New Hampshire Medicaid Care Management Program: *Stakeholder Engagement*

July 2018

Objective of Today's Meeting

The purpose of today's meeting is to inform you of the Medicaid Care Management re-procurement process and provide an opportunity to share your input and suggestions.

Executive Council District 1

Littleton
Monday, July 16
5:30 – 7:30 PM

Executive Council District 2

Keene
Tuesday, July 10
5:30 – 7:30 PM
&
Concord
Tuesday, July 24
5:30 – 7:30 PM

Executive Council District 3

Portsmouth
Wednesday, July 11
5:30 – 7:30 PM

Executive Council District 4

Manchester
Wednesday, July 18
5:30 – 7:00 PM

Executive Council District 5

Nashua
Thursday, July 19
5:30 – 7:00 PM

DHHS will hold 6 public meetings to discuss the content of the MCM RFP and Contract and solicit stakeholder input

Interested parties may send written comments concerning the MCM RFP and Contract to New Hampshire DHHS, 129 Pleasant Street, Concord, NH 03301 or via email to nhmedicaidcaremanagement@dhhs.nh.gov. DHHS will accept comments until 5:00 PM EST on July 27, 2018.

Agenda Overview

I. Level Setting

II. Executive Overview of MCM Re-Procurement

III. Key Provisions of the MCM Contract

IV. Next Steps and Questions

Overview of the MCM Program

Medicaid Care Management (MCM) is New Hampshire's Medicaid managed care program

New Hampshire currently has full-risk, capitated contracts with 2 managed care organizations (MCOs): New Hampshire Healthy Families and Well Sense Health Plan

MCM Covered Services* Include:

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

MCM Population

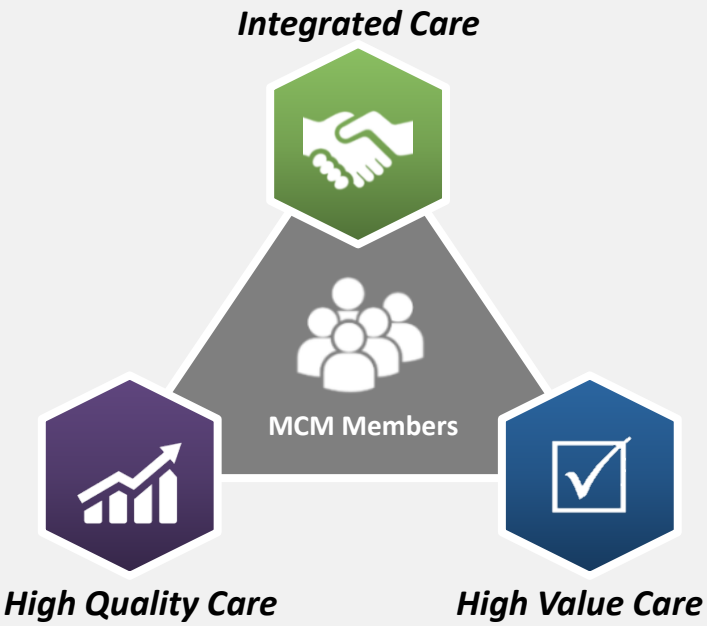
- Nearly **137,410** MCM members statewide
- Approximately **43,970** Medicaid members in New Hampshire's Expansion program will transition from Marketplace coverage offered under New Hampshire Health Protection Program into the MCM program
- Covered populations include:
  - ✓ Pregnant Women
  - ✓ Children
  - ✓ 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 (LTSS) and services for select MCM exempt populations are offered through fee-for-service (FFS) outside the MCM program.

