New Hampshire Medicaid Care Management Program and Procurement

Executive Council
March 2019

Agenda Overview

I. Overview of the Medicaid Care Management Program

II. Procurement Process

III. Key Provisions of the Medicaid Care Management Contract

IV. Financial Considerations

Overview of the Medicaid Care Management Program

Medicaid Care Management is New Hampshire's Medicaid managed care program

New Hampshire currently has full-risk, capitated contracts with two Managed Care Organizations: New Hampshire Healthy Families and Well Sense Health Plan

Covered Services* Include:

- **Physical Health**
- **Behavioral Health** *(Mental Health and Substance Use Disorder)*
- **Pharmacy Services**

Medicaid Care Management Population

- Effective July 1, 2019, projected **180,000** members statewide
- By program start, a projected **51,000** Medicaid members in NH's Granite Advantage Health Care Expansion program that transitioned from Marketplace coverage into the Medicaid Care Management program effective January 1, 2019.
- Covered populations include:
  - ✓ Pregnant Women
  - ✓ Children
  - ✓ Parents/Caretakers
  - ✓ Non-Elderly
  - ✓ Non-Disabled Adults <65
  - ✓ Aged, Blind or Disabled
  - ✓ "Granite Advantage" Expansion Adults *(beginning 12/31/18)*

*Long-term Services and Supports and Services for select exempt populations are offered through fee-for-service outside the Medicaid Care Management Program.

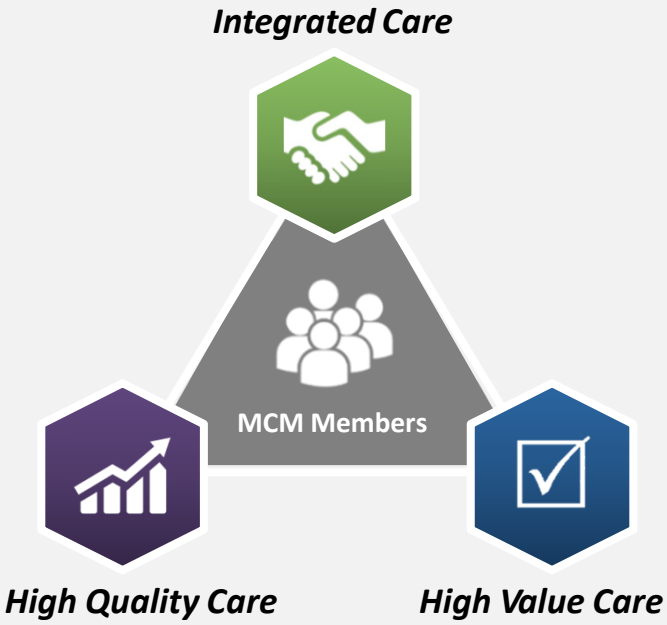
Medicaid Care Management Contract and Request for Proposals

DHHS used the Contract and Request for Proposals to get maximum value out of Medicaid and drive broader transformation of the health care system by:

1. Soliciting proposals from licensed and qualified organizations to provide health care services to eligible and enrolled Medicaid members through the Medicaid Care Management program

