

NH Department of Health and Human Services

Governor & Council Information Meeting

Nick Toumpas, Commissioner

March 26, 2012



Objective

- Information session to brief Executive Council and the public on the proposed Care Management Program



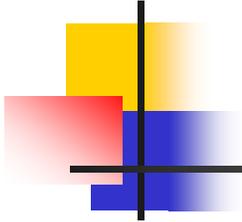
Opening

- Introduce DHHS and AG team
- Largest public policy initiative impacting 10% of the State's population
 - More in certain regions
- Care Management is a profound change
 - Many groups have expressed concerns on a number of levels
 - Timing and scope
 - Fear of managed care and its impact on their families
 - Concerns by provider organizations on financial impacts
- DHHS intent is to improve health, access, quality and outcomes by making Medicaid more efficient and effective given its vital role to over 140,000 state citizens
 - Targeted savings result from greater efficiencies
 - Provide the right care, at the right time, in the right place



Agenda

- The Perspective
- The Program
- The Process
- The Pricing
- The Protections
- Next Steps



Care Management

Perspective



New Hampshire Medicaid

- Medicaid is a State/Federal partnership
 - Primary health insurance for low income and high need populations
 - Largest source of funding for safety net providers
 - 90-95% of funding for mental health and developmental disability services
 - Significant payer of Long Term Care (LTC) services for elderly
- In NH spends approximately \$1.4B
 - Is second largest component of State budget
 - About \$1B in provider payments
 - Largest segments include
 - Medical services
 - Mental health services
 - Long-term care 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



Challenges

- Medicaid is unsustainable
 - Demographics: impacts of aging and the growth of population
 - Increasingly complex clients with multiple conditions
 - Increasingly constrained Federal and State financial resources
 - Increasing costs
 - Wide variation in cost and pricing for services with no clear relationship to quality
 - The prevalent way to pay for services, "fee for service" has some inherent weaknesses
 - Access, coordination
- Options
 - Do nothing, which has significant consequences given no additional resources
 - Augment the current model with substantial additional financial resources
 - Change the business model
 - Care Management or Managed Care provides the framework to change



What is Managed Care?

- Managed care is an **approach to delivering and financing health care** that is aimed at both **improving the quality of care and saving costs**.
- The fundamental idea is to **improve access to care and coordination of care** by assuring that enrollees have a **“medical home”** with a primary care provider (PCP), and to rely more heavily on preventive and primary care.
- As distinct from the fee-for-service system, in which individual providers are paid for each service they furnish.
- Traditional risk-based managed care systems put an organization at financial risk, paying them **a fixed monthly “capitation” rate for each enrollee** to provide all or a defined set of Medicaid-covered services.
- This payment arrangement **provides different financial incentives** to providers, and ideally, **supports an approach to practice that emphasizes early identification and treatment** of health problems and coordinated management of patients' conditions.
 - Reforming **HOW** services are paid for is central to Managed Care
- Capitation also **gives states more cost predictability** and control, and contracts with managed care plans offer states a mechanism, through quality measurement and improvement requirements, for holding plans accountable for the quality of care they provide to Medicaid enrollees.



What this means for clients?

■ Fee for Service

- Client not required to have a PCP
- Services, especially PC, provided as discrete encounters
- Services not managed or coordinated to address individual diagnoses=silos
- Services accessed through any willing provider regardless of setting
- Medical services paid per unit of service
- No single point of responsibility for case management
- Navigation of the health system left to consumer
- Leads to potential for duplication, redundancy and use of ER as PC site

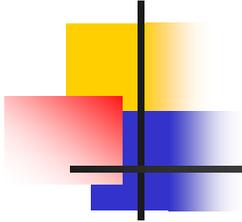
■ Care Management

- Whole person approach
- MCOs paid to manage all health care
- Patient Centered Medical Home serves as the hub and includes
 - Setting to facilitate partnership between PCP and client
 - PCP, Physician directed, integration, quality, CPI, IT enabled
- Complex cases addressed holistically through care coordination
- Consumer partners with PCP to navigate the health system