Overview of MCM Contract and Request for Proposal (RFP)

DHHS will use the MCM Contract and RFP 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 MCM program**
2. **Asking respondents how they will meet or exceed expectations and requirements described in the MCM Contract**
3. **Selecting MCOs to provide:**



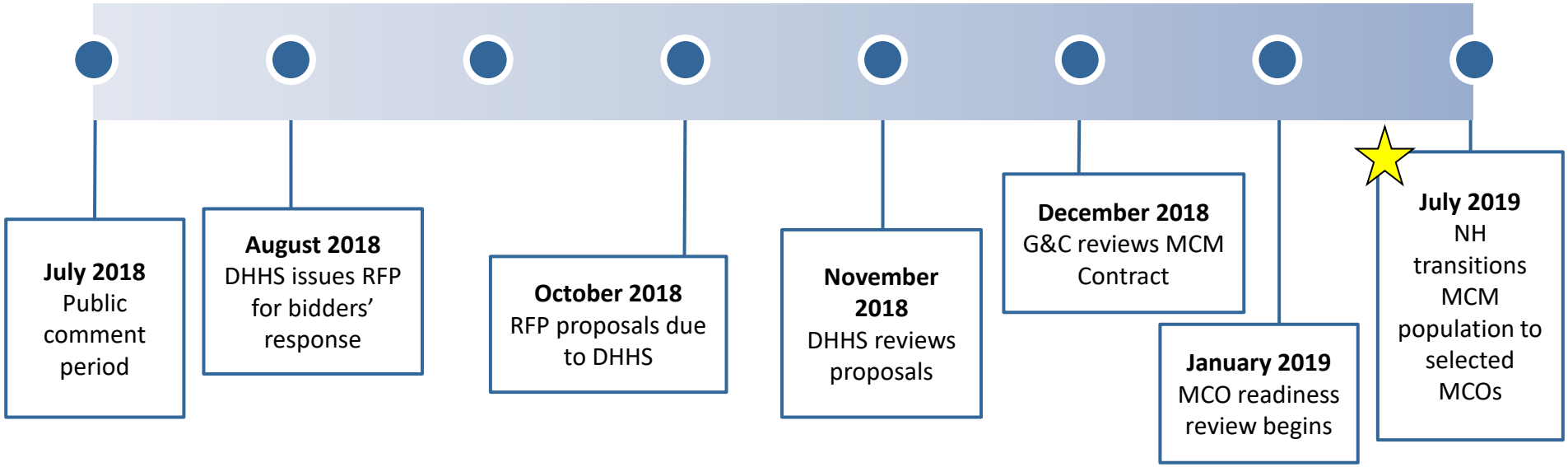
MCOs will adhere to all requirements outlined in the final MCM Contract for a 5-year term (July 1, 2019 – June 30, 2024). The contracts and rates will be reestablished annually and as needed, subject to Centers for Medicare and Medicaid Services (CMS) approval.

MCM Re-Procurement Timeline

Key Transition and Contract Dates

- **January 1, 2019:** NH transitions Granite Advantage Expansion population into existing MCOs
- **July 1, 2019**: MCM contract effective date for re-procurement

Re-Procurement Timeline



Re-Procurement Priorities (1/2)

DHHS is committed to advancing MCM program performance and will use the RFP to select MCOs with the capabilities to work with the State to provide high quality, high value care to New Hampshire residents.

1. **Beneficiary Choice and Competition:** DHHS is committed to providing Medicaid beneficiaries with three high-quality MCOs from which to choose. DHHS recognizes there are challenges for new plans entering and existing market and will utilize a program structure that allows incoming MCO(s) to achieve an equitable share of members within 18 months.

2. **Continuity of Care:** A beneficiary's decision to continue to be served by an existing MCO, if selected in the re-procurement, will be honored.

3. **Integrated Care:** MCOs are expected to provide accessible, person-centered care that takes into account members' physical health, behavioral health, and social and economic needs. MCOs will work with members, providers, integrated delivery networks (IDNs), and Community Mental Health Programs and Providers to integrate care.

4. **Increase Access to Care and Healthy Behaviors:** DHHS expects MCOs to provide members with adequate access to health care providers, and to offer incentives for member participation in healthy behaviors.

Re-Procurement Priorities (2/2)

5 **Provider Supports:** Ongoing provider support is important to ensuring Members' access to and the delivery of high-quality care. DHHS will expect MCOs to meet provider training requirements, implement prompt and accessible credentialing and re-credentialing processes, ensure providers are paid in a timely manner, and establish a provider grievance and appeals process.

