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

What is Managed Care?

- 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.

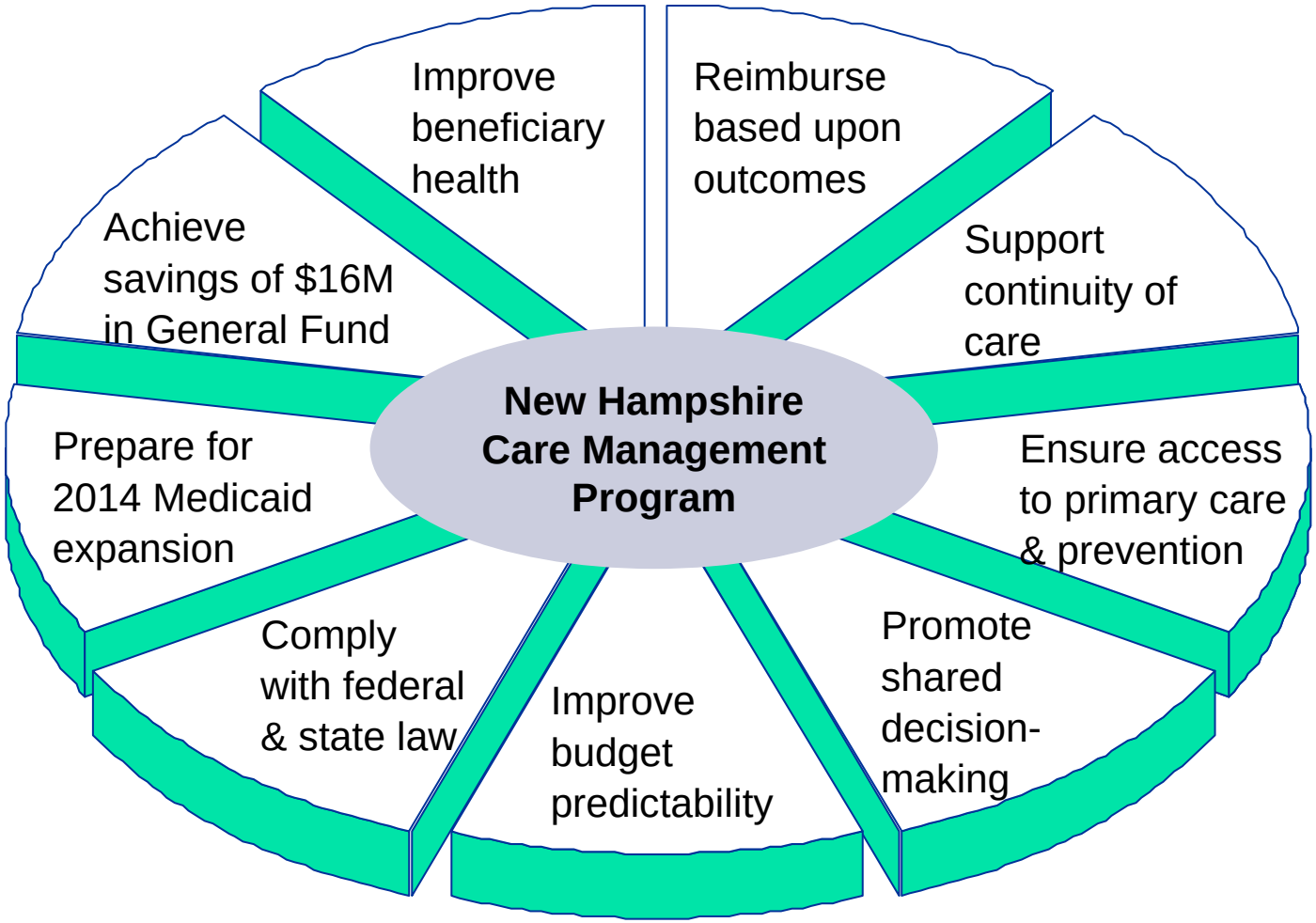
What is Managed Care?

- 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



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