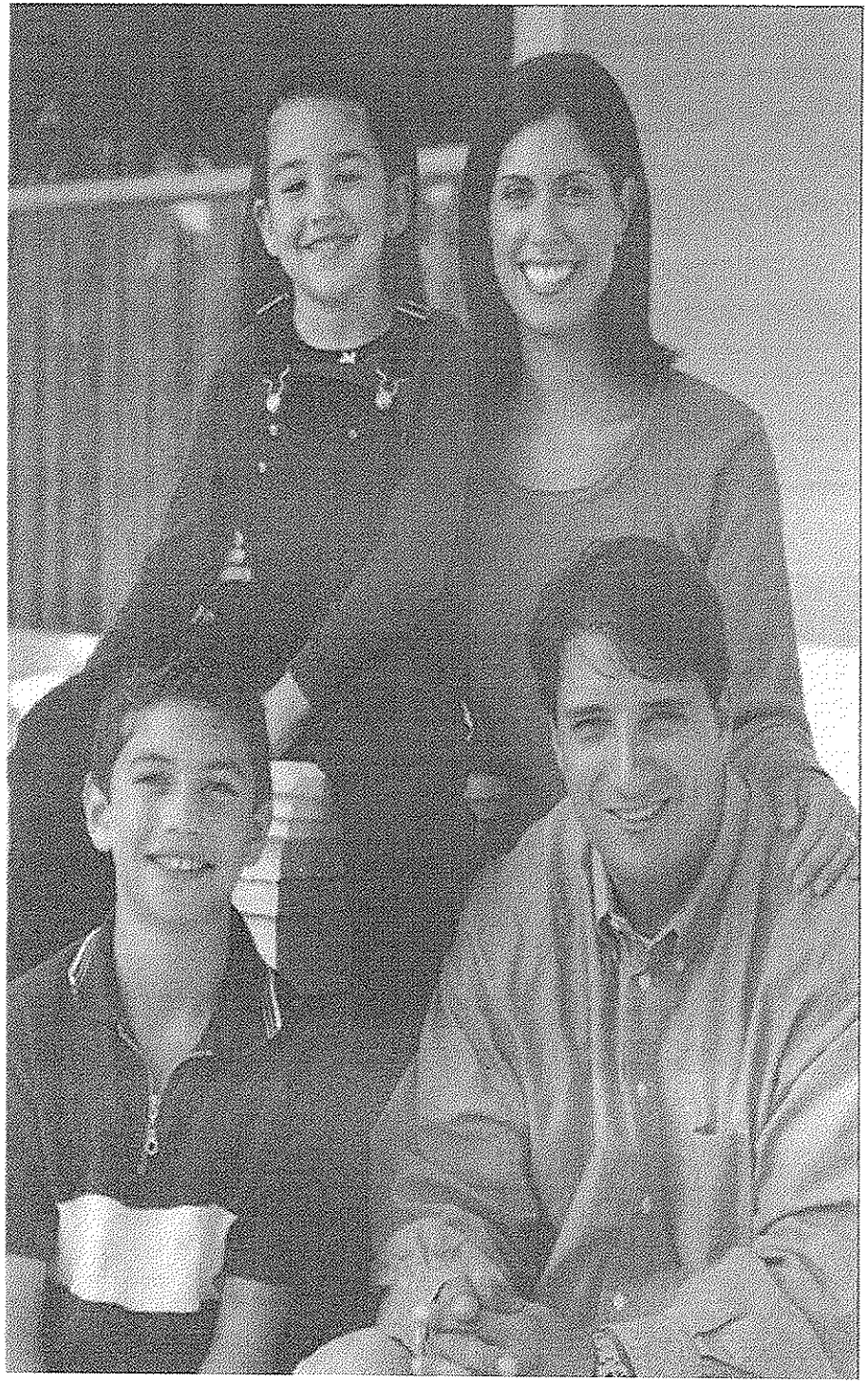


MCM Commission

Nick Toumpas

NH Department of Health and Human Services

New Hampshire MCM MEDICAID CARE MANAGEMENT

October 2, 2014

Agenda

- Monthly Enrollment Update
- Key Program Indicator Report Update
- Step 2 Update
- Other Updates
- Q&A from Commission and Public

