Heritage Health Update

Health and Human Services Committee

March 19, 2018

Dr. Matthew Van Patton

Director, Division of Medicaid and Long-Term Care

Nebraska Department of Health and Human Services

Today's Discussion

- Mission Statement
- Year-End Review
- Quality Review
- Provider and Member Experience
- Performance Management
- Committees and Forums
- Director's Tour of the Health Plans

Mission Statement

Heritage Health is a person-centered approach to administering Medicaid benefits that provides Medicaid and CHIP members a choice of a single plan that provides all of their physical health, behavioral health, and pharmacy benefits and services in an integrated health care program. Integrated care through Heritage Health will improve member health outcomes, reduce costly and avoidable care, decrease reliance on emergency and inpatient levels of care by providing evidence-based care options that emphasize early intervention and community-based treatment, addresses social determinants of health, and improves the financial sustainability of the system.

Year-End Review

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Year-End Review

Value the Heritage Health Plans bring to the program and across the State

- 3,583,726 health claims paid in 2017, totaling $720,136,725.91
- 3,416,633 pharmacy claims paid in 2017 totaling $223,579,643.15
- Health plan enrollment
- Value-added services
- Community engagement across the state
- Communication to stakeholders

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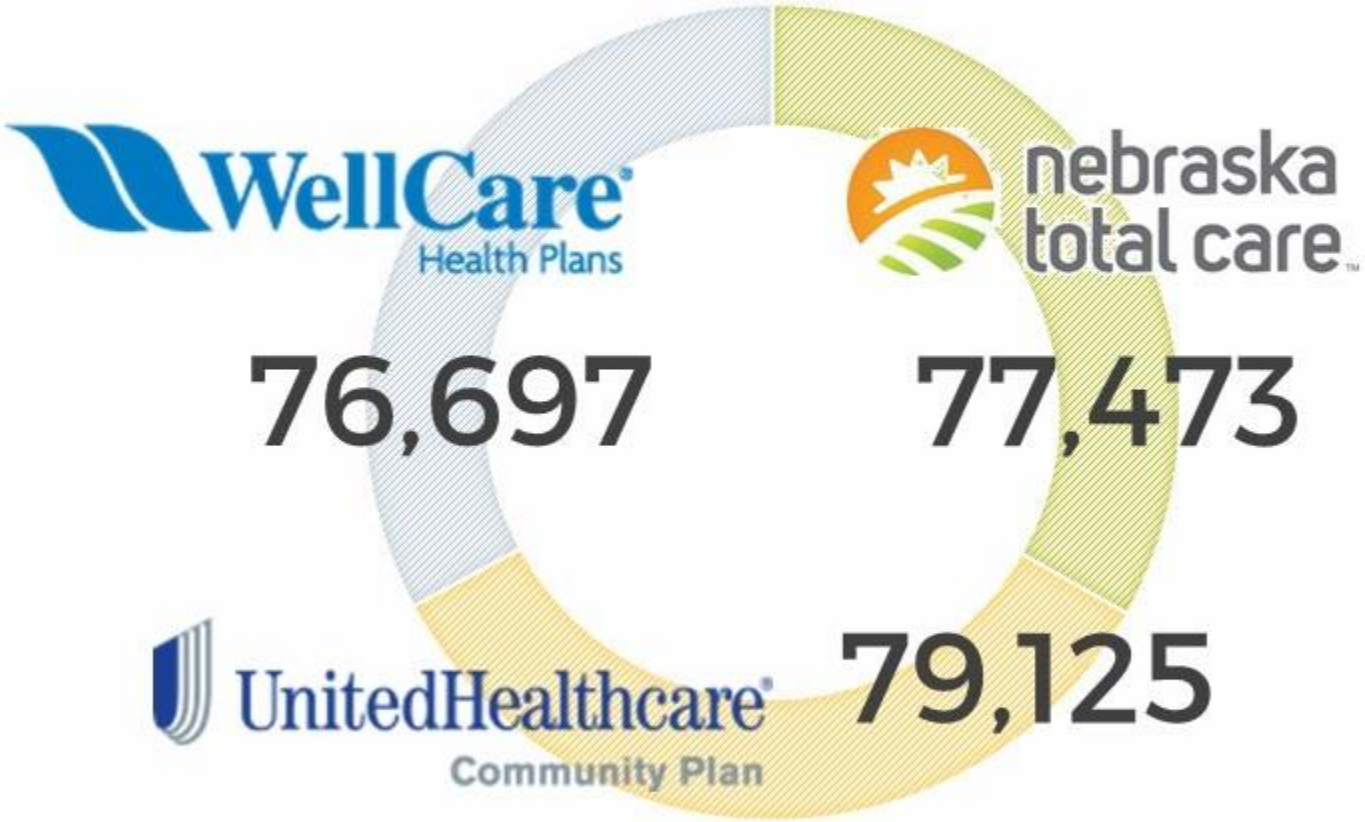
TOTAL ENROLLMENT – FEBRUARY 2018

NTC UHCCP WHP



Value-Added Services

- Managed Care brings many value-added services to members. A few highlights for new benefits in 2018 include:

- ***24hr Nurse Advice Line Mobile app*** to view resources
- ***Breast Pumps, Baby Showers and Diaper Days:*** education on prenatal and postpartum care for mothers and newborn and pediatric care for babies; rewards available
- ***ConnectionsPlus:*** free cell phone for members without reliable access to a telephone
- ***Hope Bear:*** incentive program for participation in post-hospital appointments

Value-Added Services

- Managed Care brings many value-added services to members. A few highlights for new benefits in 2018 include:

- ***Purchase of Breast Pumps***
- ***Healthy First Steps®:*** Ensures that mom and baby receive good medical attention
- ***Baby Showers:*** Education on prenatal and postpartum care; rewards available
- ***24 Hour Crisis and Nurseline℠ Health4Me Mobile App:*** To review resources

Value-Added Services

- Managed Care brings many value-added services to members. A few highlights for new benefits in 2018 include:

- ***Free Car Seats:*** Free for pregnant members
- ***Pursuant Kiosk:*** Complete Health Risk Assessment at a local Walmart kiosk to receive Walmart gift card
- ***Family Support Specialists:*** Families receive counseling through a partnership with Nebraska Family Support Network
- ***Community Room/Concierge:*** Offers community support needs such as free meeting spaces, personal assistance, and computer kiosks

