Bill as Introduced

03/16/11 0790s
03/23/11 1019s

2011 SESSION

11-0215
01/10

SENATE BILL *147-FN*

AN ACT relative to Medicaid managed care.

SPONSORS: Sen. Bradley, Dist 3; Sen. De Blois, Dist 18; Sen. Forrester, Dist 2; Sen. Forsythe, Dist 4; Sen. Gallus, Dist 1; Sen. Groen, Dist 6; Sen. Lambert, Dist 13; Sen. Luther, Dist 12; Sen. Morse, Dist 22; Sen. Odell, Dist 8; Sen. Sanborn, Dist 7; Sen. White, Dist 9; Sen. Barnes, Jr., Dist 17; Sen. Boutin, Dist 16; Sen. Carson, Dist 14

COMMITTEE: Health and Human Services

AMENDED ANALYSIS

This bill requires the commissioner of the department of health and human services to issue a 5-year request for proposal to enter into a contract with a vendor or vendors of a managed care model after consultation with the oversight committee on health and human services to provide for managed care services to the Medicaid population. The commissioner, in consultation with the fiscal committee of the general court, is granted rulemaking authority for the purposes of this bill.

- -

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Eleven

AN ACT relative to Medicaid managed care.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Paragraph; Medicaid Managed Care. Amend RSA 126-A:5 by inserting after paragraph XVIII the following new paragraph:

XIX.(a) The commissioner shall employ a managed care model for administering the Medicaid program and its enrollees to provide for managed care services for all Medicaid populations throughout as much of New Hampshire as practicable consistent with the provisions of 42 U.S.C. 1396r-2. Models for managed care may include, but not be limited to, a traditional capitated managed care organization contract, an administrative services organization, an accountable care organization, or a 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 other externally administered models. The department shall present the opportunities of the various models or combination of models to the oversight committee on health and human services with a recommendation for the best managed care model for New Hampshire, no later than June 15, 2011. Services to be managed within the model shall include all mandatory Medicaid covered services and may include, but shall not be limited to, care coordination, utilization management, disease management, pharmacy benefit management, provider network management, quality management, and customer services. The model shall not include mandatory dental services. After consultation with the oversight committee, the commissioner shall issue a 5-year request for proposals to enter into a contract with the vendor or vendors that demonstrates the greatest ability to satisfy the state's need for value, quality, efficiency, innovation and savings. The request for proposals shall be released no later than October 1, 2011. The vendor or vendors of the managed care model or combination of models demonstrating the greatest ability to satisfy the state's need for value, quality, efficiency, innovation, and savings shall be selected no later than December 1, 2011 with a final contract submitted to the governor and council as soon as practicable thereafter. After the bidding process, the commissioner shall establish a capitated rate based on the bids by the appropriate model for the contract that is full risk to the provider. The capitated rate shall be broken down into rate cells for each population including, but not limited to, the persons eligible for temporary assistance to needy families (TANF), aid for the permanently and totally disabled (APTD), breast and cervical cancer program (BCCP), home care for children with severe disabilities (HC-CSD), and those residing in nursing facilities. The capitated rate shall be approved

by the fiscal committee of the general court. The managed care model or models' selected vendor or vendors providing the Medicaid services shall establish medical homes and all Medicaid recipients shall receive their care through a medical home. In contracting for a managed care model and the various rate cells, 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. The target date for implementation of the contract is July 1, 2012. The commissioner may, in consultation with the fiscal committee, adopt rules, if necessary, to implement the provisions of this paragraph. The department shall seek all necessary and appropriate waivers to implement the provisions of this paragraph.

(b) The department shall ensure that all eligible Medicaid members are enrolled in the managed care model under contract with the department no later than 12 months after the contract is awarded to the vendor or vendors of the managed care model.

(c) For the purposes of this paragraph:

(1) An "accountable care organization" means an entity or group which accepts responsibility for the cost and quality of care delivered to Medicaid patients cared for by its clinicians.

(2) "An administrative services organization" means an entity that contracts as an insurance company with a self-funded plan but where the insurance company performs administrative services only and the self-funded entity assumes all risk.

