
UnitedHealthcare Community Plan Heritage Health Overview

Nursing Facility Provider Webinar
August 8, 2016

Our United Culture

Our mission is to help people live healthier lives.
Our role is to make health care work for everyone.

Integrity.
Compassion.
Relationships.
Innovation.
Performance.

Honor commitments
Never compromise ethics

Walk in the shoes of people we serve
and those with whom we work

Build trust through collaboration

Invent the future, learn from the past

Demonstrate excellence
in everything we do

Our Experience and Capabilities



We partner with **24 states plus Washington DC** to deliver Medicaid Managed Care services and operate Medicare plans for Medicare & Medicaid eligible individuals in 14 states.

- **Largest health benefits company** dedicated to serving the economically disadvantaged, the medically underserved and those without the benefit of employer funded coverage
- Provide **innovative Medicaid managed care solutions** to states – bridge the gap to make health care more accessible and more affordable
- Leverage the **national capabilities of UnitedHealth Group to deliver local market level support** for effective care management, strong regulatory partnerships, greater administrative efficiency, improved clinical outcomes and adaptability in a changing market environment

Nebraska Health Plan Facts

- UnitedHealthcare has been operational in Nebraska since 1984
 - Total individuals covered – over 428,000
 - With more than 328 employees in Nebraska market
 - Over 74 contractors
- UnitedHealthcare Community Plan of Nebraska
 - The Health Plan began serving Nebraska Medicaid clients in 1996 in three counties and added seven additional counties in 2010
- UnitedHealthcare Community Plan of Nebraska has been accredited by the National Committee for Quality Assurance (NCQA) since Aug. 2005

NE Medicaid Statewide Network

Hospitals	109
Primary Care Providers	1,289
Specialists	2,801
Allied Health	3,727
Federally Qualified Health Centers	10
Rural Health Centers	127

Social Determinants

Disease Prevalence

- Disproportionate prevalence of disease states – infant mortality, HIV, high risk pregnancy, physical and mental disabilities, alcohol and substance abuse
- High percentage of adult Medicaid beneficiaries have multiple chronic conditions

Communication Barriers

- Limited education and literacy (6th grade level); poor health care literacy
- Non-English speaking households; high prevalence of Spanish
- Often lack a working telephone or permanent address for mail

Transient

- Frequent address changes
- Lack of reliable transportation/restricted ability to travel to appointments
- Homeless or living in shelters and other community facilities

Limited Access to Care

- Nationally, the average continuous eligibility is nine months
- Lack of a medical home; reliance on safety net providers

Lack of Personal Support Network

- Reliance on community services (e.g., shelters, food banks, counseling, child care) and government programs (e.g., WIC, food stamps, SNAP)
- Personal network varies by age, health status

