzalez**  
VBP – Implementation Manager  
Phone: 505-923-6205  
ogonzalez3@phs.org

For more information on HEDIS and Medical Record Review contact:

**Linda Bunnell**  
Director, Performance Improvement  
Phone: (505) 923-5727  
lbunnell@phs.org
Questions?
Presbyterian Behavioral Health

Raymond M. Jones
Provider Relations Liaison
Magellan Health Services
Behavioral Health Updates
The relationship between Presbyterian Health and Magellan Healthcare is united and seamless.

Magellan will identify itself as Presbyterian Behavioral Healthcare.

All Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs) are from Magellan Healthcare for all payments processed under behavioral health.
UPDATE: Roster Maintenance
Behavioral Health

It is very important that providers maintain accurate roster for their practice or agency

• This information assists with monitoring access for our members.

• Provider counts are submitted to the state on a quarterly basis for Medicaid providers, which are based on the information reported.

• Inaccurate rosters will have an impact on claims processing.

  ❖ You may receive rejection or denials for roster provider not registered or non-participating provider if there is no record in our system.
UPDATE: Roster Maintenance
Behavioral Health

How to update your roster electronically:

• Sign in on the Magellan provider website: www.MagellanProvider.com

• Select “Display / Edit Roster” from menu

• Select the “Roster Maintenance” option to add or remove...
In order to be compliant with new CMS regulations regarding data accuracy, providers are asked to attest to specific data field every three months. Below is the message you will see:
Updating Demographic Information

Behavioral Health

It is very important that behavioral health providers update their demographic information in the Presbyterian Behavioral Health database. This helps the plan demonstrate diversity to our members and assists in directing referrals appropriately.

Some of the items we encourage providers to update are:

- Language
- Ethnicity
- Specialties
Updating Demographic Information
Behavioral Health

You can update the following:

- Mailing, service and financial address
- W9 Updates
- Termination notice
- Referral supplement to help direct referrals:
  - Language
  - Ages seen
  - Office hours
  - Specialties
Credentialing

Behavioral Health

• Presbyterian delegated the responsibility of credentialing behavioral health providers to Magellan Behavioral Health for all product lines.

• Before Presbyterian can execute a new Behavioral Health Services Agreement, providers must successfully complete the credentialing process.

• Please contact Presbyterian Behavioral Health at 1-800-424-6035 to initiate a credentialing request or for questions about credentialing or recredentialing processes.
Claim Submission
Behavioral Health

Please send paper claims to:

**Medicare/Commercial**
Presbyterian Health Plan
P.O. Box 2216
Maryland Heights, MO 63043

**Centennial Care**
Presbyterian Behavioral Health
P.O. Box 25926
Albuquerque, NM 87125-5926

For Electronic Claims Submissions (ECT), please notify your clearinghouse to update the Payer ID for ECT submissions to add Magellan Payer ID – 01260 (Magellan Payer ID for Change Healthcare institutional claims only – 12x17)
EDI Resubmission of Claims

Resubmitted claims can be sent electronically via an 837 file.

- There is a specific indicator for an adjusted claim (please consult Magellan’s EDI companion guide or call the EDI hotline for assistance at 1-800-450-7281 ext. 75890).

- Professional Corrected Claims

  - EDI 837P data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an addition loop in the 2300 loop, segment REF*F8* with the original claim number for which the corrected claim is being submitted.

**Note:** Providers must send the REF*F8 as the original transaction number or claim number to prevent a denial for a “duplicate claim.”
EDI Resubmission of Claims

Institutional Corrected Claims:

- EDI 837I data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an addition loop in the 2300 loop, segment REF*F8* with the original claim number for which the corrected claim is being submitted.

- Must send the REF*F8 as the original transaction number or claim number to prevent a denial for a “duplicate claim.”