Community Events

Statewide participation with various partners

WellCare Dental Day

NTC Vision Van

UHC Community Baby Shower

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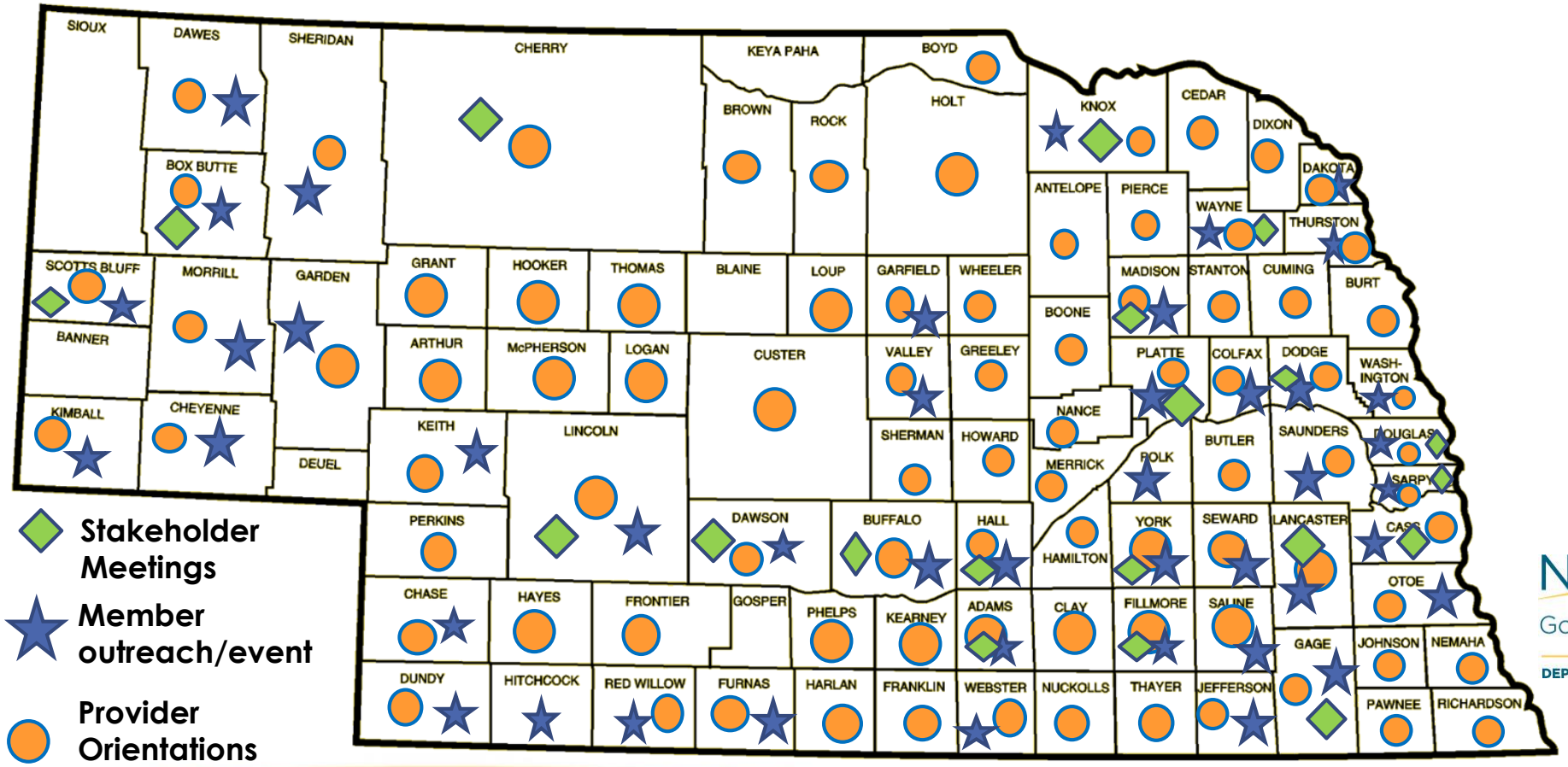
COMMUNITY CONNECTIONS



Stakeholder Meetings

Member outreach/event

Provider Orientations

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Communications to Stakeholders

- Updates on MCOs' communications and education efforts are now required in their bi-weekly meetings with Heritage Health
- These new requirements will help Heritage Health gauge the success of these efforts
- These efforts will similarly help identify opportunities to improve the program

Quality Review

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External Quality Review

Quality of Care - External Quality Review Organization (EQRO)

- An EQR is the analysis and evaluation of aggregated information on quality, timeliness, and access to Medicaid-covered services.
- Federal regulations set parameters that states must follow when conducting an EQR of contracted health plans.
- The EQRO must review the MCO's compliance with standards for access to care, structure and operations, and quality management
- The EQRO must also validate performance measures and performance review projects

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Performance Improvement Projects (PIPs)

- Collaborative project between the state, MCOs, and the EQRO to improve Nebraska Medicaid population health

- Heritage Health currently has three in development:
  - Follow-up after an emergency department visit
    - Mental illness (FUM)
    - Alcohol and other drug dependency (FUA)
  - 17p
    - Hydroxyprogesterone caproate
  - Tdap

Financial Withhold for Quality

Quality Performance Program (QPP) Measures

- Contractual requirement for 1.5% withhold of total revenue
- Funds can only be earned by meeting QPP measures
- Year Two – Shifting to a mix of administrative and clinical measures

These measures are revisited annually and can include administrative and/or clinical measures that reflect the MCO business processes, as well as CMS Medicaid Adult and Child Core Measure sets, HEDIS measures, and MLTC-identified measures.

QPP Measures Year Two

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 clean claim.	95% within 10 business days	20%
Encounter Acceptance Rate: 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	98%	20%
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.	<2%	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 20 days	10%

QPP Measures Year Two

Base Performance Requirement	Payment Threshold	% of Payment Pool
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%
Lead Screening in Children - The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	65%	10%
Well-Child Visits in the First 15 Months of Life - The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: 0 Visits, 1 Visit, 2 Visits, 3 Visits, 4 Visits, 5 Visits, 6 Visits or more	52% with 6 Visits or more	10%
Childhood Immunization Status - The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	Combination #2 - 19% Combination #10 - 8%	Combination #2 - 5% Combination #10 - 5%

Provider and Member Experience

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Provider Surveys

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Nebraska Total Care – Provider Experience

- Nearly 70 percent of NTC's provider survey respondents would recommend NTC to other physician practices
- Over 70 percent of solo practitioners would recommend NTC to other practices
- With physicians practicing 16+ years, over half would recommend NTC to other physician practices
- Access to Case Management is an area to improve

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United Healthcare – Provider Experience

- UHC's 2017 provider survey saw an increase in response rate over 2016 with more respondents replying
- Percentage of respondents who identified as "satisfied" and "very satisfied" increased over 2016
- Overall provider satisfaction increased nearly 10 percent in the last year
- Areas of high satisfaction included:
  - Specialty networks
  - Timeliness of information exchange
  - Clinical practice consultant
  - Provider administrative guide

UnitedHealthcare Community Plan

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WellCare of Nebraska – Provider Experience

- WellCare's provider survey had a total response rate of 13.9 percent
- Responses came primarily from primary care physicians and specialists (74 percent)
- Overall satisfaction was similar to other health plans, with 64.6 percent saying they would recommend WellCare to other physician practices
- Respondents had a nearly identical satisfaction level to Nebraska Total Care when it came to Access to Case Management

Member Surveys

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Nebraska Total Care – Member Experience

- CCC Rate – getting needed care: 92 percent
- CCC Rate – getting care quickly: 96 percent

- Child Rate – getting needed care: 90 percent
- Child Rate – getting care quickly: 93 percent

- Adult Rate – getting needed care: 87 percent
- Adult Rate – getting care quickly: 89 percent

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United Healthcare – Member Experience

- CCC Rate – ease of getting care: 94.6 percent
- CCC Rate – getting care quickly: 87.2 percent

- Child Rate – ease of getting care: 93 percent
- Child Rate – getting care quickly: 86.3 percent

- Adult Rate – ease of getting care: 85.8 percent
- Adult Rate – getting care quickly: 87.7 percent

WellCare of Nebraska – Member Experience

- CCC Rate – ease of getting care 93 percent
- CCC Rate – getting care quickly 91.5 percent

- Child Rate – ease of getting care 83.3 percent
- Child Rate – getting care quickly 86.2 percent

- Adult Rate – ease of getting care 85.8 percent
- Adult Rate – getting care quickly 85.5 percent

WellCare Health Plans

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Member Health

Goals MLTC set for Heritage Health

- Improved health outcomes
- Enhanced integration of services and quality of care
- Emphasis on person-centered approach, care management, enhanced preventive services, and recovery-oriented care
- Reduced rate of costly and avoidable care

Member Stories – Nebraska Total Care

Emphasis on person-centered approach and care management

- A member enrolled in case management in October 2017 with a desire to lose weight. Member has osteoarthritis, obesity and depression. She approached her Case Manager (CM) with a desire to lose weight. At the time her BMI was 49.98. The member took advantage of NTC's value-added benefits and enrolled in weight watchers and joined the YMCA. She actively participates in case management and her CM encourages increased activity and adhering to her diet. As of 2/26/18, the member has lost more than 62 pounds and her BMI is currently 39.9.

- The member is very proud of her progress and reports that she feels better and has a more positive outlook. Prior attempts with Weight Watchers had not been successful, but the support of her CM made the difference this time.

Member Stories – WellCare of Nebraska

Easy access to needed services and helpful MCO staff

- A 58-year-old WellCare of Nebraska Medicaid member called the WellCare Community Assistance Line (CAL) to request help finding food services.
- CAL is a referral tracker database with thousands of community organizations and activities that are available to low-income families and children such as food, education and utility assistance; transportation, disability and homeless services; and support groups and childcare services. It is available for WellCare members as well as the public throughout Nebraska.
- Community Liaisons Brent and Sylvia referred the member to the Salvation Army in Norfolk for assistance. The organization was able to provide the member the food she needed, when she needed it. The member expressed that she was very happy with the assistance CAL offered her and she would use it again in the future if the need arised.

Member Stories – United Healthcare

Personalized attention to coordinate care, leading to improved health and an increased quality of life.