Setting the Context

Care Management Program

December 1, 2013 – September 30, 2014

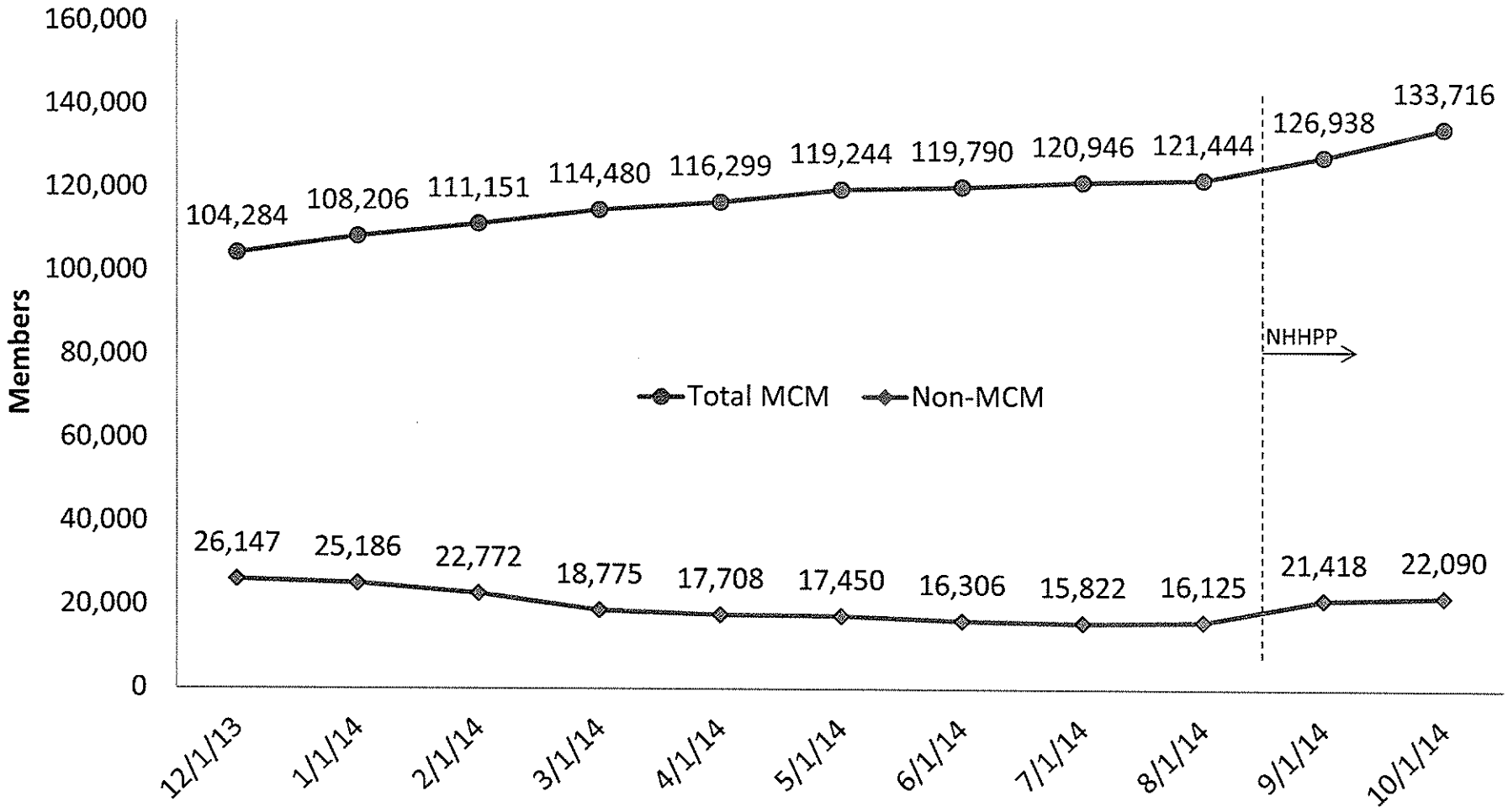
@ 10 Months

Guiding Principles of NH MCM

- Whole person management and care coordination
  - Foundation for Medicaid transformation
- Increase quality of care – right care, at the