6 **Incent Value Over Volume:** Increasingly, DHHS will expect MCOs to pay providers based on the outcomes that they achieve rather than the volume of care that they deliver through use of Alternative Payment Models (APMs).

7 **Accountability for Results:** A share of payment to MCOs will be directly linked to their performance, ensuring accountability for results, particularly in high priority areas such as addressing substance use disorders, integrating physical and behavioral health, providing robust care management, reducing unnecessary use of high-cost services, and providing high quality care.

8 **Public Reporting:** Each MCO will submit an annual report to the Governor and the legislature describing how the MCO has advanced DHHS priorities, including how it has: established innovative programs, addressed social determinants of health, and improved population health and other key program metrics.

9 **Heighten Program Efficiency:** DHHS will leverage the MCM Contract to implement programmatic changes that increase standardization of administrative practices and simplify processes that are burdensome to the State, providers, and MCOs alike.

Overview of Key Provisions of the MCM Contract

Key Design Areas

- Care Coordination and Care Management
- Behavioral Health (Mental Health and Substance Use Disorder)
- Pharmacy Management
- MCO Withhold and Incentive Program and Sanctions
- Alternative Payment Models (APMs)
- Member Cost Transparency and Incentives
- Provider Friendly Environment
- Quality Management and Access
- Children with Special Health Care Needs
- Granite Advantage Members
- Medical Loss Ratio (MLR)

☆ *= Meets legislative requirements in SB 313*

Care Coordination and Care Management

MCOs will implement care management strategies to improve patient care and health outcomes, reduce inappropriate utilization of emergency services, address unmet resource needs, integrate primary and behavioral health, and decrease total costs of care.

Key Provisions

MCOs will be required to:

- Identify priority populations for care management through health risk assessments
- Ensure priority populations receive a social and functional comprehensive assessment (for both physical and behavioral health) ☆
- Manage transitions of care for all members
- Conduct local care management or contract with a designated care management entity for at least 50% of high-risk/high-need members. Designated care management entities may include:
  - IDNs
  - Other local care management entities

DHHS certification of IDNs for care management is a new concept for the MCM Program

- Address social needs for members (e.g., promoting access to stable housing and healthy food)
- Actively link members with State, local, and community programs to assist with health and social services
- Arrange a wellness visit for adult members at the time of the welcome call that includes an assessment of both physical and behavioral health ☆

Behavioral Health: Mental Health & Substance Use Disorder

MCOs will provide a full continuum of physical health and behavioral health services, ensuring continuity and coordination of care and requiring collaboration between physical health and behavioral health providers.

Key Provisions

MCOs will be required to:

- Screen members for behavioral health needs and maximize use of integrated and co-located care
- Enter into capitated payment arrangements with Community Mental Health Programs and Providers, and reimburse substance use disorder providers at rates no less than the DHHS FFS rates ☆
- Work collaboratively with DHHS to promote suicide prevention awareness programs and help implement the 10-Year Mental Health Plan
- Contract with all willing peer recovery support providers and methadone clinics
- Monitor aspects of the behavioral health system (e.g., Assertive Community Treatment (ACT) fidelity)
- Staff clinical providers with admitting privileges at each acute care hospital to reduce psychiatric boarding
- Offer enhanced reimbursement for Medication Assisted Treatment (MAT)
- Develop alternative payment models (APMs) for both MAT and Neonatal Abstinence Syndrome ☆
- Conduct performance improvement projects for mental health and substance use disorder treatment ☆

In the future, DHHS is considering implementing health homes to address the State's opioid epidemic and to improve access to behavioral health services.

Pharmacy Management

DHHS will implement a single, State-designated Preferred Drug List (PDL), which will generate MCM program savings. DHHS will retain the option of annually establishing a select list of drugs to be covered by DHHS to ensure member access.