- This very ill member was having difficulty navigating her medical care. She is facing multiple life threatening medical diagnoses, including breast cancer. She recently moved to Nebraska to be closer to family. Her experience with the health care system in Nebraska has been very different than what she was familiar with in her previous state. She was feeling confused and frustrated which was further complicated by her language barrier. Her primary language is Arabic.
- The Care Manager listened to this member to identify all her needs and began coordinating care. She consulted UnitedHealthcare pharmacy staff regarding several essential prescriptions this member reported she had not received from the pharmacy. UnitedHealthcare pharmacy staff reached out to her doctor in order to have the prescriptions refilled. The member also received education about the Phone-A-Pharmacist program offered by the pharmacy. The program allows the member to speak directly to an Arabic-speaking pharmacist by telephone to confirm she has and understands all her needed prescriptions. The Care Manager also contacted the primary care physician's office to schedule her pre-operation appointment, scheduled an interpreter to translate the appointment, and arranged transportation for the appointment through Intelliride.
- The member received personal attention to assist her in navigating the health care system and decrease language and transportation barriers in order to get the medical care she needs in a timely manner. This member now has the information she needs to communicate with her providers, a key component to receiving quality healthcare.

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Performance Management

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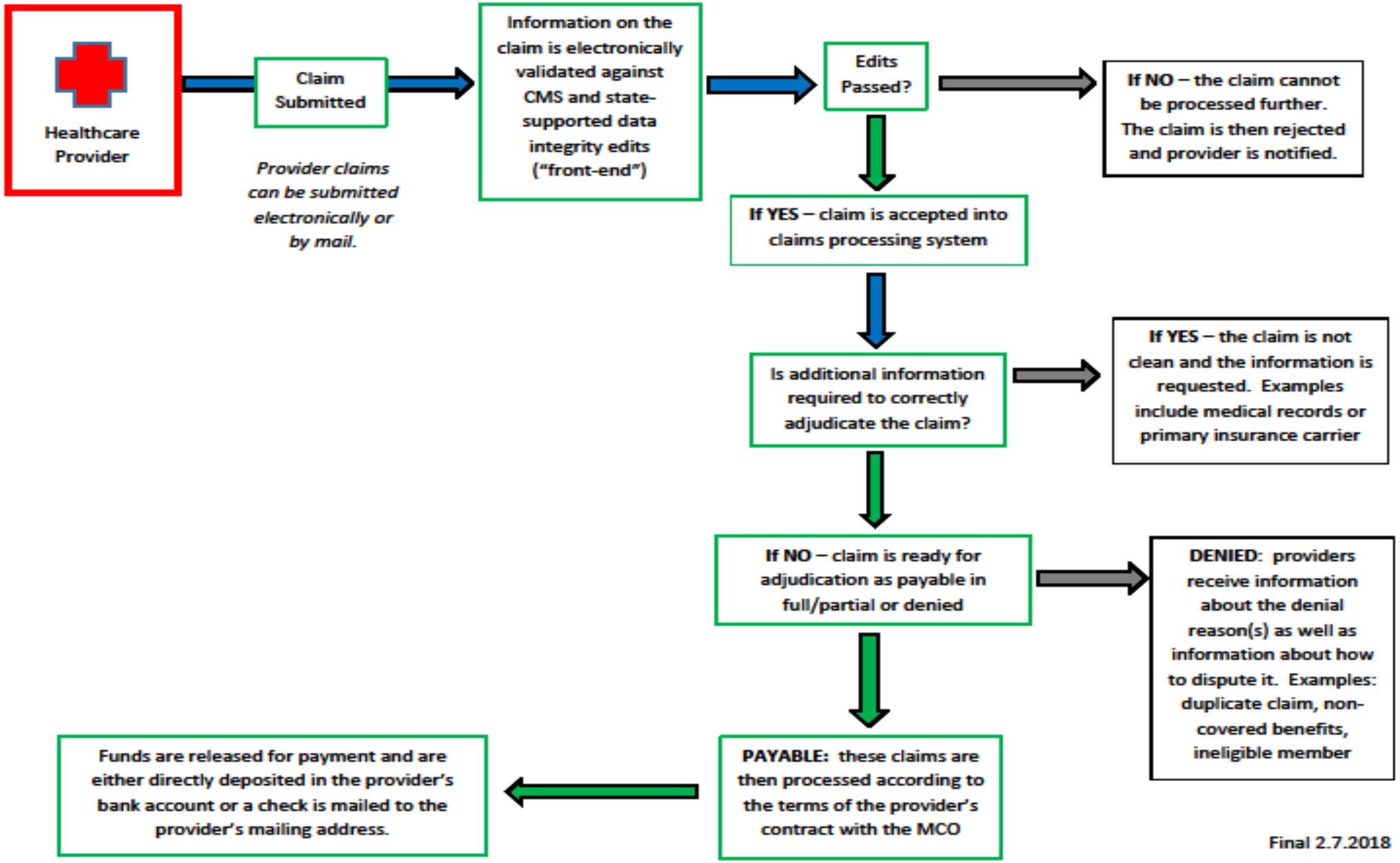
Monitoring Performance

- Data from the 50+ contractually required reports
- Evaluating and assessing whether the reporting elements are effective and assessing what could be done differently
- Plan management team is digging into the data along with MLTC's data and analytics team
- Continued evolution of the public dashboard
- Over 800 contractual requirements overseen

Better Data from Updated Reporting Templates

- In order to produce better, more accurate data, MLTC started using new reporting templates as of January 2018
- The updated templates resulted from a collaborative process with the MCOs through 2017 to streamline reporting
- Certain reports were consolidated and data definitions were clarified
- Reports updated: Grievances, Appeals, Claims, and Behavioral Health