right time, in the right place to improve beneficiary health and quality of life
- Payment reform opportunities
- Budget predictability
- Purchasing for results and delivery system integration

ENROLLMENT UPDATE

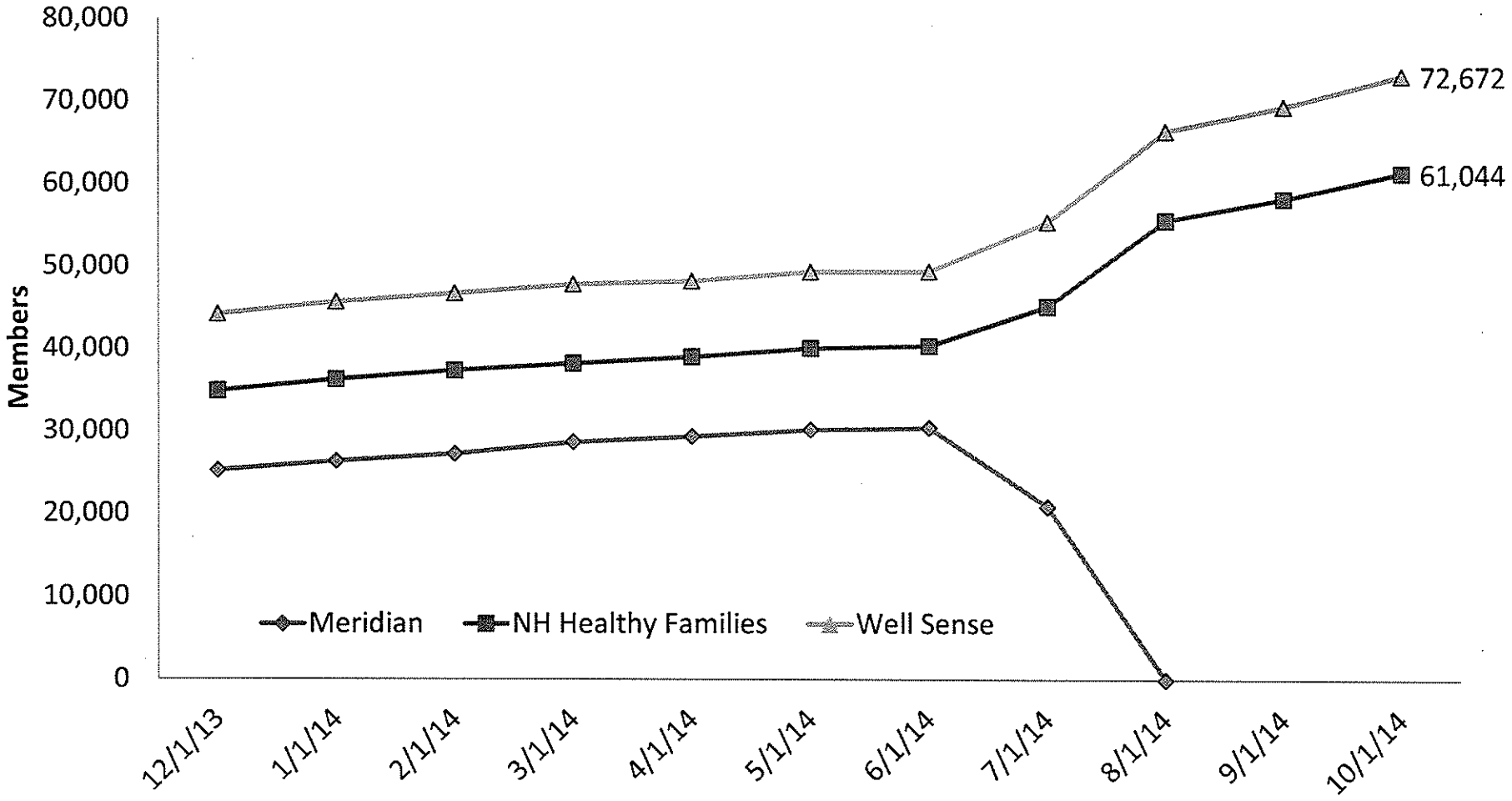
NH Medicaid Care Management Enrollment, 12/1 – 10/1



