

A decorative graphic consisting of a vertical line and a horizontal line intersecting at the center, with a shaded rectangular area to the left of the intersection.

# NH Department of Health and Human Services

G&C Breakfast Meeting  
Update on Care Management  
Nick Toumpas  
March 7, 2012



# Agenda

- Overview of Medicaid
  - Why we must change the business model
- Overview of Care Management initiative
  - Contracts timeline
  - Implementation timeline and challenges
- Q&A

# Medicaid in New Hampshire



- Spends approximately \$1.4B
  - About \$1B in provider payments
  - Largest segments include
    - Medical services
    - Mental health services
    - Long-term supports and services
  - Serves approximately 10% of population
    - ~70% low income women and children
    - ~30% elderly, physical, developmental, mental disability
  - Payment strategy is primarily "fee for service"
  - Through ~10,000 enrolled providers



# Why must we change?

- Current Medicaid system is unsustainable
  - Rising costs due to growth and aging of NH's population
  - Many with more complex needs
  - Resource constraints at the State and Federal level
  
- Current system is "transactional" from both a financial and service delivery basis
  - System does not promote efficiency and coordination



# What is Care Management?

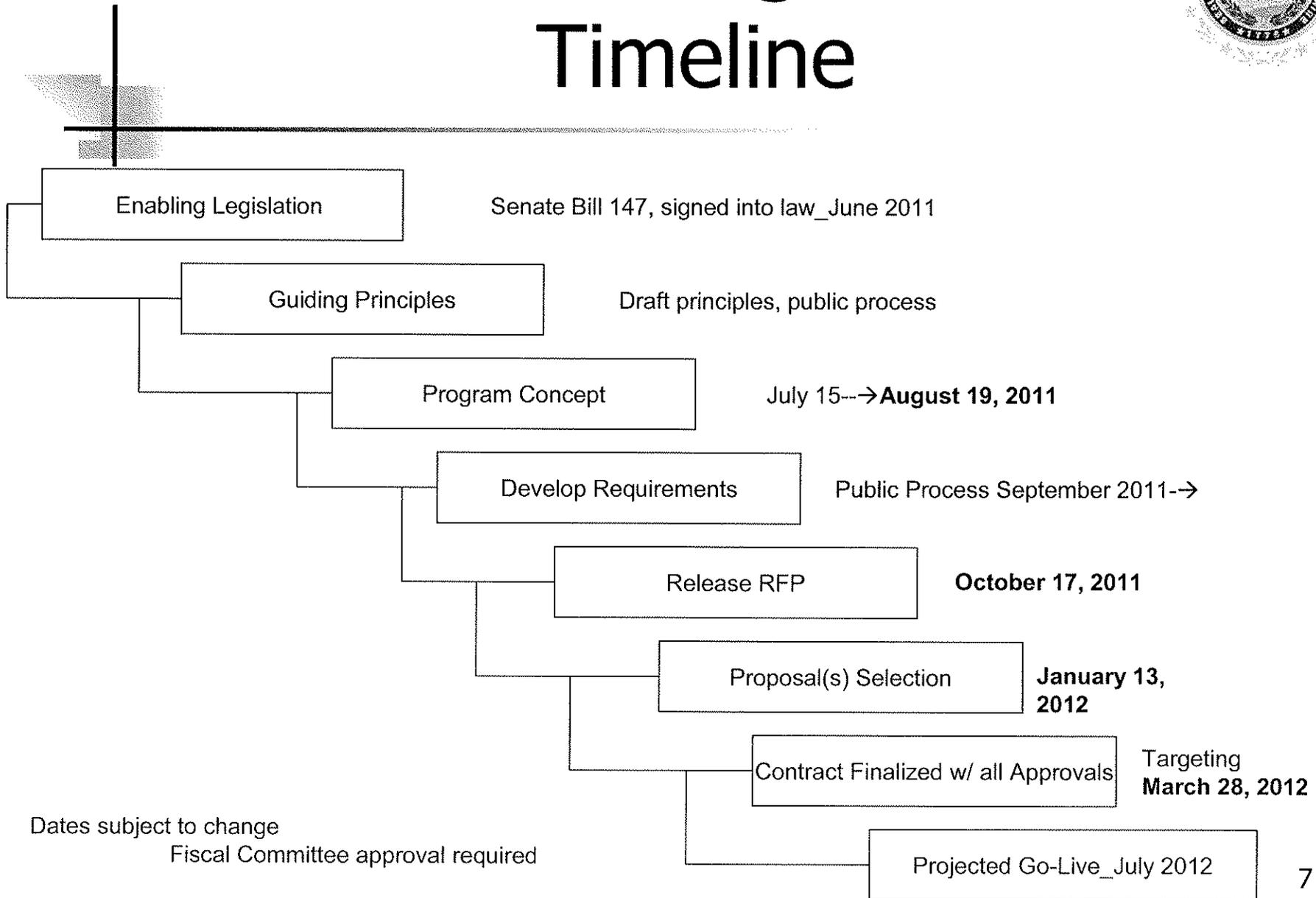
- Care management, or Managed Care is:
  - Approach to pay for and delivering health care
  - Provides coordinated services to enrollees through a network of providers
  - Manages appropriate and effective health care services