(3) A "managed care organization" means an entity that is authorized by law to provide covered health services on a capitated risk basis and arranges for the provision of medical assistance services and supplies and coordinates the care of Medicaid recipients residing in all areas of the state, including the elderly, those meeting federal supplemental security income and state standards for disability, and those who are also currently enrolled in Medicare. After the first 5 years, a "managed care organization" may include the department of health and human services, with the approval of the fiscal committee.

(4) "A primary care case management" means a system under which a primary care case management contracts with the state to furnish case management services, which include the location, coordination and monitoring of primary health care services, to Medicaid recipients.

2 Effective Date. This act shall take effect upon its passage.

LBAO
11-0215
01/25/11

SB 147-FN - FISCAL NOTE

AN ACT relative to Medicaid managed care.

FISCAL IMPACT:

The Department of Health and Human Services states this bill will have an indeterminable impact on state revenue and expenditures, and county expenditures in FY 2013 and in each year thereafter. There will be no fiscal impact on county and local revenues or local expenditures.

METHODOLOGY:

The Department of Health and Human Services states that, given the complexity and number of unknown variables, it is not able to determine the fiscal impact of this bill at this time. The Department stated that potential savings may be identified once a formal Request for Proposals is released, and the responses are received and evaluated.

The Department provided the following information:

- In 2009, a leading health care actuarial firm, Milliman, Inc., reviewed NH Medicaid claims and conducted actuarial analysis to determine the viability of Medicaid managed care in NH. Their report identified factors that impact the ability of the state to achieve savings utilizing managed care. The existing reimbursement rates, size of the Medicaid caseload, administrative costs, and wrap-around responsibility were factors.
- New Hampshire's reimbursement rates and administrative costs are comparatively low.
- The federal law requiring states to offer choice to recipients would require at least two managed care organizations to serve Medicaid enrollees.
- States must provide wrap around services; all services required by federal law including services which may not be included in the managed care benefit package.
- The Department issued a Request for Information in July, 2010 to solicit ideas from the managed care industry. Twelve entities responded and none of the responses offered savings. Most of the respondents stated they would need 6 to 9 months from the date of contract approval to program start up. Therefore the Department assumed there could be no fiscal impact until FY 2013.

- The New Hampshire Medicaid program currently utilizes most of the tools used in managed care including prior authorization, care management, and pharmacy benefit management.
- Based on the experience of other states, an up front investment is necessary as two claims adjudication systems are needed for the first 6 months after the transition date. The old MMIS system would continue to operate for 6 months since providers have 6-12 months to submit claims for services provided and new the claims would be processed through the new managed care system.
- Federal approvals required at various points in the procurement process may increase the timeline for implementation.

LBAO
11-0215
Amended 04/01/11

SB 147 FISCAL NOTE

AN ACT relative to Medicaid managed care.

FISCAL IMPACT:

The Department of Health and Human Services states this bill, **as amended by the Senate (Amendment #2011-1019s)**, will have an indeterminable impact on state revenue and expenditures, and county expenditures in FY 2013 and in each year thereafter. There will be no fiscal impact on county and local revenues, or local expenditures.

METHODOLOGY:

The Department of Health and Human Services states that, given the complexity and number of unknown variables, it is not able to determine the fiscal impact of this bill.

The Department provided the following information:

- In 2009, a leading health care actuarial firm, Milliman, Inc., reviewed NH Medicaid claims and conducted actuarial analysis to determine the viability of Medicaid managed care in NH. Their report identified factors that impact the ability of the state to achieve savings utilizing managed care. The existing reimbursement rates, size of the Medicaid caseload, administrative costs, the managed care model implemented, the wrap-around responsibility and how quickly all Medicaid populations are enrolled in the managed care are all factors which will impact potential savings.
- New Hampshire's reimbursement rates and administrative costs are comparatively low.
- The federal law requiring states to offer choice to recipients would require at least two managed care organizations to serve Medicaid enrollees.
- States must provide wrap around services; all services required by federal law including services which may not be included in the managed care benefit package.
- The Department issued a Request for Information in July, 2010 to solicit ideas from the managed care industry. Twelve entities responded and none of the responses offered savings. Most of the respondents stated they would need 6 to 9 months from the date of contract approval to program start up. Therefore the Department assumed there could be no fiscal impact until FY 2013.
- The New Hampshire Medicaid program currently utilizes most of the tools used in managed care including prior authorization, care management, and pharmacy benefit

management. The opportunity for savings in New Hampshire will be different from the savings experienced by states that did no managed care prior to implementing managed care.

