

# Medicaid Managed Care in New Hampshire

## *An Introduction*

***Community Partners, One Sky Community  
Services, and Region 10 Community Support  
Services***

***Exeter High School***

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**Deborah Fournier, Esq.**

**Policy Analyst**

**New Hampshire Fiscal Policy Institute**

**603.856.8339**

**[dfournier@nhfpi.org](mailto:dfournier@nhfpi.org)**

**[www.nhfpi.org](http://www.nhfpi.org)**

# Medicaid Managed Care in New Hampshire

- ❖ What is Managed Care?
- ❖ NH and Other States' Experience
- ❖ State Requirements – CH. 125
- ❖ Select Federal Requirements - 42 CFR 438
- ❖ RFP and Contracting Issues
- ❖ Special Populations
- ❖ Opportunities to Participate
- ❖ Recap

# What is Managed Care?

- ❖ It depends on who you ask.
- ❖ **Managed care is a broad term** and encompasses many different types of organizations, payment mechanisms, review mechanisms and collaborations. Managed care is sometimes used as a general term for the activity of organizing doctors, hospitals, and other providers into groups in order **to enhance the quality and cost-effectiveness of health care.**
- ❖ For Consumers = Alphabet Soup! MCOs, PCCMs, ACOs, PMPM, UR
- ❖ For Policy Wonks = Systems and techniques used to control the use of health care services. Includes a review of medical necessity, incentives to use certain providers, and case management

# What is Managed Care?

- ❖ Managed care techniques are most often practiced by organizations and professionals that assume risk for a defined population (e.g., health maintenance organizations) but this is not always the case.
- ❖ **Managed Care Organizations** (MCO) include HMO, PPO, POS, EPO, PHO, IDS, AHP, IPA, etc. Frequently when one speaks of a managed care organization, one is speaking of the entity that manages risk, contracts with providers, is paid by employers, patient groups, other entities (such as a state) and handles claims processing.
- ❖ Managed care has effectively formed a "go-between", brokerage or 3rd party arrangement by existing as the gatekeeper between payers (DHHS) and providers (physicians, hospitals and health centers) and patients (Medicaid members).

# What is Managed Care?

- ❖ **Managed care plans** are health insurance plans that contract with health care providers and medical facilities to provide care for members at reduced costs. These providers make up the plan's network. How much of care the plan will pay for depends on the network's rules.
- ❖ Traditionally managed care has focused on payment arrangements and reimbursement structures that are distinct from Fee-For-Service (FFS) payment.
  - FFS is a reimbursement system in which providers are paid for each service provided to each patient.
- ❖ Three major managed care payment arrangements are:
  - Risk-based capitated payment plans and
  - Primary care case management
  - Limited benefit plans

## What is Managed Care?

- ❖ **Risk-based Capitated Payment Plan:** An entity is paid a fixed per member per month fee (aka PMPM) and assumes financial risk for delivering an agreed upon set of services. The vendor and purchaser negotiate who will be enrolled and what services the vendor will provide.
- ❖ **Primary Care Case Management (PCCM):** This is an arrangement in which a primary care physician (PCP) is paid a small case management fee per patient per month to coordinate care for those patients. All other services provided by the PCP are reimbursed Fee-For-Service.

## What is Managed Care?

- ❖ **Accountable Care Organization (ACO):** an entity that is a consortium of providers assumes risk for quality and cost of care delivered for a defined population receiving an annual fee per enrollee. Think primary care, home health care, specialty care, within the same organization. Could be run by a hospital, insurer or providers themselves.
- ❖ **Administrative Services Organization (ASO):** vendor assumes responsibility for specific administrative services such as utilization management or case management; usually does not provide clinical services.
- ❖ **Limited Benefit Plans (LBP):** include a diverse assortment of plans that typically cover only a single type of benefit. Generally paid on a capitated basis

# Contract Management

- ❖ Medicaid's role is changing from claims processing and payment to a purchaser of comprehensive medical services and contract management.

