



 The logo for Heritage Health, featuring a stylized leaf icon to the left of the word "HERITAGE" in a large, blue, sans-serif font, with the word "HEALTH" in a smaller, blue, sans-serif font below it.

The State of Nebraska, Department of Health and Human Services (DHHS) has contracted with UnitedHealthCare Community Plan, Nebraska Total Care (Centene), and WellCare of Nebraska to provide statewide integrated medical, behavioral health, and pharmacy services for approximately 230,000 Medicaid and Children's Health Insurance Program (CHIP) enrollees through the Medicaid managed care delivery system. This new program is called Heritage Health. Heritage Health plans will begin operations on January 1, 2017. This fact sheet highlights major provisions of the program, including changes to the existing managed care delivery system.

### Managed Care in Nebraska

In a risk-based managed care delivery system, health plans are responsible for the management and provision of specific covered services. Plans receive a monthly payment for the provision of services under the contract for members enrolled in their health plans. Medicaid managed care in Nebraska has steadily evolved since 1995, from an initial program that provided physical health benefits in three counties, to today's program that oversees physical and behavioral health services statewide. Today, approximately 80% of individuals who qualify for Medicaid receive their physical health benefits through managed care and almost all Medicaid members receive their behavioral health benefits through managed care. By integrating responsibility for these services into a single health plan, important information is available to the care management team, allowing health care managers to identify individuals who may be at risk and facilitate earlier intervention.

### Behavioral Health Integration

Mental illness and substance use disorders often co-occur with chronic conditions such as heart disease, cancer, and diabetes. Having one health plan responsible for the full range of services for a recipient encourages investment in more cost-effective services to better address the health care needs of the whole person. DHHS has formed a Behavioral Health

Integration Advisory Committee to work carefully with the Department and the contracted health plans to prepare for the integration of services and promote a successful transition for both members and providers.

### New Populations

Heritage Health will include groups of enrollees who have previously been excluded from participation from the state's physical health managed care program, but who have received their behavioral health services through the state's behavioral health managed care contractor. These groups include individuals who are enrolled in one of the Department's home and community-based waiver programs for individuals with physical disabilities or developmental disabilities, as well as individuals who live in long-term care institutional settings such as nursing homes or intermediate care facilities for people with developmental disabilities (ICF-DDs).

While these individuals will have their physical, behavioral and pharmacy health services coordinated by their Heritage Health plan, the administration of their actual long-term supports and services (such as their institutional care or in-home care) will continue to be administered as it is today while the state works with stakeholders to study reform for that system.

### Focusing on Quality, Care Management and the Social Determinants of Health

Heritage Health plans are required to report comprehensively on a wide variety of nationally recognized health measures. Nebraska Medicaid will partner with its sister Divisions to use this reporting to design and implement quality improvement programs, with the aim of establishing Nebraska as a performance leader in a broad range of health measures for children and adults. Furthermore, quality measure reporting will lead to the establishment of performance goals tied to financial incentives for measures specific to the needs of Nebraska Medicaid's



members. These measures and quality improvement activities will be further informed by the establishment of the Heritage Health Quality Committee comprised of providers, quality experts, clinical leadership from within divisions of DHHS, and health plan representation.

Heritage Health plans are required to implement a robust care management strategy focused on the early identification of members who require active care management. Once a member is identified for active care management, the goal of the program is to ensure that the member receives the appropriate level of care and prevent costly episodes of care like emergency room visits or hospital readmissions.

The Heritage Health contracts require health plans to integrate the social determinants of health in their health risk assessment and care management strategy. There are clear connections between social factors like housing, food security and education with health outcomes. All health plan staff must be trained on how social determinates affect members' health and wellness, including issues related to housing, education, food, and trauma. Staff must also be trained on and have access to information regarding Nebraska community resources and making referrals to these agencies and other programs that are helpful to members.

## Expanding Access

Heritage Health plans must maintain robust provider networks which include hospitals, physicians, specialists, pharmacies, mental health and substance use disorder providers, Federally Qualified Health Centers, Rural Health Clinics, and allied health providers. These networks of providers must offer an appropriate range of preventive, primary care, specialty, and recovery-oriented services that meet specific provider access standards. Heritage Health plans will also support and promote Patient-Centered Medical Homes which provide comprehensive, coordinated health care through consistent, on-going contact throughout the health care system and other Health Home models.

## Enhanced Accountability

Nebraska Medicaid is dedicated to ensuring strict accountability for the Heritage Health program in regards to all requirements included in the contract and federal rules. Heritage Health plans are required to have in place policies and procedures approved by Nebraska Medicaid for specified requirements in the contract and will be required to report monthly, quarterly, semi-annually and annually on numerous operational and performance measurements. Health plans must also provide Nebraska Medicaid staff access to all information systems related to the integrated managed care program.

In addition to an extensive readiness review process prior to the contract start date, Nebraska Medicaid will conduct periodic operational reviews to ensure program compliance and identify best practices. These reviews will identify areas for improvement and assess the health plans' progress towards implementing mandated programs or operational enhancements.

