Heritage Health Update

Health and Human Services Committee

May 18, 2017

Calder Lynch

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Nebraska Department of Health and Human Services

Helping People Live Better Lives.

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Today's Discussion

- Heritage Health overview
- Oversight mechanisms
- Performance Improvement Projects (PIPs)
- Success stories

Enrollment by Plan

	nebraska total care	UnitedHealthcare Community Plan	WellCare Health Plans	Total
January 1, 2017	76,422	78,549	71,343	226,314
May 1, 2017	75,190	77,419	74,081	226,690

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Integrated Services for all Members

- 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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Resources 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!

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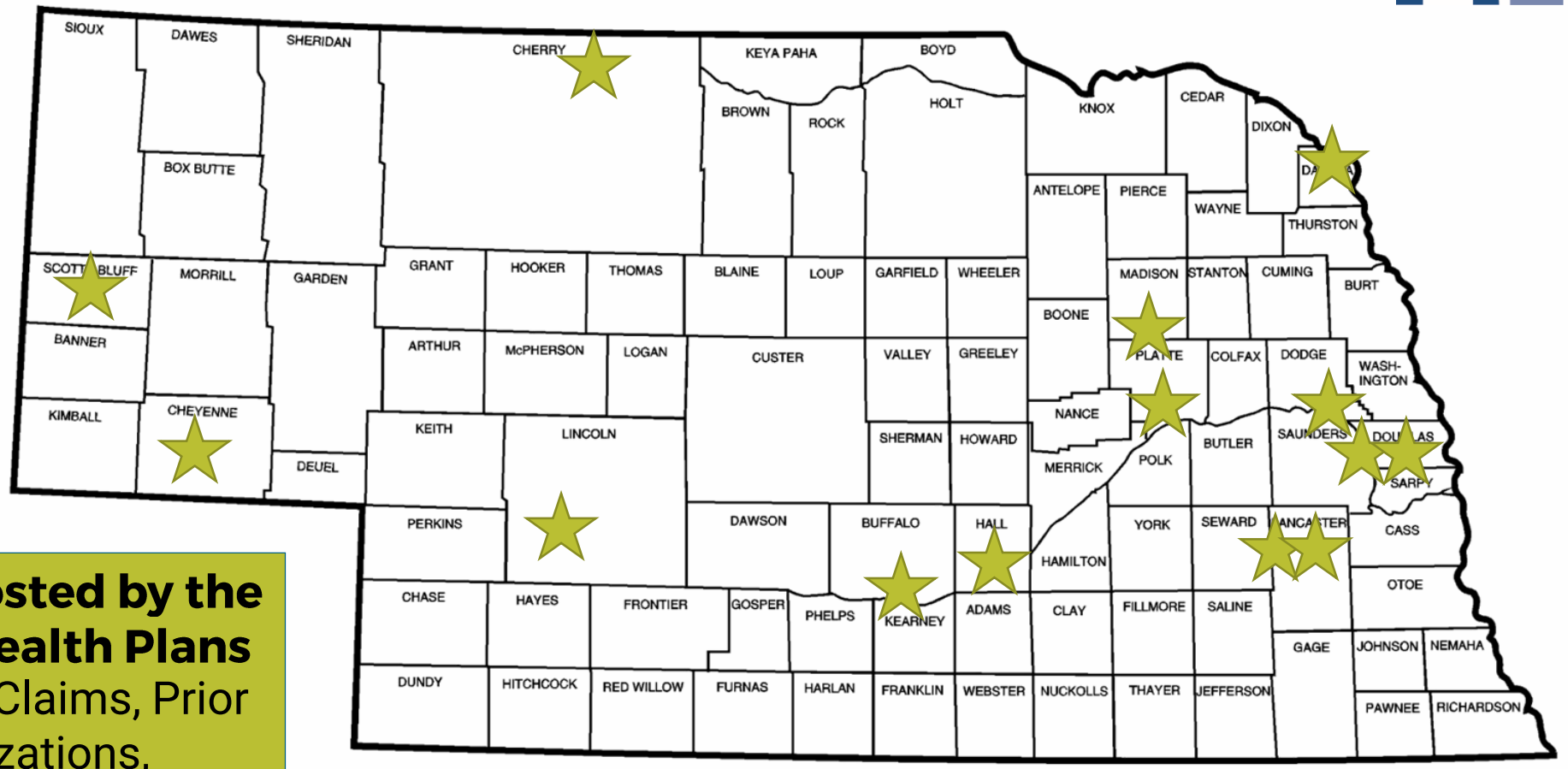
Provider Orientation Sessions, over 1000 attendees