Managed Care Increasing Efficiency



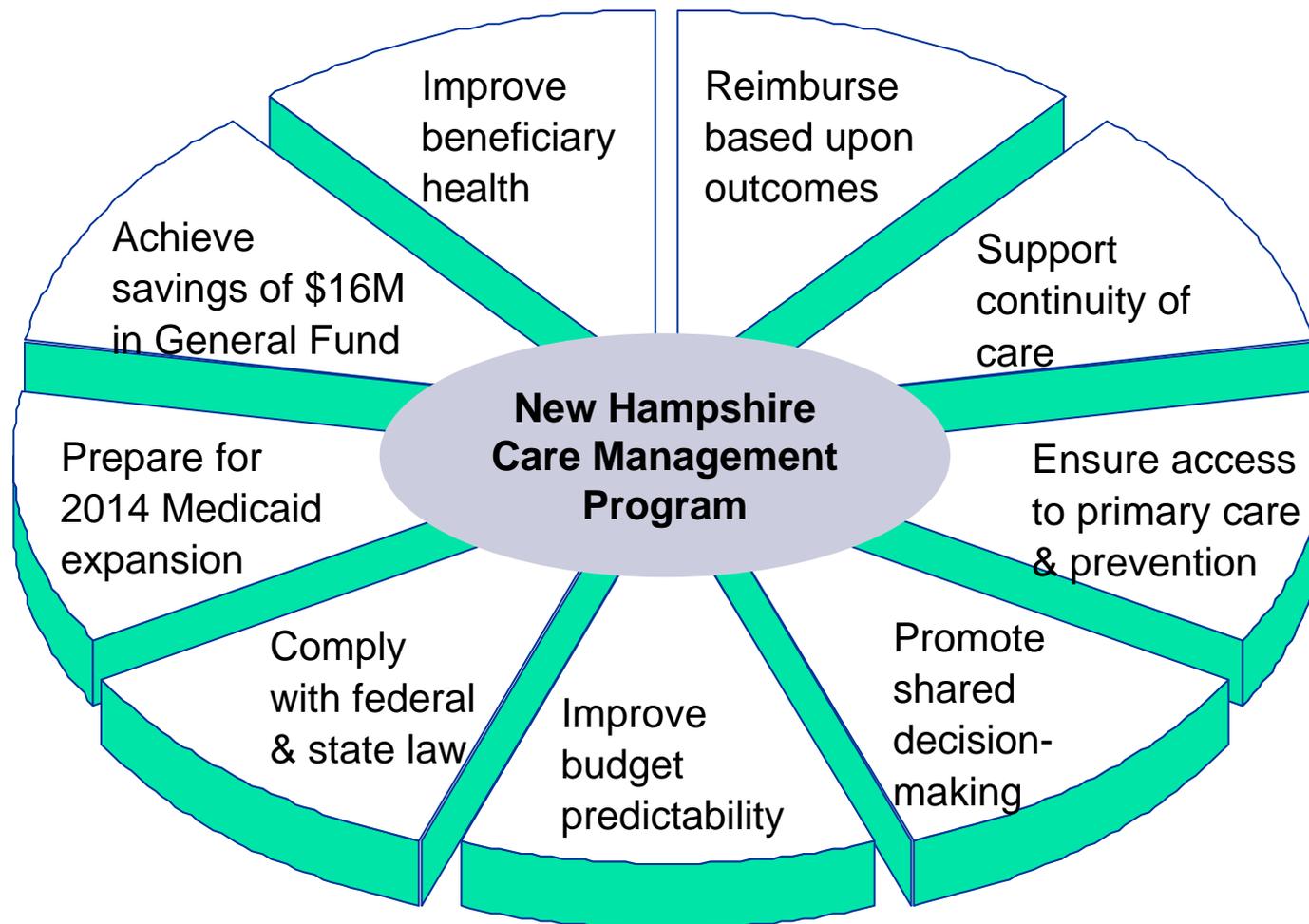
- SFY 12/13 budgeted savings projection of \$16M GF
 - Focus on **improving health**, not just health care
 - Increase timely access to **primary care**
 - Implement **single point of accountability** for care coordination
 - Better **manage transitions** between sites of care
 - **Reduce avoidable hospital 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



