

MCM Commission

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**NH Department of Health
and Human Services**



February 12, 2015

ATECH Services

Agenda

- Monthly Enrollment Update
 - MCM Step 1
 - NH HPP
- Waiver Updates
 - Premium Assistance Waiver
 - Transformation Waiver
- Key Program Indicator Report Update
- Step 2 Update
 - Phases and Timeline
 - Next Steps
- Q&A from Commission and Public

Setting the Context

Care Management Program

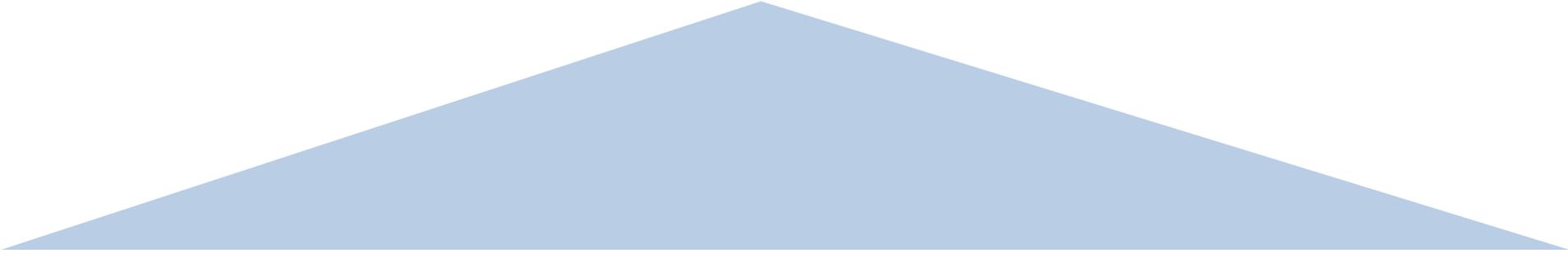
December 1, 2013 – February 12, 2015

@ 14 Months



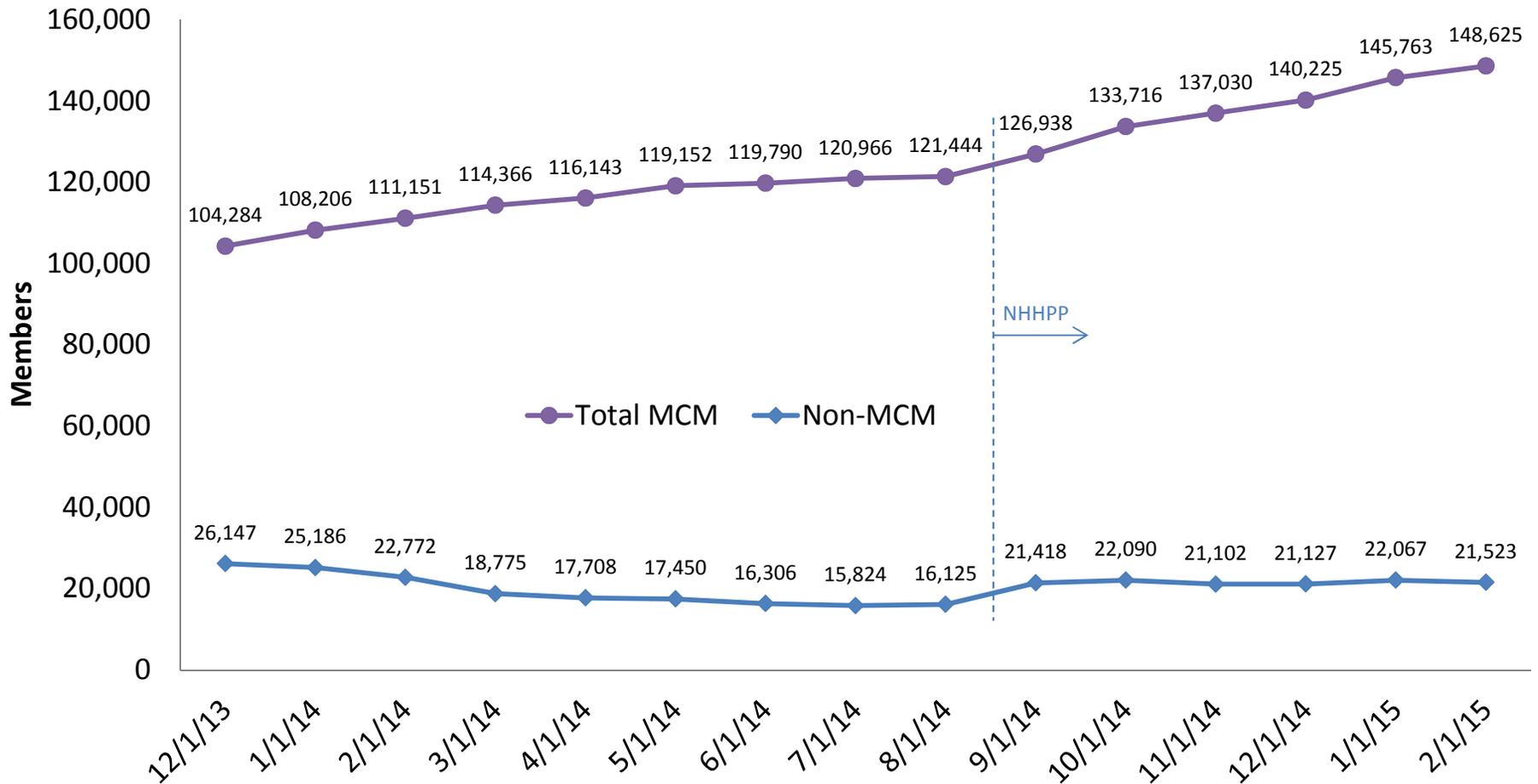
Guiding Principles of NH MCM