Sessions hosted by the Heritage Health Plans

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 a 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 required to meet an annual 85% Medical Loss Ratio.
- MCO capitation payments for Heritage Health are budgeted at $568m in total funds 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.
  - There are over $6.5m in GF savings anticipated in FY 2018 due to reductions in avoidable episodes of care through Heritage Health.

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Heritage Health – Post Implementation Operations

- The 90 day plan change period has ended – plan changes may only be granted now for “for cause” reasons until annual open enrollment.
- The Continuity of Care (CoC) period has now ended – three weeks of post-CoC provider calls did not reveal systemic issues related to end of CoC period.
- Implementation provider calls have ended – providers should work directly with plans but contact MLTC at dhhs.heritagehealth@Nebraska.gov if they are unable to achieve resolution.
- BHIAC, Administrative Simplification, and Quality committees continue to meet.
- Health plan operational metrics continue to be posted on our website – monitoring claims payment, payment timeliness, authorization timeliness, etc.

Rapid Response and Post Continuity of Care

- Rapid Response/Implementation Calls: 4,059 participants.
  - These calls were held from January 1st – February 24th. Scheduling/frequency of calls was adjusted throughout the eight weeks based on participation.
  - Rapid Response began with 7 calls per day and by the end of February our implementation calls tapered down to 3 per week.
- Post Continuity of Care Calls: 627 participants
  - These calls were held for 3 weeks April 4th – April 20th.
  - One call per plan per week.

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Oversight Mechanisms in Place

- Transparency is a key component of Heritage Health
  - Current health plan statistics, claims payment, call center, and other key information are posted to the Heritage Health website
  - Multiple advisory committees hold public meetings with invited legislative representation
  - By July 1, 2017, each plan must have a dashboard in place with minimum statistics to include:

Member enrollment	Call center statistics	Status of credentialing applications
Performance measures	Financial status	Claims payment
Care management	Grievances and appeals	Other issues identified by MLTC

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Advisory Committee Meetings

Administrative Simplification Committee	Behavioral Health Integration Advisory Committee	Quality Management Committee
January 31, 2017	**February 17, 2017**	**March 8, 2017**
May 15, 2017	**April 25, 2017**	June 7, 2017
July 18, 2017	June 20, 2017	September 2017
November 7, 2017	August 29, 2017	December 2017
	October 24, 2017	

Behavioral Health Integration Advisory Committee – Subcommittee Schedule
Service Definitions, Medical Necessity, Authorization Process, Claims and Encounters, Provider Issues
Mondays at 11:00 am

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Compliance with Federal Oversight Requirements

- MLTC must comply with extensive federal regulatory oversight requirements
  - External quality review organization (EQROs) to provide on-site and desk auditing of plan compliance with state and federal requirements as well as comprehensive operational and financial reporting to the state
  - The final new federal managed care rule also calls for extensive oversight of managed care organizations and transparency relating to:

Enrollment	Grievances and Appeals	Rate setting
Quality outcomes	Access to care	Financial reporting

  - These regulations impose the basis for impositions of sanctions, types of sanctions, and amount of civil monetary penalties to be assessed when health plan violations occur.

