

UnitedHealthcare Community Plan of Nebraska

Nebraska Legislature

Heritage Health Quarterly Briefing

September 22, 2017

- **Largest health benefits company** dedicated to serving the economically disadvantaged, the medically underserved and those without the benefit of employer funded coverage.
- Providing Medicaid services in **26 states** plus Washington, D.C., serving 6.4 million individuals.
- UnitedHealthcare has been **operational in Nebraska since 1984**
- Served the State of **Nebraska for Medicaid clients since 1996** in three counties.
- On Aug. 1, 2010: Awarded a Medicaid contract, **expanded from three to ten counties.**
- On Jan. 1, 2017: Implemented **the statewide Heritage Health Medicaid contract.**

CHALLENGES

- **Medicare Cross Over Claims.** Status: Closed.
 - For dates of service prior to July 1, not appropriately paying the cost-share and deductible.
 - Conducted internal education, training and updates to claims processing procedures.
- **Achieving continuity of care and access.** Status: Closed.
 - Initiated single case agreements for medically necessary services not available in Nebraska.
- **Providers requested consistency for all prior authorizations.** Status: Closed.
 - Admin Simplification project resulted in a common DME threshold of \$750 across all three MCOs.
- **Behavioral Health, Removal of Third Party Liability Edits.** Status: Closed.
 - Provider Bulletin17-08 required removal of third party liability edits for specific behavioral health procedure codes.
 - Removed the edits for codes in Provider Bulletin17-08.

- **Access to Durable Medical Equipment (DME) and supplies in rural areas.** Status: Closed
 - In rural areas, pharmacies traditionally provided DME and supplies but were not contracted.
 - Focused recruitment and contracting efforts were completed, adding pharmacies as an in-network provider for these services.
- **Skilled Nursing Facility Therapy.** Status: Closed.
 - Denying claims for therapy services from non-facility employed providers (PT/OT/ST).
 - UHC fee schedule was updated to include therapy codes. Claims that were previously denied from non-facility employed providers were reprocessed.

- **Skilled Nursing Facility Therapy (PT/OT/ST).** Status: Open.
 - Denying claims for therapy services from facility employed providers. System update will be implemented to allow facility billed therapy services to be submitted on the same form as their other services per request from the Nebraska Health Care Association.
- **Skilled Nursing Facility, Part A Claims.** Status: Open.
 - Paying providers the full co-insurance when processing Medicare Part A crossover claims.
 - The claims payment policy has been updated to no longer pay the co-insurance. Overpayments have been identified, providers will be notified regarding options for repayment.
- **Home Health Therapy Codes (G0151, G0152, G0153)** Status: Open.
 - Denying claims for no Medicare EOB.
 - These codes would not have a Medicare EOB when the place of service is not “homebound” as they are non-covered services. A project has been initiated to reprocess claims.

Researching and seeking process improvements related to prior authorization process for certain DME, such as custom wheelchairs. Status: Open.

- Active engagement with provider to understand and address concerns, seeking collaborative solutions.

OPEN PROJECTS

Open Projects

| Open Issues | | | | | |
|---|-----------------------------|-------------------------------------|------------------------------------|-------------------------------|----------------|
| Issue Description | Impacted Provider Specialty | Estimated Claims Configuration Date | Estimated Claims Reprocessing Date | Actual Claims Completion Date | Project Number |
| Paying providers the full co-insurance when processing Medicare Part A crossover claims | Skilled Nursing Facility | Sept. 5, 2017 | TBD | TBD | |
| Denying outpatient therapy services (PT/OT/ST) | Skilled Nursing Facility | Aug. 18, 2017 | Sept. 11, 2017 | Sept. 11, 2017 | MID 1099940 |
| G0151, G0152, G0153 Denying for Medicare Primary EOB | All | Sept. 12, 2017 | Oct. 9, 2017 | | MID 1104521 |

Claims that have been rejected or denied appropriately will not be considered part of these projects.

ACCOMPLISHMENTS

Numbers Tell the Story



On average **44K** unique members a month access medical or pharmacy services.



\$57.9M has been paid in pharmacy claims through Aug. 31.



On average **22K** unique members visit their PCP in a month.



On average there are **216** births a month.



\$204M has been paid in medical and pharmacy claims through Aug. 31.



86K calls into our member, provider and pharmacy call centers through Aug. 31.

Numbers Tell the Story



myMoney Connect™

2,755 members using the program; **\$24,380** of award incentives issued through July 31.



