UMR Remediation Plan

State of Nevada Public Employees' Benefit Program (PEBP)

Administered by UMR

Remediation Response Period:

July 1, 2022 – September 30, 2023

Presented to:

State of Nevada Public Employees' Benefit Program (PEBP)

January 26, 2024

Proprietary and Confidential

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Executive Summary

This Remediation Plan will play an integral role in managing and achieving PEBP's expectations and UMR's Performance Guarantees for the near future.

UMR has met the Performance Guarantees for Utilization Management/Case Management for the last three quarters. We also met the Performance Guarantees for Network Administration in Q1 2024. This is the standard UMR is committed to achieve for Claims Administration Performance Guarantees.

Included with this strategic Remediation Plan you will find goals and objectives that UMR leadership and staff have implemented. These steps will ensure that we bring the remaining eight Performance Guarantees outlined in this remediation plan in compliance with the agreed upon standards. More frequent status reports will be provided to PEBP staff monthly.

In addition to the legacy HealthSCOPE Benefits (HSB) staff who have worked on the PEBP account for 13 years, we continue to add additional resources in the areas of claims administration and customer care. The legacy HSB staff are directly involved in day-to-day operations and their historical knowledge is instrumental to our success. Additionally, we have increased internal audits on the PEBP account for process improvement opportunities.

For Plan Year 2023 we processed 530,438 claims for a total billed amount of over $1,082,468,170 for 9,228 unique providers and 43,665 unique participants. Additionally, we managed over 86,000 participant calls with a call satisfaction rate of 97.4%.

Access to health care in UMR's network across the state of Nevada for PEBP employees and their families has been stable and consistent since PEBP became a UMR client on July 1, 2022. In fact, we have added more providers to our networks since July 1, 2022, than the number of providers that have left the network for various reasons. Provider terminations are generally due to retirement, providers leaving the community, provider group acquisitions, etc. UMR is not aware of any provider terminations related to service issues.

Through our various networks, medical management, and payment integrity services, UMR has helped the PEBP plan achieve an estimated savings of over $872,000,000 for Plan Year 2023. These estimated savings not only saved the taxpayer funded PEBP plan but also directly saved money for PEBP participants, retirees, and their families.

UMR (including legacy HealthSCOPE Benefits) staff and PEBP have partnered to service State of Nevada participants, retirees, and their families for over a decade. We are fully committed to meet our mutual goals under the UMR brand.

Detailed Objectives

CLAIMS OPERATIONS

Our goal is to meet or exceed Performance Guarantees going forward. The section below will outline our plan for continuous improvement until we meet the requirements of the contract specific to the following areas: Financial and Overall Accuracy, Claim Turnaround Time, and Claim Adjustment Time.

1.1 Financial Accuracy and 1.2 Overall Accuracy

The objective is to improve Financial and Overall accuracy results to meet or exceed the required metrics. Leadership is focused on using errors identified through internal and Claims Technologies (CTI) audits to guide training efforts with analysts. Additional daily monitoring of internal UMR accuracy results began mid-January, will provide timely remediation at the claim analyst level. In addition, internal UMR daily audits have been implemented to identify duplicate claims. The planned result being to minimize or eliminate repetitive errors at their beginning stages.

Training sessions pertaining to “refresher subjects” and repetitive errors identified through our internal daily monitoring will be held weekly.

Targeted areas of review will be complex specialized claims, claim pricing scenarios and duplicate claim review.

Results will be measured monthly with an expectation of continuous improvement until we meet the requirements of the contract for financial and overall accuracy to meet Performance Guarantees.

1.3 Claim Turnround Time

The objective is to reduce turnaround time to meet or exceed required metrics. Based on average manual claim receipts of 25,000 per month, we increased our dedicated claim analysts from 14 to 20. We added additional support to assist with managing inventory and improve claim turnaround time. With these changes we were able to meet the Q1 Plan Year 2024 for the 14 days turnaround Performance Guarantee.