Policy development  
Actuarial and rate setting  
Procurement  
Information systems support

Contract management  
Quality assurance  
Medical management

- ❖ Contract management will require:

Performance requirements  
Reporting  
Medical management

Marketing & enrollment  
Financial stability  
Enforcement & sanctions

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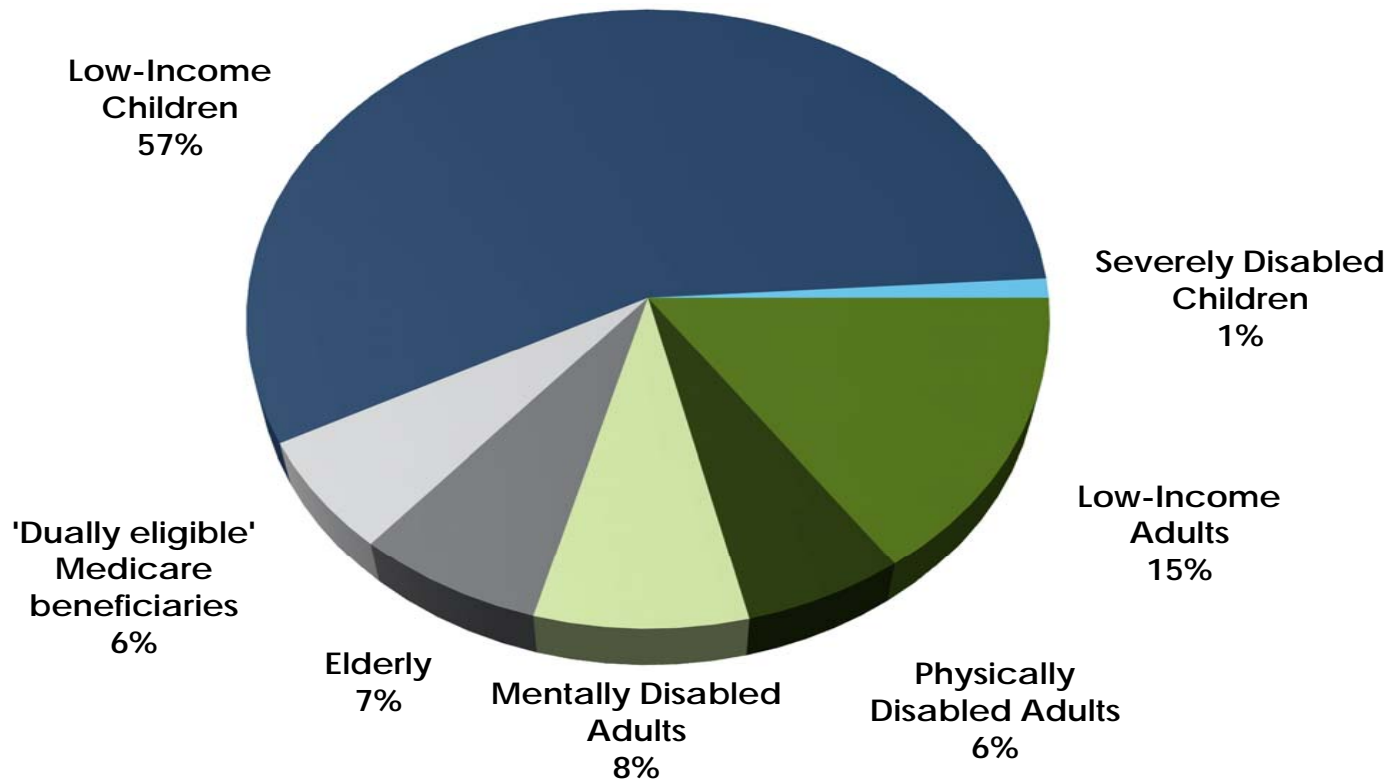
# What is New Hampshire's Experience with Managed Care?

- ❖ New Hampshire Medicaid currently employs the following managed care tools : utilization review, prior authorization, service limits, inpatient review, discharge planning, pharmacy benefit manager. However, it does not employ an overarching managed care payment arrangement.
- ❖ New Hampshire Medicaid had a voluntary, capitated-risk payment program from 1999-2003. Enrollees were children and low-income women. No special needs populations enrolled. Although 3 vendors participated initially, by 2003 only 1 was still willing to participate.
- ❖ New Hampshire employed a disease management program from 2005-2009 that provided self-management skills for Medicaid clients with chronic illnesses.