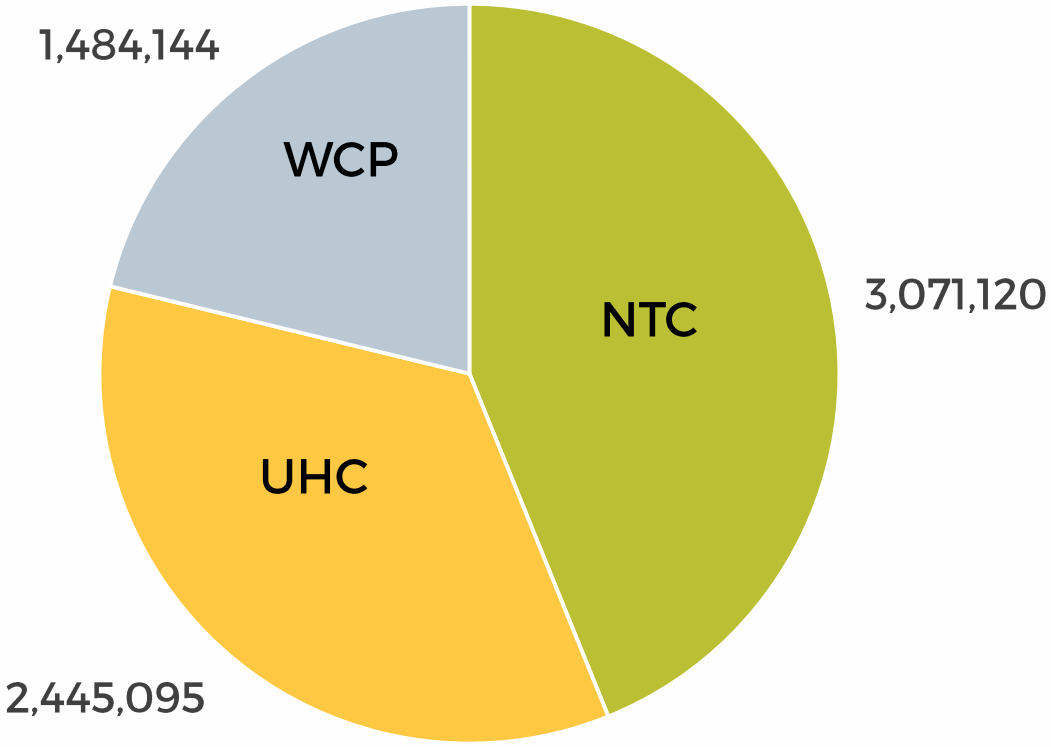
Final 2.7.2018

Clean Claims

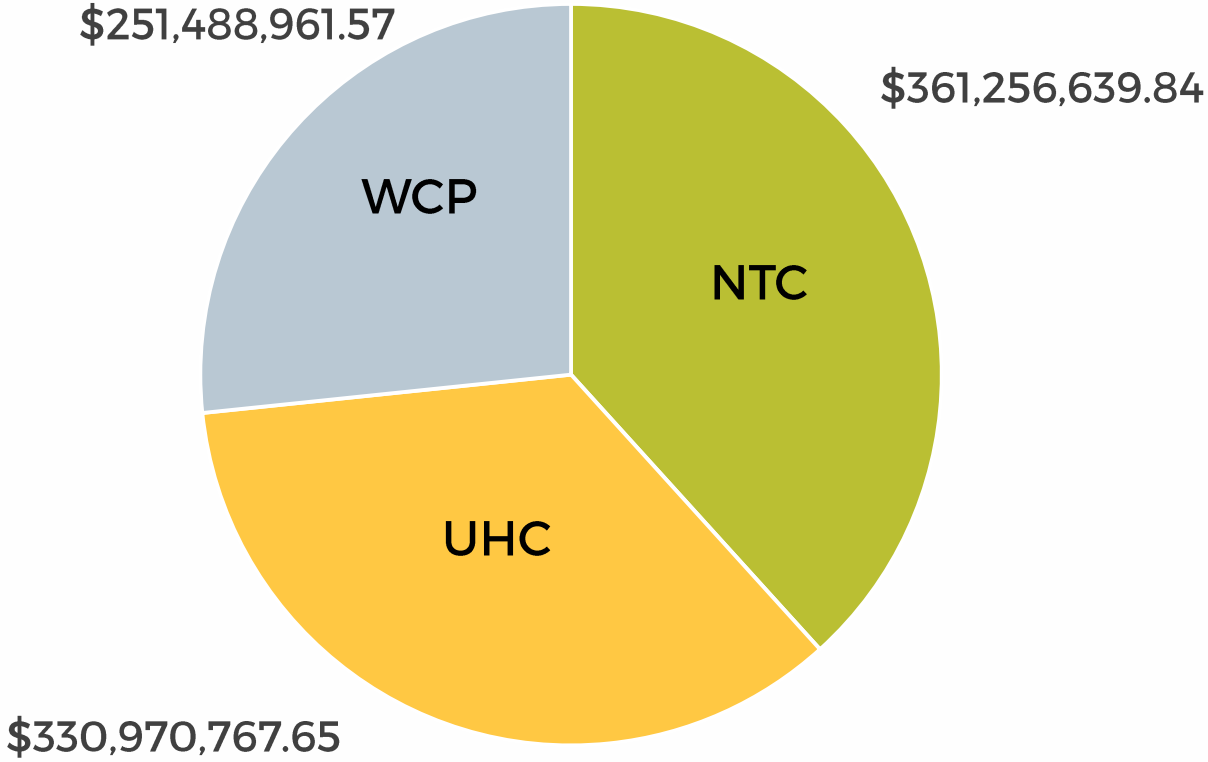
- In 2017, clean claims data was gathered on an ad hoc basis
- Beginning this year, Heritage Health is gathering information on clean claims via standardized reporting templates, which have been shared with the MCOs
- New methodology in reporting will provide more accurate data and make it possible to compare the three MCOs in terms of clean claims

Total Claims in 2017

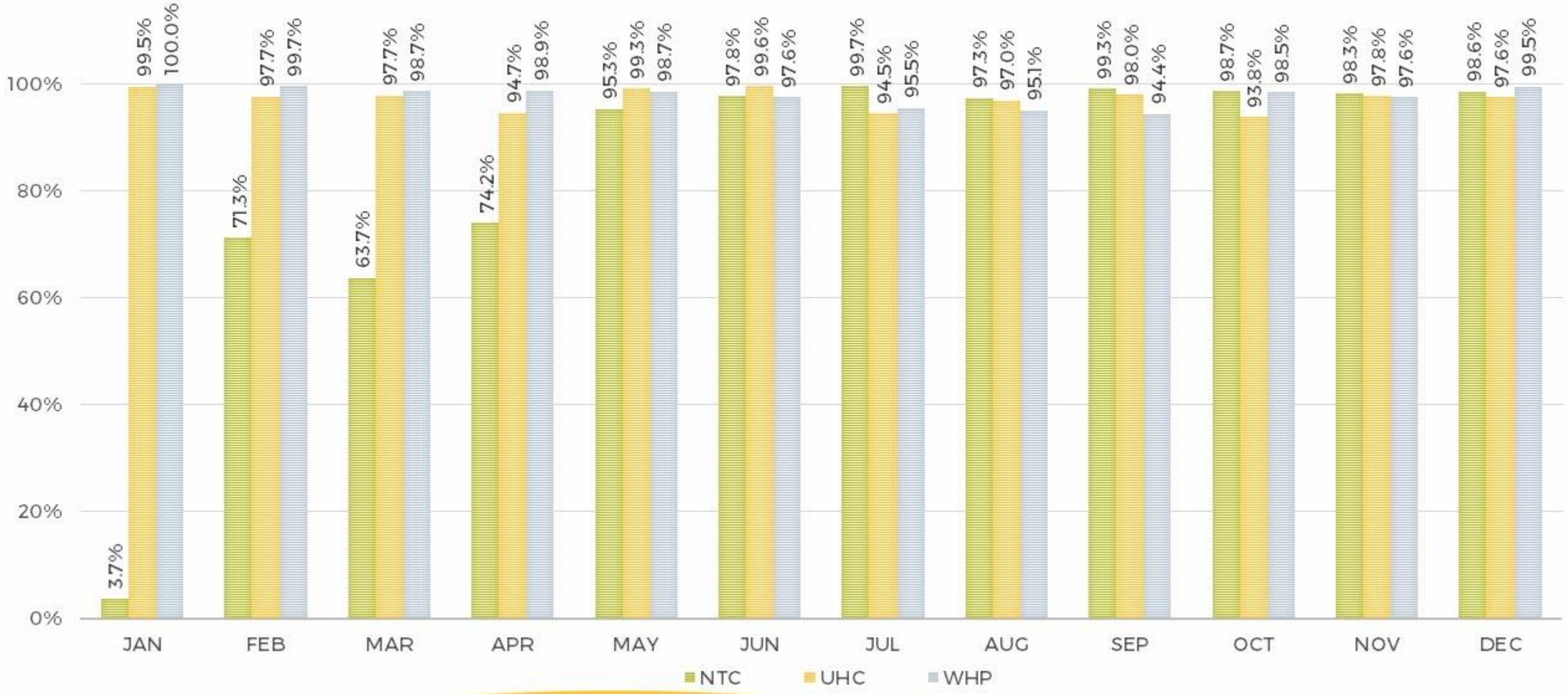
Claims Paid
(Pharmacy & Medical)



Claims Paid Amount
(Pharmacy & Medical)



CLAIMS TIMELINESS



Top Claim Denial Reasons (Dec 2017)

- Member is not Medicaid eligible or enrolled in plan on date of service
- A claim for the same service has already been filed
- This service is not covered

- A claim for the same service has already been filed
- The time limit for filing the claim has expired
- Missing, incomplete, or invalid information about client's primary insurance

- Prior authorization needed but not included on the claim
- A claim for the same service has already been filed
- Client has primary insurance

