



Nicholas A. Toumpas
Commissioner

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

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February 27, 2012

Representative Ken Weyler, Chairman
Fiscal Committee of the General Court

APPROVED BY _____

DATE 3/9/12

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ITEM # FJS-12-094

REQUESTED ACTION

Pursuant to the provisions of Chapter 125, Laws of 2011

1. Authorize capitated rates for the Medicaid Managed Care program for State Fiscal Year ending June 30, 2013, and
2. Authorize change of the date for submission of contracts to the Governor and Executive Council to March 28, 2012.

EXPLANATION

Chapter 125, Laws of 2011 requires the Commissioner to employ a managed care model for administrating the Medicaid program and its enrollees to provide for managed care services for all Medicaid populations throughout New Hampshire consistent with the provisions of 42 U.S.C 1396u-2. Specific deadlines and approvals required by the law include:

- July 15, 2011-Present the opportunities of the various models or combination of models with a recommendation for the best managed care model for New Hampshire to the Fiscal Committee of the General Court which shall consult with the Oversight Committee on Health and Human Services;
- October 15, 2011-Request For Proposals shall be released;
- January 15, 2012-Vendors shall be selected;
- The capitated rate shall be approved by the Fiscal Committee of the General Court;
- March 15, 2012-Final contracts shall be submitted to the Governor and Council unless this date is extended by the Fiscal Committee; and
- July 1, 2012-Target date for implementation of the contract.

The Department of Health and Human Services has completed the operational steps scheduled through January 15, 2012, and now seeks approval of the capitated rates and extension of the March 15, 2012, date for submission of contracts to the Governor and Executive Council.

Requested Action #1-Capitated Rates

Chapter 125, Laws of 2011 requires the commissioner to establish a capitated rate broken down into rate cells for each population and the capitated rate to be approved by the fiscal committee of the general court. The department is required to ensure no reduction in the quality of care of services provided to enrollees in the managed care model and must exercise all due diligence to maintain or increase the current level of quality of care provided.

Consistent with the language of Chapter 125, the Department developed a three-phased approach to implementing a program.

- Step 1 includes July 1, 2012, implementation of a program for Medicaid State Plan medical, pharmacy, and mental health services
- Step 2 will include July 1, 2013, implementation of a program for specialty services for the long term care populations, including nursing home services and services for the developmentally disabled and considers the State's option to manage financing for specialty services for those dually eligible for Medicaid and Medicare.
- Step 3 will include the Medicaid expansion population under the Affordable Care Act.

Proposals were received from various respondents to the Request for Proposals (RFP). A Technical Evaluation Team of senior staff and subject matter expert staff from across the Department reviewed and scored the technical merits of each proposal. The Technical Proposal was worth 70 of the 100 potential evaluation points. The following topic areas of the RFP were scored as part of the Technical response:

- Services and Populations;
- Pharmacy Management;
- Member Enrollment;
- Member Services and Cultural Considerations;
- Access and Network Management;
- Payment Reform;
- Behavioral Health;
- Care Management;
- Quality Management;
- EPSDT;
- Utilization Management; and
- Administrative Functions.

A Cost Evaluation Team analyzed and scored each cost proposal. The Cost Proposal was worth 30 of the 100 potential evaluation points. Rate negotiations were conducted individually with the three bidders receiving the highest scores.

As a result of these negotiations, each of the three highest scoring bidders agreed to the rate structure proposed by the Department. The rates are the contract rates that will be risk adjusted based on the acuity mix of member enrollment, and will be effective from date of implementation to June 30, 2013. Rates after this date will be negotiated between the Department and the Medicaid Managed Care Organizations.

Each of the bidders has agreed to a total cost for State Fiscal Year ending 2013 of \$364,685,747.84, and the average contract rate is calculated as follows:

Total Capitated Cost	\$364,685,747.84
Member Months	1,289,246.02
Average Rate-Per Member Per Month	\$282.87

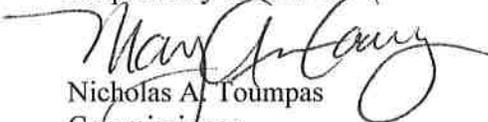
The Department and its actuaries are developing individual rates for the following populations and these will be presented on or before March 9, 2012.

1. Low Income Children – Age 2-11 Months
2. Low Income Children – Age 1-5 Years
3. Low Income Children – Age 6-13 Years
4. Low income Children – Female Age 14-18 Years
5. Low Income Children – Male Age 14-18 Years
6. Low Income Adults – Female Age 19-44 Years
7. Low Income Adults – Male 19-44 Years
8. Low Income Adults – Age 45+
9. Foster Care/Adoption
10. Breast and Cervical Cancer Program
11. Severely Disabled Children
12. Disabled Adults – Female Age 19-44, Medicaid Only
13. Disabled Adults – Male Age 19-44, Medicaid Only
14. Disabled Adults – Age 45+ Years, Medicaid Only
15. Old Age Assistance Program – Medical Only – Non-nursing Home Residents
16. Nursing Home Residents – Medicaid Only
17. Nursing Home Residents – Dual Eligibles
18. Dual Eligibles – Age 0-44
19. Dual Eligibles – Age 45-64
20. Dual Eligibles – Age 65+
21. Newborn Kick Payment
22. Maternity Kick Payment

Requested Action #2-Date for Submission of Contracts to the Governor and Executive Council

Chapter 125, Laws of 2011, requires submission of final contracts to the governor and Council no later than March 15, 2012, unless this date is extended by the Fiscal Committee. The Department fully intends to have the contracts submitted to Governor and Executive Council by this date, but the next scheduled meeting of Governor and Executive Council is March 28, 2012. The Department is requesting modification of the date from March 15, 2012 to March 28, 2012 to coincide with the meeting calendar of Governor and Executive Council.

