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
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

New Hampshire Care Management Program

- Improve beneficiary health
- Reimburse based upon outcomes
- Support continuity of care
- Ensure access to primary care & prevention
- Promote shared decision-making
- Improve budget predictability
- Comply with federal & state law
- Prepare for 2014 Medicaid expansion
- Achieve savings of $16M in General Fund
- Improve beneficiary health
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 waivered 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

Enabling Legislation
- Senate Bill 147, signed into law-June 2011

Guiding Principles
- Draft principles, public process
  - July 15 → August 19, 2011

Program Concept
- Public Process September 2011→

Develop Requirements
- October 17, 2011

Release RFP
- January 13, 2012

Proposal(s) Selection
- Targeting March 28, 2012

State Contract Approval
- Projected Go-Live-July 2012

Readiness and Implementation
- Post contract approval
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
- 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 an 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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