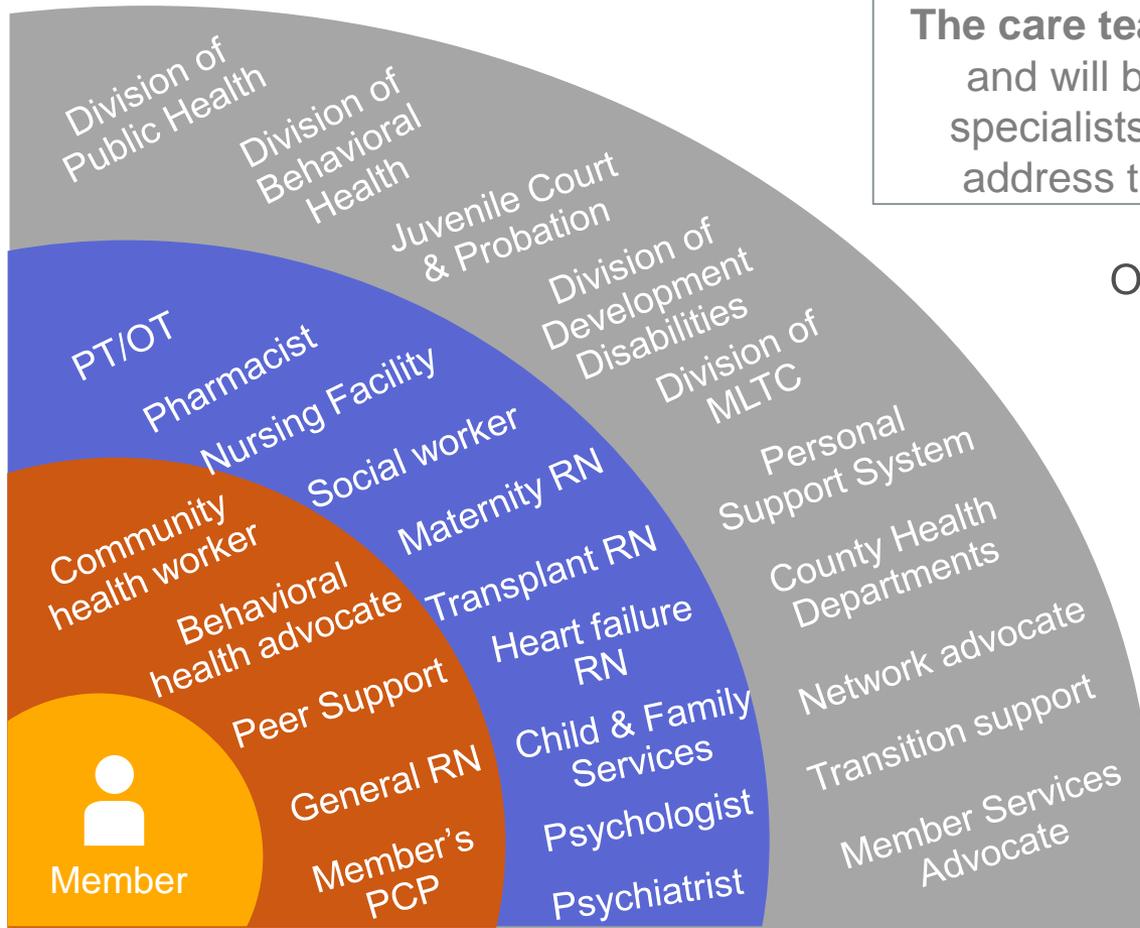
Inconsistent Patterns of Care Utilization

- Fragmented care, reduced access to care, lack of routine care and prevention
- Emergency Room utilized as primary care substitute

Six key principles behind the Care Model center on a change from traditional to integrated care

1. Moving from a disease-centric model to a member-driven, physical-behavioral-social needs model by operating with a collaborative team approach to deliver care using a standardized protocol
2. Treating members in a holistic manner by using a single member driven treatment plan, including helping the member access their natural community supports based on their strengths and preferences
3. Use of clinical systems and claims platforms that allow for a seamless coordination across interdisciplinary care teams
4. Focused on multi-morbidities in patients with chronic clinical conditions to improve health outcomes and affordability
5. Improved screening and treatment of mental health and substance use disorders
6. Providing care that is respectful and responsive to an individuals preferences and needs

Whole Person Care



The care team will report to one leader and will be supported by program specialists who can “flex” to quickly address the needs of the member

Optimal health and well-being

Whole person centered care

Whole person care focuses on how the physical, behavioral and social needs of a person are interconnected to maintain good health

Aligned to the delivery system

Care focused on supporting the physician to member relationship

Covered Benefits

- Short-term acute rehabilitation is covered and needs service authorization
- Long-term custodial care is not covered under managed care
- In-home hospice and short-stay inpatient hospice are covered
 - Inpatient hospice is covered during a period of acute medical crisis
 - Inpatient hospice care is short-term and limited to a maximum of 10 days per month
 - Hospice inpatient respite care, provided in a hospital inpatient setting or a nursing facility respite care setting, is short-term care provided to the member when necessary to relieve the caregiver
 - Hospice inpatient respite care is restricted to a maximum of five days per month counting the day of admission but not the day of discharge
- Pharmacy services provided to a member residing in a nursing home is covered
- Therapies (PT/OT/ST) provided in a nursing home are covered (age 21 and older 60 sessions per fiscal year)
- Behavioral health therapy and medication management are covered

Discharge Planning

- UnitedHealthcare screens members for continuing care following treatment in an acute care facility. We participate in the planning, scheduling and arranging of medically necessary care for the member.
- Concurrent review is conducted using Milliman Care Guidelines criteria
- When medical necessity criteria is not met, the case is referred to a physician for determination
- We partner with you for requests for information, documents or discussions with care management for purposes of concurrent review including, but not limited to, clinical information on patients status and discharge planning
- Discharges requiring home care need to be pre-certified by the agency or the facility discharge planner ordering the home care by calling the Prior Authorization Department at 1-866-604-3267 or sending a fax to 1-866-622-1428.