Key Provisions

<u>MCOs will be required to</u>:

Design formularies consistent with the single PDL that:

- **Prioritize patient care and access to necessary medications**
- **Provide access to the right information for members, prescribers, and pharmacies**
- **Minimize member and provider burden**

Provide medication management for all members, including an annual medication review and counseling by a pharmacist for members at risk of harm due to polypharmacy

Complete specific activities intended to address the medication needs of special populations including:

- **Children with Special Health Care Needs**
- **Members with Substance Use Disorders**

*Additional information regarding the list of drugs currently excluded from the MCO capitation rate is available in the Data Book.

MCO Withhold and Incentive Program and Sanctions

DHHS will withhold a portion of each MCO's capitated payment to fund a Withhold and Incentive Program*, designed to advance MCO accountability against a select set of priority initiatives and measures of performance.

Key Provisions

<u>MCOs will be required to</u>:

- **Meet certain minimum performance standards or "gating criteria" to be eligible to earn back any of the withhold or receive an incentive payment**
- **Meet targets aligned to measures that hold MCOs accountable for SB 313 and DHHS priorities, bucketed into three performance categories:**
  - **Quality Improvement**
  - **Behavioral Health**
  - **Care Management** ☆
- **Contribute any unearned withheld funds to an incentive pool, used to reward high-performing MCOs** ☆
- ***In addition to the withhold and incentive program – be subject to liquidated damages, suspension of payments and intermediate sanctions for failure to comply with terms of the MCM contract*** ☆

*Details regarding the Withhold and Incentive Program will be made available to MCOs in guidance separate from the MCM Contract on an annual basis.

Alternative Payment Models (APMs)

In alignment with the Section 1115 Building Capacity for Transformation waiver and SB 313, MCOs will develop a strategy for moving 50% of their medical expenditures into qualifying APMs, improving cost, quality, and member experience.

Key Provisions

<u>MCOs will be required to</u>:

- **Develop an APM Implementation Plan – that must be transparent to and approved by DHHS prior to implementation – and incorporates core components of the DHHS strategy, including developing total cost of care models with shared savings for large providers, ensuring that appropriate APM strategies are available for smaller providers, and maximizing alignment with the existing APM models used in the Medicare and commercial markets**
- **Incorporate DHHS and SB 313 legislative priorities, including measures related to:**
  - **Unnecessary emergency department and service utilization**
  - **Preventable admissions and 30-day all-cause readmissions**
  - **Timeliness in prenatal care**
  - **Timeliness of follow-up after mental illness or substance use disorder admission** ☆

  After year 1 and once performance data is available, the auto-assignment methodology will reward high-performing MCOs. ☆
- **Include provider incentives that align with State priorities and efforts** ☆

"Qualifying APMs" are defined by DHHS and must be in alignment with the Health Care Payment Learning & Action Network (HCP-LAN) APM framework Category 2C or above.

Member Cost Transparency and Incentives

In accordance with SB 313, MCOs will provide cost transparency information to all members and will develop member incentive programs that reward members for healthy, cost-effective behaviors.

Key Provisions

<u>MCOs will be required to</u>:

- **Publish on their websites cost transparency information indicating the settings and providers that are most cost effective** ☆
- **Propose, develop, and implement member incentive programs, including:**
  - **A Member Healthy Behavior Incentive Program**
  - **A Reference-Based Pricing Incentive Program that rewards members for ongoing use of cost effective providers/settings, using the cost transparency information provided by the MCO** ☆

Provider Supports

DHHS is committed to ensuring MCOs support providers through training, prompt and accessible credentialing and re-credentialing, standardized work processes, and timely payment.

Key Provisions

MCOs will be required to:

- **Implement a prompt and accessible credentialing and re-credentialing process that will be used to conduct provider outreach and support**
- **Standardize work processes to ensure efficient implementation of the MCM program and minimal provider burden relative to claims billing processes, reporting, and prior authorizations**
- **Employ management efficiencies to clearly communicate processes and respond to a timely manner to inquiries to reduce the volume of provider appeals**
- **Meet prompt payment requirements and pay claims based on the effective date of the Current Procedural Terminology (CPT) code.**
- **Establish a provider grievance and appeals process.**

DHHS is considering exploring opportunities to centralize Provider credentialing and re-credentialing in the future.