# Who is in New Hampshire Medicaid?

## Children Make Up Most of the Medicaid Membership...

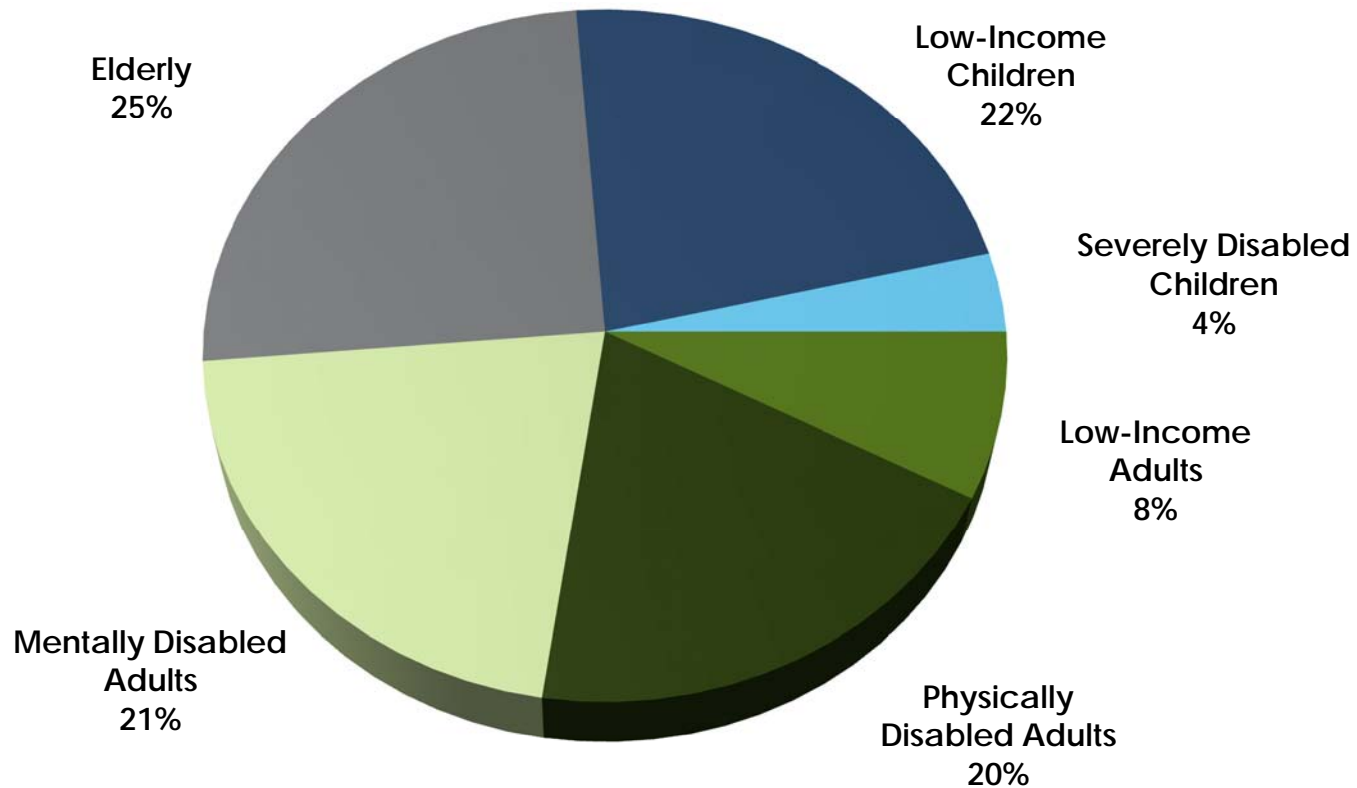
*New Hampshire Medicaid Membership, by Eligibility Group, FY 2009*



