Nebraska Medicaid's New Integrated Managed Care Program

HEALTH AND HUMAN SERVICES COMMITTEE

NOVEMBER 15, 2016

Integrated Services for all Members

Heritage Health plans operate statewide and have a full range of services including: physical health, behavioral health, and pharmacy.

Benefits and Coverage

- All Heritage Health plans offer the same package of covered health services.
- Each plan also offers a variety of "extra" benefits and services that aren't part of the Medicaid benefit package.
- **Some services aren't part of Heritage Health**, but are still covered by Medicaid. These include:
  - Dental services
  - Non-emergency transportation
  - Long-term services and supports, including:
    - Personal Assistance Services (PAS)
    - Long-term care in a facility
    - Home and community-based waiver services (HCBS) for those eligible

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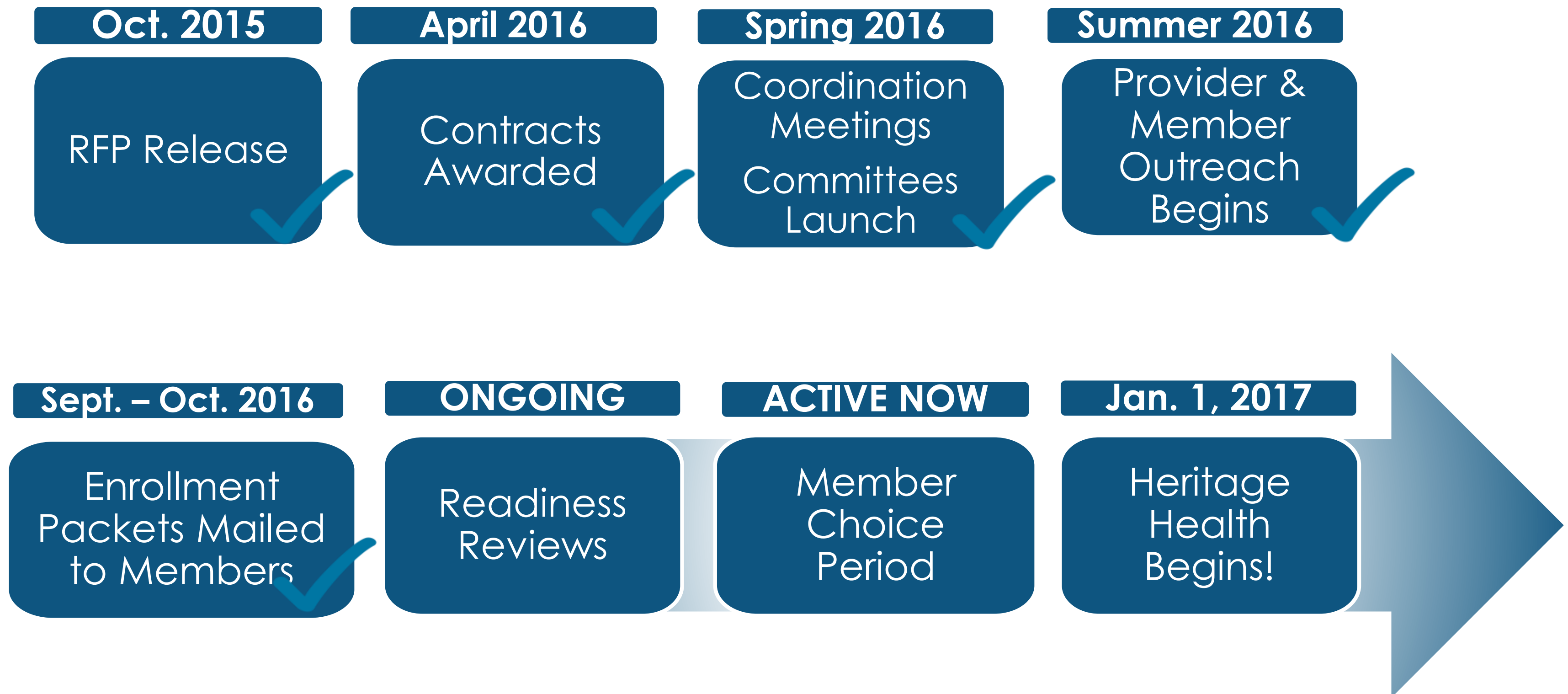
Heritage Health Timeline