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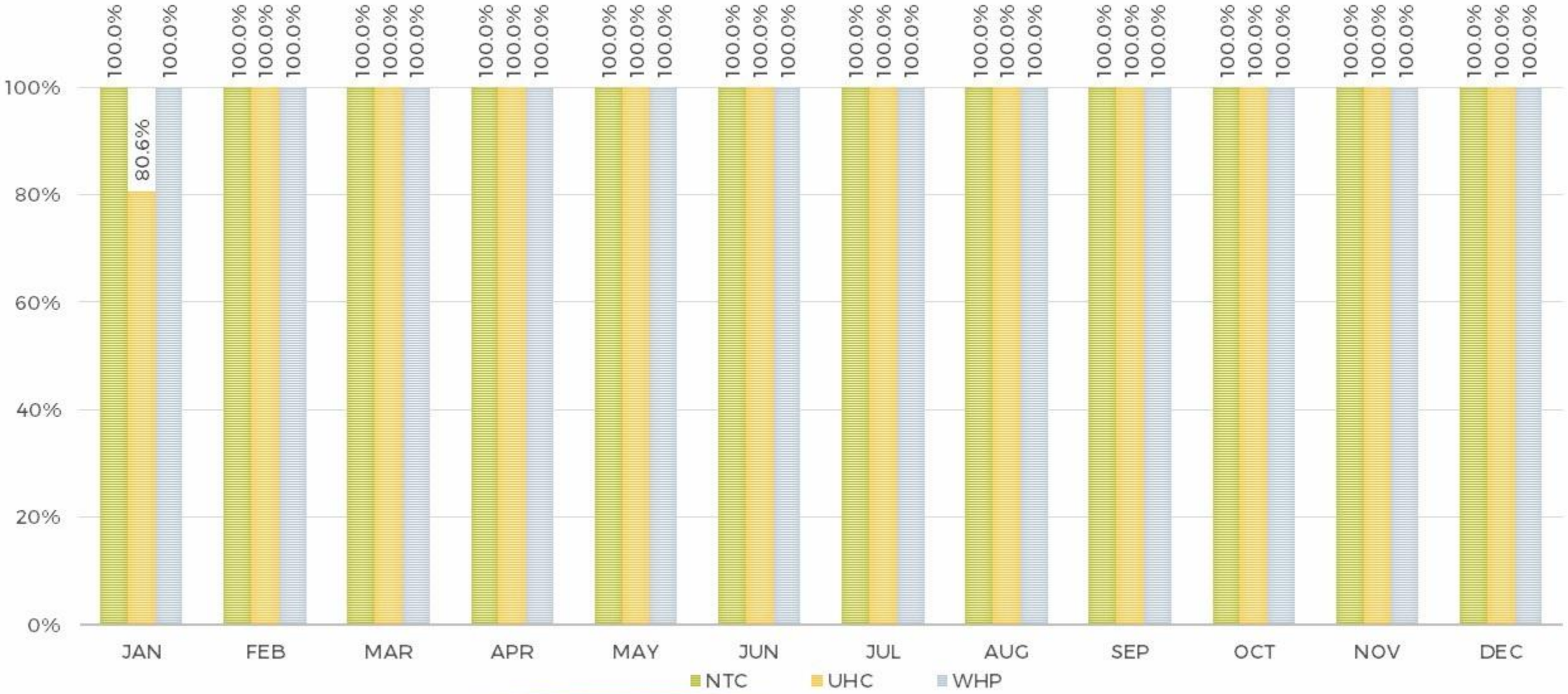
PHARMACY CLAIMS TIMELINESS



Top Claim Rejection Reasons (Dec 2017)

Drug not covered by Medicaid
Member no longer on plan
Limitation on age to receive drug or limit on drug dose

Refill too soon
Drug not covered by Medicaid
Limitation on age to receive drug or limit on drug dose

Drug not covered by Medicaid
Member no longer on plan
Plan limitations exceeded

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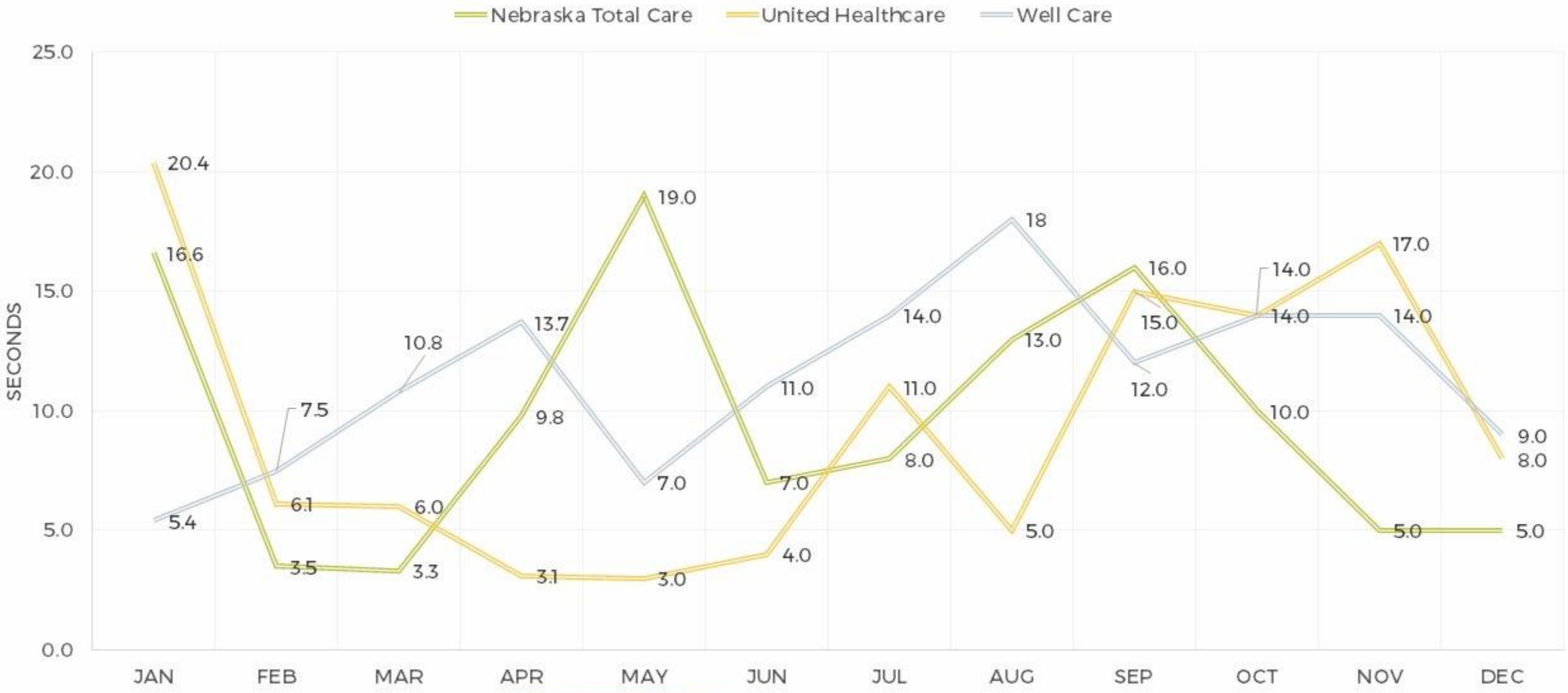
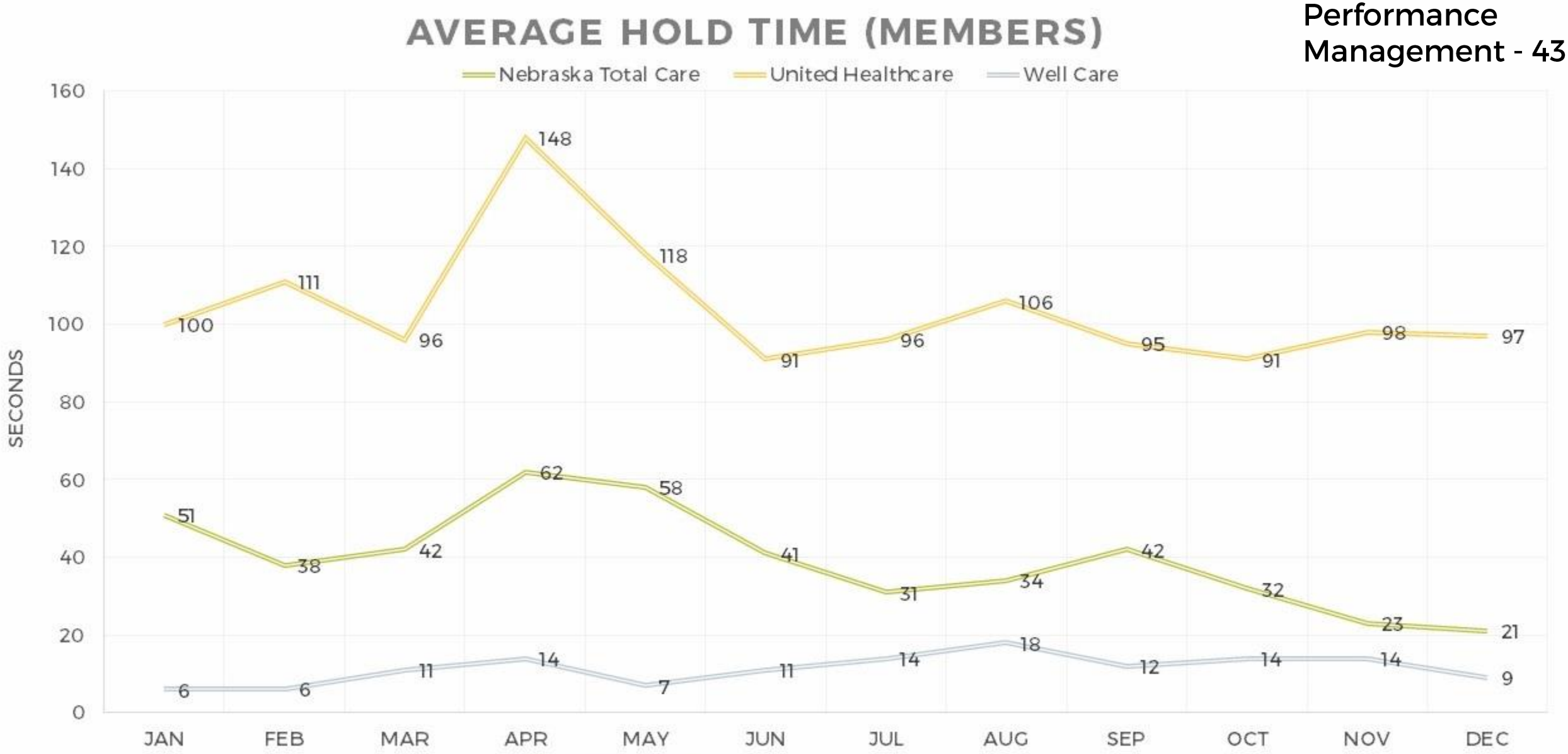
AVERAGE ANSWER SPEED (MEMBERS)