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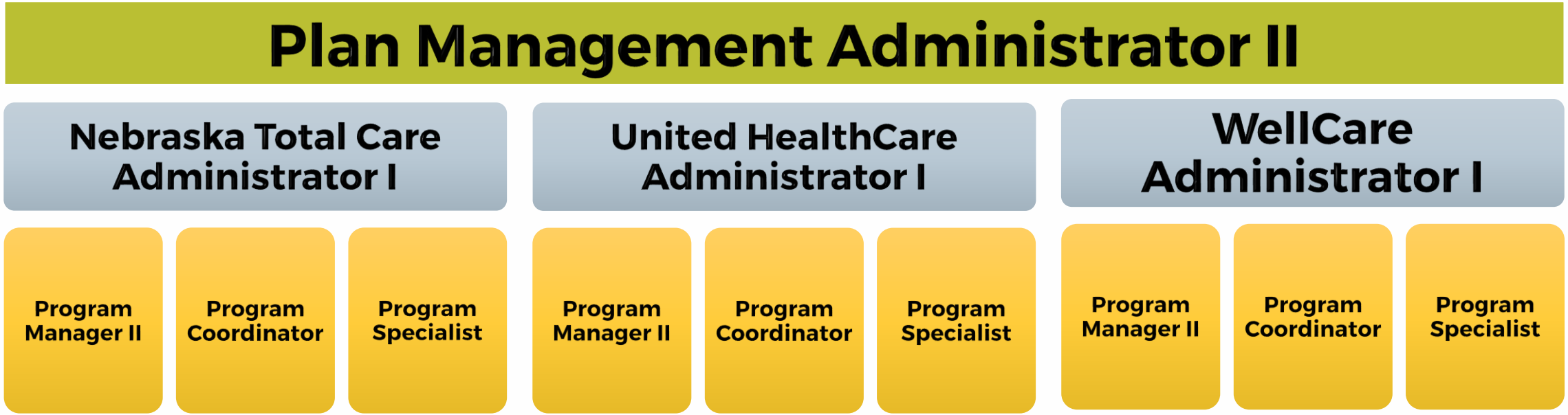
Oversight Structure within MLTC

- MLTC is completing a reorganization of its structure:



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Known Claims and Payment Issues

Behavioral Health

- Moving from one MCO (Magellan) to three MCOs, MLTC anticipated the greatest opportunity for challenges in administrative claims processing in behavioral health services and providers.
  - Credentialing & contract process
    - Time and effort to contract and credential all the providers across the state took longer than anticipated.
      - Continuity of care period extended by plans for impacted providers. Plans report contract and credentialing issues largely resolved, though some providers indicate errors that need to be remedied individually.
    - Plans were rejecting claims when the provider submitted with a valid NPI but the NPI provided did not match the state's file. DHHS directed plans to adjust edits to allow claims to process.
    - Enterprise-wide provider portal issue with one plan, actively working to resolve.
  - Fee schedule
    - Some covered services had no state-established fee schedule, causing claims to reject or pay at incorrect amounts. MLTC developed and issued a fee schedule and plans corrected systems and reprocessed claims.

Known Claims and Payment Issues

Behavioral Health (cont.)

- Initial prior authorization time periods for certain behavioral health services
  - There were notable inconsistencies among the plans in the initial authorization periods allowed for the same services.
  - Providers had become accustomed to longer authorization periods previously allowed. The authorization periods allowed by the plans initially were in some cases 30 days, when they had previously received authorizations for one year through Magellan.
  - MLTC worked with plans and providers to develop an agreed-upon set of common authorization periods for certain behavioral health services, which were outlined in Health Plan Advisory 17-05, issued May 12, 2017
- One plan experienced an early backlog of prior authorization requests, causing delays in approval. Plan added additional resources and has significantly reduced turnaround time.

Known Claims and Payment Issues

- Home health and private duty nursing for Medicare dual eligibles
  - Plans generally require a Medicare denial before payment for services as Medicaid is the secondary payer. Some home health services are not covered by Medicare. This caused claims denial and additional administrative work.
    - MLTC issued Health Plan Advisory 17-06 on May 12, 2017 requiring plans to bypass this requirement for certain home health codes.
- Durable Medical Equipment
  - Some DME claims were being denied when trying to be filled through the pharmacy point-of-sale system. When this issue was identified, the health plans quickly resolved by reaching out to the pharmacy to educate how to bill for through the pharmacy system.
  - Having these supplies dispensed through the pharmacy was a new process that the legacy Medicaid system did not allow.
    - Clarified through Health Plan Advisory 17-04, April 6, 2017.