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Follow Ups From Last Briefing

- Behavioral Health Integration Workgroup
- Health Plan Enrollment
- Outreach and Education
- Budget and Finance
- Measuring Performance

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Behavioral Health Integration

- Monthly committee meetings focusing on:
  - Definitions - Standardizing service definitions - 28 final service definitions have been posted on our website
  - Authorization Forms – Creating one common prior authorization form for certain services to be utilized by all three health plans
  - Readiness Reviews - Looking ahead to testing in the health plans systems for continuity of care for prior authorizations

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Open Enrollment Options

- There are four different ways to choose a plan:
  - **Online** at www.neheritagehealth.com
  - **By phone** by calling toll-free at 1-888-255-2605 Monday through Friday, 7am to 7pm.
  - **By mail** by returning the enrollment form included in the packet.
  - **By fax** by returning that same form to 1-800-852-6311.
- Members who don't choose a plan by Dec. 1 will be assigned to one by AHS using a method designed to preserve family and provider relationships.
- All members will have 90 days to change plans after January 1st if they would like, or wait for open enrollment in the Fall.

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Health Plan Enrollment Update

- As of November 14th the total number of members that have selected a new plan = 36,272
- Strategies to increase member selection rate include:
  - New dedicated website for community organizations and stakeholders with resources to assist members in the community
  - A series of lunchtime webinars for providers and other stakeholders who may be assisting members
  - Outbound calls and reminder letters for members who have not chosen a plan
  - Direct outreach to community health centers

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Materials for members and providers

- Examples of resources available include:
  - Open enrollment materials
  - Information for Medicare/Medicaid dual eligibles
  - Highlights for long-term care providers
  - Provider bulletins
  - Past webinars
  - Past presentations
  - Press releases
  - Contracts and the RFP
  - More!

Coordinated Outreach

- DHHS, along with the three health plans (Nebraska Total Care, UnitedHealthcare Community Plan of Nebraska, WellCare of Nebraska), and the enrollment broker (Automated Health Systems) have been working together to broadcast information about Heritage Health.
- Requests for presenters are received daily and our continued efforts are reaching large audiences across the state every week.
  - Providers
  - Advocacy Groups
  - Facilities
  - Members

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Currently on the road:
Provider Orientation Sessions, 1000 attendees so far

Scottsbluff - 104
Sidney - 34
North Platte - 90
Omaha - 326
South Sioux City - 76
Lincoln - 370
Fremont - 86
Valentine - 23
Norfolk
Kearney
Grand Island
Columbus

Sessions hosted by the Heritage Health Plans (MCOs)
Key Topics: Claims, Prior Authorizations, Contracting, Provider Resources, Behavioral Health and Pharmacy.

Financing Heritage Health

- MCOs are paid a "take it or leave it" prospective per member per month (PMPM) capitation rate. The rates are set by our contracted actuary and must be approved by CMS.
  - The payments are made based on their total enrollment and membership mix each month. Rates vary by service region and category of eligibility, due to differences in cost and utilization.
- MCOs are not paid until they have membership.
- MCOs are required to meet an annual 85% Medical Loss Ratio.
- MCO capitation payments for Heritage Health are budgeted at $568m in total finds for year one.
- Due to one time claim lag experience and the fact that the majority of services are moving from one managed environment to another, there are no budgeted savings for year one. However, we anticipate that Heritage Health will help deflect future cost growth.