Service Authorization

- Medical necessity reviews are performed by a physician
- Short-term acute rehabilitation is covered and needs service authorization, please review the list online at www.UHCCommunityPlan.com
- Authorizations can be made:
 - Phone: 1-866-604-3267
 - Fax: 1-866-622-1428
 - Secure portal link. www.unitedhealthcareonline.com
- Prescribers may submit pharmacy prior authorization requests or ask questions:
 - Phone: 1-800-310-6826
 - Fax: 1-866-940-7328

Nursing Facility Pharmacy

- The Preferred Drug List (PDL) is defined by MLTC
- The PDL requires prior authorization on certain medications
- Pharmacies receive notification of prior authorization and edit requirements via pharmacy point-of-sale messaging
- The Point Of Sale (POS) claim processing system will provide detailed messages to pharmacies on claim rejects (i.e., preferred drug list, quantity limit, prior auth required) to help the pharmacy identify and resolve the reason for the denial
- Additional pharmacy resources at www.UHCCommunityPlan.com



Initiating Credentialing

To initiate credentialing for UnitedHealthcare Community Plan Provider Network, please call our automated service line at 1-877-842-3210. Please be ready to provide your tax identification number (TIN) or social security number (SSN) and then follow the prompts:

- Health Care Professional Services > Credentialing > Request for Participation

If you have **specific questions, additional information is provided below:**

- Nursing facility and physical health credentialing assistance is available online at www.unitedhealthcareonline.com or call 1-877-842-3210
- Pharmacy credentialing assistance is available online at www.optumrx.com, or call 1-877-633-4701, option 2 or email pharmacycredentialing@optum.com.

Contracting

If you have **specific contracting questions**, please contact us at the addresses below, mailboxes are reviewed daily:

- For nursing facility and physical health provider questions, please call 1-866-331-2243 or email the Nebraska contracting team mailbox at Nebraska_PR_Team@uhc.com. For more information regarding the contracting process you can visit www.unitedhealthcareonline.com
- For pharmacy provider questions, call OptumRx pharmacy network relations at 1-877-633-4701, option 2 or email provider.relations@optum.com

Claims Submission Process

- **How to submit:**
 - Submit Electronically
 - Accepting several clearinghouses including: Web MD ENVOY, Medavant, and ENSHealth
 - www.UnitedHealthcareOnline.com
 - Secure portal to view eligibility, submit prior authorization request and submit claims for Medicaid members
 - Paper claims may be submitted to the following address:
 - UnitedHealthcare • PO Box 31365 • Salt Lake City, UT 84131
- **What to include:**
 - Submit claims with member's subscriber ID number
 - Use Payer ID number 87726 for all Community Plan claims
- We will utilize cross over agreements to pay claims for dual eligible members.

Pharmacy Claims Information

- **Pharmacy POS (Point-of-Sale)**
 - **Pharmacy Claims System** adjudicates the pharmacy claim at the point-of-sale
 - Pharmacy Claims Processing Identifiers (effective 01.01.17)
 - ✓ Process ID (BIN): 610494
 - ✓ Processor Control Number (PCN): 4444
 - ✓ Group: ACUNE