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Known Claims and Payment Issues

- Telehealth & Telemonitoring
  - Plans were only processing claims for telehealth and telemonitoring services for mental health and physician services. This was attributable to limitations of the legacy MMIS and so the state had not included them on the fee schedule. The plans are now paying for these services as required.
    - Corrected in Health Plan Advisory 17-05, April 5, 2017.

Known Claims and Payment Issues

Higher level and isolated issues

- Issues with “bounced” checks
  - NTC issued a check that had an incorrect account number to a provider. A replacement check was issued within two days.
  - A provider reported that they had received checks from WellCare that were returned but later realized this was on an error on their part.
- Physical and occupational therapy authorizations
  - There is a perception that the authorizations are taking longer. The plans are meeting or exceeding the 14 day standard contractually required. There is an expedited authorization process for cases where medical necessity requires a quicker turnaround than the 14 day standard.

Performance Metrics

- Plans are “holding back” 1.5% of their total payment and will have to earn this back by 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 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%

Performance Improvement Projects (PIPs)

Federal rules require Medicaid MCOs to conduct performance improvement projects (PIPs) on both clinical and nonclinical measures

- Designed to achieve significant, sustainable improvement in health outcomes and satisfaction
  - PIPs must include:
    - Measurement of performance with objective quality indicators
    - Implementation of interventions to improve access or quality
- MCOs must report status and results of each project to the State on at least an annual basis

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Careful selection of the PIPs

- MCOs must conduct a total of three (3) PIPs:
  - A minimum of one (1) PIP addressing a clinical issue of concern to the MCO's population that is expected to favorably impact health outcomes/enrollee satisfaction
  - A second clinical PIP must address a behavioral health concern
  - A minimum of one (1) joint PIP with the other MCOs
- Alignment with state priorities
  - Integration of physical and behavioral health benefits
  - Decreased reliance on emergency and inpatient levels of care
    - Evidence-based care including community based care
    - Care for the whole person
    - Early identification of members at risk
  - Reduction of racial and ethnic disparities

Three Identified PIPs

17-OH progesterone in eligible pregnant women

- This PIP will focus on encouraging regular use of 17-hydroxyprogesterone (17-P) in pregnant women, particularly those who may be underserved.
  - Clinical evidence shows that appropriate use of 17-P in women with a prior pre-term both lowers the risk of a repeat pre-term birth, improving outcomes and reducing NICU costs.

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Three Identified PIPs cont.

Emergency Department (ED) follow up for patients with mental illness & substance use disorders

- This PIP will track and gather data on the follow up care provided within 7 and 30 days after discharge from an emergency department for individuals with mental health and substance use disorders as the presenting illness.
  - Encouraging appropriate follow-up care can help reduced future ED visits and hospitalizations by ensuring the clients have a stable care plan.

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Three Identified PIPs cont.

Tdap in pregnancy

- This PIP will focus on increasing tetanus, diphtheria, pertussis (Tdap) immunization rates in women within 27-36 weeks of pregnancy.
  - This is recommended by the CDC to help pass protection against Whooping Cough to the infant early in life, as this can result in serious complications.
  - Nebraska had the highest incidence of Whooping Cough of the 50 states in the most recently reported CDC data.