AVERAGE HOLD TIME (MEMBERS)
Nebraska Total Care
United Healthcare
Well Care
SECONDS
160
140
120
100
80
60
40
20
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JAN
FEB
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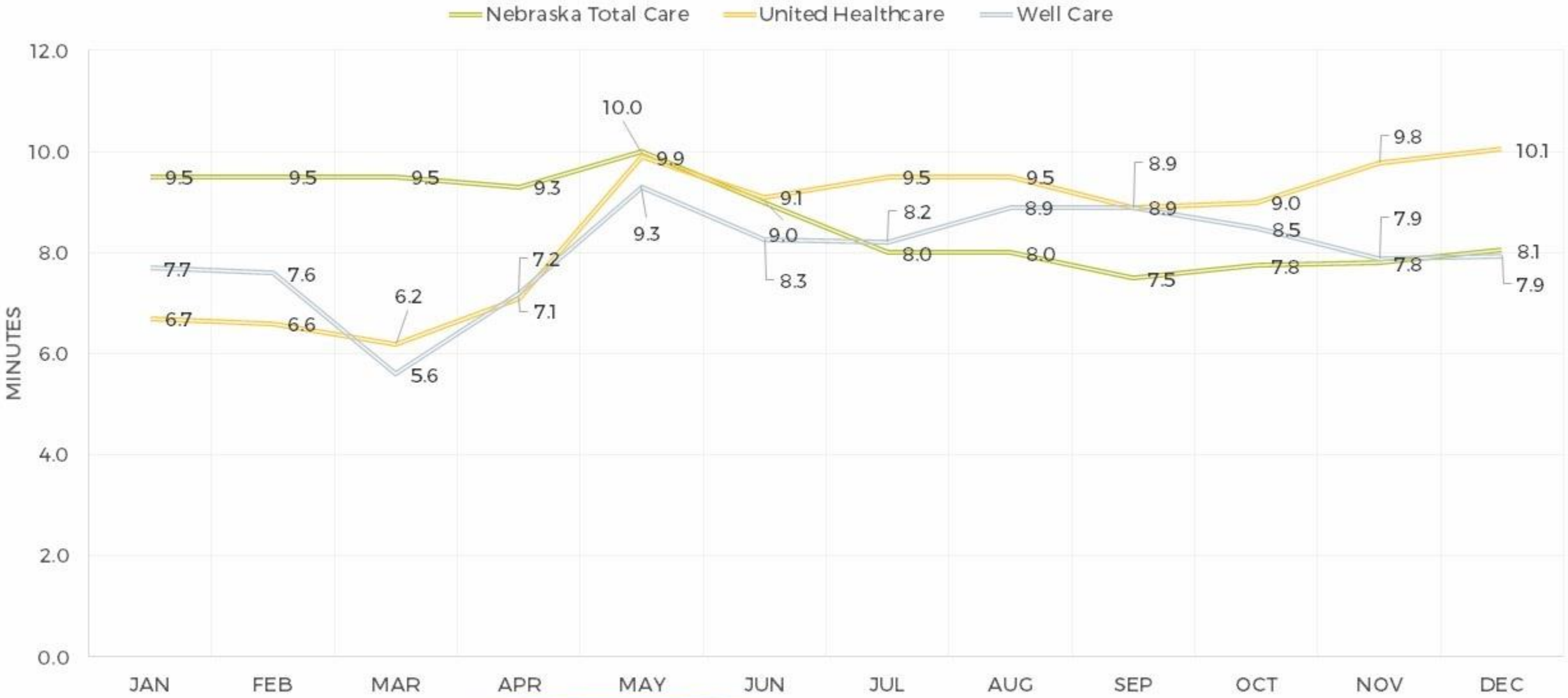
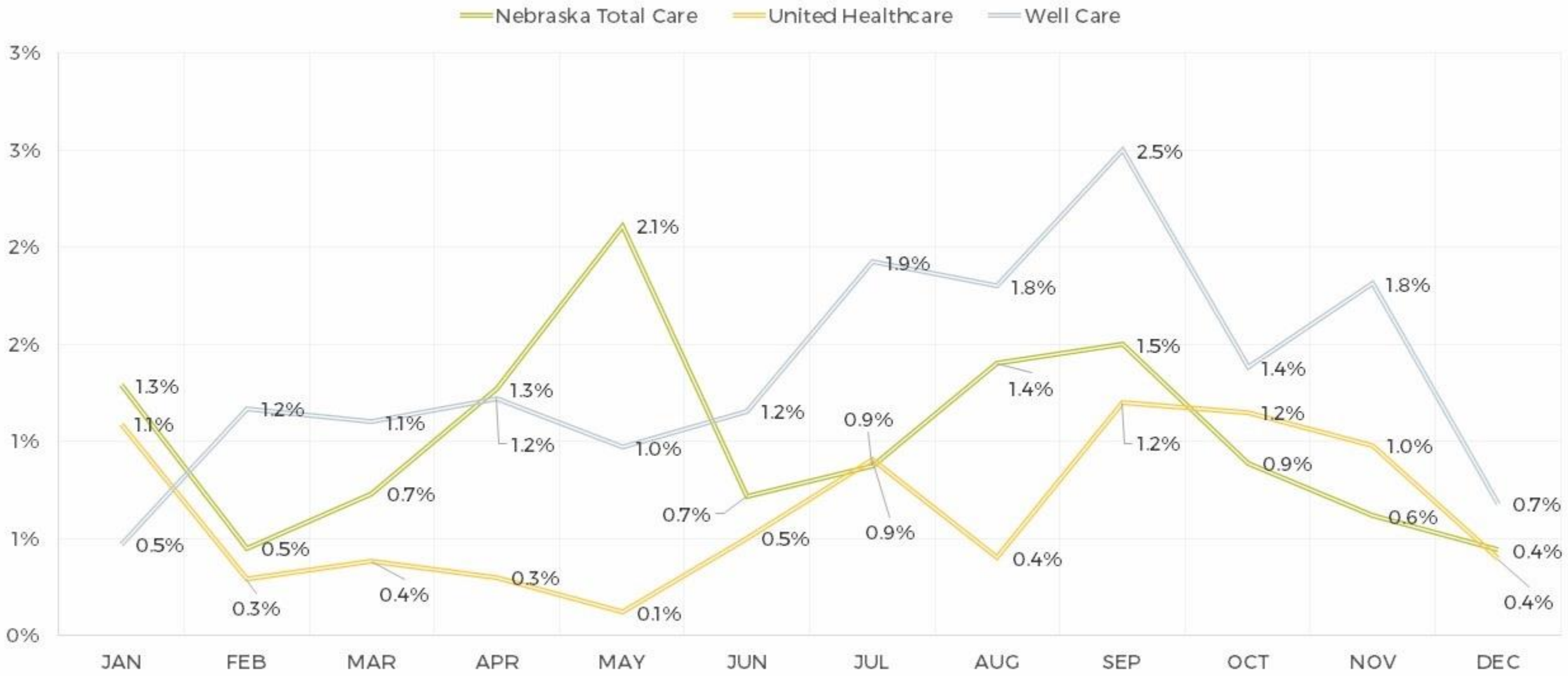
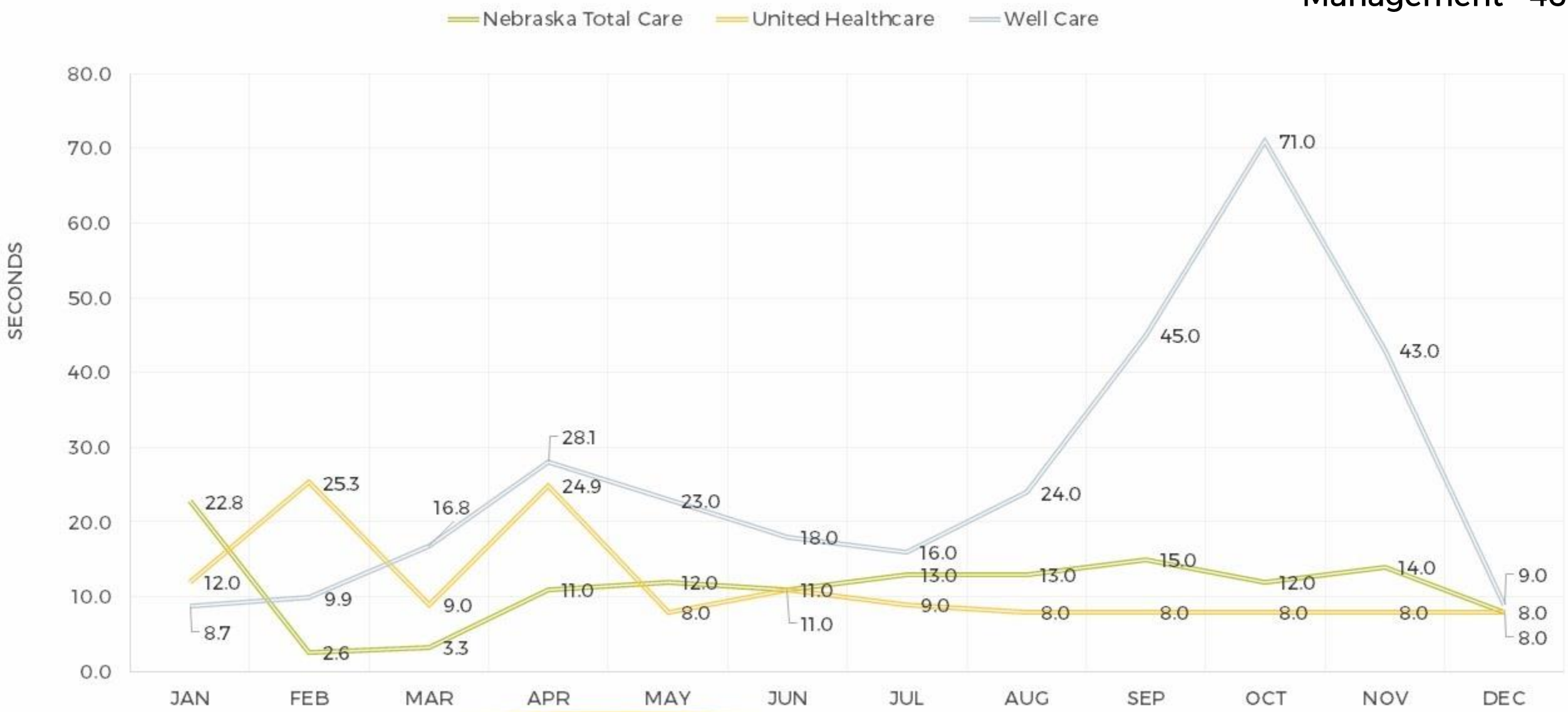
AVERAGE CALL LENGTH (MEMBERS)



