Today’s Discussion

- Accomplishments
- Quality
- System improvements
- Member health
- Performance measures review
- Oversight
- Committees and forums
- Looking ahead to 2018
Mission Statement

- Heritage Health is a person-centered approach to administering Medicaid benefits that provides Medicaid and CHIP members a choice of a single plan that provides all of their physical health, behavioral health, and pharmacy benefits and services in an integrated health care program. Integrated care through Heritage Health will improve member health outcomes, reduce costly and avoidable care, decrease reliance on emergency and inpatient levels of care by providing evidence-based care options that emphasize early intervention and community-based treatment, addresses social determinants of health, and improves the financial sustainability of the system.
Accomplishments

Value the Heritage Health Plans bring to the program and across the State

- 2,950,721 claims paid January 1 through October 31
- $743,546,345.11 claims paid January 1 through October 31
- Health plan enrollment
- Care management for members
- Access to value-added services
- Health plans’ NCQA accreditation
- Community partners across the state
- Giving back to the communities
Open Enrollment – November 1st through December 15th

- Annual opportunity for members to select a new health plan.
- Our Enrollment Broker, Automated Health Systems, outreached out to members to offer assistance with their plan changes by mail, a call campaign, and online announcements.
- Members who are happy with their health plans do not have to take any action during the annual open enrollment period.
Managed Care brings many value-added services to members. A few highlights for 2018 include:

- **Weight Watchers**: free membership for members in active case management
- **YMCA**: 3-month membership in most communities for members in active case management
- **Boys and Girls Club**: free membership
- **CentAccount**: rewards card for healthy behaviors
- **Start Smart for Your Baby**: maternity management program (includes breast pumps)
- **Over the Counter**: certain OTC products at no cost, up to $30 per household per quarter
  
  Call 1-844-385-2192 or visit online: NebraskaTotalCare.com

- **myHealthLine**: no cost smartphone program with texting to help members manage health
- **No Copays**: there are no costs to you for benefits and services
- **myMoney Connect**: prepaid reloadable debit MasterCard with wellness rewards
- **Healthy First Steps**: Ensures that mom and baby get good medical attention
- **Baby Blocks**: reminders and reward gift cards to keep mom-to-be and baby healthy
- **Transportation**: Member transportation to WIC, parenting classes, AA/NA Meetings
  
  Call 1-800-641-1902 or visit online: www.uhccommunityplan.com/ne

- **Girl Scouts/Boy Scouts**: annual membership for members ages 6-18
- **Lifeline**: free cell phone
- **Steps2Success**: Free job training and personal finance training, plus free GED testing
- **Additional Waived Co-Payments**
- **Car Seats**: for pregnant members
- **Healthy Rewards Program**: gift card rewards for specific wellness visits and preventive care
  
  Call 1-855-599-3811 or visit online: www.wellcare.com/nebraska

NCQA is the industry recognized gold standard for health plans, and its review encompasses quality, network, utilization management, credentialing, rights and responsibilities and member connections.

UnitedHealthcare Community Plan has been accredited by the National Committee for Quality Assurance (NCQA) since 2005 and has maintained a status of commendable.

WellCare of Nebraska obtained their Interim Health Plan Evaluation on June 13, 2017.

Nebraska Total Care obtained their Interim Health Plan Evaluation on October 6, 2017.
Community Events
Statewide participation with various partners

Omaha JDRF Walk
Community Baby Showers
Helping People Live Better Lives. Together Omaha, Hydration Station
Giving Back to the Communities

A snapshot of programs & activities

- Community gardens
- Resource grants to 501c3 organizations
- Baby’s First, free texting program for new parents
- Foster Care Connections Duffle Bag Program
- Kicking with the Jays – free soccer clinic for children
- Adopt-a-school partner
- Vision Van

- Coordinating with the Division of Behavioral Health, Division of Children and Family Services, Division of Developmental Disabilities, Department of Education, The Office of Probation, Nebraska Association Behavioral Health Organizations, other community & local agencies.
Member Advisory Committee