Note: Non-MCM Includes retroactive enrollment and excludes members who only have Medicare savings plans (e.g., QMB)

Source: NH MMIS as of 10/2/14 for most current period; Data subject to revision.

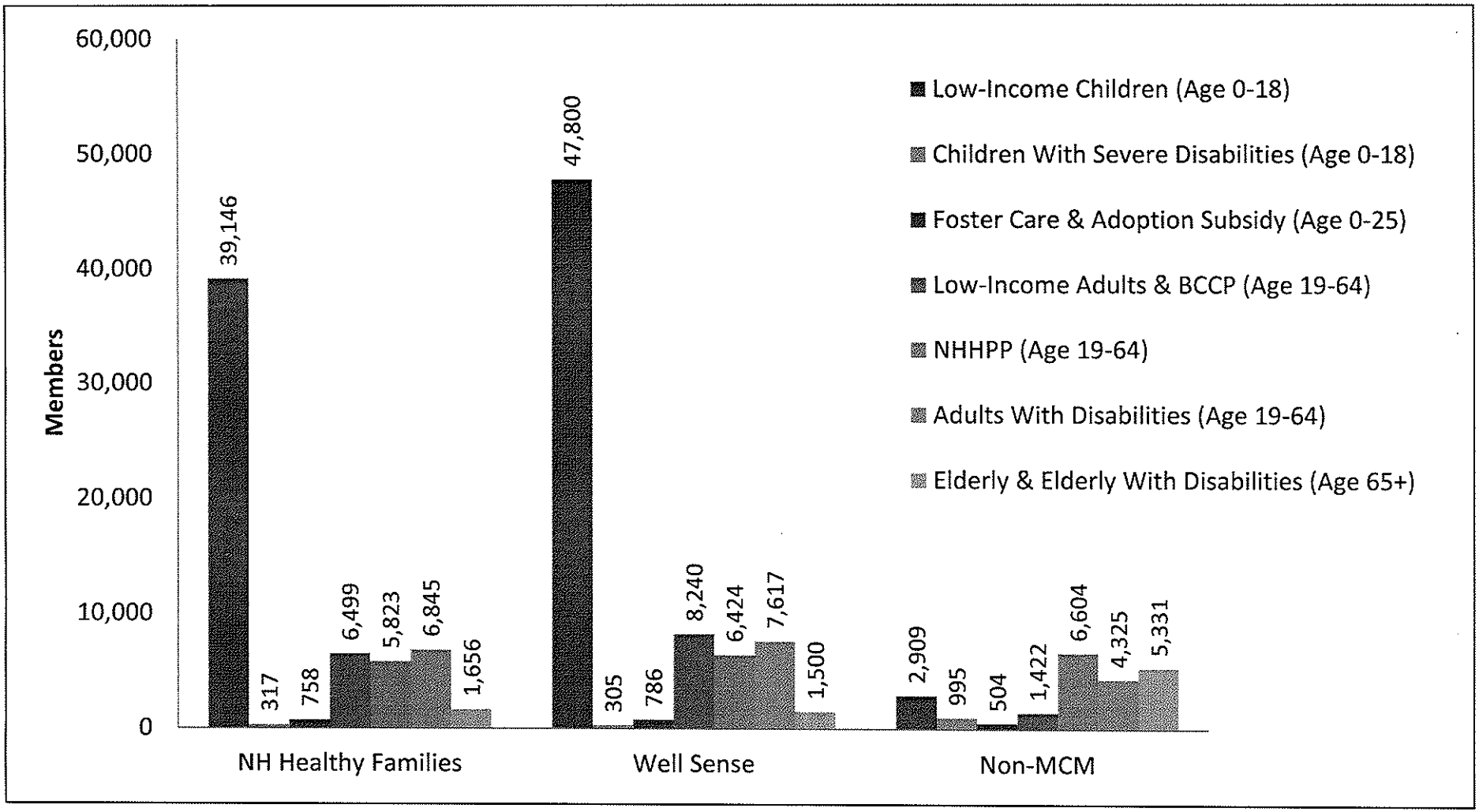
NH Medicaid Care Management Enrollment by Plan, 12/1 – 10/1