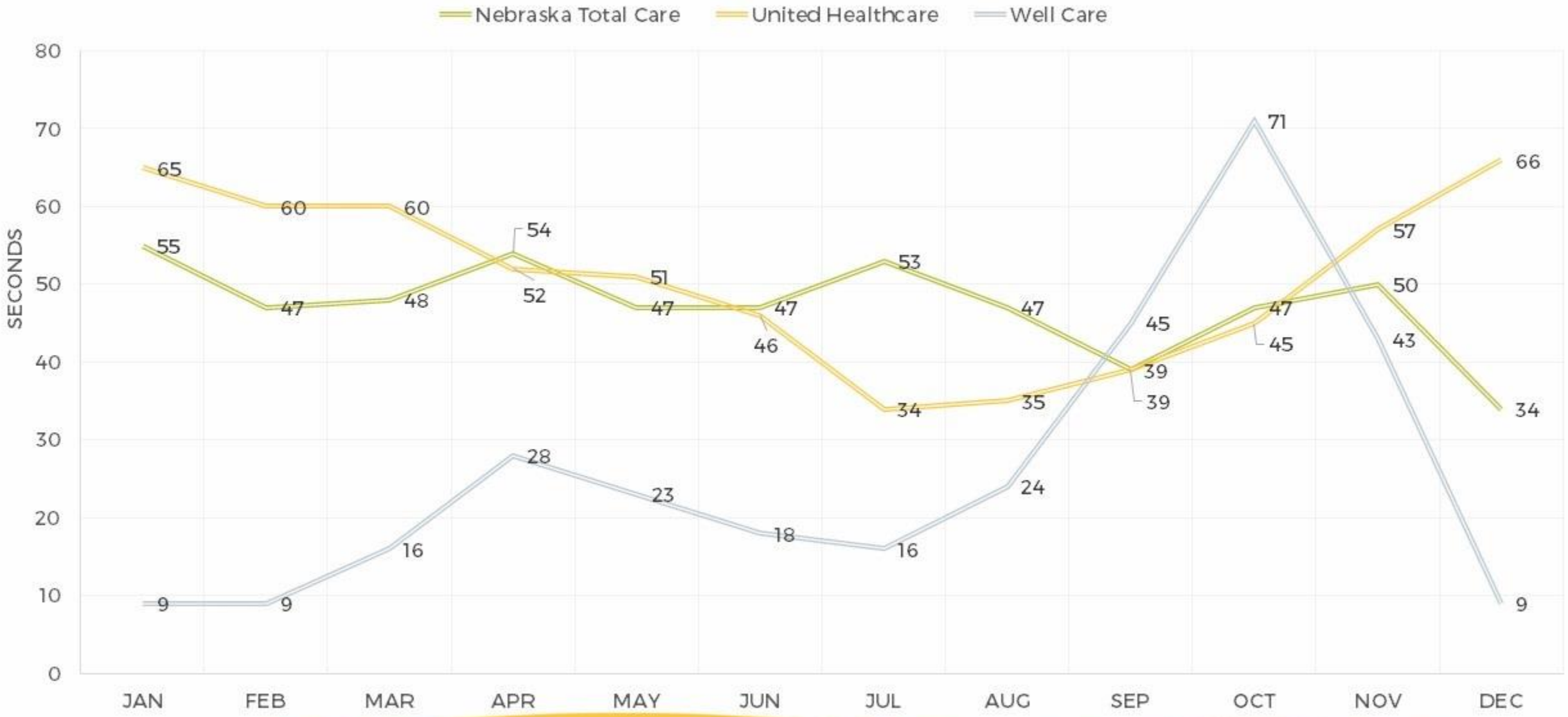
ABANDONMENT (MEMBERS)



