



MCM Commission

Nick Toumpas

**NH Department of Health
and Human Services**



January 8, 2015

Legislative Office Building

Agenda

- Monthly Enrollment Update
 - MCM Step 1
 - NH HPP
- Key Program Indicator Report Update
- Step 2 Update
- Q&A from Commission and Public

Setting the Context

Care Management Program

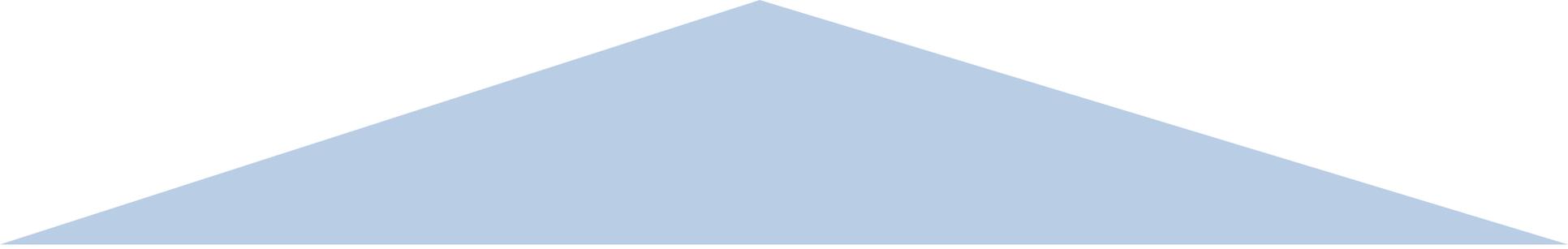
December 1, 2013 – January 8, 2015

@ 13 Months



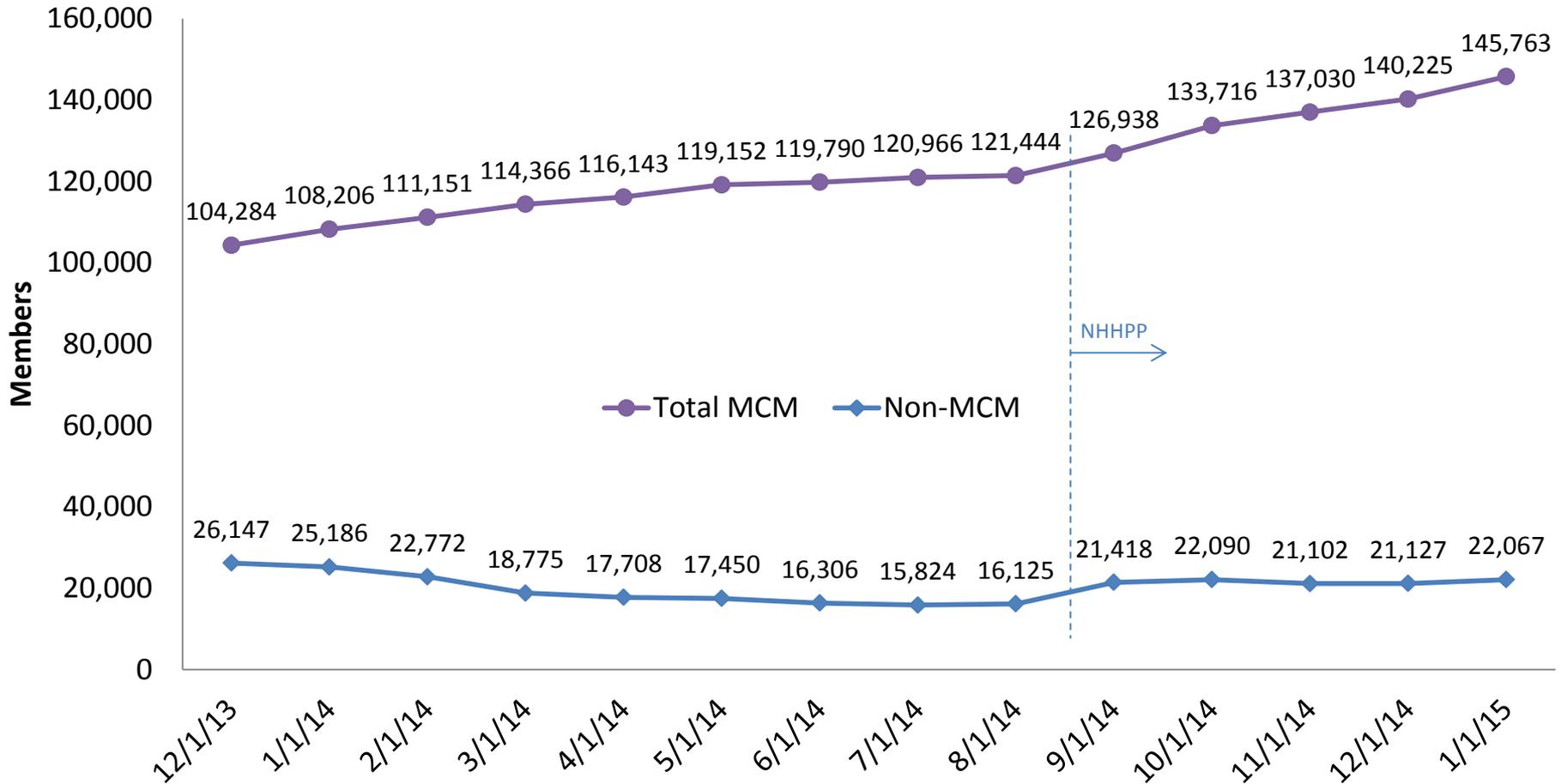
Guiding Principles of NH MCM

- Whole person management and care coordination
 - Foundation for Medicaid transformation
- Increase quality of care – right care, at the right time, in the right place to improve beneficiary health and quality of life
- Payment reform opportunities
- Budget predictability
- Purchasing for results and delivery system integration