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Success Stories from Care Management

- **Homeless man in Omaha area**
  - Housing Navigator built trust, helped with housing, and care management
  - Had been visiting ED a couple times a week, now in his own apartment
- **Woman forced to choose between food and prescriptions**
  - Patient with co-occuring conditions - diabetes, cataracts, and schizophrenia
  - CM helped member reduce utility bills through community resources, avoided institutionalization
- **Woman with three ED visits in three months**
  - Poorly controlled diabetes, congestive heart failure, living alone with little support
  - Education, transportation, scale, and BP cuff has led to much improved condition
- **Diabetic man with inadequate footwear during the winter**
  - Incredibly hard time getting physician-ordered diabetic shoes
  - Shoe company would not accept Medicaid, health plan purchased the shoes
  - Member was nearly in tears, forever grateful to care management staff

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Questions & Answers

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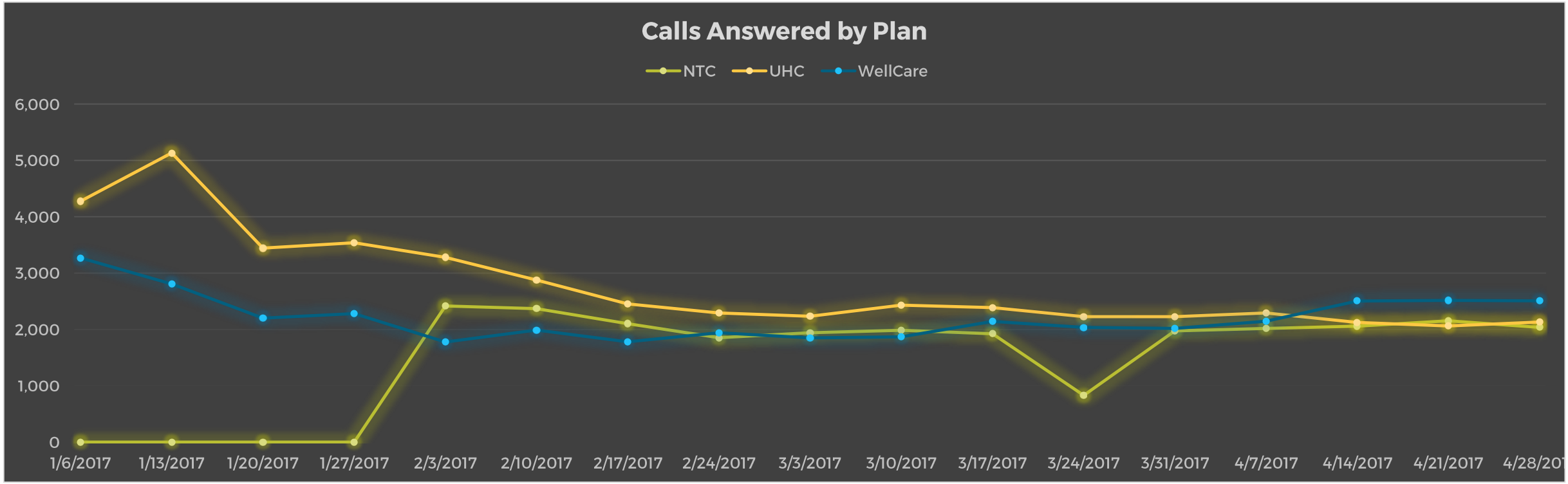
Key Operational Metrics