- Based on the experience of other states, an up front investment is necessary as two claims adjudication systems are needed for the first 6 months after the transition date. The old MMIS system would continue to operate for 6 months since providers have 6-12 months to submit claims for services provided and new the claims would be processed through the new managed care system. The Department estimates the 6 months cost of claims run-out will be about $85,000,000. Due to the upfront investment, the Department states it could be several years before savings if any are realized.
- Federal approvals required at various points in the procurement process may increase the timeline for implementation.

Amendments

"NOT ADOPTED"

Rep. Almy, Graf. 11
April 15, 2011
2011-1445h
01/04

Amendment to SB 147-FN

Amend RSA 126-A:5, XIX(a) as inserted by section 1 of the bill by replacing it with the following:

XIX.(a) The commissioner shall employ a managed care model for administering the Medicaid program and its enrollees to provide for managed care services for all Medicaid populations throughout as much of New Hampshire as practicable consistent with the provisions of 42 U.S.C. 1396r-2. Models for managed care may include, but not be limited to, a traditional capitated managed care organization contract, an administrative services organization, an accountable care organization, or a 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 other externally administered models. The department shall present the opportunities of the various models or combination of models to the fiscal committee of the general court and to the oversight committee on health and human services with a recommendation for the best managed care model for New Hampshire, no later than June 15, 2011. Services to be managed within the model shall include all mandatory Medicaid covered services and may include, but shall not be limited to, care coordination, utilization management, disease management, pharmacy benefit management, provider network management, quality management, and customer services. The model shall not include mandatory dental services. After consultation with the fiscal committee of the general court with input from the oversight committee, the commissioner shall issue a 5-year request for proposals to enter into a contract with the vendor or vendors that demonstrates the greatest ability to satisfy the state's need for value, quality, efficiency, innovation and savings. The request for proposals shall be released no later than October 1, 2011. The vendor or vendors of the managed care model or combination of models demonstrating the greatest ability to satisfy the state's need for value, quality, efficiency, innovation, and savings shall be selected no later than December 1, 2011 with a final contract submitted to the governor and council as soon as practicable thereafter. After the bidding process, the commissioner shall establish a capitated rate based on the bids by the appropriate model for the contract that is full risk to the provider. The capitated rate shall be broken down into rate cells for each population including, but not limited to, the persons eligible for temporary assistance to needy families (TANF), aid for the permanently and totally disabled (APTD), breast and cervical cancer program (BCCP), home care for children with severe disabilities (HC-CSD), and those residing in nursing facilities. The capitated rate shall be approved by the fiscal committee of the general court. The managed care model or models' selected vendor or vendors providing the Medicaid services shall establish medical homes

and all Medicaid recipients shall receive their care through a medical home. In contracting for a managed care model and the various rate cells, 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. The target date for implementation of the contract is July 1, 2012. The commissioner may, in consultation with the fiscal committee, adopt rules, if necessary, to implement the provisions of this paragraph. The department shall seek all necessary and appropriate waivers to implement the provisions of this paragraph.

2011-1445h

AMENDED ANALYSIS

This bill requires the commissioner of the department of health and human services to issue a 5-year request for proposal to enter into a contract with a vendor or vendors of a managed care model after consultation with the fiscal committee of the general court with input from the oversight committee on health and human services to provide for managed care services to the Medicaid population. The commissioner, in consultation with the fiscal committee of the general court, is granted rulemaking authority for the purposes of this bill.

"NOT ADOPTED" 1

Rep. Major, Rock. 8
April 20, 2011
2011-1506h
01/09

Amendment to SB 147-FN

Amend RSA 126-A:5, XIX(a) as inserted by section 1 of the bill by replacing it with the following:

XIX.(a) The commissioner shall employ a managed care model for administering the Medicaid program and its enrollees to provide for managed care services for all Medicaid populations throughout New Hampshire consistent with the provisions of 42 U.S.C. 1396r-2. Models for managed care may include, but not be limited to, a traditional capitated managed care organization contract, an administrative services organization, an accountable care organization, or a 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 other externally administered models. ~~The department shall present the~~ opportunities of the various models or combination of models to the fiscal committee of the general court with a recommendation for the best managed care model for New Hampshire, no later than July 15, 2011. Services to be managed within the model shall include all mandatory Medicaid covered services and may include, but shall not be limited to, care coordination, utilization management, disease management, pharmacy benefit management, provider network management, quality management, and customer services. The model shall not include mandatory dental services. After consultation ~~with the oversight committee~~, the commissioner shall issue a 5-year request for proposals to enter into a contract with the vendor or vendors that demonstrates the greatest ability to satisfy the state's need for value, quality, efficiency, innovation, and savings. The request for proposals shall be released no later than November 15, 2011. The vendor or vendors of the managed care model or combination of models demonstrating the greatest ability to satisfy the state's need for value, quality, efficiency, innovation, and savings shall be selected no later than January 15, 2012 with a final contract submitted to the governor and council as soon as practicable thereafter. After the bidding process, the commissioner shall establish a capitated rate based on the bids by the appropriate model for the contract that is full risk to the provider. The capitated rate shall be broken down into rate cells for each population including, but not limited to, the persons eligible for temporary assistance to needy families (TANF), aid for the permanently and totally disabled (APTD), breast and cervical cancer program (BCCP), home care for children with severe disabilities (HC-CSD), and those residing in nursing facilities. The capitated rate shall be approved by the fiscal committee of the general court. The managed care model or models' selected vendor or vendors providing the Medicaid services shall establish medical homes and all Medicaid recipients shall receive their care through a medical home. In contracting for a managed care model and the various

rate cells, 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. The target date for implementation of the contract is July 1, 2012. The commissioner may, in consultation with the fiscal committee, adopt rules, if necessary, to implement the provisions of this paragraph. The department shall seek all necessary and appropriate waivers to implement the provisions of this paragraph.

Amend RSA 126-A:5, XIX(c)(3) as inserted by section 1 of the bill by replacing it with the following:

(3) A "managed care organization" means an entity that is authorized by law to provide covered health services on a capitated risk basis and arranges for the provision of medical assistance services and supplies and coordinates the care of Medicaid recipients residing in all areas of the state, including the elderly, those meeting federal supplemental security income and state standards for disability, and those who are also currently enrolled in Medicare.

" NOT ADOPTED

Rep. Major, Rock. 8
Rep. Almy, Graf. 11
April 22, 2011
2011-1538h
09/04

Amendment to SB 147-FN

Amend RSA 126-A:5, XIX(a) as inserted by section 1 of the bill by replacing it with the following:

XIX.(a) The commissioner shall employ a managed care model for administering the Medicaid program and its enrollees to provide for managed care services for all Medicaid populations throughout New Hampshire consistent with the provisions of 42 U.S.C. 1396r-2. Models for managed care may include, but not be limited to, a traditional capitated managed care organization contract, an administrative services organization, an accountable care organization, or a 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 other externally administered models. The department shall present the opportunities of the various models or combination of models with a recommendation for the best managed care model for New Hampshire, no later than July 15, 2011, to the fiscal committee of the general court which shall consult with the oversight committee on health and human services. Services to be managed within the model shall include all mandatory Medicaid covered services and may include, but shall not be limited to, care coordination, utilization management, disease management, pharmacy benefit management, provider network management, quality management, and customer services. The model shall not include mandatory dental services. The commissioner shall issue a 5-year request for proposals to enter into a contract with the vendor or vendors that demonstrates the greatest ability to satisfy the state's need for value, quality, efficiency, innovation, and savings. The request for proposals shall be released no later than November 15, 2011. The vendor or vendors of the managed care model or combination of models demonstrating the greatest ability to satisfy the state's need for value, quality, efficiency, innovation, and savings shall be selected no later than January 15, 2012 with a final contract submitted to the governor and council as soon as practicable thereafter. After the bidding process, the commissioner shall establish a capitated rate based on the bids by the appropriate model for the contract that is full risk to the provider. The capitated rate shall be broken down into rate cells for each population including, but not limited to, the persons eligible for temporary assistance to needy families (TANF), aid for the permanently and totally disabled (APTD), breast and cervical cancer program (BCCP), home care for children with severe disabilities (HC-CSD), and those residing in nursing facilities. The capitated rate shall be approved by the fiscal committee of the general court. The managed care model or models' selected vendor or vendors providing the Medicaid services shall establish medical homes and all Medicaid recipients

shall receive their care through a medical home. In contracting for a managed care model and the various rate cells, 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. The target date for implementation of the contract is July 1, 2012. The commissioner may, in consultation with the fiscal committee, adopt rules, if necessary, to implement the provisions of this paragraph. The department shall seek all necessary and appropriate waivers to implement the provisions of this paragraph.