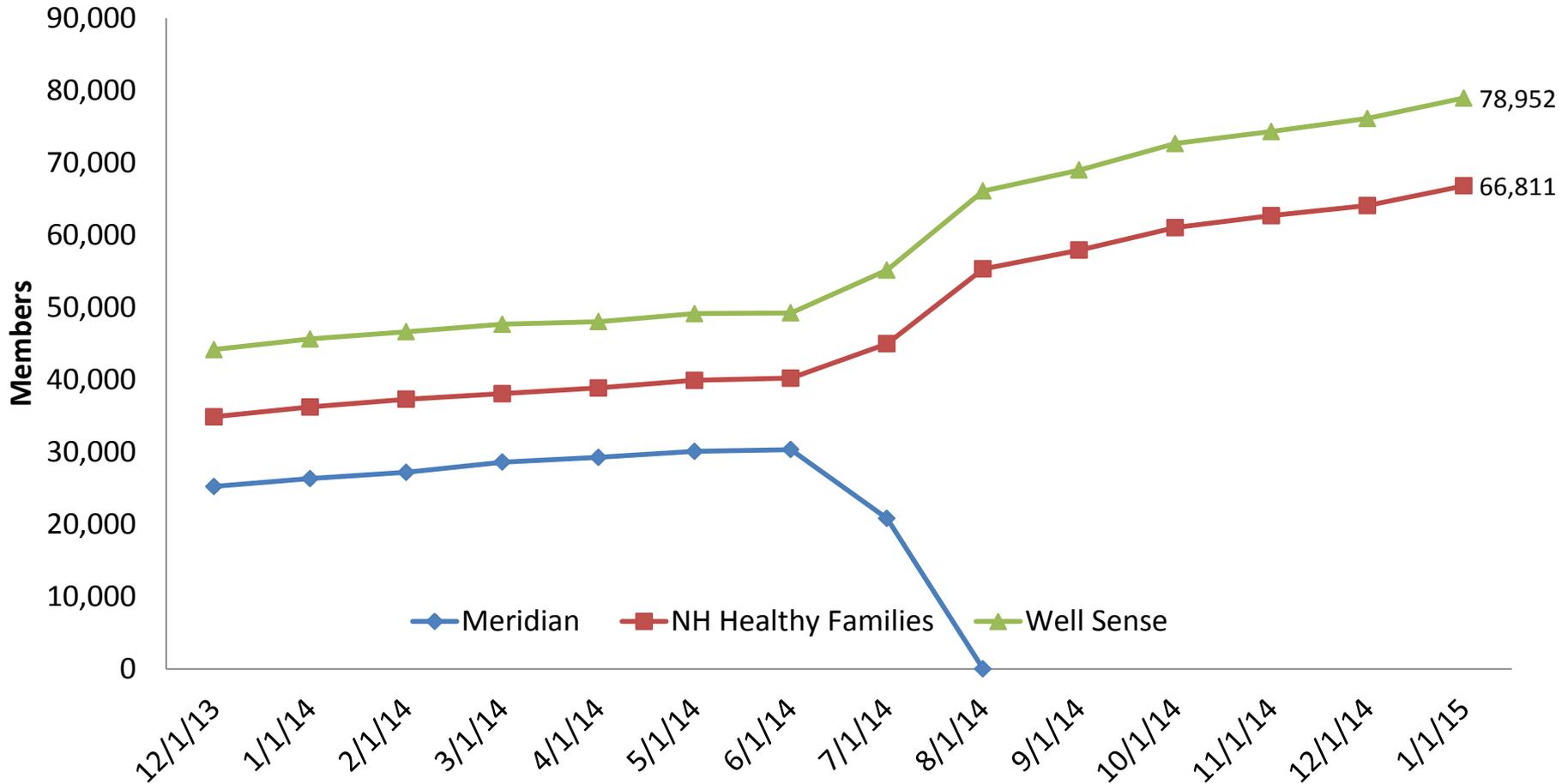
MCM Monthly Enrollment Update

NH Medicaid Care Management Enrollment, 12/1/13 – 1/1/15



Note: Non-MCM Includes retroactive enrollment