# Care Management

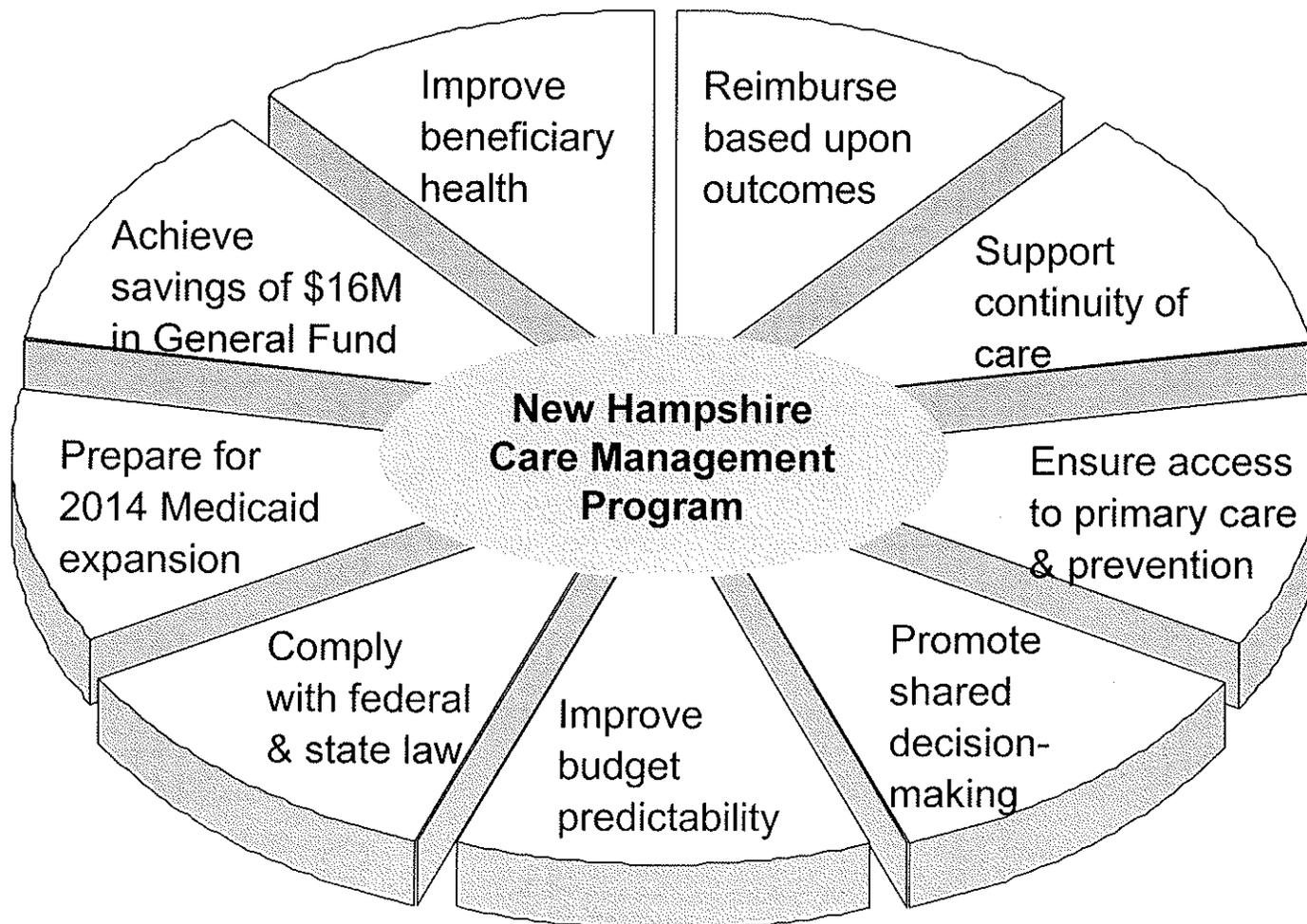
Timeline and Contract

# Care Management Timeline





# Program Goals





# Program Design

- The Care Management program will be implemented via a three-step approach
  - Step 1: All populations. "Duals" (those eligible for Medicaid and Medicare), foster children and Home Care for Children with Severe Disabilities on an optional basis, waiver and nursing home services remain in fee-for-service
    - Target date is July 1, 2012
  - Step 2: All populations mandatory, waiver and nursing home services added
    - Target date is July 1, 2013 or one-year after go-live of Step 1
  - Step 3: Assuming Patient Protection and Affordable Care Act remains in law, the Medicaid expansion population is added
    - Effective date is January 1, 2014



# Program Design Features

- Care coordination
  - Primary care, specialty care, transportation and other covered services
- Patient Centered Medical Home Support
- Chronic Disease Management
- Special Needs Program
  - For high cost/high risk members with complex issues
- Wellness and Prevention Programs
- Quality Assessment and Performance Improvement Program
- Quality Incentives
- Payment Reform



# Managed Care

## How do we increase efficiency?

- SFY 12/13 budgeted savings projection of \$16M GF
  - Focus on **improving health**, not just health care
  - Increase timely access to **primary care**
  - Implement **single point of accountability** for care coordination