Housing

Assisted **107** members with supportive housing through Aug. 31.

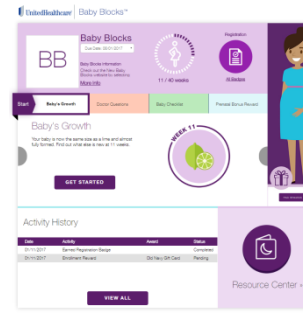


On average **7K** unique members a month access behavioral health services.



Healthy First Steps

292 members signed up for Healthy First Steps program through Aug. 31.



Baby Blocks™

516 members enrolled in the program; **1,239** logged into the tool through Aug. 31.

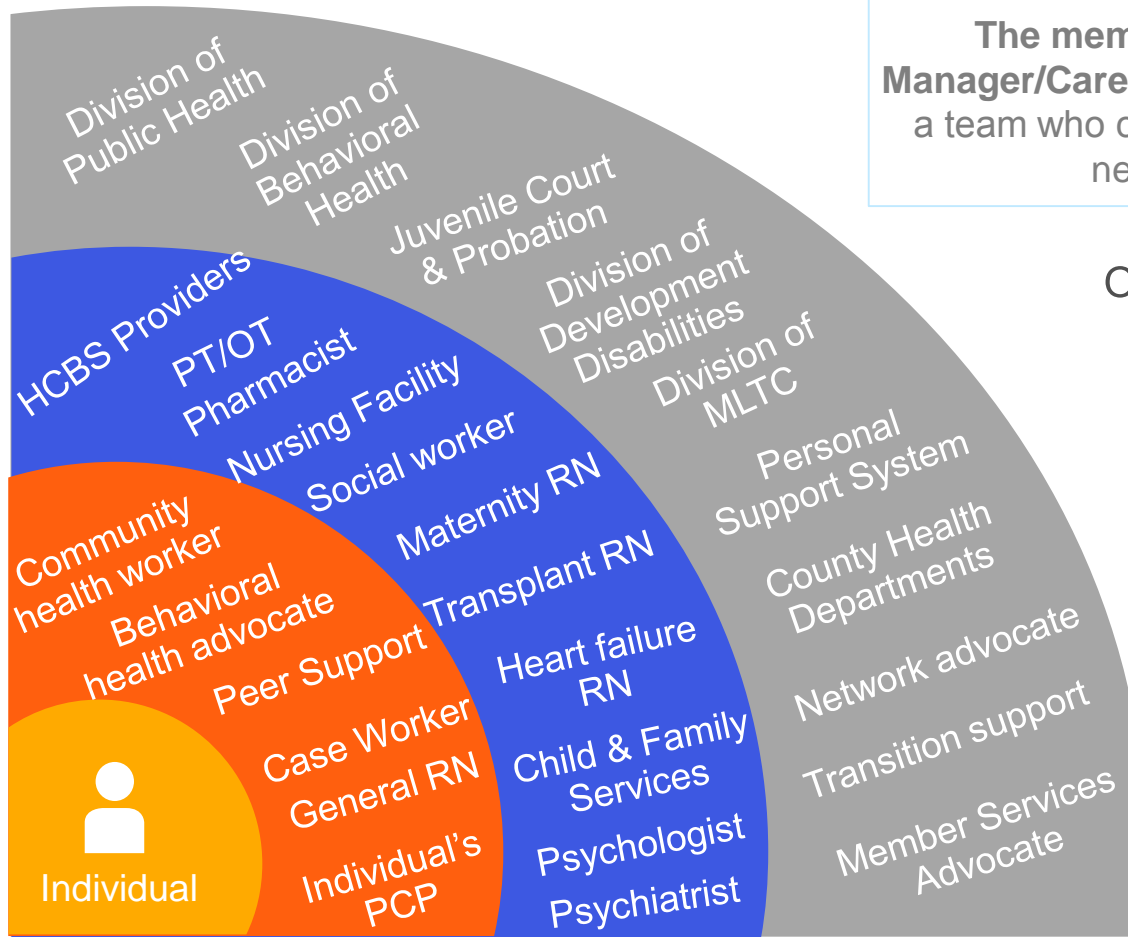
Accomplishments

- **Strengthened our Provider Network:** 136 hospitals; 1,572 Primary Care Providers; 2,934 specialists; 6,241 allied health professionals; 11 Federally Qualified Health Centers and 160 rural health centers; added border state providers in Kansas, Colorado, South Dakota, Iowa and Wyoming.
- **Implemented innovations** focused on a member-driven referral and screening tool to assess social needs of complex patients and referring them to partner resources, such as “Housing-Health Support”. Adding wrap-around services to improve health; reduce usage of ER and provide Housing First solutions.
- **Improvements** were made in **11 out of 22 targeted HEDIS measures.**
- **Annual External Quality Review Oversight audit** was held on Sept. 13, 2017. Based on closing session comments from the auditors, the audit went very well. The reviewers were impressed with documentation, content of the case files, member outreach and our SDOH innovations.
- **Established Member and Provider Call Centers** in Nebraska.
- Received a **certificate of appreciation** from The Arc of Nebraska and Nebraska Statewide Independent Living Council for participation in Disability Pride 2017.
- **Implemented PreCheck MyScript** a new UHC app that care providers and their staff can use to submit a pharmacy trial claim and get real-time prescription coverage detail for patients. The tool provides the formulary/PDL alternatives, alerts care providers when a medication requires prior authorization, and they can request an authorization within the app.

Accomplishments

- Provide **monthly all staff training and education** through our Lunch and Learn program. Community organizations from across the state provide information on services and programs that would benefit our members.
- **Provider Support.** Provider Relations has an average of 433 interactions per month with different provider offices across the state.
- **Provider Education/Training.** On Sept. 14, the health plan hosted a Provider Expo with 135 providers in attendance. There were breakout sessions throughout the day to demonstrate and provide assistance for using online tools such as LINK, UHC on Air, and Electronic Payments and Statements.
- **Quality Committees.** Successfully initiated all quality committees with diverse representation to obtain the voice of the customer: members, parents/guardians, providers and agencies, from across the state.
- Implemented **Medication Therapy Management** for identified members with multiple chronic conditions, multiple maintenance medications, non-adherence to critical medications or other identified pharmacy related risks. Addresses issues of polypharmacy, preventable adverse drug events, medication adherence and medication misuse, close gaps in therapy and improve quality-based measures.