and excludes members who only have Medicare savings plans (e.g., QMB)

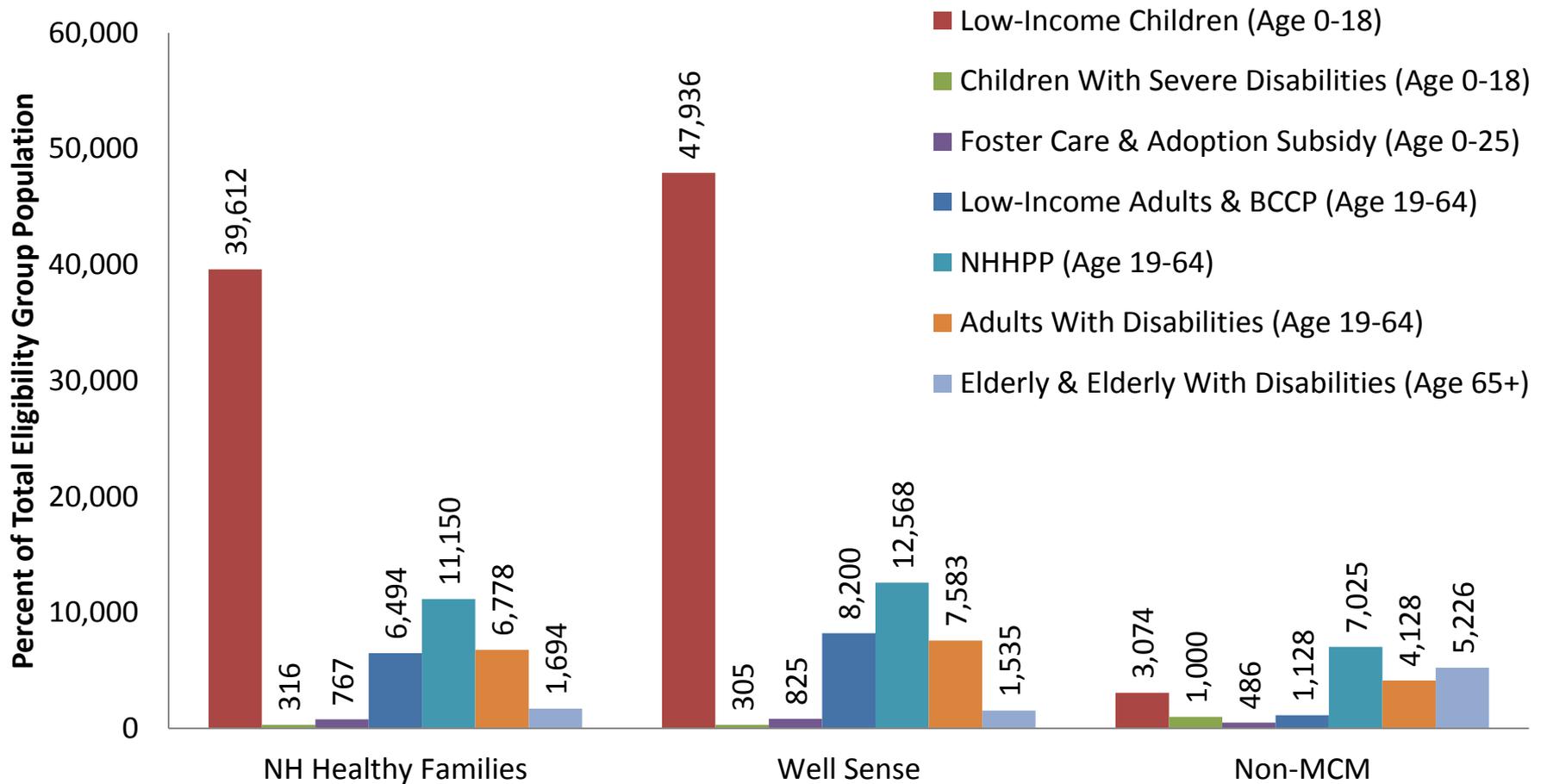
NH Medicaid Care Management Enrollment by Plan, 12/1/13 – 1/1/15