Respectfully submitted,


Nicholas A. Toumpas
Commissioner

Attachment

CHAPTER 125
SB 147-FN – FINAL VERSION
2011 SESSION

SENATE BILL *147-FN*
AN ACT relative to Medicaid managed care.

AMENDED ANALYSIS

This bill requires the commissioner of the department of health and human services to issue a 5-year request for proposals to enter into contracts with vendors of a managed care model to provide for managed care services to the Medicaid population. The commissioner, in consultation with the fiscal committee of the general court, is granted rulemaking authority for the purposes of this bill.

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Explanation: Matter added to current law appears in *bold italics*.
Matter removed from current law appears [~~in brackets and struck through.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Eleven

AN ACT relative to Medicaid managed care.

Be it Enacted by the Senate and House of Representatives in General Court convened:

125:1 New Paragraph; Medicaid Managed Care. Amend RSA 126-A:5 by inserting after paragraph XVIII the following new paragraph:

XIX.(a) The commissioner shall employ a managed care model for administering the Medicaid program and its enrollees to provide for managed care services for all Medicaid populations throughout New Hampshire consistent with the provisions of 42 U.S.C. 1396u-2. Models for managed care may include, but not be limited to, a traditional capitated managed care organization contract, an administrative services organization, an accountable care organization, or a primary care case management model, or a combination thereof, offering the best value, quality assurance, and efficiency, maximizing the potential for savings, and presenting the most innovative approach compared to other externally administered models. The department shall present the opportunities of the various models or combination of models with a recommendation for the best managed care model for New Hampshire, no later than July 15, 2011, to the fiscal committee of the general court which shall consult with the oversight committee on health and human services. Services to be managed within the model shall include all mandatory Medicaid covered services and may include, but shall not be limited to, care coordination, utilization management, disease management, pharmacy benefit management, provider network management, quality management, and customer services. The model shall not include mandatory dental services. The commissioner shall issue a 5-year request for proposals to enter into contracts with the vendors that demonstrate the greatest ability to satisfy the state's need for value, quality, efficiency, innovation, and savings. The request for proposals shall be released no later than October 15, 2011. The vendors of the managed care model or combination of models demonstrating the greatest ability to satisfy the state's need for value, quality, efficiency, innovation, and savings shall be selected no later than January 15, 2012 with final contracts

submitted to the governor and council no later than March 15, 2012 unless this date is extended by the fiscal committee. After the bidding process, the commissioner shall establish a capitated rate based on the bids by the appropriate model for the contract that is full risk to the vendors. The capitated rate shall be broken down into rate cells for each population including, but not limited to, the persons eligible for temporary assistance to needy families (TANF), aid for the permanently and totally disabled (APTD), breast and cervical cancer program (BCCP), home care for children with severe disabilities (HC-CSD), and those residing in nursing facilities. The capitated rate shall be approved by the fiscal committee of the general court. The managed care model or models' selected vendors providing the Medicaid services shall establish medical homes and all Medicaid recipients shall receive their care through a medical home. In contracting for a managed care model and the various rate cells, the department shall ensure no reduction in the quality of care of services provided to enrollees in the managed care model and shall exercise all due diligence to maintain or increase the current level of quality of care provided. The target date for implementation of the contract is July 1, 2012. The commissioner may, in consultation with the fiscal committee, adopt rules, if necessary, to implement the provisions of this paragraph. The department shall seek, with the approval of the fiscal committee, all necessary and appropriate waivers to implement the provisions of this paragraph.

(b) The department shall ensure that all eligible Medicaid members are enrolled in the managed care model under contract with the department no later than 12 months after the contract is awarded to the vendor or vendors of the managed care model.

(c) For the purposes of this paragraph:

(1) An "accountable care organization" means an entity or group which accepts responsibility for the cost and quality of care delivered to Medicaid patients cared for by its clinicians.

(2) "An administrative services organization" means an entity that contracts as an insurance company with a self-funded plan but where the insurance company performs administrative services only and the self-funded entity assumes all risk.

(3) A "managed care organization" means an entity that is authorized by law to provide covered health services on a capitated risk basis and arranges for the provision of medical assistance services and supplies and coordinates the care of Medicaid recipients residing in all areas of the state, including the elderly, those meeting federal supplemental security income and state standards for disability, and those who are also currently enrolled in Medicare.

(4) "A primary care case management" means a system under which a primary care case management contracts with the state to furnish case management services, which include the location, coordination, and monitoring of primary health care services, to Medicaid recipients.

125:2 Effective Date. This act shall take effect upon its passage.

Approved: June 2, 2011

Effective Date: June 2, 2011