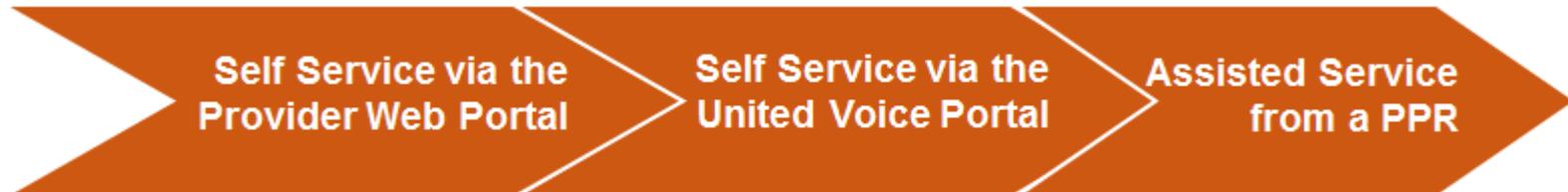
- **PDL**
 - The Nebraska Medicaid program will define the PDL

- **Waiving Copayments**
 - To encourage members to adhere to medication schedules, UHC waives copayments on covered pharmacy services

Electronic Payments & Statements (EPS)

- With EPS, you receive electronic funds transfer (EFT) for claim payments, plus your EOBs are delivered online
 - Lessens administrative costs and simplifies bookkeeping
 - Reduces reimbursement turnaround time
 - Funds are available as soon as they are posted to your bank account
- To receive direct deposit and electronic statements through EPS, please enroll at myservices.optumhealthpaymentservices.com. The following information needed:
 - Bank account information for direct deposit
 - Either a voided check or a bank letter to verify bank account information
 - A copy of your practice's W-9 form
- If you are already signed up for EPS, you will automatically receive direct deposit and electronic statements through EPS for UnitedHealthcare Community Plan of Nebraska
- *For more information, please call 866-842-3278, option 5 or go to www.UnitedHealthcareOnline.com > Quick Links > Electronic Payments and Statements*

Provider Relations Service Model



Options for Interaction



Access the self-service options available 24 hours a day via Link at www.unitedhealthcareonline.com



Call the Voice Portal for self-service information at 1-866-331-2243



Call Customer Care 1-866-331-2243 to speak with a Provider Phone Representative

Contact the Provider Advocate team mailbox at Nebraska_PR_Team@uhc.com to serve as your navigational specialist

Online Provider Resources

- **Link**

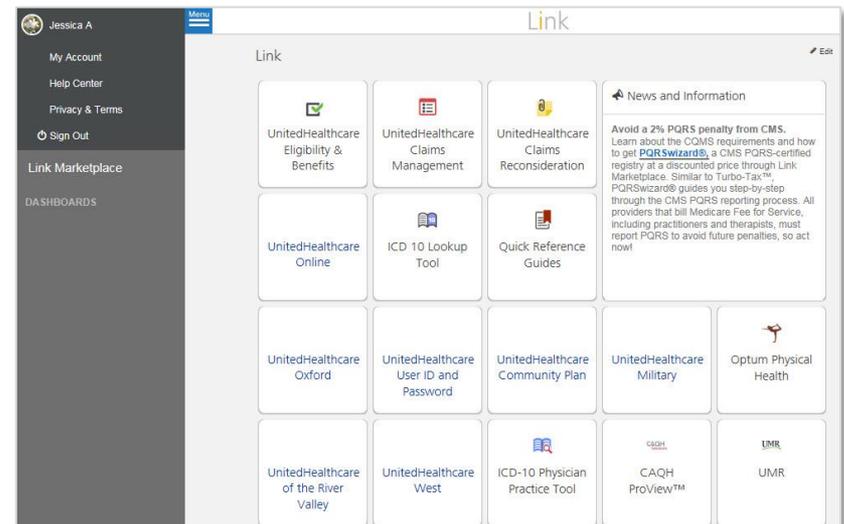
- Your gateway to UnitedHealthcare online tools and resources
- www.UnitedHealthcareOnline.com > *Link Sign In* > *sign in with your Optum ID*

- **UnitedHealthcare Community Plan application**

- Documents specific to UnitedHealthcare Community Plan of Nebraska, including:
 - Administrative Guide
 - Reimbursement & Clinical Policies
- www.UHCCommunityPlan.com > *For Health Care Professionals* > *Select Your State* > *Nebraska*

- **UnitedHealthcareOnline application**

- Resources including:
 - Claim submission
 - Advance notification
 - Prior authorization guidelines
 - Member eligibility
- www.UnitedHealthcareOnline.com



Contacts-Please call with questions

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