Note: Non-MCM Includes retroactive enrollment and excludes members who only have Medicare savings plans (e.g., QMB)

Source: NH MMIS as of 1/2/15 for most current period; Data subject to revision.

NH Medicaid Care Management by Eligibility Group, 1/1/15

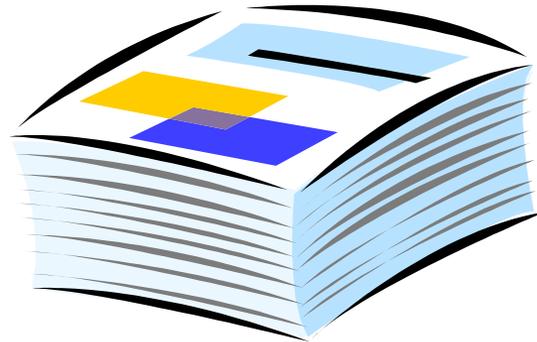


NH HPP Update

As of 1/6/2015

- Total Recipients
 - 30,419
 - Over 14,609 are new to DHHS
 - Over 7,882 are new to NH HPP but have been clients in the past
- Benefit Plans
 - 28,369 are in the ABP (Alternative Benefit Plan)
 - 1,691 of Medically Frail are in the ABP
 - 359 of Medically Frail in standard Medicaid
- Care Management / HIPP
 - 105 Enrolled in HIPP
 - 589 are Potential HIPP
- Bridge
 - 12,801 are enrolled in WSHP
 - 11,357 are enrolled in NHHF
 - 5,567 are in Fee For Service/not yet enrolled in a plan

Key Performance Indicator Report



MCM Key Indicators

Metrics in the Key Indicators Report include:

- Access & Use of Care
- Customer Experience of Care
- Provider Service Experience
- Utilization Management
- Grievance & Appeals
- Preventative Care
- Chronic Medical Care
- Behavioral Health Care
- Substance Use Disorder Care
- General

Notable Results Summary 1

- Provider clean claims are being processed close to MCM contract standards for timeliness. A slight downward trend from September can be attributed to recent staff turnover at one MCO. In addition to replacing staff, the MCO is supporting providers in the transition from paper to electronic billing, as paper claims have longer processing timeframes. (Figure 3-1)
 - Well Sense was the MCO identified above
 - November data shows this measure within contract standards.
- Provider calls are being handled quickly when compared to contract standards for member call centers. There is a slight upward trend in abandoned provider calls. The Department will monitor this trend. (Figure 3-5 and 3-6)
- Data Notes:
 - One MCO has incorrectly reported provider call center data from their transportation vendor. After this data has been corrected, transportation call center data will be added back to this measure. (Figure 3-5 and 3-6)

Notable Results Summary 2

- Urgent, routine and pharmacy service authorizations are being processed very close to MCM contract standards for timeliness. The Department will continue to monitor this indicator. (Figures 4-1, 4-2 and 4-3)
- The service authorization denial rate has remained consistent in 2014 Q3 with Q2, while the quarterly member enrollment has increased. In addition, requests in Q3 have shown significant increases for the following services: out-of-network inpatient admissions, wheel-chair van, medical supplies, and imaging services. The Department will be monitoring and discussing the increase in requests with the MCOs.(Figure 4-4)
- Generic drug substitution rate continues to be very high and could contribute to program cost containment. (Figure 4-5)

Figure 4-4: Service Authorization Requests and Benefit Decisions by Type of Service