Note: Non-MCM Includes retroactive enrollment and excludes members who only have Medicare savings plans (e.g., QMB)

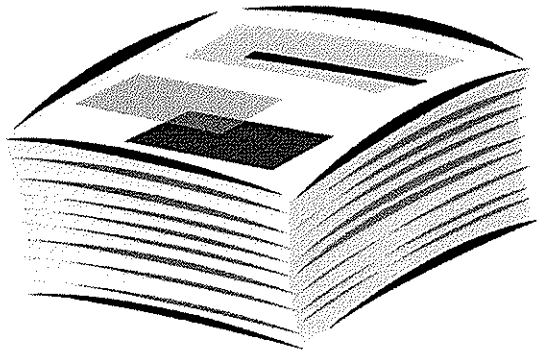
Source: NH MMIS as of 10/2/14 for most current period; Data subject to revision.

NH Medicaid Care Management by Eligibility Group, 10/1/14



Source: NH MMIS as of 10/2/14; Data subject to revision.

Key Performance Indicator Report



MCM Key Indicators Report

- DHHS tool for monitoring program performance
- Organized by various domains that represent indicators of the health of the program
  - This provides foundation for comparison of the two MCOs.
- Some indicators and metrics have prescribed benchmarks such that performance and compliance is illustrated.
- Some indicators require a trend in order to show performance and compliance over time.
- Some indicators are reported monthly, some quarterly and still more are reported annually.
- User Guide is integrated into the body of the report

MCM Key Indicators

Metrics in the Key Indicators Report include:

- Access & Use of Care
- Customer Experience of Care
- Provider Service Experience
- Utilization Management
- Grievance & Appeals
- Preventative Care
- Chronic Medical Care
- Behavioral Health Care
- Substance Use Disorder Care
- General

Follow-up Horn Report

Details on how the findings of the Horn Report are being implemented into Step 1 MCM and will be considered during Step 2 planning and design.

DHHS Response: The Horn Report provides valuable input from members which may not be captured by other means. Information captured was from a small sample yet represents an important element for consideration in future designs.

- Experience with Care Management: Focus group participants indicated that the Department's communication strategy for Step 1 Care Management was successful in informing members about the Medicaid program changes. Participants would have liked additional support in choosing between MCOs. In future, the **Department will provide additional information to assist members in selecting an MCO.**

- Access to Care: Focus group participants indicated that members chose their MCO so that they could continue to have the same access to their providers. Participants also stated that their access to doctors stayed the same. Some concerns raised about access to medications and specialist requiring a prior authorization. **The Department is currently engaged in a review of prior authorization processes.**

- Quality of Care and Care Management: Focus group participants indicated that members have had an active role in making decisions about their health care and that their care was coordinated. **The Department will continue to emphasize the importance of shared decision making and care coordination in the MCM program.**

- Information Needs: Focus group participants indicated that members may not have received any materials from the MCOs. Some participants would prefer to receive hard copies of information vs. retrieving information from a web site. **The Department will reinforce the importance of mailed and printed materials for members.**

Follow-up

MCM Commission September KPI Report

Further review of the Key Performance Indicator Report data to determine if patients visiting the ED are being directed there by after-hours nurses or going themselves; review if fewer pediatricians are taking Medicaid patients therefore resulting in higher utilization of family physicians.