# Who is in New Hampshire Medicaid?

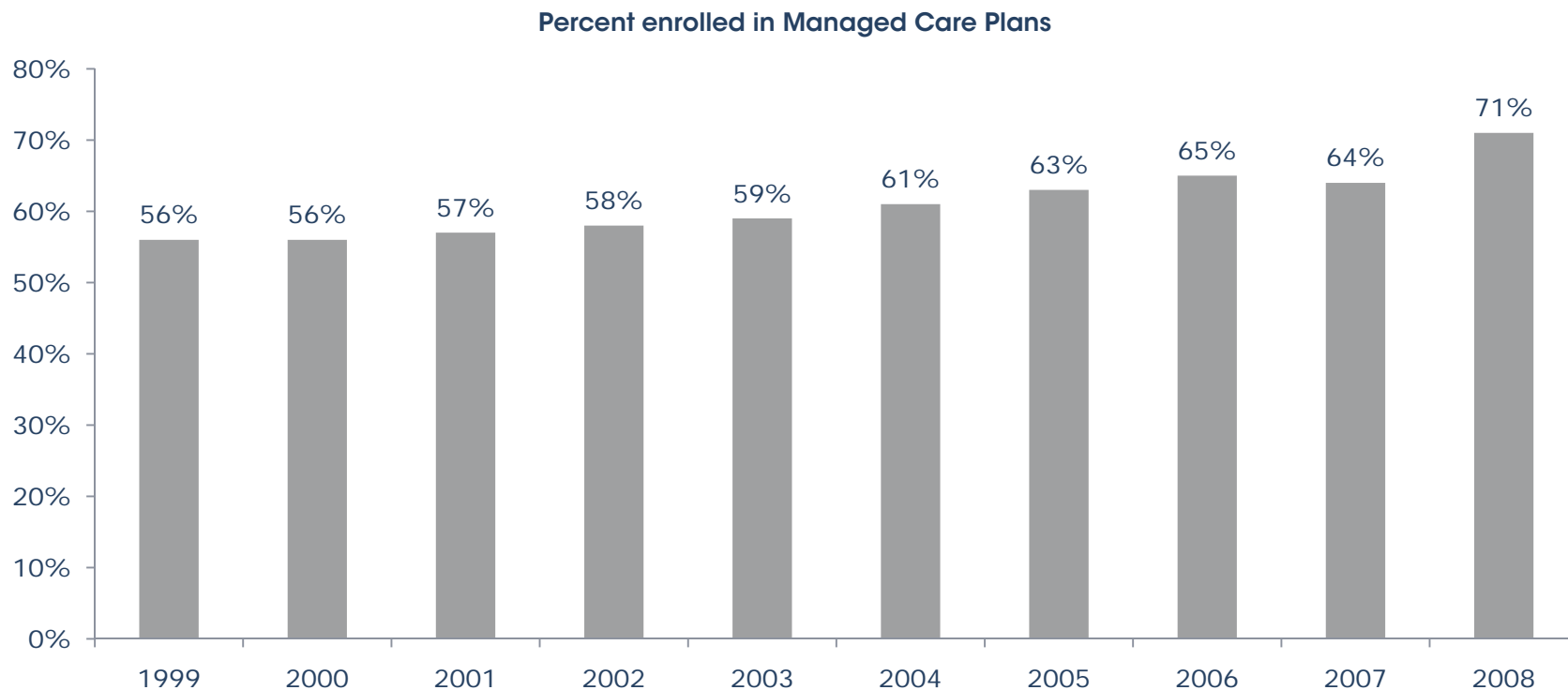
... but Costs are Concentrated Among Elderly, Disabled