- 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



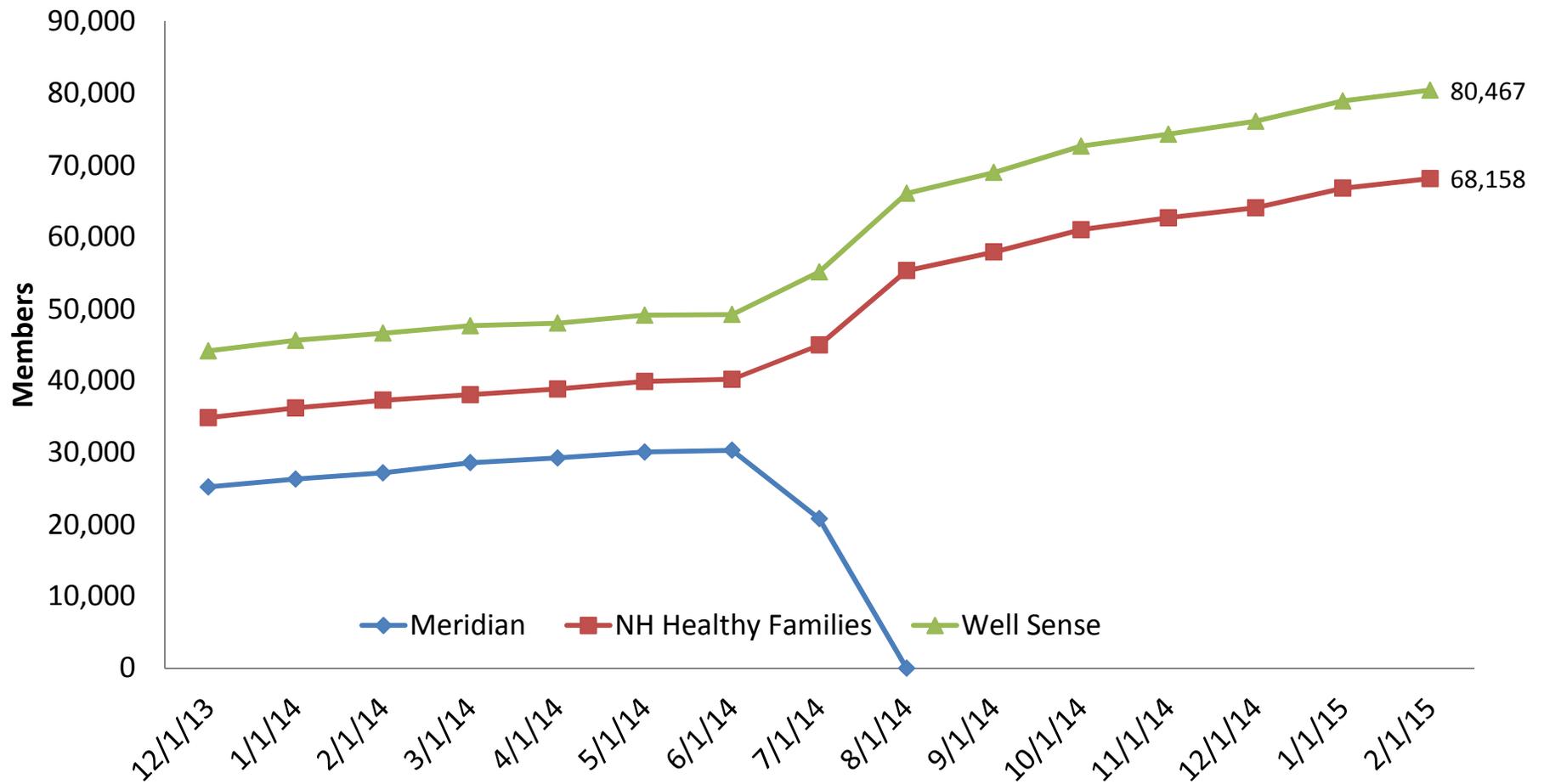
MCM Monthly Enrollment Update

NH Medicaid Care Management Enrollment, 12/1/13 – 2/1/15



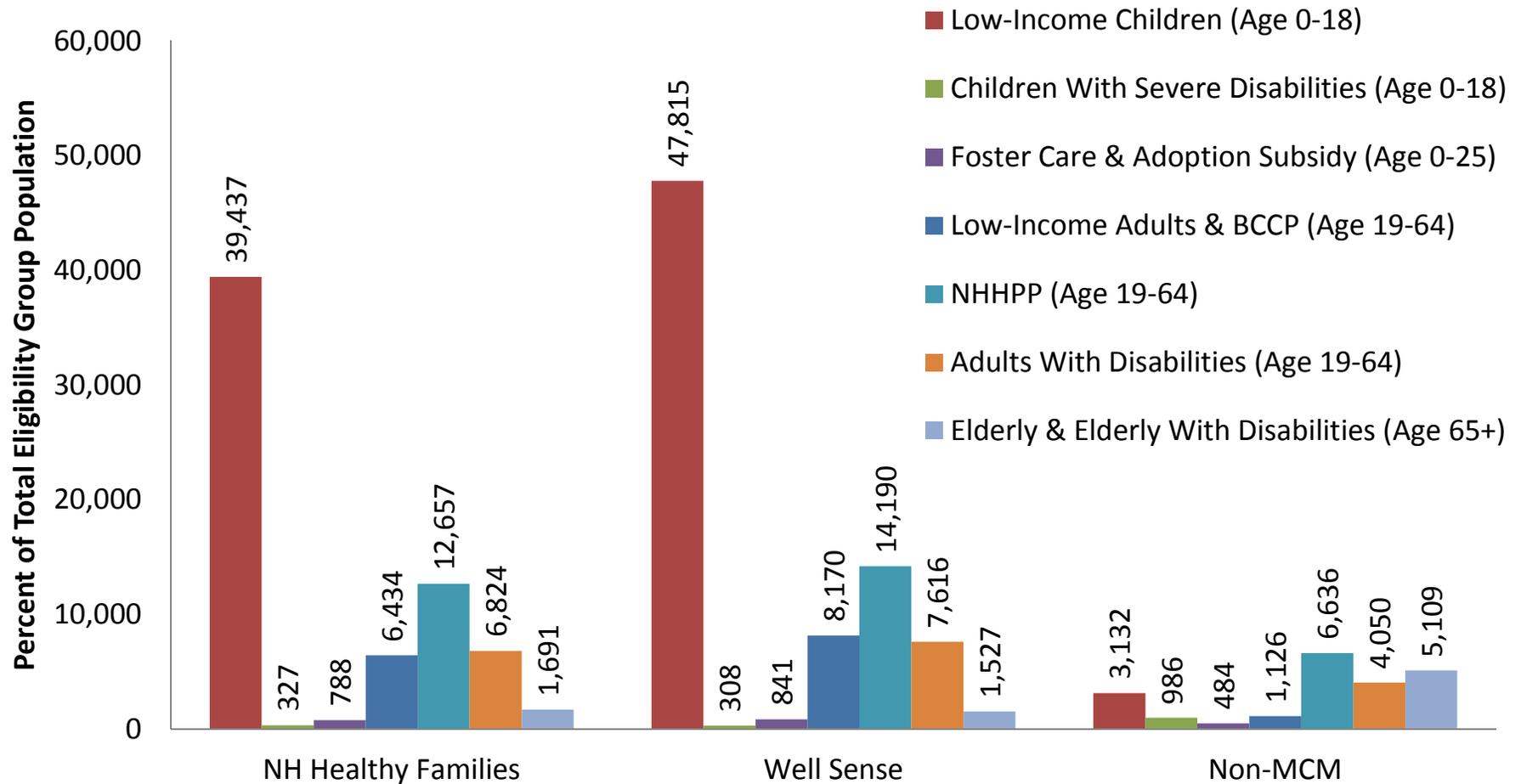
Note: Non-MCM Includes retroactive enrollment and excludes members who only have Medicare savings plans (e.g., QMB)