- To promote a collaborative effort to enhance the MCO’s patient-centered service delivery system
- Comprised of members, members’ representatives, providers, and advocates who reflect the MCO’s population and communities served
- Orientation and ongoing training provided for committee members to ensure they have sufficient information and understanding of the managed care program to fulfill their responsibilities
- Quarterly meetings
- Allows clients to provide input into the MCO’s planning and delivery of services; quality management; program monitoring and evaluation; and member, family, and provider education
- Health plans report to MLTC on membership, training, and committee activities semi-annually
Provider Advisory Committee

- The MCO’s provider advisory committee must have representation from the major provider organizations in the State, as well as individual providers;
- The MCO’s provider advisory committee must include behavioral health and pharmacy providers, as well as providers who primarily serve individuals with disabilities;
- Whenever feasible, MCO staff shall work collaboratively with the provider advisory committee, as well as established provider organizations, to create network development and management strategies and procedures.
- In addition, the MCO must establish a behavioral health advisory committee to provide input to the provider advisory committee.
Quality

- Value-based contracting
- Enhanced partnership with sister DHHS divisions
- Performance measures specific to Nebraska’s Medicaid members
- Performance improvement projects (PIPs)
- Care management
- Social determinants of health determinations
- Referrals to community resources
- Customer satisfaction surveys
- HEDIS measures
An EQR is the analysis and evaluation of aggregated information on quality, timeliness, and access to Medicaid-covered services.

Federal regulation set parameters that states must follow when conducting an EQR of the contracted health plans.

The EQRO must review the MCO’s compliance with standards for access to care, structure and operations, and quality management.

The EQRO must also validate performance measures and performance review projects.

Looking Ahead...

Managed care auditor: MLTC plans to procure the services of a managed care financial auditor in 2018.
Financial Incentive for Quality

Quality Performance Program (QPP) Measures

- Contractual requirement for 1.5% withhold of total revenue
- Funds can only be earned by meeting QPP measures
- Year One – administrative measures
- Year Two – Shifting to a mix of clinical and administrative measures

These measures are revisited annually and can include operational and/or administrative measures that reflect MCO business processes and may lead to improved access to and quality of care, CMS Medicaid Adult and Child Core Measure sets, HEDIS measures, and MLTC-identified measures that represent opportunities for improvement.
<table>
<thead>
<tr>
<th>Base Performance Requirement</th>
<th>Payment Threshold</th>
<th>% of Payment Pool</th>
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</thead>
<tbody>
<tr>
<td>Claims Processing Timeliness - 15 Days: Process and pay or deny, as appropriate, at least 90% of all clean claims for medical services provided to members within 15 business days of the date of receipt. The date of receipt is the date the MCO receives the clean claim.</td>
<td>95% within 15 business days</td>
<td>20%</td>
</tr>
<tr>
<td>Pharmacy Claims Processing Timeliness - 7 Days: Process and pay or deny, as appropriate, at least 90% of all clean claims from pharmacy providers for covered services within seven calendar days of receipt. The date of receipt is the date the MCO receives the claim.</td>
<td>95% within 7 calendar days</td>
<td>10%</td>
</tr>
<tr>
<td>Encounter Acceptance Rate: 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.</td>
<td>98%</td>
<td>20%</td>
</tr>
<tr>
<td>Call Abandonment Rate: Less than 5% of calls that reach the Member/Provider 800 lines and are placed in queue but are not answered because the caller hangs up before a representative answers the call. Measured using annual system-generated reports.</td>
<td>&lt;3%</td>
<td>10%</td>
</tr>
<tr>
<td>Average Speed to Answer: Calls to Member/Provider lines must be answered on average within 30 seconds. Measured using annual system-generated reports.</td>
<td>30 seconds</td>
<td>10%</td>
</tr>
<tr>
<td>Appeal Resolution Timeliness: The MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 45 calendar days from the day the MCO receives the appeal.</td>
<td>95% within 30 days</td>
<td>10%</td>
</tr>
<tr>
<td>Grievance Resolution Timeliness: The MCO must dispose of each grievance and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes not to exceed 90 calendar days from the day the MCO receives the grievance.</td>
<td>95% within 60 days</td>
<td>10%</td>
</tr>
<tr>
<td>PDL Compliance: The MCO shall dispense medications in PDL categories compliant with Nebraska State PDL Preferred Status at least 92% of the time each quarter.</td>
<td>95%</td>
<td>10%</td>
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### QPP Measures Year Two