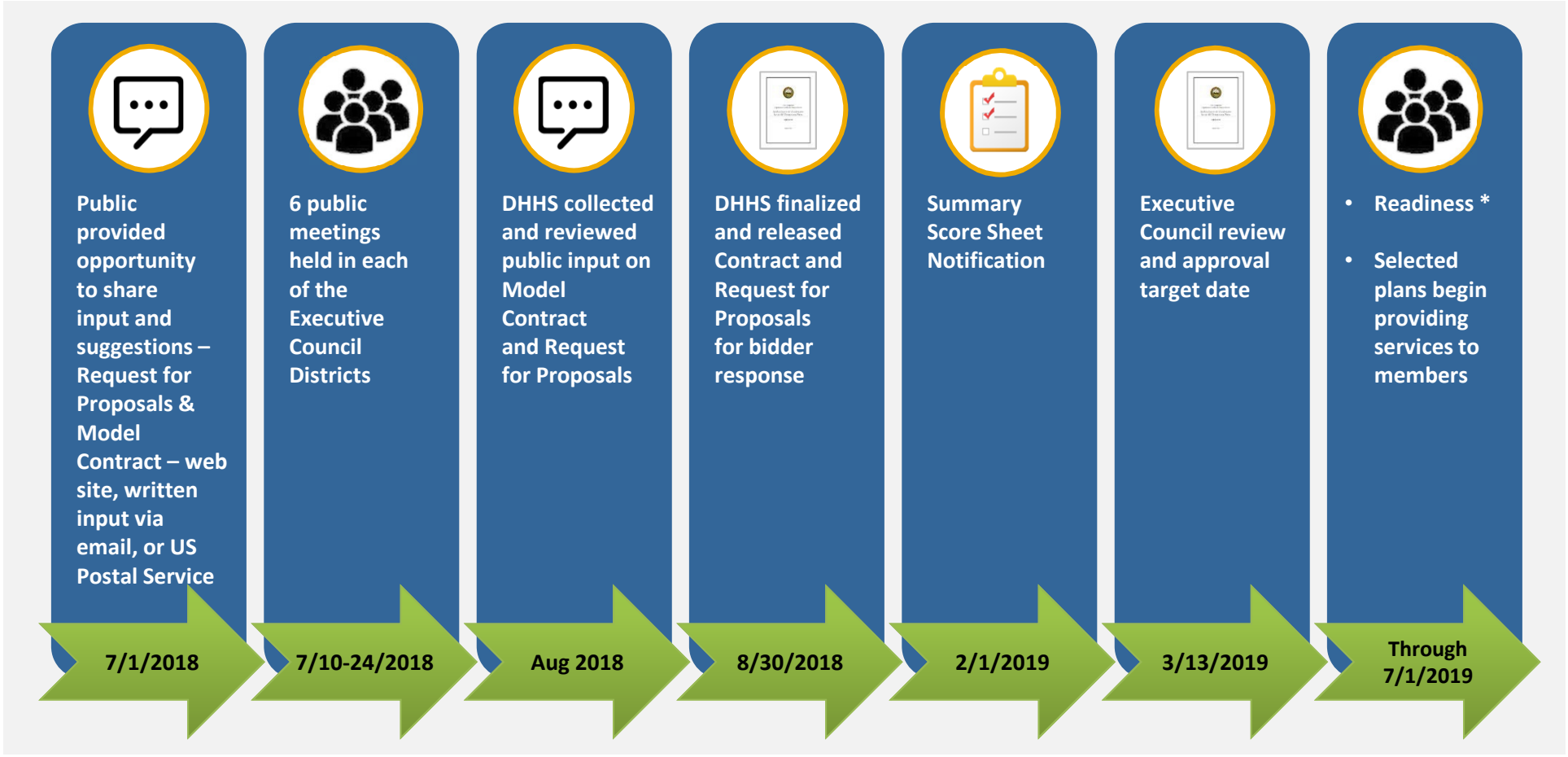
2. Asking respondents how they would meet or exceed expectations and requirements described in the Medicaid Care Management Contract

3. Selecting plans to provide:



Plans will adhere to all requirements outlined in the final Contract for a 5-year program (July 1, 2019 – June 30, 2024).
The contracts and rates are established annually and as needed, subject to Centers for Medicare and Medicaid Services approval.

Transparent, Competitive Procurement



The Department's process for the development of the program reflected in the contracts and the contracts themselves represent a significant improvement over the prior procurement process and the program itself. The Department -- for the first time ever – put out the Request for Proposals for public comment and held public information sessions in each of the Executive Council Districts last July in Concord, Keene, Manchester, Nashua, Littleton and Portsmouth before it was issued to potential respondents.

* In order to meet the 7/1/2019 program start-date, selected plans will work collaboratively with the Department to meet readiness requirements as conditioned in the contract.

Selected Managed Care Organizations

AmeriHealth Caritas New Hampshire

nh healthy families

WELL SENSE HEALTH PLAN

These three (3) Vendors were selected through a competitive bid process. A Request for Proposals RFP-2019-OMS-MANAG-02 was posted on the Department of Health and Human Services' web site from August 30, 2018 through October 31, 2018. A mandatory bidder's conference was held on September 7, 2018. In-person attendance at the Mandatory Bidder's Conference was a requirement to submit a proposal. The Department received four (4) proposals. The proposals were reviewed and scored by a team of individuals with program specific knowledge.