*New Hampshire Medicaid Provider Expenditures, by Eligibility Group, FY 2009*



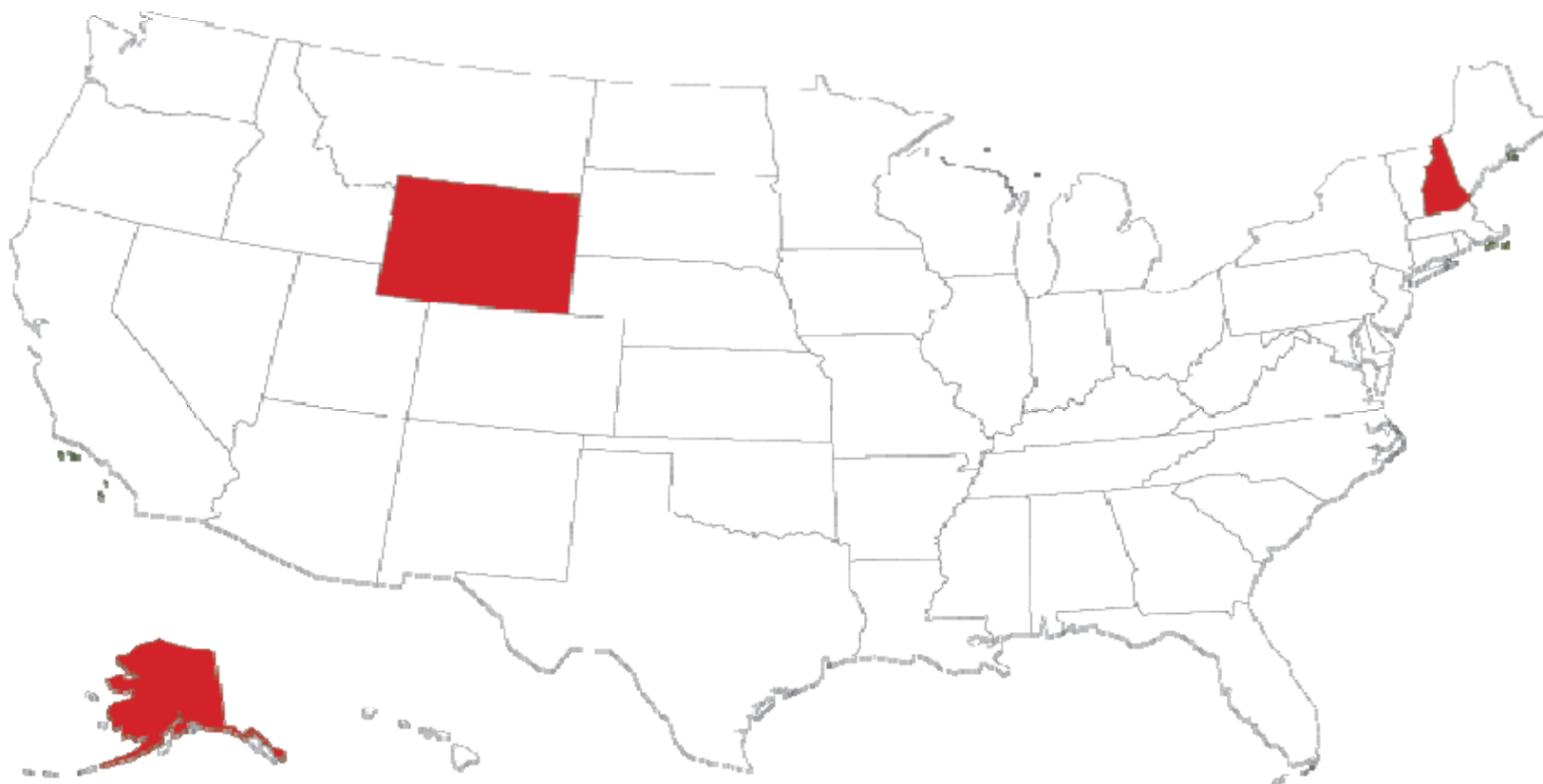
# Do Other States Use Medicaid Managed Care?

## Share of Medicaid Beneficiaries Enrolled in Managed Care, 1999-2008, Nationwide



# New Hampshire is Unique

Nearly Every State in the Union Uses Managed Care Payment Plans In Medicaid Programs except for Wyoming, Alaska and New Hampshire



Source: Kaiser Family Foundation

## How Has Managed Care Worked in Other States with Respect to Savings?

- ❖ If you've seen one Medicaid program, you've seen only one.
- ❖ Savings are unpredictable - Lewin report indicates range from 0.5% to 20%
- ❖ Savings greater in urban vs. rural areas
- ❖ Savings greater for older persons and people with disabilities than for parents and children; little experience with older people and people with disabilities in capitated risk programs
- ❖ Savings greater in risk-based models than in PCCM models
- ❖ Savings realized in mature systems – not right away
- ❖ Full-risk contract may not be possible throughout entire state

## What Are Other New England States' Experiences With Medicaid Managed Care?

- ❖ Maine and Vermont both ended fully capitated risk payment programs in 1990s. CT just ended its full-risk program in 2011.
- ❖ Maine abandoned plans to return to full-risk plans in 2011. Sticking with PCCM.
- ❖ Vermont was granted a Section 1115 Global Commitment waiver and is pursuing a single payer system. The 1115 Global Commitment waiver carves out SCHIP and LTC. Vermont has a separate 1115 LTC waiver. Dually eligible members (Medicare and Medicaid) are in both waivers.

# What Are Other New England States' Experiences With Medicaid Managed Care?

- ❖ Rhode Island has a Section 1115 waiver and has a large percentage of its members in managed care. Enrollment became mandatory for some adults in fall of 2009. Rhode Island uses a blend of MCOs and PCCMs.
- ❖ Massachusetts has state wide managed care provided through MCOs and PCCMs, but does not include long-term care services or duals in those plans. MA has lost MCO vendors in some parts of the state in the past.

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## State Requirements – CH. 125

- ❖ Overarching goal: HHS “**shall employ** a managed care model for administering the Medicaid program and its enrollees...**for all Medicaid populations** throughout New Hampshire...”
  
