NH Department of Health and Human Services

NH Oral Health Coalition Forum 2013
June 13, 2013
Topics

- NH Medicaid Care Management Program
- Affordable Care Act in New Hampshire
  - Medicaid Expansion
  - Primary Care Rate Enhancement
Care Management

Perspective
New Hampshire Medicaid

- Medicaid is a State/Federal partnership
  - Primary health insurance for low income and high need populations
  - Largest source of funding for safety net providers
  - 90-95% of funding for mental health and developmental disability services
  - Significant payer of Long Term Care (LTC) services for elderly
- In NH spends approximately $1.4B
  - Is second largest component of State budget
  - About $1B in provider payments
  - Largest segments include
    - Medical services
    - Mental health services
    - Long-term care services
    - Long-term supports and services
  - Serves approximately 10% of population
    - ~70% low income women and children
    - ~30% elderly, physical, developmental, mental disability
  - Payment strategy is primarily “fee for service”
  - Through ~12,000 enrolled providers
Challenges

- Medicaid as it is delivered today is unsustainable
  - Demographics: impacts of aging and the growth of population
  - Increasingly complex clients with multiple conditions
  - Increasingly constrained Federal and State financial resources
  - Increasing costs
    - Wide variation in cost and pricing for services with no clear relationship to quality
  - The prevalent way to pay for services, “fee for service” has some inherent weaknesses

- Options
  - Do nothing, which has significant consequences given no additional resources
  - Augment the current model with substantial additional financial resources
  - Change the business model
    - Care Management or Managed Care provides the framework to change
Managed care is an **approach to delivering and financing health care** that is aimed at both **improving the quality of care and saving costs**.

The fundamental approach is to **improve access to care and coordination of care** by assuring that enrollees have a **“medical home”** with a primary care provider (PCP), and to rely more heavily on preventive and primary care.

As distinct from the fee-for-service system, in which individual providers are paid for each service they furnish.

Payment based on **a fixed monthly “capitation” rate for each enrollee** to provide all or a defined set of Medicaid-covered services specific to enrollee need.
What is Managed Care?

- This payment arrangement **provides different financial incentives** to providers, and ideally, **supports an approach to practice that emphasizes early identification and treatment** of health problems and coordinated management of patients’ conditions.
  - Reforming **HOW** services are paid for is central to Managed Care
  - Capitation also **gives states more cost predictability** and control, and contracts with managed care plans offer states a mechanism, through quality measurement and improvement requirements, for holding plans accountable for the quality of care they provide to Medicaid enrollees.
Care Management

Program
Program Goals

New Hampshire Care Management Program

- Improve beneficiary health
- Reimburse based upon outcomes
- Support continuity of care
- Ensure access to primary care & prevention
- Achieve savings of $16M in General Fund
- Prepare for 2014 Medicaid expansion
- Comply with federal & state law
- Improve budget predictability
- Promote shared decision-making
What this change means for clients?

**Fee for Service**
- Client not required to have a PCP
- Services, especially PC, provided as discrete encounters
- Services not managed or coordinated to address individual diagnoses=silos
- Services accessed through any willing provider regardless of setting
- Medical services paid per unit of service
- No single point of responsibility for case management
- Navigation of the health system left to consumer
- Leads to potential for duplication, redundancy and use of ER as PC site

**Care Management**
- Whole person approach
- MCOs paid to manage all health care, emphasis on prevention
- Patient Centered Medical Home serves as the hub and includes
  - Setting to facilitate partnership between PCP and client
  - PCP, Physician directed, integration, quality, CPI, IT enabled
- Complex cases addressed holistically through care coordination
- Consumer partners with PCP to navigate the health system
Managed Care
Increasing Efficiency

- Focus on **improving health**, not just health care
- Increase timely access to **primary care**
- Implement **single point of accountability** for care coordination
- Better **manage transitions** between sites of care
- **Reduce avoidable hospital admissions and readmissions**
- **Reduce emergency department** use for primary care
- Improve compliance with recommended care
- **Reduce duplication of tests**
- Greater integration of public health and prevention
Program Design

- A three-step approach to Care Management program
  - Two key variables: populations and covered services

- Step 1:
  - Children and pregnant women
  - Children’s Health Insurance Program
  - Includes primary care oral health assessment & fluoride varnish requirement
  - Those eligible for Medicaid and Medicare (referred to as duals), foster children, and those who qualify for home care for children with disabilities with a temporary opt out provision

- Step 2: One year post go live Step 1
  - Services for those with developmental disabilities, acquired brain disorders, elderly and physically disabled (known as waivered services) and the “opt-out” populations

- Step 3: January 1, 2014
  - Medicaid expansion population: childless adults up to 138% of federal poverty level
Program Features

- Patient Centered Medical Home Support
- Care Coordination
  - Primary care, specialty care, transportation and other covered services
- Chronic Disease Management
- Special Needs Program
  - For high cost/high risk members with complex issues
- Wellness and Prevention Programs
- Quality Assessment and Performance Improvement Program
- Quality Incentives
- Payment Reform
Protections for Consumers

- **Medical Homes** Required for All Clients
- Specific Access Standards and **Measures**
- Transitions & **Continuity** of Care
- Quality **Incentives**: 1% of capitation payment withhold that is earned by meeting performance measures.
  - Including Getting Needed Care Composite Measure (member satisfaction survey)
- Member Rights
- Grievance & Appeals Process
- Member Advisory Boards
Protections for Providers

- No exclusive contracting requirements permitted
- Provider Advisory Boards
- Provider Inquiry Line
- Provider Satisfaction Survey
- Network and credentialing Standards per NH Insurance Department
- MCO cannot discriminate against providers serving high risk populations or specializing in conditions requiring high cost treatment
Protections for State

- Budget predictability
- Full Risk Capitated Rate
- Insurance Licensure
- Program Management Plan
- Program Implementation Plan
- Readiness Reviews
- External Quality Review Organization
- Liquidated Damages/Penalties
Status of Program Implementation

- 3 MCOs under contract.
- Year 2 amendment and rates underway
- Delay due to inability to establish provider network
  - Seeing significant movement from hospitals in past 2 weeks
- Once two MCOs confirmed to reach substantial network development – start the clock and work plan kicks in.
  - Client & Provider outreach & education
  - Enrollment
  - Program Go-live 120 – 150 days after clock starts
Affordable Care Act

- Medicaid Expansion
  - Step 3 of Care Management program
    - Will come on line before Step 2
  - Bring on line after Care Management Program go live
  - Currently significant issue with SFY 14 and SFY 15 budget
Medicaid Expansion

- ACA provides:
  - Coverage for 19-64 yr. old up to 138% FPL
  - 100% FMAP for 3 years then decrease over next 4 years to 90% match

- NH’s anticipates:
  - 44,000 – 60,000 newly covered lives (average over 7 years = 58,000)
  - Significant reduction in uncompensated care
    - Hospitals, FQHCs, CMHCs and all other providers

- Adds $2.5 billion to NH economy
Key Components

- Streamlined coordination of real-time eligibility determination by Medicaid and Federal Facilitated Exchange ("Marketplace")
- Essential Health Benefits for newly eligibles
  - NH Medicaid assessing changes to current Medicaid benefit in area of mental health parity and substance use disorder
- Missed opportunity for CMS to mandate adult dental benefit
Status of Expansion in NH

- Included in Governor’s and House approved SFY ‘14 & ‘15 budgets
- Not included in Senate budget
- Sure to be prominent issue in Committee of Conference hearings
  - Question whether Governor needs legislative approval to move ahead