DHHS Response: The Department has located data errors in the previously reported emergency room utilization data. The rate in the October Key Indicators report shows lower utilization than previously reported.

MCM Commission September Quality Indicators and Communications with Providers

DHHS Response: The Key Indicators Report can be found at: http://www.dhhs.nh.gov/ombp/quality/index.htm. The Department is compiling a mailing list to inform stakeholders when a new report is created.

To be added to this list, stakeholder should e-mail MedicaidQuality@dhhs.state.nh.us with the subject line "Key Indicators Mailing List."

Notable Results
Access and Use of Care

1. 23% of transportation requested were not approved or not delivered. While this may represent appropriate utilization, the Department has determined that the measure does not provide all the necessary information to draw data based conclusions about transportation requests. As part of investigating the results the Department is:
   - Developing improved measures, and
   - Ad hoc data has been requested from the MCOs to better evaluate the reasons for non-delivery of transportation requests.

2. As part of the State's **External Quality Review** program, the following measures are undergoing detailed validation to ensure accurate measures in calculation and reporting:
   - Physician and ARNP Clinic Visits,
   - Member to Provider Ratio,
   - Emergency Department Visits,
   - Emergency Department Visits Potentially Treatable by Primary Care, and
   - Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members.

Notable Results
Customer Experience of Care

1. Member calls are being answered quickly and within MCM contract standards.
2. Member hold times decreased in August, reflecting in part the completion of Meridian members' transition into new health plans. The Department:
   - Is currently investigating the measure to determine consistent reporting between the MCOs, and
   - Can report that one MCO has seen a higher upward trend until July; this MCO has since reported hiring additional call center staff with the intent of improving customer service.

Notable Results
Provider Service Experience

1. Provider claims are being paid, accurately and within MCM contract standards for timeliness.
2. Pharmacy claims processing rates have improved: now 0.2% below the contract standard.
3. Provider hold times continue to trend upwards. The Department:
   - Is currently investigating the measure to determine consistent reporting between the MCOs, and
   - Can report that one MCO has seen a higher upward trend until July; this MCO has since reported hiring additional call center staff with the intent of improving customer service.
4. As part of the State's External Quality Review program, the following measures are undergoing detailed validation to ensure accurate measures of calculation and reporting:
   - Professional and Facility Claims Processed in 30 Days, and
   - Claims Processing Accuracy.

Notable Results
Utilization Management

1. Urgent and routine service authorizations are being processed very close to MCM contract standards for timeliness.
2. The pharmacy service authorization processing rate is slowing.
   - Driven by a change in one MCO's pharmacy utilization management.
   - A review of pharmacy service authorizations is underway.
   - The Department will continue to closely monitor this indicator.
3. The service authorization requests and benefit decision rate has increased.
   - This is being driven by an increase in denials for inpatient surgical admissions, physician/medical services, private duty nursing, and personal care attendant services.
     - This increase is being driven primarily by one MCO's service utilization management.
   - These changes may represent more appropriate utilization.
   - The Department is currently investigating the drivers, and will closely monitoring this indicator.
4. Generic drug utilization is increasing.
5. As part of the State's External Quality Review program, the following measures undergoing detailed validation to ensure accurate measures of calculation and reporting:
   - Routine Medical Service Authorization Processing Rate.