Daily monitoring of the claim analysts productivity and availability is conducted by the Claims Director to ensure individual analyst metrics are achieved. This process began January 2, 2024.

As a result of these improvements, we expect to see continuous improvement in turnaround time metrics until we meet the requirements of the contract.

1.4 Claim Adjustment Time

The objective is to improve Claim Adjustment Turnaround Time to meet or exceed required metrics. Leadership will distribute adjustment assignments daily to analysts as priority and implement check-ins at the 72-hour mark to ensure adjustments are managed timely.

Results will be measured monthly with an expectation of continuous improvement until we meet the requirements of the contract.

CUSTOMER CARE

Our goal is to meet or exceed Performance Guarantees going forward. This section below will outline our plan for continuous improvement until we meet the requirements of the contract specific to the following areas: First Call Resolution, Open Inquiry Closure, Quality Audit Scores, and Callback Performance.

1.7 First Call Resolution

In July 2022, during the transition from HealthSCOPE Benefits (HSB) to UMR, call staffing levels increased from 18 call agents to 22 agents. In August 2023, the call staff was increased from 22 to 27 agents and then again in November 2023, the call staff was increased from 27 to 31 agents. The increase in staffing was implemented to support the Performance Guarantee for calls answered within 30 seconds, which has been consistently met since reaching a level of 31 call staff.

The increase to 31 call agents along with 2 dedicated claims analysts, will support the steady improvement of first call resolution toward consistently meeting quarterly Performance Guarantees.

1.8 Open Inquiry Closure

As indicated under 1.7, call staffing has steadily increased over the past 18 months. We currently have 31 call agents assigned to PEBP account. The increase in call agents along with 2 dedicated claims analysts has helped to consistently meet the 90% within 48 hours goal and steadily improve on the 98% within 5 business days goal toward meeting quarterly Performance Guarantees.

1.9 CSR Audit or Quality Scores

In January 2024 we increased the call audits from 120 to 180 calls per month. The additional call audits, along with an increase of supervisor reviews of live calls, will give UMR a larger sampling to help identify areas and individuals that may be struggling. Quality results are reviewed during biweekly team meetings and our weekly one on ones with call agents. Coaching and training are also performed as needed. The increased reviews and heightened awareness will improve the overall quality scores and give more consistency month over month to meet quarterly Performance Guarantee.

1.10 CSR Callback Performance

Additional reporting was implemented January 2024 to identify outstanding callbacks. This internal report is used to monitor and resolve any calls within 24 hours. There is also some redundancy built into the monitoring through multiple leaders to ensure no days are missed which will enable us to meet Performance Guarantees.

PPO PRICING ERRORS

Summary of action items taken and discussed within the Remediation Plan.

- Increase of claim audits from 400 per month to 600 per month to eliminate pricing errors and to improve accuracy and efficiency.
- Network Repricing Unit (NRU) to complete back-end reporting for quality improvement.
- Network team will collaborate in our internal weekly management meetings.
- Continued collaboration between internal team to improve overall Performance.

Objective:

Our objective is to reduce and eliminate pricing errors and to improve accuracy and efficiency in network administration. We have conducted a thorough analysis of pricing errors and identified gaps in the process.

We will conduct coaching and additional training sessions to help staff thoroughly understand the internal workflow process. These sessions will also focus on the importance of accuracy and attention to detail. We will review and streamline the processes for network pricing to make it more efficient. This will include review of increasing our ability to systematically price claims, provide clear procedural guidelines and training materials for staff, and utilize our efforts for continuous monitoring and improvement. Continuing education sessions on the handling of claims will take place collaboratively with the UMR Network team and Claim Operations.

UMR will increase internal audits from 400 to 600 on a monthly basis immediately to ensure claims process accurately. It is important to increase the population of audited claims on a weekly basis, this will help to identify and address any ongoing issues and ensure that discounts apply correctly. In addition to audits, it is also important to implement additional back-end audit production reports. These reports will generate on claims that require manual pricing from the network team which will identify any discrepancies and allow for prompt action. UMR Network Team has started running back-end audit reports to review accuracy.