- ❖ “Models may include but not be limited to”:
  - traditional capitated managed care organization contract
  - An administrative services organization;
  - An accountable care organization;
  - Primary care case management model;
  - Or a combination thereof offering the best value, quality assurance, and efficiency, maximizing the potential for savings and presenting the most innovative approach compared to externally administered models.”
  - Whatever models are used must employ **medical homes** and all Medicaid members shall receive care through a medical home.

## State Requirements – CH. 125

- ❖ Services to be covered: “...**all mandatory Medicaid covered services**; [covered services] may include but shall not be limited to:
  - Care coordination
  - Utilization management
  - Disease management
  - Pharmacy benefit management
  - Provider network management
  - Quality management and customer service
  - The model **shall not include mandatory dental services**” (emphasis supplied)

## State Requirements – CH. 125

- ❖ Quality: “The Department shall ensure no reduction in the quality of care of services provided to enrollees in the managed care model and shall exercise all due diligence to maintain or increase the current level of quality of care provided.”
  
- ❖ Schedule:
  - A Five year Request for Proposals to enter into contracts with vendors is to be released **no later than 10/15/2011**;
  - Vendors to be selected not later than **1/15/2012**;
  - Final contracts submitted to Governor and Council no later than **3/15/2012**.
  - Target date for implementation of the contract is **7/1/2012**.
  - All eligible Medicaid members are to be **enrolled no later than 12 months after contract is awarded**.

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## Select Federal Requirements

- ❖ State must provide members a choice of no less than 2 entities
- ❖ Members must be able to terminate or change enrollment for cause at any time and for no cause within certain time frames.
- ❖ Members must be given comparative information chart on each MCO
- ❖ MCO may not distribute marketing materials directly to members
- ❖ Capitation rates must be approved by CMS as actuarially sound.
- ❖ Member protections include grievance procedure, demonstration of network adequacy and services
- ❖ How will these requirements be enforced at state level?

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# RFP and Contracting Process

## *RFP Process Issues to Consider (I)*

- ❖ How will the RFP be structured?
  - HHS will issue requirements and allow market to respond
- ❖ State has guiding principles and is contracting with vendor to help draft RFP and contract.
  - What is the evaluation process for scoring proposals?
  - HHS has said it will describe its basic requirements to applicants. Will it require specific examples of how plans will put requirements into operation/how will plan implement the program and deal with hypothetical scenarios?

# RFP and Contracting Process

## *RFP Process Issues to Consider (II)*

- ❖ Will state do a needs assessment before issuing RFP?
  - Needs to understand cost, utilization rates, and quality of existing system. Stakeholder engagement process and RFP drafting process happening concurrently. How will stakeholder participation feedback into RFP?
  
- ❖ What will selection process with bidders be?
  - Competitive Bid Process?
  - Selection of all plans that meet basic requirements?

# RFP and Contracting Process

## *RFP Substantive Issues to Consider (I)*

### *(aka questions to ask a potential vendor)*

- ❖ **COMPREHENSIVE BENEFITS VS. CARVE OUTS:** How will benefits be managed? Will the plan manage all physical health and mental health but subcontract management of a particular benefit to another entity or separate entities responsible for different benefits (carve outs)?
- ❖ **STAKEHOLDER INVOLVEMENT:** How will consumers be actively engaged by the vendor? How will they be involved in planning and oversight – are there any “consumers” who are directly employed within the managed care organization? How will recommendations/feedback from consumers be incorporated into operations?

# RFP and Contracting Process

## *RFP Substantive Issues to Consider (II)*

- ❖ **SUFFICIENCY OF SERVICES:** What health services will be covered: eligibility criteria, authorization requirements, duration/scope of services? What is the definition of medical necessity?
- ❖ **PROVIDER ADEQUACY:** What are provider network adequacy requirements? How will these benchmarks be created and standards measured?

# RFP and Contracting Process

## *RFP Substantive Issues to Consider (III)*

- ❖ **QUALITY:** What are quality assurance requirements? How will quality benchmarks be created and standards measured?
  - Will plans describe quality improvement programs and existing outcome and best practice currently in place for plan?
  - Will plans describe modifications to existing quality assurance programs in order to serve Medicaid population?
  - Will plans describe proposed process for assessing member satisfaction and frequency of surveys for Medicaid population?
  - What will be minimum standards with respect to data collection, reporting, education, communications with Medicaid members, compliance with medical delivery standards, provider network and staffing ratios?