- Call abandonment rate: less than 5%

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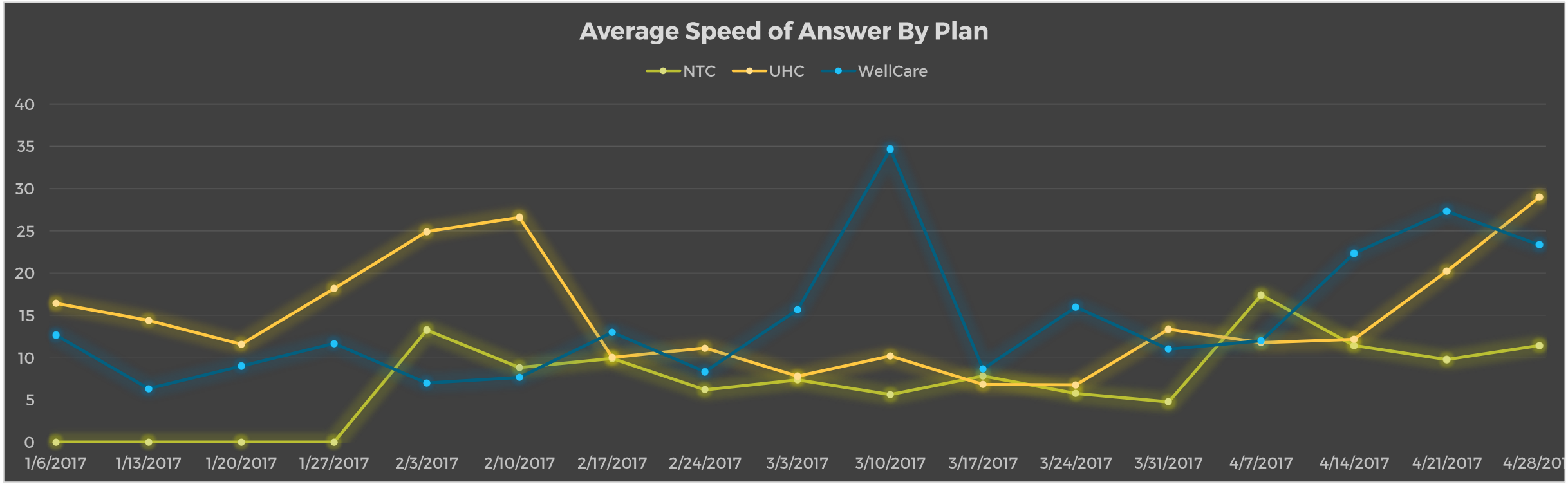

- Average speed to answer calls: 30 seconds

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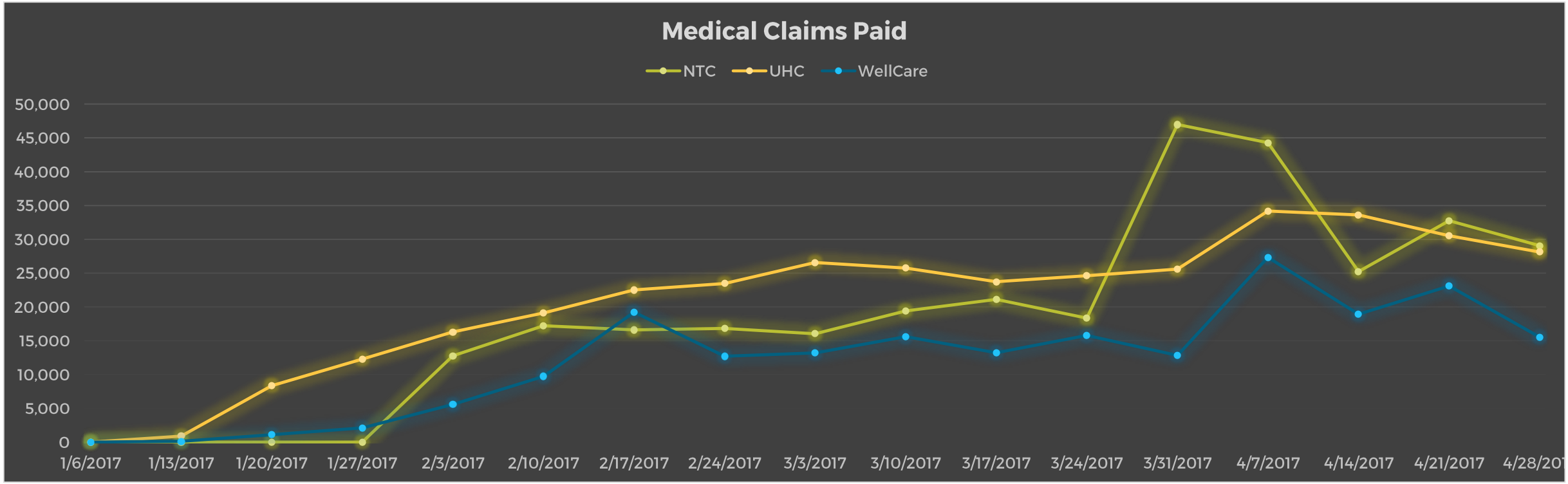