<table>
<thead>
<tr>
<th>Base Performance Requirement</th>
<th>Payment Threshold</th>
<th>% of Payment Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claims Processing Timeliness - 15 Days:</strong> Process and pay or deny, as appropriate, at least 90% of all clean claims for medical services provided to members within 15 days of the date of receipt. The date of receipt is the date the MCO receives the clean claim.</td>
<td>95% within 10 business days</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Encounter Acceptance Rate:</strong> 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.</td>
<td>98%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Call Abandonment Rate:</strong> Less than 5% of calls that reach the Member/Provider 800 lines and are placed in queue but are not answered because the caller hangs up before a representative answers the call. Measured using annual system-generated reports.</td>
<td>&lt;2%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Appeal Resolution Timeliness:</strong> The MCO must resolve each appeal, and provide notice, as expeditiously as the member’s health condition requires, within 45 calendar days from the day the MCO receives the appeal.</td>
<td>95% within 20 days</td>
<td>10%</td>
</tr>
<tr>
<td><strong>PDL Compliance:</strong> The MCO shall dispense medications in PDL categories compliant with Nebraska State PDL Preferred Status at least 92% of the time each quarter.</td>
<td>95%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Lead Screening in Children - The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.</strong></td>
<td>65%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Well-Child Visits in the First 15 Months of Life - The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life:</strong></td>
<td>52% with 6 Visits or more</td>
<td>10%</td>
</tr>
<tr>
<td>0 Visits, 1 Visit, 2 Visits, 3 Visits, 4 Visits, 5 Visits, 6 Visits or more</td>
<td><strong>Childhood Immunization Status:</strong> The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.</td>
<td>Combination #2 - 19%</td>
</tr>
<tr>
<td><strong>Combination #10 - 8%</strong></td>
<td><strong>Combination #10 - 5%</strong></td>
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</tbody>
</table>
System Improvements

Administrative Simplification Projects in Process

- Review of over-the-counter medications
  • Create a comprehensive list of OTCs that are preferred by Medicaid

- Prior authorization for DME based on price limits
  • Offer consistency across the plans to ease the administrative burden on providers

- Common form to change PCP selection for members
  • Ease the administrative burden for providers by having one form available to all members who express an interest in changing their PCP assignment on their member ID card.
Member Health

Goals MLTC set for Heritage Health

- Improved health outcomes
- Enhanced integration of services and quality of care
- Emphasis on person-centered approach, care management, enhanced preventive services, and recovery-oriented care
- Reduced rate of costly and avoidable care
29 year old member with multiple conditions and mobility issues. Her grandmother has taken over her care due to member’s mother passing away a couple of months ago. NTC I/DD case manager (CM) received a call from the grandmother requesting our help with getting a Hoyer lift for member. Grandmother is elderly and has medical problems and is not able to lift the member.

- A prior authorization (PA) had been received by NTC but clinical notes were missing.
- CM spoke with the staff that was working on the PA and explained the situation.

With the help of NTC’s prior authorization department the authorization was able to be approved quickly. When CM called the member’s grandmother to inform of the approval, she was in tears. “Thanks so much for all the help you all have given us.”
57-year-old male member who was has been diagnosed with uncontrolled Type 2 Diabetes, hypertension, chronic back pain, depression, and schizophrenia.

41-year-old female member experiencing mental illness, seizures, and learning disabilities.

The couple was homeless and had been living at a shelter for two years.

They do not have transportation which has been a barrier to their health and to accessing social supports and resources.