Changes to the Current Medicaid Care Management Program

Key Areas

- Care Coordination and Care Management
- Behavioral Health (Mental Health and Substance Use Disorder)
- Emergency Room Waiting Measures
- Support the Community Mental Health Centers and Substance Use Disorder Providers
- Pharmacy Counselling and Management
- Beneficiary Choice and Competition
- Withhold and Incentive Program and Sanctions
- Alternative Payment Models
- Cost Transparency
- Accountability for Results
- Public Reporting
- New Provider Supports
- Quality Management and Access
- Children with Special Health Care Needs
- Community Engagement -- Granite Advantage Members
- Heighten Program Compliance and Integrity Provisions
- Medical Loss Ratio

Central Features of the New Medicaid Care Management Program

Key Features

- Improve care of Members
- Improve health outcomes
- Reduce inpatient hospitalization and re-admissions
- Improve continuity of care across the full continuum of care
- Improve transition planning when care is completed
- Improve medication management
- Reduce unnecessary emergency services
- Decrease the total cost of care
- Increase member satisfaction
- Improve provider participation in the program

Ratemaking and Budget

Estimated member months for SFY 2020 to be served among all contracts is 2,108,199. The price limitation for SFY 2020 among all contracts $924,150,000 based on the projected members per month.

Department actuary developed SFY 2020 capitation rates as an update to the January 2019 – June 2019 capitation rates using a methodology consistent with the SFY 2019 capitation rates certified in their June 12, 2018 and December 2, 2018 reports.

DHHS and its actuary will update the SFY 2020 capitation rates to reflect SFY 2018 encounter data and fee-for-service data, as well as CY 2018 Comprehensive Health Care Information System data.

Additional program changes that may be made during the legislative session will be included at a later date.

Medical Loss Ratio: Contract specifies a minimum amount that must be spent on service delivery to beneficiaries; any amount less is rebated back to the program.

Actuarially Sound Rate

New Hampshire Department of Health and Human Services SFY 2020 Capitation Rate Change Based on Projected SFY 2020 Enrollment by Rate Cell			
Population	**January 2019 to June 2019 Capitation Rate**	**SFY 2020 Capitation Rate**	**Percentage Change**
Standard Medicaid			
Base Population	$303.54	$315.15	3.8%
Children's Health Insurance Program*	188.36	196.71	4.4%
Behavioral Health Population	1,294.03	1,386.51	7.1%
Total Standard Medicaid	**$371.26**	**$389.03**	**4.8%**
Granite Advantage Health Care Program			
Medically Frail	$993.36	$1,025.07	3.2%
Non-Medically Frail	423.21	482.8	14.1%
Total Granite Advantage Program	**$532.03**	**$586.30**	**10.2%**
Total	**$416.29**	**$444.28**	**6.7%**

* The Children's Health Insurance Program capitation rate is an average of the specific rate cells in which Children's Health Insurance Program members are enrolled. We do not develop a Children's Health Insurance Program specific capitation rate.

Administrative and Margin Allowance

Administrative allowance is applied as a percent of revenue. It is based on an analysis of program elements and it is benchmarked to other Medicaid programs on a national level.

Increase of 1.0% in the Medicaid Care Management Program administrative allowance over the current SFY 2019 allowance. Change reflects additional Care Management to provide for a short- and long-term focus for achieving improved quality, cost benefit, access, and beneficiary experience.

An overall 9.0% administrative cost allowance for the Standard Medicaid population, 10.9% for the Non-Medically Frail Granite Advantage population and 8.4% for the Medically Frail Granite Advantage population.

Allowed margin is 1.5% of revenue for all programs (prior to the Community Mental Health Center-directed payment and the premium tax allowance); the historic initial margin under the existing contract was 2.0%.

Source of Funds

State Fiscal Year	Accounting Unit	Class/Account	Class Title	Total Amount
SFY 2020	Granite Advantage	101-500729	Medical Payments to Providers	$360,150,000
SFY 2020	Child Health Insurance Program	101-500729	Medical Payments to Providers	$59,700,000
SFY 2020	Medicaid Care Management	101-500729	Medical Payments to Providers	$504,300,000
			Grand Total	**$924,150,000**

- Funds for Granite Advantage Health Program are 93% Federal as appropriated by Congress and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020; funds for the Child Health Insurance Program are 79.4% Federal as appropriated by Congress and 20.6% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal as appropriated by Congress, 24.3% General and 24.7% Other funds.
- In the event that Federal funds become no longer available or are decreased below the 93% level for CY 2019 or 90% level for CY 2020, for the Granite Advantage Health Program, consistent with RSA 126-AA:3, no state general funds shall be deposited into the fund and medical services for this population would end consistent with RSA 126-AA:3, VI.