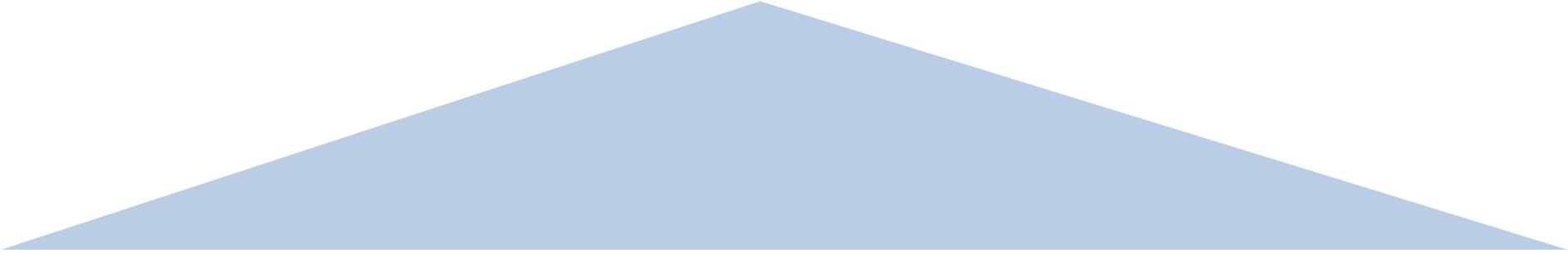
NH Medicaid Care Management Enrollment by Plan, 12/1/13 – 2/1/15



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

NH Medicaid Care Management by Eligibility Group, 2/1/15





NH Health Protection Program & Other Updates

NH HPP Update

As of 2/11/2015

- Total Recipients
 - 33,860
 - Over 16,611 are new to DHHS
 - Over 8,933 are new to NH HPP but have been clients in the past
- Benefit Plans
 - 31,658 are in the ABP (Alternative Benefit Plan)
 - 1,840 of Medically Frail are in the ABP
 - 362 of Medically Frail in standard Medicaid
- Care Management / HIPP
 - 138 Enrolled in HIPP
 - 443 are Potential HIPP
- Bridge
 - 14,750 are enrolled in WSHP
 - 13,117 are enrolled in NHHF
 - 5,412 are in Fee For Service/not yet enrolled in a plan