The Heritage Health contracts include financial incentives and penalties designed to ensure compliance with key operational provisions and to incentivize strong performance on program goals. The contract allows Nebraska Medicaid to adjust penalties and incentives as the program evolves to address operational needs or incentivize quality improvement on measures identified by the State in consultation with stakeholders.

## Supporting Providers

The integrated managed care contracts include provisions that will improve the overall experience for providers through process simplification and communication enhancement. Key provider focused provisions include:

- Timely payment requirements that shorten the time period between the filing of claims and the receipt of payments,
- Claims processing requirements which simplify the filing process for providers and allow providers to more closely track the status of their claims,



- ➔ Requirement that health plans utilize the common state preferred drug list (PDL) for prescription drugs,
- ➔ Extensive provider training requirements to assure providers receive the information they require and have ongoing access to training staff and materials,
- ➔ Requirements for dedicated provider services staff including a provider services manager, provider claims educator, and provider call center staff,
- ➔ Health plan-established Provider Advisory Committees that include participation from a variety of provider types, and
- ➔ A provider complaint system that allows for the timely identification and resolution of provider concerns.

In addition, Nebraska Medicaid is forming a Provider Administrative Simplification Committee to meet regularly with providers, administrative staff, DHHS staff, and health plan staff to identify further opportunities to streamline the administrative experience of providers as the program evolves.

## Focusing on Value

Medicaid programs and other health system payers are focused on moving away from the fee-for-service model of reimbursing for health care services which encourages volume and may do little to promote value. The Heritage Health program has been designed to promote greater collaboration between health plans and providers by encouraging more sophisticated strategies for purchasing health care services. Value-based purchasing requirements promote added value for members and providers by aligning the financial goals of the health plan and the provider. The Heritage Health contracts defines value-based contracts as payment and contractual arrangements between the health plans and providers that include two components:

- ➔ Accountability for improvements in health outcomes, care quality, or cost efficiency; and

- ➔ Payment methodologies that align providers' financial and contractual incentives with those of the health plan.

Heritage Health plans are required to enter into value-based contracts with a growing portion of its contracted providers by the third year of the contract and to have in place value-based contracts with at least 50% of its providers by the fifth year of the contract.

## Supporting our Partners

Collaboration with other state and community agencies is important to ensuring that members served by multiple programs have full access to the benefits and services for which they are eligible. To help ensure stronger collaboration, Heritage Health plans are required to coordinate with other DHHS Division and State agency programs including:

- ➔ Division of Behavioral Health funded programs,
- ➔ Division of Children and Family Services funded programs that support the safety, permanency, and well-being of children in the care and custody of the State,
- ➔ Division of Developmental Disabilities programs that involve rehabilitative and habilitative services for persons with developmental disabilities,
- ➔ The Nebraska Department of Education,
- ➔ Community agencies including but not limited to the Area Agencies on Aging and League of Human Dignity Waiver Offices,
- ➔ The Office of Probation, and
- ➔ Other programs and initiatives within MLTC related to primary care and behavioral health integration/coordination and pharmacy management.

## Engaging and Protecting Members

The Heritage Health RFP includes strong protections for Medicaid members and provisions that ensure members receive timely information in easily accessible formats that empower them to actively engage in their health care decisions. Heritage Health Plans are required to proactively provide



information on benefits and services in a variety of physical and electronic formats. Plans are required to operate a toll-free member services call center in accordance with requirements that ensure member questions and concerns are addressed in a timely and accurate fashion. Each Heritage Health plan must evaluate member experience annually using a nationally-recognized survey, and report results to Nebraska Medicaid. Finally, health plans are required to have an extensive DHHS-approved grievance and appeals process and members will always have access to the state fair hearing process.

A key principle for Heritage Health is member choice. DHHS has contracted with Automated Health Systems to act as an independent enrollment broker to provide member outreach and support in choosing the right Heritage Health Plan for the recipient or their family. Enrollment activities will begin in the fall of 2016.

## Calendar of Events

Activity	Date
<b>DHHS announces the signing of contracts with UnitedHealthCare Community Plan, Nebraska Total Care (Centene), and WellCare of Nebraska, for the Heritage Health program.</b>	April 15, 2016
<b>DHHS announces the signing of a contract with Automated Health Systems for Enrollment Broker Services.</b>	May 9, 2016
<b>Coordination and planning meetings begin between DHHS, Heritage Health plans, and the enrollment broker.</b>	Spring 2016
<b>DHHS launches meetings of the Behavioral Health Integration Advisory Committee, Administrative Simplification Committee, and Quality Management Committee.</b>	Spring/Summer 2016
<b>DHHS begins Readiness Reviews of Heritage Health plans.</b>	Summer 2016
<b>Heritage Health enrollment begins.</b>	Fall 2016
<b>Heritage Health plans begin operations.</b>	January 1, 2017