Nebraska's New Integrated Managed Care Program

HERITAGE HEALTH

EDN SERVICES COORDINATION
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Department of Health & Human Services
DHHS
NEBRASKA

Current Nebraska Medicaid

- Nebraska Medicaid provides health care coverage to approximately 230,000 people at an annual cost of approximately $1.8 billion.
- 12% of Nebraska's population is Medicaid eligible.

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Current Managed Care

- Nebraska Medicaid contracts with:
  - Three regional MCOs for physical health services
  - A separate managed care entity for behavioral health services
  - A pharmacy benefit management contractor for pharmacy services
- An individual receives his or her health care through three separate contractors.
- 82% of Medicaid clients are enrolled in physical health managed care and more than 99% are enrolled in behavioral health managed care.

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Financing Care

Capitated Payments

- A fixed amount, per covered individual, is paid each month to a managed care organization (MCO). In return, the provider or MCO is responsible to pay for (and is "at risk" for) the medical care for its patients or members.
- These rates are developed by actuaries and are based on historical costs and projected trends.

Comparing Models

A Comparison

"At Risk" Model

- Payment is made to the health plan before services are delivered.
- The MCO has a financial incentive to provide cost effective services.
- Risk is assumed by the managed care organization.

Fee for Service (FFS) System

- Payment is made after a service is delivered (retrospectively).
- Providers bill for services delivered and are paid a predetermined rate for each service directly by the State.
- The recipient of the FFS payment (providers) has a financial incentive to deliver more services.
- Risk is assumed by the State.

Key Health Plan Responsibilities

Care Management

- Emphasis on use of primary care providers
- Triage and referral for behavioral health
- Disease management
- Clinical standards and best practices

Quality Management

- Formal, structured program
- National standard performance measures (e.g. HEDIS, member experience)
- Focused performance improvement projects

Key Health Plan Responsibilities

- Utilization Management
  - Prospective review – precertification and preauthorization guidelines (not for emergency services)
  - Concurrent review – discharge planning
  - Retrospective review -- use of claims data to determine areas of opportunity
- Provider Network Management
  - Explicit standards for selecting providers
  - Policies for continued access to care when providers change
  - Provider education

New Integrated Managed Care Program: Heritage Health

On April 15, 2016, Nebraska Medicaid announced the signing of contracts for **Heritage Health**, a new managed care program providing integrated health care services.

- The three awarded health plans are UnitedHealthCare Community Plan of Nebraska, Nebraska Total Care (Centene), and WellCare of Nebraska.
- Each health plan will coordinate a full range of services, including physical health, behavioral health, and pharmacy services.

Start Date → January 1 2017

Uniformity with Credentialing

- Council for Affordable Quality Healthcare (CAQH)
  - National non-profit organization dedicated to reducing the administrative burden of provider credentialing. www.caqh.org
  - Ensure profile is up to date and has been attested to within the last six months
  - Select each Heritage Health plan as an approved payer in order for the plan to access the CAQH profile.

Heritage Health Goals

- 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
- Improved financially-sustainable system

Behavioral Health Integration

- Designed to better address co-occurring mental illness and substance use disorders – focus on the whole person
- Plans are financially and contractually incentivized to invest in preventive and community-based care
- MLTC established a behavioral health integration advisory committee to guide transition

"There is no health without behavioral health, and individuals with serious behavioral health conditions often have untreated or undertreated physical health conditions. Bringing together the responsibility for managing these services is an important step toward recognizing the importance of treating the whole person in an integrated setting."

Sheri Dawson
Director of the DHHS Division of Behavioral Health

New Populations

- Individuals participating in home and community based waivers (Aged and Disabled Waiver, TBI Waiver, and DD Waivers)
- Individuals who live in long-term care institutional settings, such as nursing facilities and intermediate care facilities for people with developmental disabilities.

These individuals will have their physical health (for example, physician and hospital care), behavioral health, and pharmacy services coordinated by their Heritage Health plan.

Long-term services and supports will continue to be administered as it is today.

