



New Hampshire Medicaid Care Management Program and Procurement

February 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

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)

Covered Services* Include:



Physical Health



Behavioral Health

(Mental Health and Substance Use Disorder)



Pharmacy Services

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



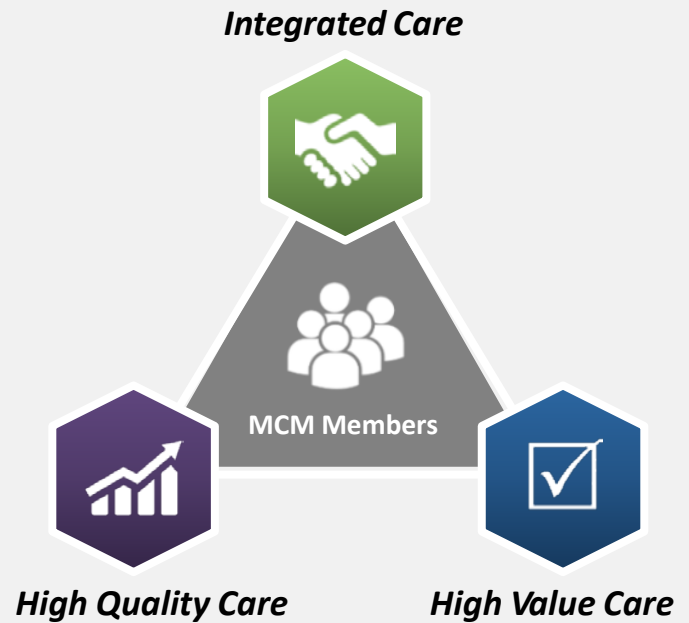
Medicaid Care Management Contract and Request for Proposals

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

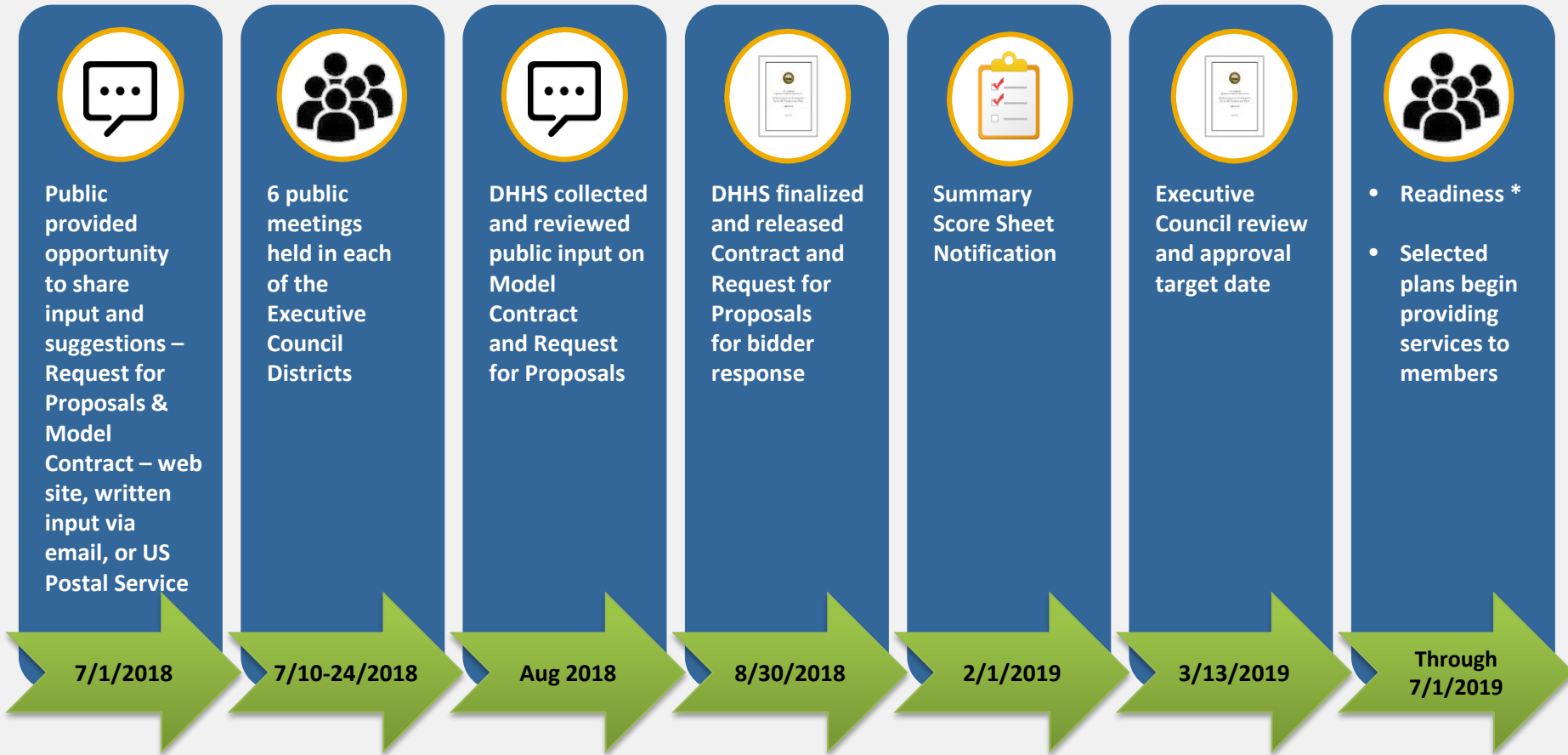
3 Selecting plans to provide:



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



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 and



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.