Premium Assistance Waiver Update

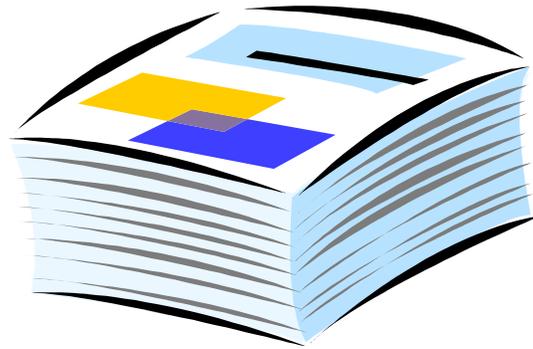
- Third phase of NHHPP program is Premium Assistance Program
 - Transition population from managed care coverage to Qualified Health Plans on FFM beginning on January 1, 2016 (per SB 413)
 - Final waiver application submitted and approved by Legislative Fiscal Committee on 11/10/14
 - Waiver submitted to CMS on 11/20/14
 - <http://www.dhhs.nh.gov/pap-1115-waiver/>
 - Waiver **must be approved by CMS by 3/31/15** for program to continue
 - **DHHS has had continuous communication with CMS and expects to get approval by the deadline**

1115 Waiver

Building Capacity for Transformation

- Waiver application was submitted to CMS at the end of May 2014
- CMS provided feedback and urged New Hampshire to amend the application to focus on Behavioral Health
- Public Session was on Friday, December 19th
- DHHS has briefed both House and Senate
- Waiver amendment will be submitted to CMS next week

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

- MCO provider networks are meeting network adequacy standards. (Figure 1-2)
Requests for **transportation** approved and delivered are falling. The Department is **following this trend and collecting data on the reasons that transportation was not delivered.** (Figure 1-4)
- **Emergency department visits**, emergency department visits potentially treatable in primary care and inpatient hospitalization for maternity, medical and surgical care are **lower** in the MCM program than either NH Medicaid pre-MCM or New England and national Medicaid managed care rates. (Figures 1-6, 1-7 and 1-8)
- **Inpatient Hospital Utilization** for Ambulatory Care Sensitive Conditions for Adult Medicaid Members is **slightly higher** than the NH Medicaid pre-MCM rate. The Department will follow this trend. (Figure 1-9)

Notable Results Summary 2

- Member calls are being answered quickly and within MCM contract standards. Calls are being answered within 30 seconds more frequently in the MCM program than the New England and national averages. (Figure 2-1 and 2-2)
- Member ratings of their health plans for both adults and children are lower than the New England and national averages. (Figure 2-6)
- Member ratings of personal doctor's communication in for adult ratings were equivalent to the NH pre-MCM, New England and national averages. Children ratings were equivalent to the NH pre-MCM average and higher than the national average. (Figure 2-10)
- Member ratings of shared decision making, specifically for medications, are low for all populations including the MCM program, Medicaid pre-MCM and both the New England and national averages. (Figure 2-11)
- Adult ratings for care coordination by a personal doctor are equivalent to NH Medicaid pre-MCM and both New England and national averages. Children ratings are equivalent to NH Medicaid pre-MCM and higher than the national average. (Figure 2-12)

Notable Results Summary 3

- Provider clean claims are being processed within MCM contract standards for timeliness. (Figures 3-1, 3-2, 3-3 and 3-4)
- Provider calls are being handled more quickly than the contract standards for member call centers. (Figure 3-5 and 3-6)