# RFP and Contracting Process

## *RFP Substantive Issues to Consider (IV)*

- ❖ **ACCESS TO SERVICES:** Are there measurable standards for access to care? What are they? Do they specify reasonable range of services (miles), specify maximum wait time? Availability of language interpretation services, etc.?
- ❖ **GRIEVANCES AND APPEALS:** What are procedures for grievances/complaints, appeals/request for reconsideration and standards for customer service?
- ❖ **COORDINATION OF CARE:** How will care be coordinated/integrated? Will there be integrated or coordinated care for substance abuse/primary care/mental healthcare/chronic conditions/comorbidities? What are incentives at clinical level to do this?

# RFP and Contracting Process

## *Contract Issues to Consider (I)*

### ❖ **How comprehensive will it be?**

HHS is indicating it will pursue an MCO full-risk capitated model for “state plan medical services” for all populations in first of three phases; still assessing what model will be appropriate for HCBC services, services for dual eligibles, and institutional care.

### ❖ **Which services will be included?**

By statute, only mandatory services must be included. HHS has publicly indicated it wants to build on existing infrastructure for “specialty” (waiver) and long-term care services. Phases 2 and 3 will address these services.

# RFP and Contracting Process

## *Contract Issues to Consider (II)*

- ❖ If services carved out, who provides the carved out services? How does that affect coordination of care and cost savings?
- ❖ What delivery models will be chosen? Will there be different models for different regions? Statewide models?

HHS has indicated full risk capitated plan for first phase; PCCM for rural regions or waiver services still an option.

- ❖ What is the mechanism to allow state to monitor/enforce quality and network adequacy required under federal law?

# RFP and Contracting Process

## *Enrollment Issues to Consider*

- ❖ Will there be an enrollment broker? What is enrollment and outreach capacity?
- ❖ How will notice be given to members?
- ❖ How will enrollment be conducted? Phone? Online? In person? Mail?
- ❖ How will enrollment be phased in? By re-determination period? By population? By county?

HHS early on indicated that the first population to be enrolled will be the TANF population and that they hope for staggered enrollment for other populations. More attention has been paid to RFP and contracting in recent weeks.

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# Special Populations

- ❖ **Who are our special needs populations?**

**Children and Adults with Disabilities (physical disability, mental illness, substance abuse, developmental disability) and Seniors/Duals**

- ❖ **First Things First - Needs Assessment**

**To identify gaps in service; cost and utilization rates; consumers and their providers' experiences;**

## Special Populations

### *Issues to Consider – Benefit Packages (I)*

- ❖ People with disabilities have different needs: mental illness, substance abuse, intellectual and developmental disabilities, physical disabilities all require different service bundles.
- ❖ Duals, Katie Beckett kids, foster children will require waivers from feds for mandatory enrollment in managed care. (1915b most likely)
- ❖ Carve out strategies important to consider especially with respect to achieving coordinated care.
- ❖ Special attention should be paid to effectiveness of care management and capacity to meet medical and social support needs.
- ❖ Within commercial plans, the scope of coverage assumes rehabilitation is the goal as compared to habilitation or optimizing condition/capacity.

# States Have 3 Paths for Gaining Federal Approval to Implement Medicaid Managed Care

- **State Plan Amendment (known as “1932(a) SPA”): Exempts states from their state plan requirements for statewideness, comparability, and freedom of choice**
  - Allows for mandatory managed care, but *prohibits* moving children with special needs, dual eligibles, and Native Americans into MC
  - Does not have to demonstrate cost effectiveness or budget neutrality
  - Once approved, does not have to be renewed
- **Freedom of Choice Waivers (1915(b) Waivers): Allows states to waive their state plan requirements for statewideness, comparability, and freedom of choice**
  - All state plan populations can be placed in MC
  - Prohibits states from modifying cost sharing and benefits rules
  - Must demonstrate cost effectiveness: actual expenditures over the life of the waiver cannot be greater than the projected expenditures in the absence of the waiver
  - Approved for 2 years, although CMS can extend for up to 5 years
- **Demonstration Waivers (1115 Waivers): Grants states the same flexibility as 1915(b) waivers, but also allows them to waive other requirements for the purpose of testing innovative policies that further the objectives of Medicaid**
  - Often used as a vehicle to expand health coverage in a state
  - All state plan populations, as well as special populations, can be placed in MC
  - HHS Secretary can provide a federal match for services the state previously paid for entirely on its own
  - Must be budget neutral to the federal government
  - Initially approved for 5 years

# Special Populations

## *Issues to Consider - Benefit Packages (II)*

- ❖ Scope of coverage sufficient?
  - Rehabilitation and Habilitation
  - Home Health Care and Personal Care Assistance
  - DME and Medical Supplies
  - Transportation (non emergency)
  - EPSDT
  - Early Intervention
  
- ❖ Will contract include a description of differences between commercial coverage and Medicaid coverage?
  