Care Management Program



Program Goals





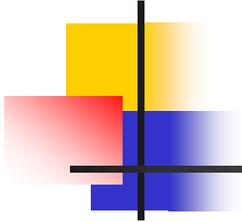
Program Design

- A three-step approach to Care Management program
 - Two key variables: populations and covered services
- Step 1: Target date of July 1, 2012. Includes:
 - Children and pregnant women
 - Children's Health Insurance Program
 - Those eligible for Medicaid and Medicare (referred to as duals), foster children, and those who qualify for home care for children with disabilities with a temporary opt out provision
- Step 2: Target date of July 1, 2013. Includes:
 - Services for those with developmental disabilities, acquired brain disorders, elderly and physically disabled (known as waived services) and the "opt-out" populations
- Step 3: January 1, 2014
 - Medicaid expansion population: childless adults up to 138% of federal poverty level (assuming the Affordable Care Act remains in effect)
 - Operating assumption is that this would add ~40-50K new members, largely the uninsured



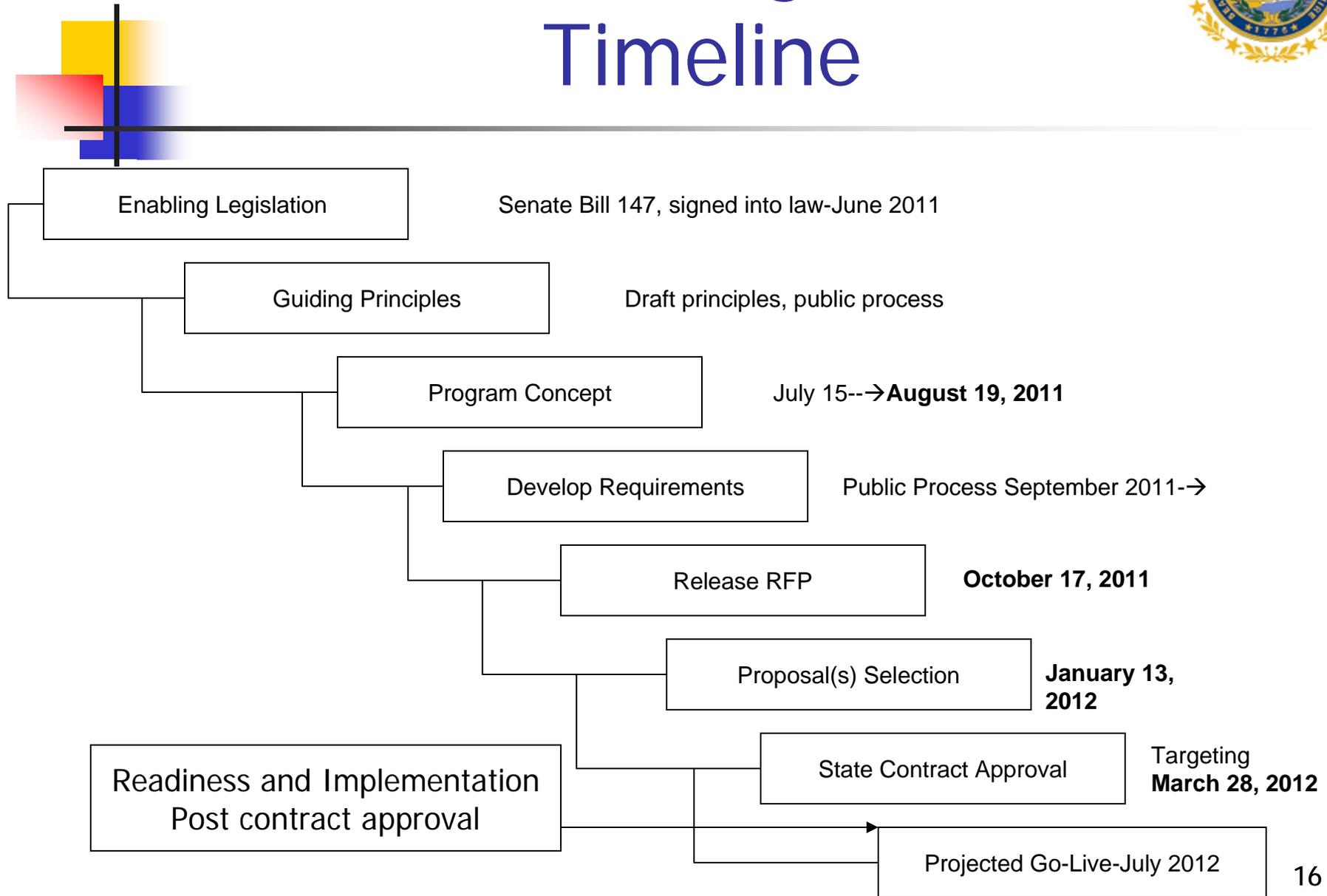
Program Features

- Patient Centered Medical Home Support
- Care Coordination
 - Primary care, specialty care, transportation and other covered services
- 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



Care Management Process

Care Management Timeline





Procurement Process

- DHHS commitment to transparency
 - Over 40 documents posted on DHHS website
 - RFP, data, questions, stakeholder issues, status updates, Q&A
 - Bound by State procurement process
- Stakeholder outreach August-September 2011
 - Public forums: 6
 - Focus groups: 9
 - Online survey: 700+ completed surveys
- Program design September-October 2011
 - Request for Proposals released October 17, 2011
- Proposals submitted December 2011
 - Technical and Cost Evaluation Review December 2011-January 2012
- Contract negotiations January-March 2012
- Contracts to G&C March 23, 2012



Technical Evaluation

- Proposals were scored in 11 topic areas
 - Services and Populations
 - Pharmacy Management
 - Member Enrollment, Members Services and Cultural Considerations
 - Access and Network Management
 - Payment Reform
 - Behavioral Health
 - Care Management