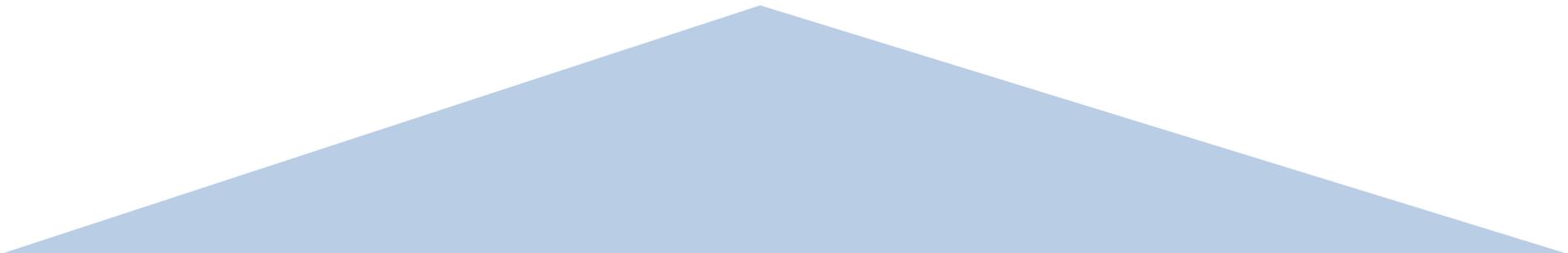
Notable Results Summary 4

- 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)
- Out-of-network inpatient admissions and imaging studies denials are increasing. Pharmacy service denials are increasing. The Department is following these trends and collecting additional data on the reasons for pharmacy denials. (Figure 4-4)
- Generic drug substitution rate is higher than in the Medicaid pre-MCM rate. (Figure 4-5)

Service Authorizations Summary

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		
	Requested	Denied	% Denial	Requested	Denied	% Denial	Requested	Denied	% Denial
All Services	24,063	3,296	14%	29,463	5,194	18%	33,174	5,815	18%
Service Category	Requested	Denied	% Denial	Requested	Denied	% Denial	Requested	Denied	% Denial
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%



Step 2 Update

Concepts
Timeline

Reasons and Benefits of Step 2 Timeline Adjustments

- Department considered feedback for forums
- Align with the Federal Marketplace events, reducing confusion for Medicaid clients moving into Premium Assistance Program
- Eliminates duplication in IT Systems file transfers and testing when working with marketplace Qualified Health Plans
- Provide additional time for LTC providers to prepare for doing business with MCOs