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(3) A "managed care organization" means an entity that is authorized by law to provide covered health services on a capitated risk basis and arranges for the provision of medical assistance services and supplies and coordinates the care of Medicaid recipients residing in all areas of the state, including the elderly, those meeting federal supplemental security income and state standards for disability, and those who are also currently enrolled in Medicare.

Rep. Major, Rock. 8
Rep. Almy, Graf. 11
April 25, 2011
2011-1564h
01/09

Amendment to SB 147-FN

Amend RSA 126-A:5, XIX(a) as inserted by section 1 of the bill by replacing it with the following:

XIX.(a) The commissioner shall employ a managed care model for administering the Medicaid program and its enrollees to provide for managed care services for all Medicaid populations throughout New Hampshire consistent with the provisions of 42 U.S.C. 1396r-2. Models for managed care may include, but not be limited to, a traditional capitated managed care organization contract, an administrative services organization, an accountable care organization, or a 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 other externally administered models. The department shall present the opportunities of the various models or combination of models with a recommendation for the best managed care model for New Hampshire, no later than July 15, 2011, to the fiscal committee of the general court which shall consult with the oversight committee on health and human services. Services to be managed within the model shall include all mandatory Medicaid covered services and may include, but shall not be limited to, care coordination, utilization management, disease management, pharmacy benefit management, provider network management, quality management, and customer services. The commissioner shall issue a 5-year request for proposals to enter into contracts with the vendors that demonstrate the greatest ability to satisfy the state's need for value, quality, efficiency, innovation, and savings. The request for proposals shall be released no later than October 15, 2011. The vendors of the managed care model or combination of models demonstrating the greatest ability to satisfy the state's need for value, quality, efficiency, innovation, and savings shall be selected no later than January 15, 2012 with final contracts submitted to the governor and council no later than March 15, 2012 unless this date is extended by the fiscal committee. After the bidding process, the commissioner shall establish a capitated rate based on the bids by the appropriate model for the contract that is full risk to the vendors. The capitated rate shall be broken down into rate cells for each population including, but not limited to, the persons eligible for temporary assistance to needy families (TANF), aid for the permanently and totally disabled (APTD), breast and cervical cancer program (BCCP), home care for children with severe disabilities (HC-CSD), and those residing in nursing facilities. The capitated rate shall be approved by the fiscal committee of the general court. The managed care model or models' selected vendors providing the Medicaid services shall establish medical homes and all Medicaid recipients shall receive their care through a medical home. In

contracting for a managed care model and the various rate cells, 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. The target date for implementation of the contract is July 1, 2012. The commissioner may, in consultation with the fiscal committee, adopt rules, if necessary, to implement the provisions of this paragraph. The department shall seek, with the approval of the fiscal committee, all necessary and appropriate waivers to implement the provisions of this paragraph.

Amend RSA 126-A:5, XIX(c)(3) as inserted by section 1 of the bill by replacing it with the following:

(3) A "managed care organization" means an entity that is authorized by law to provide covered health services on a capitated risk basis and arranges for the provision of medical assistance services and supplies and coordinates the care of Medicaid recipients residing in all areas of the state, including the elderly, those meeting federal supplemental security income and state standards for disability, and those who are also currently enrolled in Medicare.

2011-1564h

AMENDED ANALYSIS

This bill requires the commissioner of the department of health and human services to issue a 5-year request for proposals to enter into contracts with vendors of a managed care model to provide for managed care services to the Medicaid population. The commissioner, in consultation with the fiscal committee of the general court, is granted rulemaking authority for the purposes of this bill.