Accomplishment: Implementation of Whole Person Care



The member is assigned to a Care Manager/Care Navigator and is supported by a team who can “flex” to quickly address the needs of the individual

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 and focus on individuals’ personal goals

Aligned to the delivery system

Care focused on supporting the physician to member relationship

24,383 of the health plan 76,498 members are assigned to a Care Manager

Accomplishments: Quality Management Program

- The UnitedHealthcare Community Plan of Nebraska Quality Program has been fully implemented and all activities are on target.
- The health plan completed a successful NCQA reaccreditation in July 2017.
- NCQA status is Commendable. This score is a combination of the accreditation score, Healthcare Data and Information Set (HEDIS) score, and Consumer Assessment of Healthcare Provider and Systems survey (CAHPS) score.
- We obtain member and provider feedback throughout the year through our quality committees which include participants representing the populations and geographic areas we serve.
- Our quality program includes member incentives and provider assistance to promote care gap closures to ensure individuals receive evidence based preventive and chronic disease management.

MEMBER EXPERIENCES

Customer Satisfaction Metrics

CAHPS Survey

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is an annual survey which measures how members perceive their health care services and experiences.
 - The CAHPS survey asks members about important quality topics like their access to care and the communication they have with their physicians.
 - The survey focuses on experiences over the past 6 months.
 - UnitedHealthcare uses CAHPS survey results to identify ways in which we can better meet our members' needs to work with our physicians and health care partners, as well as evaluate our own processes to continue to drive quality improvements.
- UnitedHealthcare members are randomly selected to take part in the survey from February to May each year, and their participation is voluntary.
 - In early February, surveys will be mailed out. If the survey is not completed and mailed back:
 - Reminder postcards will be mailed toward the end of February.
 - A second survey will be mailed at the end of March.
 - Two weeks later, reminder postcards will be mailed again.
 - Telephone interviews begin mid- to end of April.

Customer Satisfaction Metrics

CAHPS Survey

- An annual survey is conducted for our adult, child, CHIP members to assess consumer experiences with their health care.
- We monitor year over year performance on five key metrics.
- We take actions to improve our consumer experience in areas such as services provided by the health plan, in particular Customer Service and Rating of the Health Plan.
- **Survey Results:**

Members completing the 2017 Adult, Child and Children's Health Insurance Program (CHIP) survey rated:

 - The health plan with an 8, 9 and 10 in 78% or greater of the surveys.
 - Our customer service at an 8, 9, and 10 in 86% or greater of the surveys.

APPENDIX

Contact List

Contacts

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