- Claims processing timeliness: 15 days to process and pay or deny, as appropriate at least 90% of all clean claims for medical services

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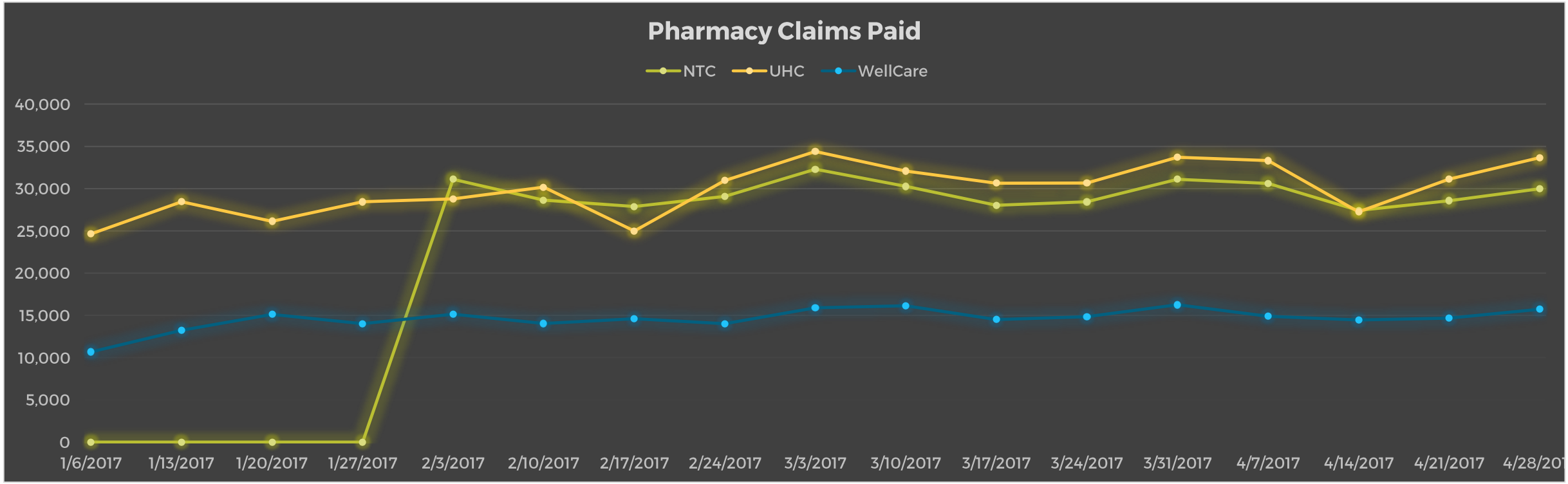
Key Operational Metrics



- Pharmacy claims processing timelines: 7 days to process and pay or deny, as appropriate at least 90% of all clean claims