  - Better **manage transitions** between sites of care
  - **Reduce avoidable hospital admissions and readmissions**
  - **Reduce emergency department** use for primary care
  - Improve compliance with recommended care
  - **Reduce duplication of tests**
  - Greater integration of public health and prevention



# Contract Features

- Target 2-3 Managed Care Organizations
  - Statewide coverage is required by each
- One core contract
  - Unique and individual approaches to meeting requirements
- NH Insurance Department HMO license
- Fraud, Waste and Abuse
- Adherence to Administrative Quality Assurance Standards
- Specified Liquidated Damages

# Medicaid Care Management Protections for Consumers



- Medical Homes Required for All Clients
- Access Standards
- Transitions of Care
- Quality Incentives
  - Including Getting Needed Care Composite Measure
- Member Rights
- Grievance & Appeals
- Member Advisory Board

# Medicaid Care Management Protections for Providers

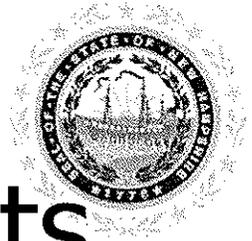


- Rates for FQHC's and RHC's set by Federal Government
- No exclusive contracting requirements permitted
- Provider Advisory Board
- Provider Inquiry Line
- Provider Satisfaction Survey
- Payment Reform

# Medicaid Care Management Protections for State



- Full Risk Capitated Rate
- Insurance Licensure
- Implementation Plan
- Management Plan
- Readiness Reviews
- Liquidated Damages/Penalties