	2014 Q1			2014 Q2			2014 Q3		
Average Membership	111,241			118,362			123,116		
	<i>Requested</i>	<i>Denied</i>	<i>% Denial</i>	<i>Requested</i>	<i>Denied</i>	<i>% Denial</i>	<i>Requested</i>	<i>Denied</i>	<i>% Denial</i>
All Services	24,063	3,296	14%	29,463	5,194	18%	33,174	5,815	18%
Service Category	<i>Requested</i>	<i>Denied</i>	<i>% Denial</i>	<i>Requested</i>	<i>Denied</i>	<i>% Denial</i>	<i>Requested</i>	<i>Denied</i>	<i>% Denial</i>
In-Network Inpatient Admissions Non-Surgical	1,945	37	2%	2,806	36	1%	3,117	28	1%
In-Network Inpatient Admissions Surgical	214	2	1%	187	11	6%	194	3	2%
Out-of-Network Inpatient Admissions	344	14	4%	213	3	1%	361	33	9%
Outpatient Surgeries	1,202	77	6%	817	63	8%	473	77	16%
Community Mental Health Center	84	10	12%	191	10	5%	116	7	6%
Physician/Medical Services	2,492	143	6%	2,643	230	9%	3,317	364	11%
Psychology	278	13	5%	303	16	5%	361	7	2%
PT/OT/ST	2,120	143	7%	2,472	170	7%	3,422	189	6%
Wheelchair Van	497	16	3%	710	17	2%	1,652	11	1%
Pharmacy	8,734	2,417	28%	12,766	4,163	33%	11,072	4,360	39%
Private Duty Nursing	307	0	0%	279	1	0%	386	0	0%
Medical Supplies	1,381	55	4%	1,063	27	3%	1,592	19	1%
DME Pediatric and Adults	1,514	171	11%	1,318	38	3%	1,588	80	5%
Imaging Studies	1,794	94	5%	1,887	99	5%	3,792	372	10%
Other	909	99	11%	1,472	302	21%	1,393	255	18%

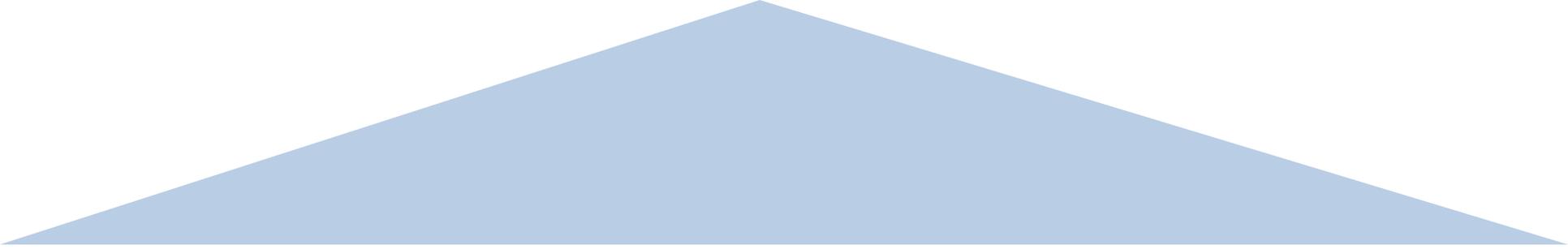
Omits services with < 100 requests in the most recent quarter (Psychology, License Nurse Attendant, Vision, Podiatry, Audiology, Transplant)
 Note: Data has changed due to resubmitted data.

Notable Results Summary 3

- The number of grievances has decreased. (Figure 5-1)
- The total number of appeals has decreased, primarily due to a decrease in pharmacy appeals. There has been an increase in the number of physician services appeals. The Department will monitor this trend. (Figure 5-2)
- Grievances and appeals (standard and expedited) are being resolved within MCM contract standards. (Figures 5-3 through 5-5)
- There were no Fair Hearings for 2014 Q3. (Figure 5-6)

Notable Results Summary 4

- Maintenance medication gaps are falling indicating a smaller number of prescriptions with long gaps between refills. Taking medications regularly by ensuring their availability should contribute to better chronic disease management. (Figure 6-2)