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Rates by Rating Region and Category

Rating Region 1		Rating Region 2	
Category Of Aid	**Payment Rate**	**Category of Aid**	**Payment Rate**
AABD 00-20 M&F	$ 1,246.12	AABD 00-20 M&F	$ 1,269.71
AABD 21+ M&F	$ 1,743.70	AABD 21+ M&F	$ 1,830.94
AABD 21+ M&F-WWC	$ 2,953.88	AABD 21+ M&F-WWC	$ 3,280.48
CHIP M&F	$ 191.42	CHIP M&F	$ 189.33
Family Under 1 M&F	$ 724.80	Family Under 1 M&F	$ 699.89
Family 01-05 M&F	$ 157.86	Family 01-05 M&F	$ 164.57
Family 06-20 F	$ 182.61	Family 06-20 F	$ 188.62
Family 06-20 M	$ 199.16	Family 06-20 M	$ 225.65
Family 21+ M&F	$ 428.92	Family 21+ M&F	$ 513.99
Foster Care M&F	$ 527.43	Foster Care M&F	$ 539.27
Katie Beckett 00-18 M&F	$ 13,308.51	Katie Beckett 00-18 M&F	$ 13,308.51
599 CHIP - Cohort	$ 422.11	599 CHIP - Cohort	$ 422.11
599 CHIP - Supplemental	$ 5,450.16	599 CHIP - Supplemental	$ 5,450.16
Maternity	$ 8,309.96	Maternity	$ 8,206.98
Healthy Dual	$ 344.39	Healthy Dual	$ 292.28
Dual LTC	$ 283.10	Dual LTC	$ 241.12
Non-Dual LTC	$ 3,236.28	Non-Dual LTC	$ 2,395.39
Dual Waiver	$ 333.40	Dual Waiver	$ 302.98
Non-Dual Waiver	$ 1,682.79	Non-Dual Waiver	$ 1,652.38

Performance Metrics

- The MCOs will be "holding back" 1.5% of their total payment and will have to earn this back through meeting performance targets across five metrics in year one.
- Year one metrics are focused on operational performance. Future metrics will be determined with input from the Quality Management Committee.

Base Performance Requirement	Payment Threshold	% of Payment Pool
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 days of the date of receipt. The date of receipt is the date the MCO receives the claim.	95% within 15 days	20%
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 days of receipt. The date of receipt is the date the MCO receives the claim.	95% within 7 days	10%
Encounter Acceptance Rate: 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	98%	20%

Performance Metrics (cont’d)

Base Performance Requirement	Payment Threshold	% of Pool
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.	<3%	10%
Average Speed to Answer: Calls to Member/Provider lines must be answered on average within 30 seconds. Measured using annual system-generated reports.	30 seconds	10%
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.	95% within 30 days	10%
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.	95% within 60 days	10%
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.	95%	10%

Long-Term Care Redesign

The State is taking an opportunity to open a broader dialogue with stakeholders regarding a more comprehensive redesign of Long-Term Care (LTC) services in Nebraska.

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Medicaid & Long-Term Care

Long-Term Care Redesign

Six Guiding Principles

- Improve the quality of services and health outcome for members,
- Promote independent living in the least restrictive setting using person-centered services and living options,
- Strengthen access, coordination, and integration of care through eligibility processes and collaborative care management,
- Improve the capacity to match available resources with needs through innovative benefit structures,
- Decrease fragmentation for members and providers, and
- Rebalance the system for sustainability.

Department of Health & Human Services
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Long-Term Care Redesign

Redesign Scope

- Primarily Medicaid-funded services; however, it includes other services administered by Medicaid and Long-Term Care, including the State Unit on Aging, and the Division of Developmental Disabilities.
- This recognizes that individuals receiving LTC on rely on a variety of programs beyond those funded by Medicaid.
- This includes:
  - Medicaid-funded Community-Based Services,
  - Community-Based services funded by other sources, and
  - Medicaid-funded institutional Long-Term Services and Supports.