Speakers

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # SB 147- FN Date 4/12/2011

Committee Ways + Means

** Please Print All Information **

Name	Address	Phone	Representing	(check one) Pro	Con
SEN. DAVID BOUTIN	HOOKSETT		DISTRICT #16	✓	
SENATOR SHARON CARSON	LONDONDERRY		SD #14	X	
Sen Jeanie Forrester			Dist. 2	✓	
Sen Watters			Dist 9	✓	
Sen Luther	Nashua		Dist. 12	✓	
Senator Morse			D22	✓	
Sen Tom LaBlois	manchester		dist 18	X	

Hearing Minutes

HOUSE COMMITTEE ON WAYS AND MEANS

PUBLIC HEARING ON SB 147-FN

BILL TITLE: relative to Medicaid managed care.

DATE: April 12, 2011

LOB ROOM: 202 **Time Public Hearing Called to Order:** 1:05 PM

Time Adjourned: 2:22 PM

(please circle if present)

Committee Members: Reps. Stepanek, Major, Griffin, Hess, Sapareto, Ulery, Osgood, Ober, Abrami, Azarian, Daugherty, McDonnell, Murphy, Ohm, Sanborn, Shuler, Almy, Hamm, Butynski, Hatch and Cooney

Bill Sponsors: Sens. Bradley, Dist 3; DeBlois, Dist 18; Forrester, Dist 2; Forsythe, Dist 4; Gallus, Dist 1; Groen, Dist 6; Lambert, Dist 13; Luther, Dist 12; Morse, Dist 22; Odell, Dist 8; Sanborn, Dist 7; White, Dist 9; Barnes, Jr., Dist 17; Boutin, Dist 16; Carson, Dist 14

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Representative Hess – supports. He introduced the bill for Senator Bradley, prime sponsor.

Representative Kurk – supports with amendment. He commented that this bill has been implemented in HB 2.

***Representative Keene – supports.** See written testimony. He covers the differences between HB 2 and this version.

Senator Bradley, prime sponsor – supports. He comments about savings of $33 million using this proposal.

Lisabritt Solsky, DHHS – supports.

***John H. Robinson, M.D., Aetna Medicaid – supports.** See written testimony.

***Leslie Melby, New Hampshire Hospital Association – supports with suggested changes.** See written testimony.

***Doug McNutt, AARP New Hampshire.** See written testimony and handouts from "independent living."

***Tom Bunnell, New Hampshire Voices for Health.** See written testimony. He made suggestions for amendments.

Respectfully submitted,

Russell J. Ober

Representative Russell Ober, Clerk

HOUSE COMMITTEE ON WAYS AND MEANS

PUBLIC HEARING ON SB 147-FN

BILL TITLE: relative to Medicaid managed care.

DATE: 6/12/2011

LOB ROOM: 202 **Time Public Hearing Called to Order:** 1:05 pm

Time Adjourned: 2:22 pm

(please circle if present)

Committee Members: Reps. Stepanek, Major, Griffin, Hess, Sapareto, Ulery, Osgood, Ober, Abrami, Azarian, Daugherty, McDonnell, Murphy, Ohm, Sanborn, Shuler, Almy, Hamm, Butynski, Hatch and Cooney.

Bill Sponsors: Sens. Bradley, Dist 3; DeBlois, Dist 18; Forrester, Dist 2; Forsythe, Dist 4; Gallus, Dist 1; Groen, Dist 6; Lambert, Dist 13; Luther, Dist 12; Morse, Dist 22; Odell, Dist 8; Sanborn, Dist 7; White, Dist 9; Barnes, Jr., Dist 17; Boutin, Dist 16; Carson, Dist 14

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Rep Hess - for Sen Bradley (intro)

Rep Kurk - supports bill - comment that this bill has been implemented in HB-2

Rep Keene* supports bill - covers differences between HB-2 and this version

Sen Bradley - prime sponsor - comments about savings of $33M using this proposal

Rosemarie Sobsky, DHHS, favors bill

John Robinson*, AETNA, MEDICAID - favors bill

Leslie Melby* - NH Hospital Assn - favors bill - with some suggested changes

Doug McNutt* AARP favors bill now handouts from "independent living"

Tom Bunnell* NH Voices for Health, also made suggestions for amendments (in writte

Testimony

File Copy SB 147-FN

John H Robinson, MD, CPE

Medical Officer

Schaller Anderson Medical Administrators, Inc.,
New Hampshire

L4185

Aetna

What is our Clinical Value Proposition for Medicaid recipients?