Notable Results
Grievances and Appeals

1. Grievances continued to decrease.
2. The number of appeals has increased.
   - This increase is driven exclusively by a 119% increase in pharmacy appeals, primarily related to a change in one MCO's pharmacy utilization management.
   - A review of pharmacy service authorizations is underway.
   - The Department will continue to closely monitor this indicator.
3. Grievances and appeals (standard and expedited) are being resolved within MCM contract standards.
4. Member knowledge of the MCOs Grievance and Appeals process will be measured during the next member Focus Group to be held in October.
5. As part of the State's External Quality Review program, the following measures are undergoing detailed validation to ensure accurate measures of calculation and reporting:
   - Standard Appeals Resolved in 30 Calendar Days, and
   - Expedited Appeals Resolved in 3 Calendar Days.

Notable Results
Behavioral Health Care

1. Members seeing providers within 7 days for a follow-up appointment after hospitalization for mental illness is the focus of a Performance Improvement Project that is outlined in the MCM contract.

2. Performance Improvement Projects typically require 2-3 years to complete. Interim improvement will be measured as well as adherence to rigorous Center for Medicare & Medicaid Services (CMS) protocols.

    1. CMS protocols include:

    - Design – Collection of data to establish a baseline rate
    - Implementation – Actions to correct identified problem
    - Outcomes – Assessment of and sustained improvement.

Step 2 Timeline

Update on Step 2 Timeline

- Current Timeline
  - Phase 1 Mandatory Populations by 1/1/15
  - Phase 2 CFI and NF Services by 4/1/15
  - Phase 3 DD, ABD and IHS date TBD
- Changes and Next Steps
  - Postpone the mandatory populations and the CFI and NF Service
  - Announce new timeline at the November 6 MCM Commission Meeting

Context for Delay

- Challenges to implement 1915 waiver for Mandatory enrollment
- Two separate dates for Mandatory and CFI and NF services potential challenge for clients
- MCOs have seen significant growth in populations being served: driven by MAGI, MHP transition and NH HPP
- Concerns raised since implementation on key processes for Service Authorizations, Prior Authorizations and Transportation services
- We want to expand opportunities for substantive discussions
- DHHS has developed a detailed framework for Step 2 Concepts built on the prior SIM work, Stakeholder feedback and input, and the draft principles from the Commission and other sources
- DHHS will present these concepts at the next MCM Commission meeting
- Affirm again the commitment that we will move forward but not until we are ready to do so

NH HEALTH PROTECTION PROGRAM
&
OTHER UPDATES

NH HPP Update
As of 10/1/2014

- Recipients
  - 18,612 enrolled
- Benefit Plans
  - 17,151 are in the ABP (Alternative Benefit Plan)
  - 1,214 of Medically Frail are in the ABP
  - 247 of Medically Frail in standard Medicaid
- Care Management / HIPP
  - 826 are Potential HIPP
  - 6,562 are enrolled in WSHP
  - 5,983 are enrolled in NHHF
  - 5,241 are in Fee For Service/not yet enrolled in a plan

Premium Assistance Waiver Update

- Third phase of NHHPP program is Premium Assistance Program
  - Transition population from managed care coverage to Qualified Health Plans on FFM
    - Target January 1, 2016
  - SB 413 requires a waiver submitted to CMS by December 1, 2014
  - DHHS must brief the Joint Health Reform Oversight Committee
  - **Public notice on the draft waiver done October 1, 2014**
  - DHHS briefed the MCAC on Monday, September 29
  - Public Hearings scheduled: Webcast and Phone Conference
    - October 8 @ DPHS from 6:30 to 8:30
    - October 20 @ NHHA from 1:00 to 3:00
  - Essential that we get approval of the waiver by March 31, 2015

1115 Waiver
Building Capacity for Transformation

- Application was submitted to CMS at the end of May 2014
- Since that time, DHHS having discussions with CMS on the transformations and initiatives we seek to fund
- Recent guidance by CMS requires State to demonstrate how it will change delivery and payment systems with new Federal funding

Questions?