 - Quality Management
 - EPSDT
 - Utilization Management
 - Administration Functions
- Evaluation team composed of senior DHHS and AG staff



Care Management

Pricing



Contract Features

- One core contract
 - Contract documents include the proposals submitted reflecting the unique and individual approaches to meeting requirements
- 3 year contract with one 2 year renewal option
 - Requirement of SB 147
- Three Managed Care Organizations
 - Centene Corp., Meridian Health Plan, Boston Medical Center Health Plan
 - Statewide coverage is required by each
 - Federal law requires choice among plans for clients
- Number of specific deliverables and plans required by the MCO's
 - Multiple well-defined checkpoints for MCO in to demonstrate readiness for go live
- DHHS role shifts from program management to contract management
 - MCO's as partners bring new perspectives, techniques, technologies and strategies
 - Specific measures, targets, some with specific financial incentives or penalties
 - Yes, MCO's target a profit or surplus as does any organization we work with today
 - Our focus is on the value that they bring in administering the programs
- DHHS remains responsible for oversight and management
 - We are not outsourcing the program's management given the level of oversight and approvals we will maintain



Contract Pricing

- Contract amount for SFY 13 is up to \$381.9M
 - Total contract for three year period is not to exceed \$2.226B
 - Amounts not set for each organization as client selection dictates amounts
 - All three MCO's to receive same capitated payment rate
- Rates are capitated and are full risk to MCO
 - Rates must be "actuarially sound" meaning that they must cover costs to serve a population group
 - 22 specific "rate cells" defined each with a "per member per month" or PMPM rate
 - Rates will be established for each subsequent year
 - CMS must certify that rates were developed through actuarially sound process and be approved by CMS
- Year 1 budget was verified against DHHS Medicaid budget
 - Rate cells verified against projected 2013 fee for service budget and validate achievement of savings and efficiency targets