The 57-year-old member was a frequent user of the ER and was often hospitalized for infections and diabetes.

The UnitedHealthcare Community Plan housing navigator assisted the couple to secure housing.

Care management has resulted in improved health and decreased emergency room visits.

Improved health outcomes, reduced rate of costly and avoidable care.
The 55-year-old female referred to CM; she was diagnosed with diabetes, cataracts and schizophrenia. She was not taking her medications because her income forced her to choose between getting her prescriptions or having enough food for the month. She had not seen a psychiatrist in several months.

Her new WellCare care manager coordinated appointments for her with an ophthalmologist, a dentist and a psychiatrist. He ensured that transportation was arranged for each appointment and that she kept each appointment. He ensured that she got her prescriptions filled and also assisted her in identifying and applying for community resources that provide free cell phones and another which helped her lower her monthly utility bills.

This WellCare member was facing institutionalization without CM assistance due to her decline in both medical and mental health.
Monitoring Performance

- Data from the 50+ contractually required reports
- Evaluating and assessing whether the reporting elements are effective and assessing what could be done differently
- Plan management team are digging into the data along with MLTC’s data and analytics team
- Continued evolution of the public dashboard
According to guidelines developed by the Strategic National Implementation Process (SNIP), a part of Workgroup for Electronic Data Interchange (WEDI), entities need to test their system(s) to seven different types to assure compliance.

1. Integrity testing
2. Requirement testing
3. Balancing testing
4. Situation testing
5. Code set testing
6. Product types/types of service testing
7. Trading partner-specific testing
# Top Claim Rejection Reasons

<table>
<thead>
<tr>
<th>Nebraska Total Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>RENDERING NPI/TIN ON DOS NOT ENROLLED WITH STATE</td>
</tr>
<tr>
<td>MBR NOT VALID AT DOS</td>
</tr>
<tr>
<td>INVALID MBR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UnitedHealthcare Community Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUBSCRIBER AND SUBSCRIBER ID NOT FOUND</td>
</tr>
<tr>
<td>PROVIDER TAX ID IS NOT FOUND</td>
</tr>
<tr>
<td>PATIENT ELIGIBILITY NOT FOUND</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>WellCare Health Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT WAS NOT ELIGIBLE FOR BENEFITS UNDER THIS PLAN ON THE DATE OF SERVICE</td>
</tr>
<tr>
<td>BILLING OR RENDERING PROVIDER NOT ON STATE ROSTER</td>
</tr>
<tr>
<td>NO TAXONOMY TO ACCOMPANY NPI</td>
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</table>
### Top Claim Denial Reasons

<table>
<thead>
<tr>
<th>Reason</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duplicate Claim Service</strong></td>
<td>Bill primary insurer 1st, resubmit with EOB. Coverage not in effect when service provided.</td>
</tr>
<tr>
<td><strong>Exact Duplicate Claim/Service</strong></td>
<td>Expenses incurred after coverage terminated. Missing/incomplete/invalid prior insurance carrier(s) EOB.</td>
</tr>
<tr>
<td><strong>Prior Authorization Required But Not Obtained</strong></td>
<td>Exact duplicate of another claim or service. Must submit an EOB from the primary insurance carrier.</td>
</tr>
</tbody>
</table>
AVERAGE CALL LENGTH (MEMBERS)