- ❖ Will contract's definition of medical necessity include maintenance of function/prevention of deterioration of function?

# Special Populations

## *Issues to Consider – Benefit Packages (III)*

- ❖ **Mental Health and Addiction Services**
  - Trend towards carving out these services
  - Many people with disabilities have co-morbidities across physical/developmental/mental health/substance abuse
    - Coordination less likely to happen in carve out
    - Potential disagreement over who is responsible for what
  
- ❖ **Limited Mental Health/Substance Abuse benefit with FFS wrap option for those with more intensive needs.**
  - Fragmentation and lack of coordination still possible
  
- ❖ **Full Integration**
  - Multiple funding streams
  - Trend toward carve out
  - Little experience in doing both

# Special Populations

## *Issues to Consider - Benefit Packages (IV)*

### ❖ Long -Term Care

- Multiple funding streams/multiple entities
- Cost Shifting by different entities
- Consumer Choice/self direction vs. gatekeeping and care management

### ❖ Home and Community Based Care benefits important to consider:

- |                       |                      |                     |
|-----------------------|----------------------|---------------------|
| ○ Personal assistance | Adaptive technology  | Employment Supports |
| ○ Homemaker services  | Home modifications   | Respite             |
| ○ Adult foster care   | Private duty nursing |                     |
| ○ Adult day health    | Case management      |                     |

### ❖ Integration of care is ideal, however:

- Providers with acute care experience may not be experienced in LTC
- Acute care decisions = clinical. LTC decisions = not medical condition alone.
- Capitation rate setting difficult
- Managing variety of funding streams challenge

## Special Populations

### *Issues to Consider - Responsive Provider Networks (I)*

- ❖ Development of responsive provider network requires knowledge of service needs of population and analysis of those needs under existing FFS system, including needs/capacity of providers.
- ❖ Co-morbidities can lead to uncoordinated care. Lack of access to primary care may be an existing need.
- ❖ Are there PCP in network with experience treating people with complex medical needs? Do they have adequate space access, accommodating equipment, language capacity, to accommodate people with disabilities?

## Special Populations

### *Issues to Consider – Responsive Provider Networks (II)*

- ❖ Will state clarify role and responsibilities of PCP and specialists and teams? Will state dictate performance specifications for providers and specific types of care?
- ❖ Will state identify and develop quality indicators and outcomes that target needs of special needs populations?

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# Opportunities to Participate

## ❖ Regional Forums

- **9/13** Keene Public Library 2-4 pm
- **9/14** Nashua Community College 6-8pm
- **9/22** Somersworth Avis/Goodwin Ctr 10-12 am
- **9/23** Manchester Mental Health Dept 10-12 am
- **TBD** North Country Granite State Distance Learning Network

# Opportunities to Participate

## ❖ 11 Focus Groups

- 3 TANF
- 2 people with developmental disabilities
- 1 people with physical disabilities
- 3 seniors
- 2 people with substance abuse and mental health

# RECAP

- ❖ Every population (in Medicaid) is in;
- ❖ Whether and how specialty/long-term care benefits will be covered is \*the\* question;
- ❖ Medical Homes must be part of plan;
- ❖ Most states haven't put all special populations or Long Term Care services in capitated plans – but that is where the savings (and political pressure) are estimated to be;
- ❖ Assessment of costs/utilization/quality/fragmentation of care BEFORE contracts are done is vital; as is
- ❖ Stakeholder participation in RFP, contract development, and implementation;
- ❖ Special Populations, Special Populations, Special Populations



*economic opportunity, prosperity, and security for all New Hampshire residents*

11 Depot Street – 2<sup>nd</sup> Floor  
Concord, NH 03301  
603.856.8337  
[www.nhfpi.org](http://www.nhfpi.org)