Contract Structure

- Introduction
- Glossary of Terms & Acronyms
- General Terms and Conditions
- Organization
- Subcontractors
- Staffing
- Program Management and Planning
- Covered Populations and Services
- Payment Reform Plan
- Care Management Program
- EPSDT
- Behavioral Health
- Pharmacy Management
- Member enrollment and Disenrollment
- Member Services
- Cultural Considerations
- Grievance and Appeals
- Access
- Network Management
- Quality Management
- Utilization Management
- MCIS
- Data Reporting
- Fraud, Waste and Abuse
- Third Party Liability
- Compliance with State and Federal Laws
- Administrative Quality Assurance Standards
- Privacy and Security of Members
- Finance
- Termination
- Agreement Closeout
- Remedies



Care Management Protections



Protections for Consumers

- **Medical Homes** Required for All Clients
- Specific Access Standards and **Measures**
- Transitions & **Continuity** of Care
- Quality **Incentives**: 1% of capitation payment withhold that is earned by meeting performance measures.
 - Including Getting Needed Care Composite Measure (member satisfaction survey)
- Member Rights
- Grievance & Appeals Process
- Member Advisory Boards



Protections for Providers

- **Payment Reform:** 1% withhold of capitation payments that is earned based on implementation milestones
 - Rates for FQHC's and RHC's set per Federal regulations
 - All other providers must negotiate rates with the MCO's
- No exclusive contracting requirements permitted
- Provider Advisory Boards
- Provider Inquiry Line
- Provider Satisfaction Survey
- Credentialing Standards per NH Insurance Department
- MCO cannot discriminate against providers serving high risk populations or specializing in conditions requiring high cost treatment



Protections for State

- Budget predictability
- Full Risk Capitated Rate
- Insurance Licensure
- Program Management Plan
- Program Implementation Plan
- Readiness Reviews
- Liquidated Damages/Penalties
- Suspension of Payment

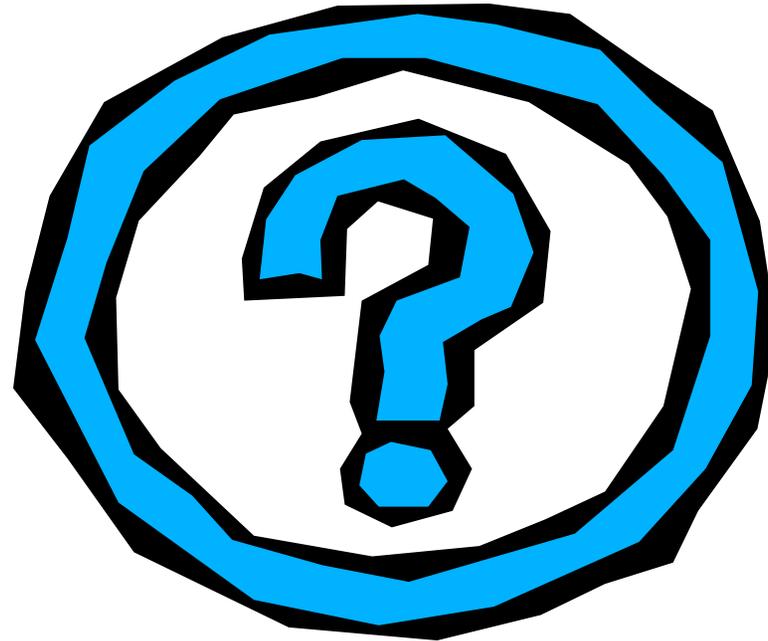


Next Steps

- G&C action
- Federal approvals
 - Contracts
 - Rates
 - State Plan Amendment
 - Waiver to mandate all populations (future)
- DHHS organization
 - Contract management
 - Enrollment and member services
 - Ability to support managed care and fee for service
- Step 2 planning continues
- Deploy Systems
 - MMIS
 - Eligibility system
 - Enrollment system
 - MCIS interfaces
- MCO Plans (subset)
 - Program management
 - Communications
 - Emergency response
 - Networks and payment plans and payment reform
 - Step 1 Implementation plan
 - Care management
 - Behavioral health



Thank You



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