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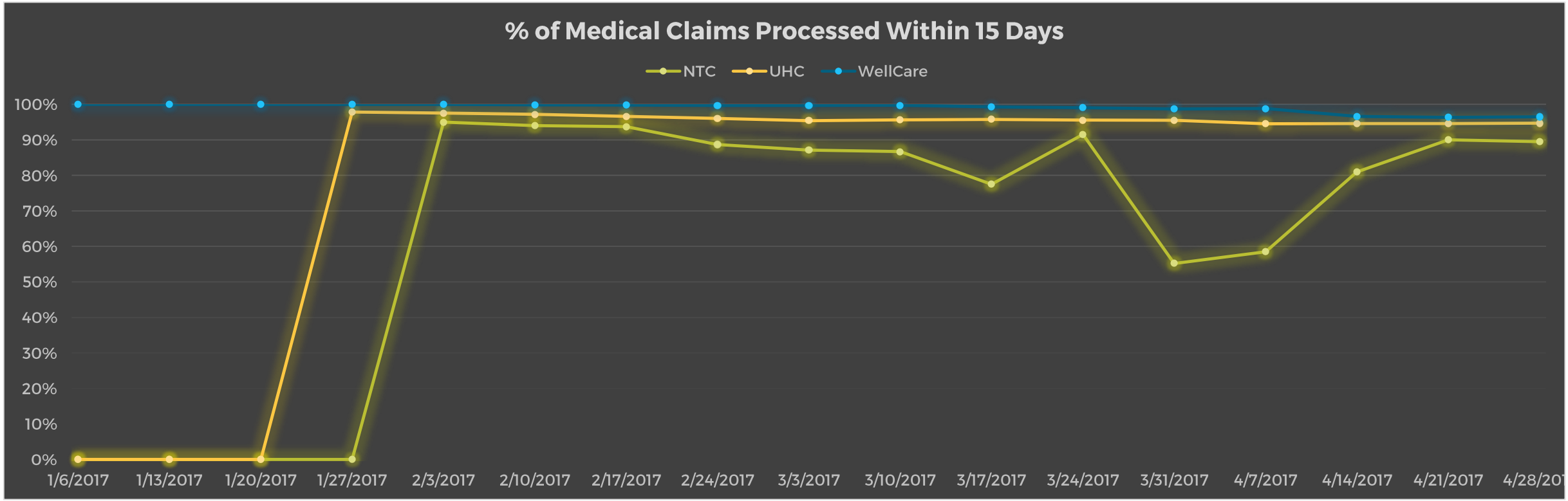

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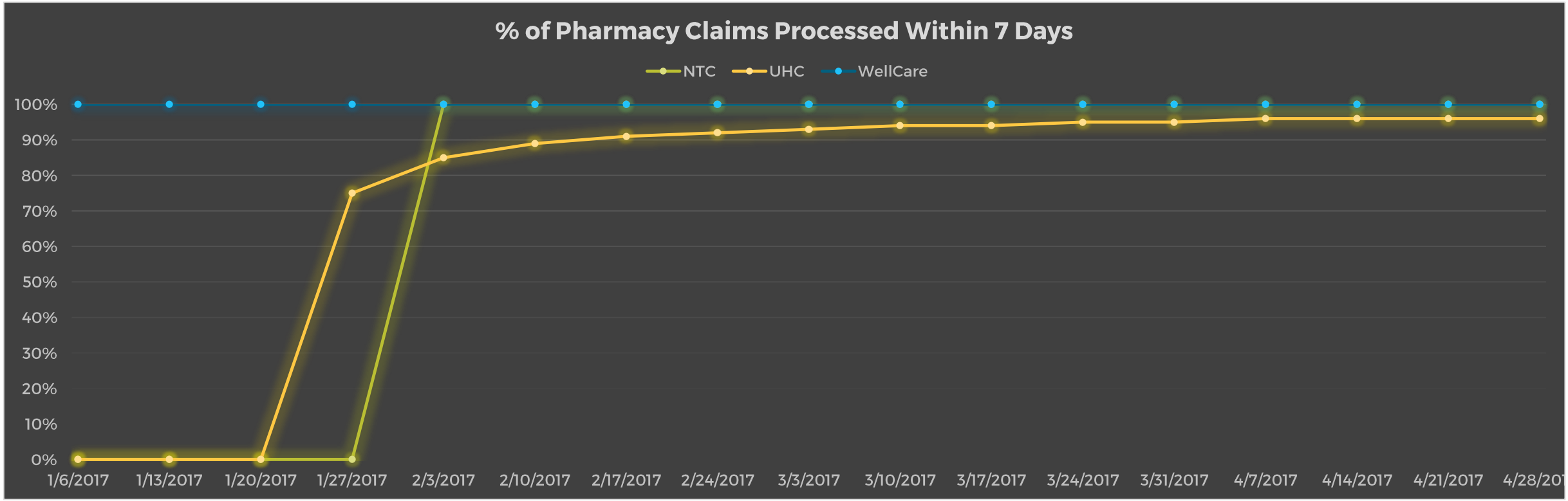

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