We will regularly monitor the progress of the Remediation Plan and track the reduction in pricing errors. This will identify any ongoing issues and allow for timely action. Any identified issues or concerns will be addressed promptly. We will share the progress internally with UMR Leadership and highlight any improvements. There will be open communication with the UMR Network Team, Account Management and Claim Operations about the Remediation Plan progress. This will help manage expectations and build trust in the accuracy of claim administration as well as provide an opportunity for feedback and suggestions for improvement. We will accomplish this through weekly internal meetings.

We understand pricing errors have a significant impact on the accuracy and efficiency of claim administration. By following this Remediation Plan, we aim to reduce and eliminate these errors, leading to improved customer satisfaction and increased productivity. Regular monitoring and continuous improvement will be key to the success of this plan.

Conclusion

UMR holds our partnership with State of Nevada Public Employees' Benefit Plan (PEBP) with the upmost importance. UMR's objectives and goals are in alignment with PEBP and it is our commitment to improve and meet all Performance Guarantees.

The forty-two (42) PEBP Performance Guarantees reported either quarterly or annually are the largest number of Performance Guarantees, and the most stringent, that UMR has for our entire book of business. We agreed to these standards, and as agreed upon in our contract, we have paid $531,507.56 in Performance Guarantee penalties.

UMR leadership and staff are committed to meeting the challenge to bring the remaining 8 Performance Guarantees outlined in this remediation plan in compliance with the standards. When comparing the average miss for the 8 Performance Guarantees from Q1 2023 to Q1 2024, we have improved the average miss from 4.4% to 2.4%, or an improvement of 46%.

In addition to the steps outlined in this Remediation Plan, UMR will also submit a monthly Performance Guarantee report to PEBP beginning mid-February. Our goal is to document our efforts and meet the standards established in this Remediation Plan.

UMR appreciates the ongoing partnership with PEBP to work together to provide high-level service to the State employees, retirees, their families, and the provider community.

Appendix

Book of Business Provider Add/Term Counts

Total Provider Count (Facility, Ancillary Professional) – UHC Choice Plus Network (SOUTH)

As of July 1, 2022	7,052
Terms 7/1/22 – 12/18/23	2,024
Adds 7/1/22 – 12/18/23	2,915
Net as of 12/18/23	7,943

Total Provider Count (Facility, Ancillary Professional) – UHC Choice Plus Network (NORTH)

As of July 1, 2022	4,429
Terms 7/1/22 – 12/18/23	1,356
Adds 7/1/22 – 12/18/23	1,649
Net as of 12/18/23	4,722

Total Provider Count (Facility, Ancillary Professional) – SHO/BHO (SOUTH)

As of July 1, 2022	11,600
Terms 7/1/22 – 12/31/23	3,056
Adds 7/1/22 – 12/31/23	2,994
Net as of 12/31/23	11,538

Total Provider Count (Facility, Ancillary Professional) – SHO/BHO (NORTH)

As of July 1, 2022	3,762
Terms 7/1/22 – 12/31/23	912
Adds 7/1/22 – 12/31/23	937
Net as of 12/31/23	3,787

*Terminations are for reasons such as retirement, providers leaving the community, provider group acquisitions, etc.

NV PUBLIC EMPLOYEES BENEFITS PROGRAM
Medical Plans Claims & Call
Utilization Process Period 7/1/2022 6/30/2023

How many claims have we processed?	530,438
Total Dollar amount billed?	$1,082,468,170
Total Dollar amount paid?	$169,265,027

Quarter	Calls Received	Surveys Answered	Positive Answers	Survey Score
1st Quarter	22,478	445	434	97.5%
2nd Quarter	17,395	359	349	97.2%
3rd Quarter	22,867	435	431	99.1%
4th Quarter	23,677	422	403	95.5%
Total	86,417	1,661	1,617	97.4%

Provider Satisfaction Survey