- Achieve and maintain optimal health and ability to function in the community
- Facilitate a holistic approach to health and well-being
  - By members
  - By caregivers
  - By health care providers
- Right care, Right time, Right place, Right cost
  - Deliver care based on medical evidence
  - Deliver necessary and appropriate care
  - Deliver timely care in the most cost-effective setting
- Stratify care management resources according to bio-psycho-social needs assessment

Aetna

What is our Clinical Strategy?

- Focus clinical resources and outreach efforts
  - Deliver measurable plan value
  - Minimize low-value activities or contacts
  - Risk stratify and tier intensity of intervention
- Carve-in!! Full coordination improves the quality and cost of care
  - Pharmacy
  - Behavioral Health
  - Waiver programs
  - LTC
- Help patients find and obtain the right care, most efficiently, where and when they need it
- Provide member choice
- Provide actionable clinical information to providers
- Ensure alignment of incentives among patient, provider, and the health plan
- Excel at managed care basics
  - Precertification/Prior auth
  - Concurrent Review
  - Medical Claims Policies
  - Case management

Aetna®

Provider Collaboration- "Supplement, Not Supplant"

- Providers are at the center of efforts to deliver high quality care to engaged Medicaid recipients
- Health plans must add value to those efforts
  - Be a resource to providers
    - Compile and share actionable clinical information- including claims data
    - Coordinate communications and interventions with members and other providers
- Align incentives to improve quality and manage costs
  - Pay for Performance initiatives
    - Quality metrics – HEDIS
    - Member Satisfaction metrics – CAHPS
  - Patient-Centered Medical Home (PCMH) pilots
  - Accountable Care Organization (ACO) shared savings models
  - Health Information Technology (HIT) efforts
    - Dynamo
    - Active Health Care Considerations
    - Medicity

Aetna

Integrated Care Management (ICM) Principles

- *Moving from disease focus to member focus*
  - Evaluating every member for physical, behavioral and social risks to their current and future health
- *Identifying and employing the most effective intensity of evidence-based, plan-covered systems and services*
  - Facilitating access to a continuum of services based on the intensity and complexity of each member's needs
- *Behavioral engagement for change*
  - Using a single point of contact to engage each member in a plan that addresses his or her critical physical, behavioral and social needs to promote resiliency, recovery and optimal self-management
- *Teaming with the member and care providers to enhance care outcomes*
  - Work as an interdisciplinary team that combines core competencies in physical and behavioral health within a systems framework to manage psycho-social complexity and challenging relationships with members and their families
- *Collaboration with Plan sponsors to influence benefit design*
  - Focus on coordinating and integrating fragmented services into a system of care that addresses each member's individual needs within the context of their family and cultural community

Aetna®

Integrated Care Management (ICM) Elements

- ICM considers the full array of physical, behavioral and psychosocial needs
- Step 1 - Stratify the entire Medicaid population based on risk and need
  - Evidence-based Predictive Modeling – CORE
  - Self-report Tools – HRQ
  - Population Surveillance
- Step 2 - Assign recipients to the most appropriate intensity of intervention
  - Intensive Care Management – most vulnerable, highest-risk members
  - Supportive Care – short-term condition-specific issues
  - Wellness and Prevention assistance
- Step 3 - Assure Accountability for Outcomes
  - Did the intervention meet recipient-identified needs?
  - Is there measureable improvement in health and well-being?
  - Is utilization of health care services more efficient and effective?

Aetna

Care Management Tools

- Dynamo- central platform for ICM
- Technology
  - Text messaging
  - Remote monitoring
- Programs
  - Management of Care Transitions
    - Reduce avoidable readmissions
  - Field-based Care Management
  - Pharmacy Coaching
  - Long-term Care
  - Palliative Care

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Joe Moser

Testimony for the Record

Submitted by

Joe Moser

Director of Federal Affairs

Medicaid Health Plans of America

Public Hearing

House Bill 2 Re: An Act on Medicaid Managed Care

Health and Human Services Committee

New Hampshire State House

April 12, 2011

Chairman Stepanek, members of the committee, my name is Joe Moser, and I am the Director of Federal Affairs at Medicaid Health Plans of America (MHPA), a national trade association based in Washington, D.C., representing 26 health plans in 34 states and the District of Columbia. Our member health plans provide coverage for more than 14 million Medicaid and Children's Health Insurance Program (CHIP) beneficiaries. Our association represents Medicaid health plans ranging from large multi-state plans to small community-based plans. I appreciate the invitation to testify before the committee today.