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Long-Term Care Redesign

The State is seeking feedback on:

- Methods to promote care management and care coordination to match services with care needs;
- How to best achieve federal compliance with requirements for non-duplication of services;
- Ways to improve and streamline administrative oversight with reliable data sources and to ensure regular evaluation of provider reimbursement so provider compensation and service reimbursement are appropriate, financially prudent, and based upon industry practice;
- The scope of the design beyond Medicaid-funded programs;
- Ways for the state to make it easier for the LTC population to navigate and be connected to the program or programs that best fit their needs;
- Tools and methods to ensure that the long-term care needs of its clients are assessed fairly and uniformly across programs.

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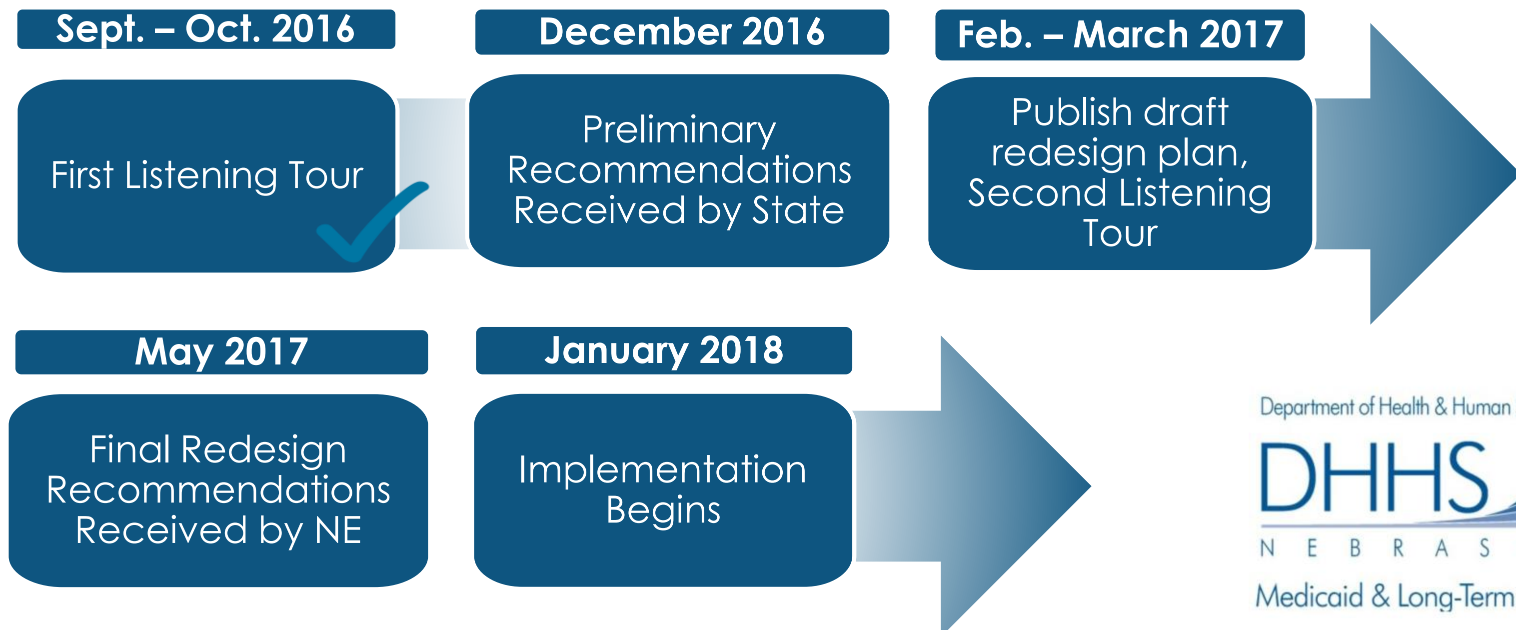
Long-Term Care Redesign

- The potential for establishing "baseline" quality metrics, as well as which areas should be prioritized as the most critical domains for measuring and assessing outcomes in the LTC system; and
- The potential timeline and key considerations for a transition to comprehensive managed care for long-term services and supports



Questions

For more information about Heritage Health or Long-Term Care Redesign visit us online:
www.dhhs.ne.gov/heritagehealth
www.dhhs.ne.gov/ltc

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