Quality Management and Access

MCOs will be required to meet minimum standards and develop strategies that must be approved by DHHS for improving access to and quality of care for MCM members.

Key Provisions

<u>MCOs will be required to</u>:

- **Develop comprehensive quality assessment and performance improvement (QAPI) programs that include performance improvement projects with a focus on:**
  - **Behavioral health (mental health and substance use disorder treatment)**
  - **Areas where clinical quality performance in the prior year was relatively poor**
  - **Addressing social determinants of health and integrating physical and behavioral health**
- **Achieve Health Plan Accreditation from the National Committee for Quality Assurance (NCQA), including the NCQA Medicaid Module**
- **Report nationally-recognized quality measures, including the CMS Adult and Child Core measures, NCQA measures required for accreditation, member satisfaction measures (CAHPS), and a select set of measures related to NH priorities and waivers**
- **Exceed federal standards and meet Statewide standards for access to care, including for primary care providers and specialty care providers**
- **Provide access and adhere to provider payment requirements for minimum Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) reimbursement rates**

Children with Special Health Care Needs

MCOs will develop and maintain a robust program for Children with Special Health Care Needs, including children in foster care, that ensures health care access and services are provided in accordance with DHHS requirements.

Key Provisions

<u>MCOs will be required to</u>:

- **Ensure access to providers during transitions of care**
- **Improve care coordination and care management**
- **Provide targeted provider training**

In the future, DHHS is considering developing a specialized MCO product that will serve children within the Division of Children, Youth and Families (DCYF) system and other Children with Special Health Care Needs.

Granite Advantage Members

Under Granite Advantage, individuals who currently receive premium assistance for Marketplace coverage offered through Qualified Health Plans (QHPs) will transition to the MCM program January 1, 2019.

Key Provisions

<u>MCOs will be required to</u>:

Fulfill obligations related to the administration of work and community engagement requirements for Granite Advantage members, including: ☆

- **General outreach and education activities**
- **Member support services including assistance with reporting compliance**
- **Obtaining good cause or other exemptions**
- **Where applicable, identifying exempt or potentially exempt enrollees**
- **Status tracking and targeted outreach**

Provide assistance to Granite Advantage members who become ineligible for Medicaid to obtain other health insurance coverage ☆

Medical Loss Ratio (MLR)

DHHS will institute a minimum MLR of 85% that promotes cost efficiency in the delivery of care to the entire Medicaid population and transfers any surplus funds to the State General Fund.

Key Provisions

<u>MCOs will be required to</u>:

- **Meet a minimum 85% MLR that will encourage cost efficiency in the delivery of care to the entire Medicaid population** ☆

  A Medical Loss Ratio (MLR) is the percent of premium an insurer spends on claims and expenses that improve health care quality

- **Refund the State the difference between the actual MLR and the dollar amount corresponding to an 85% MLR in the event the MCO's MLR is below 85%** ☆

  If an MCO uses 85 cents out of every dollar to pay its members' medical claims and activities that improve the quality of care, the MCO has an MLR of 85%. An MLR of 85% indicates that the MCO is using the remaining 15 cents of each dollar to pay overhead/administrative expenses

MCM Re-Procurement Next Steps

July 2018 – July 2019

DHHS collects and reviews public input on MCM Contract and RFP

DHHS finalizes and releases MCM Contract and RFP for bidders' response

DHHS reviews proposals

DHHS and MCOs execute MCM Contract, Executive Council review and approval, and CMS approval*

Selected MCOs begin providing services to MCM members

Interested parties may send written comments concerning the MCM RFP and Contract to New Hampshire DHHS, 129 Pleasant Street, Concord, NH 03301 or via email to nhmedicaidcaremanagement@dhhs.nh.gov. DHHS will accept comments until 5:00 PM EST on July 27, 2018.

The draft MCM Contract may be found at: www.dhhs.nh.gov/ombp/medicaid/documents/mcmcontractdraft.pdf
The draft MCM RFP may be found at: www.dhhs.nh.gov/ombp/medicaid/documents/mcmrfpdraft.pdf

*CMS approval of the MCM Contract is dependent on outside factors; however, approval will not hinder the program start date