MCM Program Managed Care Plan Assignment – Current Practice

- **Current Managed Care Members:**
  - An annual open enrollment period is held (June).
  - All existing MCO members are given the choice to switch to a different MCO or keep their MCO through the open enrollment.
  - Existing members who take no action automatically keep their current plan assignment.
  - Only those members who chose a new plan are switched.
- **New Medicaid Enrollees:**
  - New members may preselect any MCO at the time of Medicaid application through NH EASY or by contacting DHHS customer service.
  - If the new member does not preselect a plan, a plan will be chosen for them by looking at several factors:
    - Family members already in an MCO (e.g., newborns are assigned to their mother's MCO)
    - Prior enrollment in an MCO in the past 18 months
    - Known member connection (through claims data) to a primary care provider not in all MCOs
  - If no connection can be found between a new member and a specific MCO, members will be assigned to one of the two MCOs on 1:1 basis (assuming adequacy of network and readiness of plan operations).
- **After a new plan selections/assignments:**
  - Members have 90 days to switch to a different MCO of their choice. Even after the 90 day period members can switch with a good cause exception.

New MCM Program Managed Care Plan Assignment – Initial Term

Current Managed Care Members:

- There will be a 30 day open enrollment period in August 2019.
- All existing MCO members will be given the choice to switch to a different MCO or keep their MCO Existing members who take no action will automatically keep their current plan assignment.
- Only those members who chose a new plan will be switched.

New Medicaid Enrollees:

- Starting September 1, 2019, new members may preselect any MCO at the time of Medicaid application through NH EASY or contacting DHHS customer service
- If the new member does not preselect a plan, a plan will be chosen for them by looking at several factors:
  - Family members already in an MCO (e.g., newborns are assigned to their mother's MCO)
  - Prior enrollment in an MCO in the past 18 months
  - Known member connection (through claims data) to a primary care provider not in all MCOs
- If no connection can be found between a new member and a specific MCO, members will be assigned to the new MCO (assuming adequacy of network and readiness of plan operations) until a minimum viable enrollment is achieved.

After new plan selections/assignments:

- Members will have 90 days to switch to a different MCO of their choice. Even after the 90 day period members can switch with a good cause exception.

New MCM Program Managed Care Plan Assignment– Long Term

Current Managed Care Members:

- In June 2020, and beyond, there will be a 30 day open enrollment period.
- All existing MCO members will be given the choice to switch to a different MCO or keep their MCO (similar to prior annual open enrollments; future open enrollments will be in June of each year to align with the start of the state's fiscal year).
- Existing members who take no action will automatically keep their current plan assignment.
- Only those members who chose a new plan will be switched.

New Medicaid Enrollees:

- After the minimum viable assignment target is attained for the new MCO, the long-term target for the new MCO is for reasonable parity with one of the incumbent MCOs.
- Estimated timeframe for reasonable parity is 12-24 months.
- DHHS will regularly monitor the progression.
- Thereafter, assignment of new members not tied to an MCO will be modified to distribute members using the existing distribution method for unassigned members on the basis of 1:1:1. (assuming adequacy of network and readiness of plan operations).

After new plan selections/assignments:

- Members will have 90 days to switch to a different MCO of their choice. Even after the 90 day period members can switch with a good cause exception.

Incentive Provisions of SB 313 and this RFP:

- Provide for a future preferential assignment algorithm to factor in differential MCO quality performance as a basis for incentive.

NH Medicaid Care Management Population by Council District Estimated

Medicaid care Management Population by Council District Estimated for 7/1/19

Executive Council District	Medicaid Care Management Members
District 1	42,363
District 2	41,250
District 3	23,300
District 4	40,127
District 5	32,224

Data is for 2/1/19 with projection for transition of remaining members mandatory for managed care; does not account for any enrollment trend