- Nebraska Total Care
- United Healthcare
- Well Care

<table>
<thead>
<tr>
<th>Month</th>
<th>Nebraska Total Care</th>
<th>United Healthcare</th>
<th>Well Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>9.5</td>
<td>9.5</td>
<td>7.7</td>
</tr>
<tr>
<td>Feb</td>
<td>9.5</td>
<td>9.5</td>
<td>7.6</td>
</tr>
<tr>
<td>Mar</td>
<td>9.5</td>
<td>6.6</td>
<td>6.2</td>
</tr>
<tr>
<td>Apr</td>
<td>9.5</td>
<td>6.2</td>
<td>5.6</td>
</tr>
<tr>
<td>May</td>
<td>9.3</td>
<td>7.2</td>
<td>8.3</td>
</tr>
<tr>
<td>Jun</td>
<td>9.9</td>
<td>9.3</td>
<td>8.0</td>
</tr>
<tr>
<td>Jul</td>
<td>9.0</td>
<td>8.2</td>
<td>8.9</td>
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<tr>
<td>Aug</td>
<td>9.5</td>
<td>9.5</td>
<td>8.9</td>
</tr>
<tr>
<td>Sep</td>
<td>9.5</td>
<td>8.9</td>
<td>8.5</td>
</tr>
<tr>
<td>Oct</td>
<td>9.0</td>
<td>9.0</td>
<td>8.5</td>
</tr>
</tbody>
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Minutes
ABANDONMENT (PROVIDERS)

- Nebraska Total Care
- United Healthcare
- Well Care

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<thead>
<tr>
<th></th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
<th>JUL</th>
<th>AUG</th>
<th>SEP</th>
<th>OCT</th>
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<tr>
<td></td>
<td>0.7%</td>
<td>0.5%</td>
<td>0.8%</td>
<td>1.0%</td>
<td>1.5%</td>
<td>1.7%</td>
<td>0.9%</td>
<td>1.0%</td>
<td>0.5%</td>
<td>2.0%</td>
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<tr>
<td></td>
<td>1.3%</td>
<td>1.0%</td>
<td>0.7%</td>
<td>1.0%</td>
<td>0.9%</td>
<td>1.0%</td>
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<td>0.2%</td>
<td>0.4%</td>
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<tr>
<td></td>
<td>1.9%</td>
<td>0.7%</td>
<td>0.4%</td>
<td>1.3%</td>
<td>1.5%</td>
<td>2.0%</td>
<td>1.7%</td>
<td>0.6%</td>
<td>0.5%</td>
<td>4.3%</td>
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Oversight

- Regular meetings and conference calls with health plan leadership, onsite visits, weekly monitoring of all active issues, provider outreach, ad hoc requests for claims payment information and review of contractually required reports.
- Looking forward to 2018 with new QPPs and continued progress with issue resolution.
- Additional year two recourses include managed care auditor, member surveys.
- WellCare CAP was lifted after extensive efforts to improve systems & ensure claims payment accuracy.
  - WellCare has to continued to:
    - Provide MLTC with claims payment reports.
    - Participate in bi-weekly calls with MLTC with plan leadership regarding issues raised in the CAP.
    - Maintain the “Known Issues and Resolution Timeframes” log on public website.

 neoliberalism

## Committees and forums

<table>
<thead>
<tr>
<th>Administrative Simplification Committee</th>
<th>Behavioral Health Integration Advisory Committee</th>
<th>Quality Management Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 20, 2018</td>
<td>December 15, 2017</td>
<td>January 17, 2018</td>
</tr>
<tr>
<td>May 15, 2018</td>
<td>February 13, 2018</td>
<td>April 18, 2018</td>
</tr>
<tr>
<td>August 21, 2018</td>
<td>April 17, 2018</td>
<td>July 18, 2018</td>
</tr>
<tr>
<td>November 20, 2018</td>
<td>June 12, 2018</td>
<td></td>
</tr>
</tbody>
</table>

### Administrative Simplification Subcommittee
- Updates on Known Issues and Open Forum for Providers
- December 19, 2017
Committee Accomplishments

- Common authorization forms for behavioral health providers
- Utilization of provider and association feedback to improve processes related to:
  - Billing forms
  - Billing instructions
  - Physical therapy authorizations
  - Home health services
  - Crossover claims
- Improved relationships with and continued outreach to providers
- Progress toward a steady state of operations
- Steady decline of issues reported to MLTC since June
Questions & Answers

Thomas “Rocky” Thompson, Interim Director

Medicaid & Long-Term Care
rocky.thompson@nebraska.gov

Heritage Health Website:
dhhs.ne.gov/heritagehealth