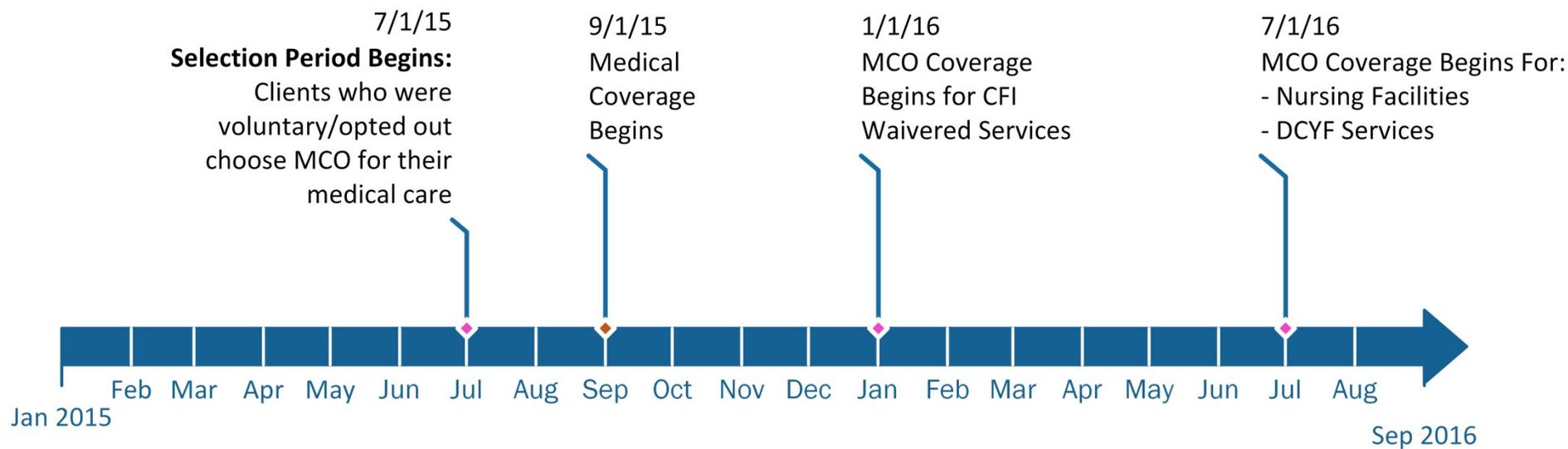
Updated Step 2 Timeline

- Step 2 will still be phased in
 - **Mandatory Populations:**
 - Enrollment begins 7/1/15,
 - 9/1/15 Medical coverage begins for clients who select MCO by 8/31/15
 - Clients that were voluntary/opted out that do not choose an MCO will auto enrolled in early September for 10/1/15 coverage date.
 - **CFI waived Services : Coverage begins in 1/1/16**
 - CFI waiver approval is required. Work to evaluate this waiver along with the 3 DD waivers will streamline the approval process with the Federal government

Updated Step 2 Timeline (cont.)

- **Nursing Facility:**
 - Provides additional time for State to work with the county and private nursing home associations to prepare for the transition
 - Integration of per diem, pro share, and MQIP rates will occur prior to MCM integration, so that State and NF have the opportunity to make that adjustment prior to MCM integration
- **Waivered Services for Developmental Disabilities, Acquired Brain Disorder, In Home Supports:**
 - Department is reviewing written feedback from several organizations and will determine a date for integration of these services in the next month

Medicaid Care Management Step 2 Phase 1 Timeline



Date To Be Determined:
 MCO Coverage for Waivered Services

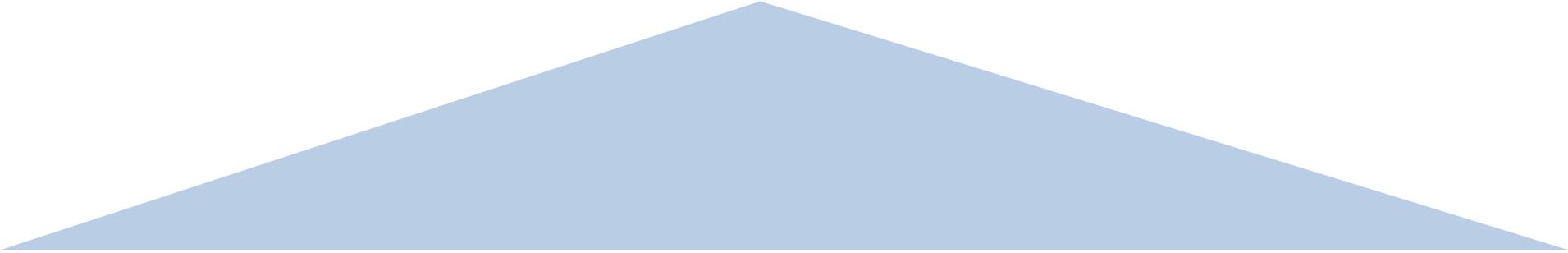
- Development Disabilities
- Acquired Brain Disorder
- In Home Supports

MCM Commission Step 2 Principles

- The Department has reviewed the vision, principles, and guidance recommended by the MCM Commission for implementing a Managed Long Term Services and Supports Program (MLTSS): Promoting Health, Wellness, Independence, and Self-Sufficiency.
- In response, the Department conducted a crosswalk of its actions taken and/or planned for Step 2 to each of the MCM Commission's recommended principles and principle implementation guidance.
- This crosswalk will evolve over time and be shared publically as the Department plans for and implements Step 2.
- Department is reviewing additional written feedback from the Quality Council, the Nursing Homes and other stakeholders.

Next Steps

- Public Hearing/Public Comments
- Working with key stakeholder groups
- Third Round Stakeholder Forums
- Development of Waiver(s) and public process
- Organization Readiness
 - Systems modifications
 - Rate development
 - Contract modifications
- Weekly Meeting with MCOs



Questions?