Step 2 Update

Concepts
Timeline

Key Changes

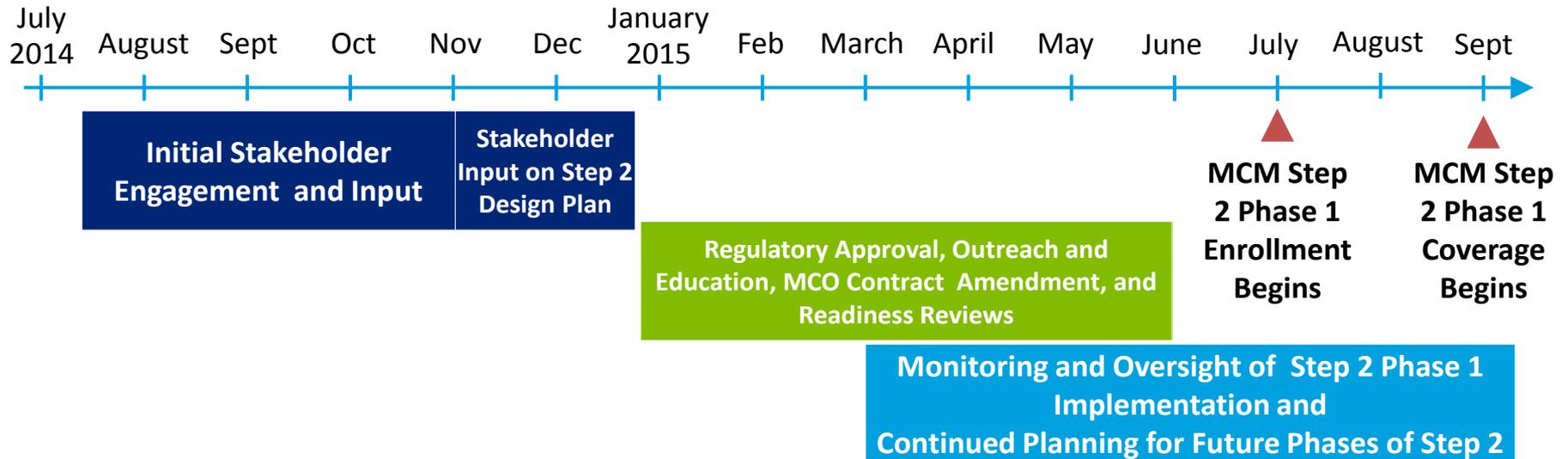
- Phase I and Phase II, Mandatory Enrollment and the integration of Choices for Independence Waiver and Nursing Facility services into Medicaid Care Management, have been combined.
- Step 2 will still be phased in.
- Design considerations of managed long term services and supports, including provider contracting and payment, will evolve over time.



Revised Step 2 Timeline

- Earlier Timeline
 - Phase 1 Mandatory Populations by January 1, 2015
 - Phase 2 Choices For Independence (CFI) and Nursing Facility Services (NF) by April 1, 2015
 - Phase 3 Developmental Disabilities, Acquired Brain Disorder and In Home Support waivers will be implemented at a date to be determined.
- New Timeline
 - Phase 1 and Phase 2 combined
 - Enrollment begins July 1, 2015
 - Services begin September 1, 2015

Timeline

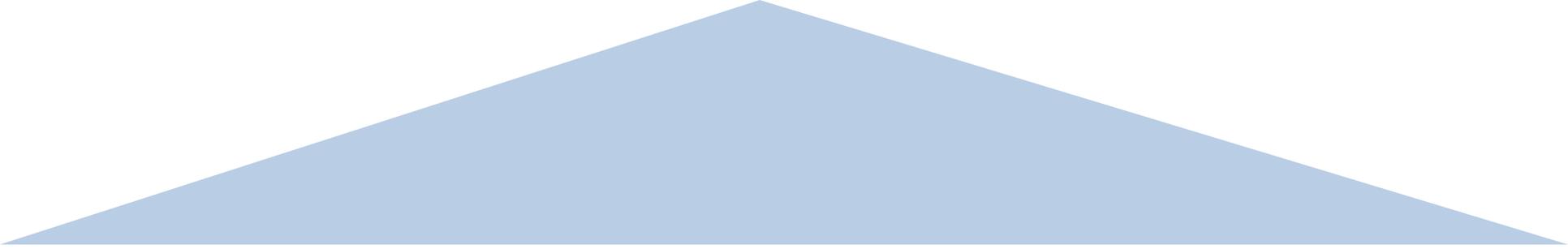


- **Stakeholder Input Process: July to December 2014**

- Initial Stakeholder Engagement and Input completed in October 2014
- Additional forums were held to elicit stakeholder feedback on the Step 2 Design Considerations in November and December of 2014

- **Step 2 Phase 1:**

- On **July 1, 2015**, require all populations to enroll with a health plan for their medical services, Choices for Independence Waiver and Nursing Facility services
- On **September 1, 2015**, coverage with the health plan begins for medical services, Choices for Independence Waiver and Nursing Facility services



Questions?