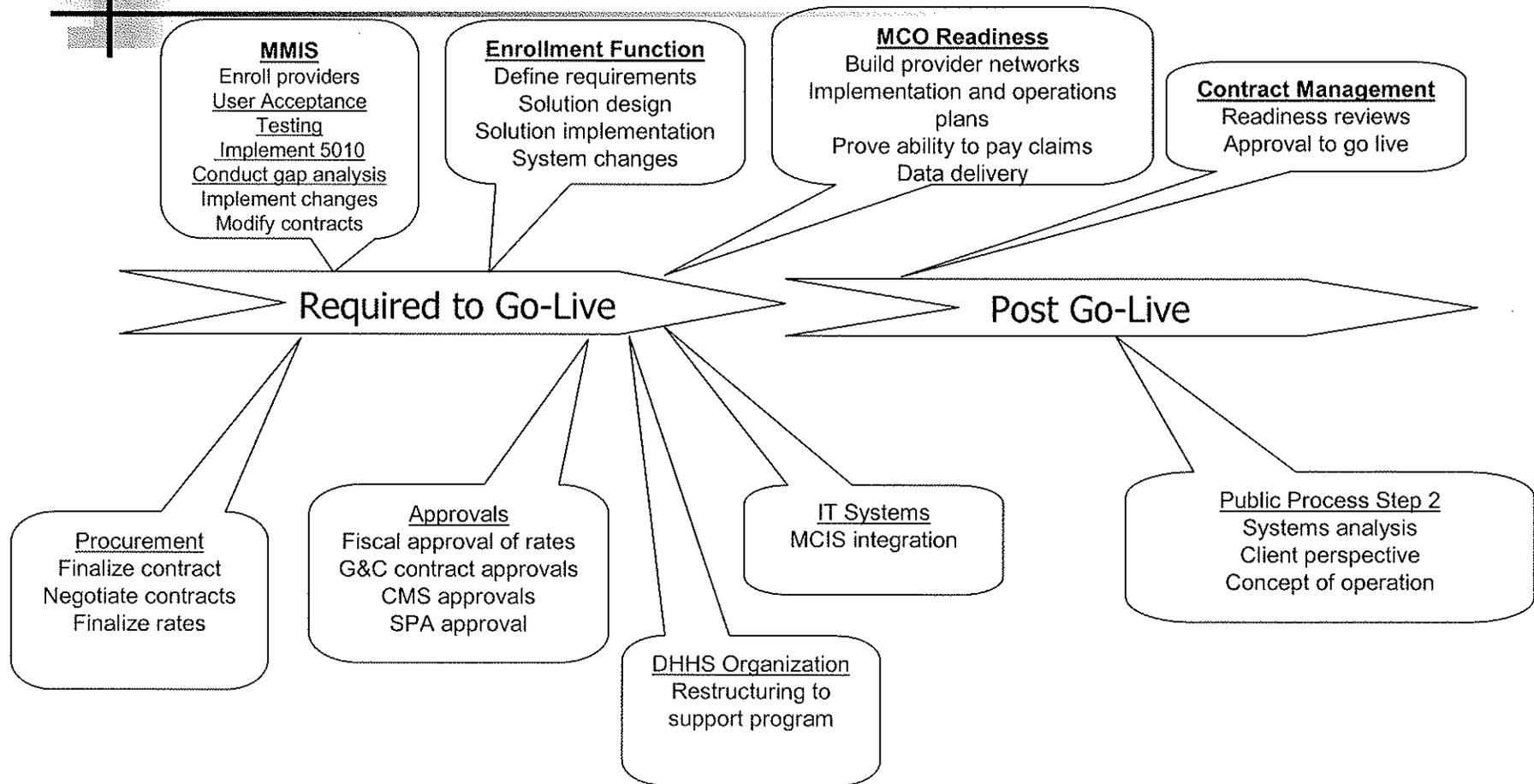
# Select Federal Requirements

- State must provide members a choice of no less than 2 entities
- Members must be able to terminate or change enrollment for cause at any time and for no cause within certain time frames.
- Members must be given comparative information chart on each MCO
- MCO may not distribute marketing materials directly to members
- Reimbursement rates must be approved by CMS as actuarially sound.
- Member protections include grievance procedure, demonstration of network adequacy and services



# Targeting July 1, 2012

## Tasks Required





Thank You



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