Contract Key Features

Focusing on Quality, Care Management, and Social Determinants of Health

- Enhanced MLTC partnership with sister Divisions
- Performance measures specific to Nebraska's Medicaid members
- New MLTC Heritage Health Quality Committee
- Early identification of care management need
- Inclusion of social determinants of health in health risk assessment and care management strategy
- Referrals to community resources

Contract Key Features

Expanding Access

- Requirements for robust provider networks including hospitals, physicians, specialists, pharmacies, mental health and substance use disorder providers, and allied health providers
- Preventive, primary care, specialty care, and recovery-oriented services
- Patient-centered medical homes

Contract Key Features

Enhanced Accountability

- MLTC-approved policies and procedures
- Reporting on numerous operational and performance measurements
- MLTC staff access to information systems
- Readiness reviews
- Periodic operational reviews
- Financial incentives and penalties

Contract Key Features

Supporting Providers

- Process simplification and communication
- Timely payment requirements, shortening the time between filing and receipt of payment
- Enhanced claim tracking tools
- Common state preferred drug list
- Extensive provider training
- Dedicated provider services staff
- Provider advisory committees
- Provider complaint system

Contract Key Features

Focusing on Value

- Moving away from fee for service, and toward more sophisticated strategies for purchasing health care services
- Plans will be required to meet specific thresholds for "Value-Based Contracts"
  - Include quality, outcome, or cost metric for providers
  - Aligns financial incentive of MCO with provider (e.g., shared savings, performance pay)

Contract Key Features

Engaging and Protecting Members

- Proactive provision of information, accessible formats
- Availability of toll-free call center
- Extensive MLTC-approved grievance process
- Evaluation of member experience, using national survey
- Member choice – MLTC contracts with Enrollment Broker to provide choice counseling

Contract Key Features

Supporting MLTC Partners

Heritage Health plans are required to coordinate with other DHHS and State agency programs, including:

- Division of Behavioral Health
- Division of Children and Family Services
- Division of Developmental Disabilities
- Department of Education
- Community Agencies, including and not limited to the Area Agencies on Aging and League of Human Dignity
- The Office of Probation
- Other programs and initiatives related to primary care and behavioral health integration/coordination and pharmacy management

Contract Key Features

Ensuring a smooth transition

- MLTC-approved transition and implementation plan
- Nine-month collaborative implementation period
- Key staffing requirements
- Provider network in place 90 days in advance
- Strong continuity of care protections to ensure no disruption

MLTC and its contracted enrollment broker will coordinate member education and enrollment with the Heritage Health MCOs.

Heritage Health Enrollment Broker

In April 2016, Nebraska Medicaid signed a contract with Automated Health Systems to act as Medicaid's enrollment broker for the Heritage Health program. The enrollment broker is an independent entity that provides the following services to Medicaid members:

- Plan selection outreach
  - Written and phone-based outreach alerting Heritage Health members to the open enrollment period and the timeline for making a voluntary plan selection
- Comprehensive and unbiased choice counseling
- Searchable databases of providers that allow members to determine whether his/her current primary care provider or preferred specialist is a part of a specific health plan's network prior to the member selecting his/her health plan

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Communications

- Heritage Health branding
- New and redesigned webpages
  - News releases and program updates
  - FAQs
  - Links to procurement site and contracts
- Public/stakeholder involvement

"Nebraska has a proud heritage for taking care of ourselves, our families and our neighbors. Heritage Health will be a vehicle for better health for nearly 230,000 Nebraskans, many of whom are among our most vulnerable."

Courtney Phillips, CEO Nebraska DHHS

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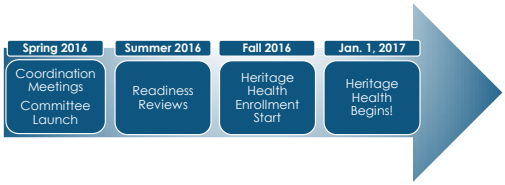
Implementation Timeline



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Helping People Live Better Lives – *Better Together*

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Questions

Heritage Health Website
http://dhhs.ne.gov/heritagehealth

"We are excited about all of the improvements and enhanced accountability that Heritage Health will bring to Nebraska Medicaid. Integration of behavioral and pharmacy services and inclusion of some of our highest need and highest cost populations will help us deliver better outcomes to recipients and greater value for taxpayers."

Calder Lynch
Director, Division of Medicaid and Long-Term Care