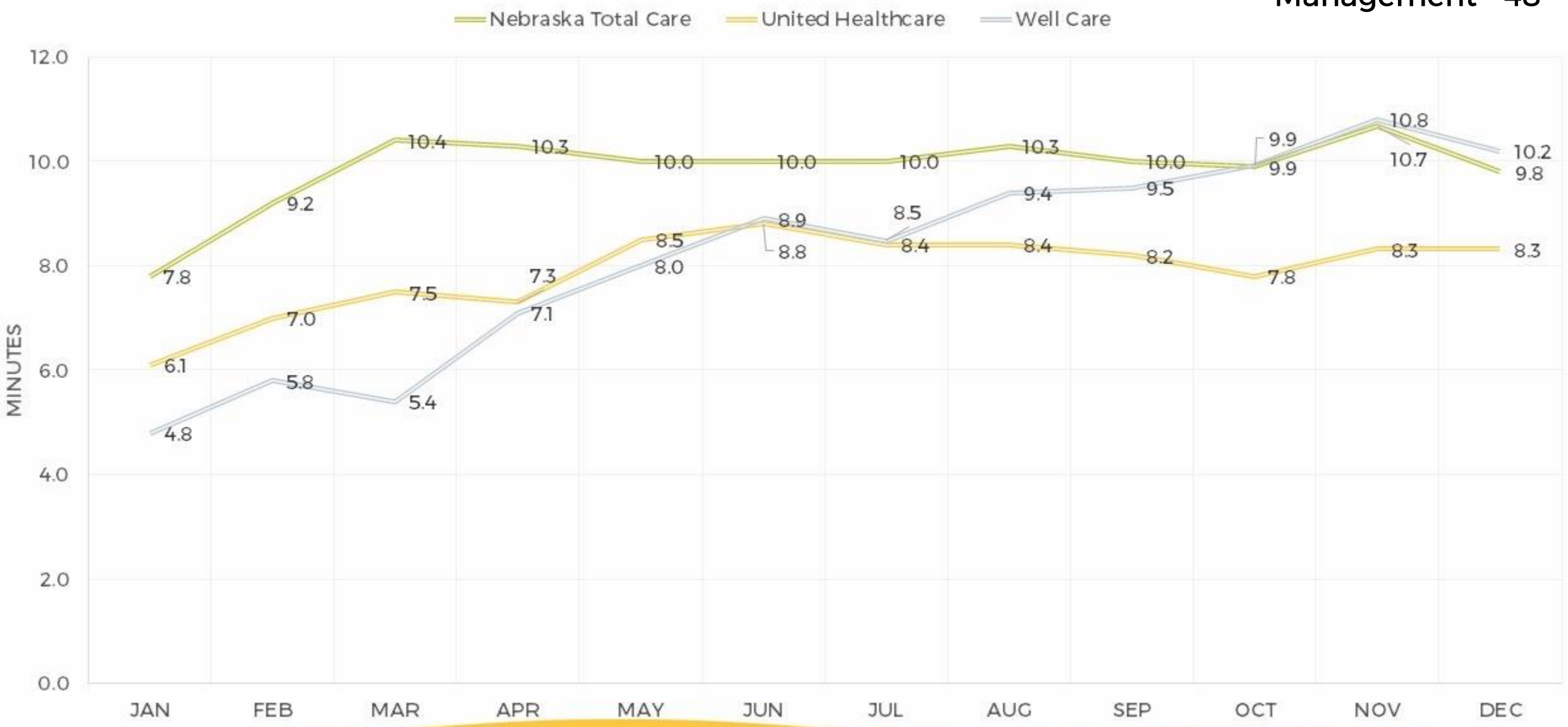
AVERAGE ANSWER SPEED (PROVIDERS)



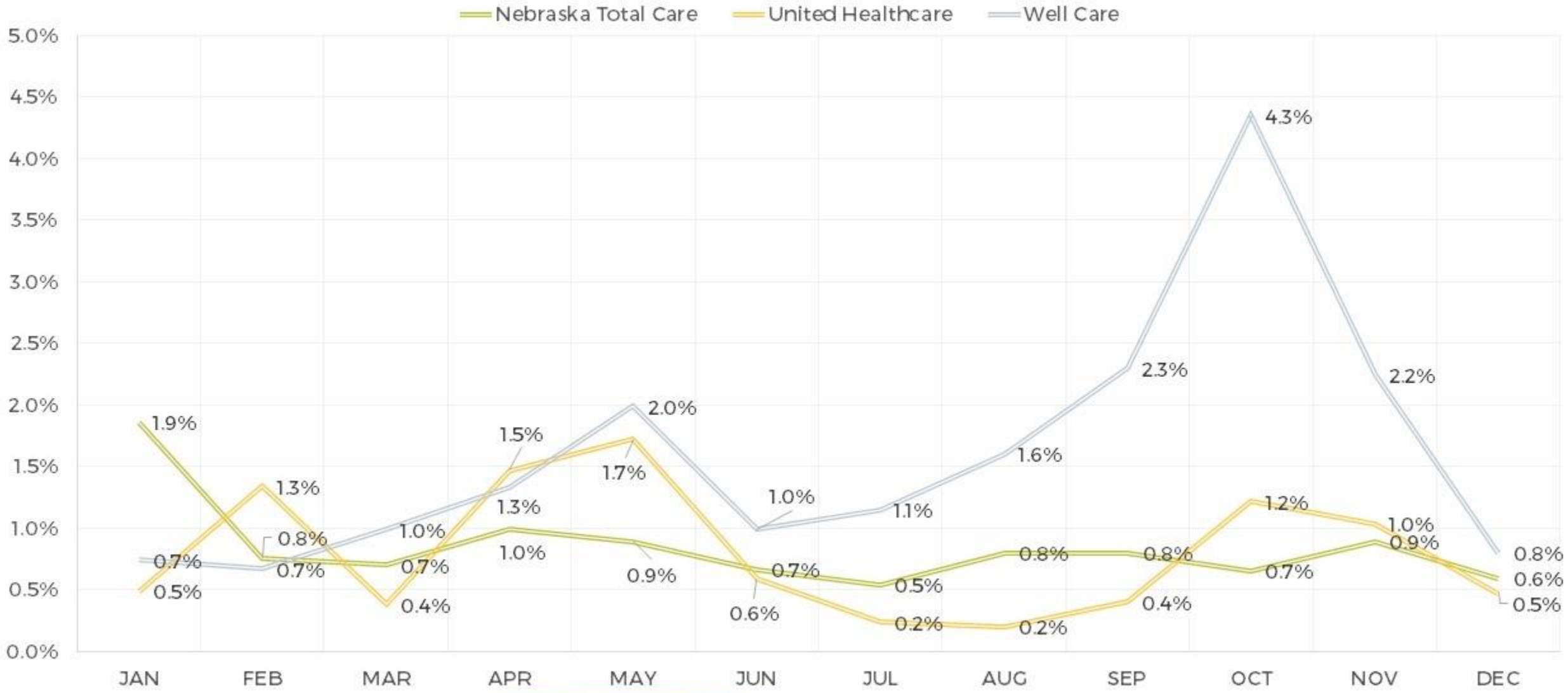
AVERAGE HOLD TIME (PROVIDERS)



AVERAGE CALL LENGTH (PROVIDERS)



ABANDONMENT (PROVIDERS)



Committees and Forums

Administrative Simplifications

Administrative Simplification Projects in Process

- Review of over-the-counter (OTC) medications
  - Create a comprehensive list of OTCs that are preferred by Medicaid
- Prior authorization for DME based on price limits is now complete
  - Offers consistency across the plans and eases administrative burden on providers
- Common form to change primary care provider selection for members
  - Heritage Health is now actively seeking feedback on this, with plans to finalize in April 2018
- Prior authorization for wheelchairs
  - Engagement with Administrative Simplification Committee was directional
  - Plans in place to engage with MCOs and DME association to revise forms

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Committees and forums

Administrative Simplification Committee	Behavioral Health Integration Advisory Committee	Quality Management Committee
May 15, 2018	April 17, 2018	April 18, 2018
August 21, 2018	June 12, 2018	July 18, 2018
November 20, 2018	August 14, 2018	
	October 16, 2018	

Administrative Simplification Subcommittee
Updates on Known Issues and Open Forum for Providers
April 4, 2018

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Director's Tour of the MCOs

- Touring each of the health plans on March 22
- These tours will include touring facilities, seeing call centers in action, receiving presentations on each Care Management program, Utilization Management program, and Quality Management program
- Looking forward to meeting other providers in the coming weeks as well

Questions & Answers

Dr. Matthew Van Patton, Director

Medicaid & Long-Term Care

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Heritage Health Website:

dhhs.ne.gov/heritagehealth