Note: If correcting the bill type on a claim, do not use 7 as the third digit.
PHP Physical Health

Payer ID: PREHP

- Processes all physical health claims (Centennial, Commercial, Medicare) with the physical health contract (executed by PHP). Processes inpatient detox and all claims not billed with an F category DX.
  - The PHP system will look at TIN/NPI, then Taxonomy/ZIP Code to determine processing.
- FQHC claims are processed when billed with rev code 0529, regardless of rendering provider/primary diagnosis.

PHP Behavioral Health

Payer ID: 01260

- Processes all behavioral health claims (Centennial, Commercial, Medicare) with the behavioral health contract (executed by PHP). Processes UB 04 based on DX and/or rev code. Process CMS 1500 based on rendering provider type.
- FQHC claims are processed by Magellan when billed with rev code 0919, regardless of rendering provider/primary diagnosis.
Requesting Centennial Care Authorizations
Behavioral Health

To request a behavioral health prior authorization, you must utilize the appropriate BH form.

- To find the form, go to [www.phs.org](http://www.phs.org)
  - “For Providers” tab
  - “Authorizations” tab

- Submit by faxing requests to (505) 213-0169 or emailing form to [NMCentennialCare@magellanhealth.com](mailto:NMCentennialCare@magellanhealth.com)

*Authorizations cannot be seen on the Magellan provider portal*
Requesting Commercial/Medicare Authorizations

Behavioral Health

Providers must request prior authorizations by calling the Presbyterian Behavioral Health Utilization Management line at 1-800-424-4657.

To view prior authorizations on the Magellan provider portal:

• Sign in on the Magellan provider website; www.MagellanProvider.com

• Select “View Authorizations” from the menu

➤ This will show the provider information, codes and dates of service under which the authorization was completed.
Utilization Management
Behavioral Health

Presbyterian’s utilization management includes:

• List of services that will require prior authorization

• Higher levels of care and some community based services

• Conformity to parity requirements — prior authorization for behavioral health services will not be more restrictive than a comparable physical health service

• Review of utilization trends of services that do not require authorization to identify outlier cases or providers, and/or to re-evaluate need for prior authorization
Presbyterian Behavioral Health Training

Behavioral Health

• In-depth training for our provider portal is offered on a monthly basis [https://www.magellanprovider.com](https://www.magellanprovider.com)

• New provider orientation training monthly

• Quarterly in-person town hall discussions with our leadership team

Providers may request one-on-one training on the Magellan provider portal with their provider liaison.
Contact Information

To contact a Behavioral Health provider specialist, please contact: 1-800-424-6035 or phpccbh@magellanhealth.com.

Amber Grewal, Network Director, (505) 923-6852, AMGrewal@magellanhealth.com

Amy Hallquist, Area Contract Manager:
• (505) 923-6746
• ahallquist@magellanhealth.com

Adam Saxton, Provider Relations Manager:
• (505) 923-6752
• masaxton@magellanhealth.com

Jessica Taylor, Sr. Provider Relations Liaison:
• (505) 923-6761
• jtaylor4@magellanhealth.com

Gina Romero, Provider Relations Liaison:
• (505) 923-6753
• romerog@magellanhealth.com

Raymond M. Jones, Provider Relations Liaison:
• (505) 923-6754
• mjones@magellanhealth.com

Vanessa Chavez, Provider Relations Liaison:
• (505) 923-5427
• chavezv@magellanhealth.com
Quality Updates
We are here to help…PCP Toolkit

Behavioral Health

Presbyterian, in partnership with Magellan, offers resources that can help with:

• Screening for BH conditions, including: ADHD, anxiety, depression, eating disorders, schizophrenia, substance abuse, suicidal ideation and many, many more

• Diagnostic tools for PCPs and other providers

• Clinical practice guidelines

• Informational handouts, including information about network quality metrics

Behavioral Health Toolkit for Medical Providers

The primary care provider’s resource for coordinating a patient’s behavioral health needs.

Manage behavioral health conditions

- Behavioral health conditions
- Diagnostic screening tools
- Clinical practice guidelines
- Patient handouts
- Community resources
- Quality Measures

Refer a patient or request a consultation

- About this toolkit
- Refer to a behavioral health provider
- Request consultation with a medical director
Questions?