Today I want to address the experiences in other states that have moved to contract with full-risk health plans in their Medicaid programs, particularly as it pertains to the cost-savings and better quality care those states have experienced with moving to Medicaid managed care. The theme of my testimony today is that New Hampshire can improve the delivery of care and quality of outcomes for your lower-income citizens by contracting with health plans, while also experiencing significant budget savings.

Defining Medicaid Managed Care

First, let me explain some terms. The terms "Medicaid managed care" or "managed Medicaid" can have many different meanings. The federal Centers for Medicare and Medicaid Services (CMS) recognizes two fundamentally different types of Medicaid care management as "Medicaid managed care." Thirty-one states have Primary Care Case Management (PCCM) programs. These are often extensions of traditional fee-for-service Medicaid and involve linking beneficiaries to primary care providers and paying the providers an additional monthly payment (usually about $3 per beneficiary) for a limited range of care management activities, such as providing authorization for emergency room and specialist visits. Some of these states have enhanced these basic PCCM programs with additional features, such as more intensive care management and care coordination for high-need beneficiaries, financial incentives for primary care providers, and increased use of performance and quality measures.

The other type of Medicaid managed care recognized by CMS involves states contracting with Medicaid health plans to administer benefits as a complete alternative to the state administering benefits. Thirty-six states and the District of Columbia currently have some or all of their Medicaid beneficiaries enrolled in Medicaid health plans. For purposes of my testimony, I will be referring to comprehensive risk contracts with health plans as Medicaid managed care. There are other types of limited-risk or non-risk arrangements with health plans or similar entities to provide specific services, such as behavioral healthcare, inpatient services and transportation. Additionally, 18 states have some blend of both PCCM and health plans in their Medicaid programs.

Medicaid Health Plan Model

The way this alternative delivery model works is by better coordinating care and ensuring appropriate service utilization, which naturally produces large-scale savings. Better health care delivery and health outcomes really do save money. Under the

traditional fee-for-service Medicaid model, or "traditional Medicaid," the state pays providers more based on the number of services they provide. Clearly the incentive here is to provide more services to yield more payment, but this doesn't necessarily mean proper spending. More services and more spending doesn't always mean better outcomes.

Medicaid health plans ensure that enrollees have access to a primary care provider and a network of qualified specialists. Depending upon the state rules, enrollees either choose a health plan or are automatically assigned to a health plan. Patients then choose a primary care physician, or have one assigned to them if they do not choose, that is the patient's primary point of contact for their health care services. This medical home model is built into the Medicaid health plan approach that has proven successful in improving outcomes and lowering costs and has been in use by Medicaid health plans for more than 20 years. In addition to appropriately managing access to acute care providers and care coordination, Medicaid health plans also provide specific disease management programs, case management, and additional benefits that may not be provided in traditional Medicaid but address the needs of the whole person, such as support services, that ultimately lower costs and keep people healthy.

I understand New Hampshire currently has the traditional fee-for-service model, but contracts with Schaller Anderson Medical Administrators to provide limited utilization management tools for certain services including imaging and clinical laboratory services, and with Magellan Medicaid Administration to provide pharmacy management services. These administrative services organizations help to control utilization compared to not having them, but are set up to be limited in scope and lack the comprehensive, patient-centered approach that a fully at-risk capitated managed care program provides.

Capitation Payments

Under a full risk capitated Medicaid managed care program, managed care organizations (MCOs), or "health plans," are pre-paid a monthly per-member per-month rate, or "capitation payment," to deliver all services covered under the contract. Rates are inclusive of predicted medical and administrative costs, taxes, and fees. The state's actuary determines an acceptable rate range based on prior cost experience and medical cost trends, and the state negotiates final rates with each plan within the rate range. Rates are risk-adjusted to reflect the severity of enrollees' condition. Health plans keep any savings that are achieved through better care management and healthier outcomes, and share these savings with the state through the rate-setting process that lowers the cost platform in the program. Conversely, health plans assume the risk of higher than expected costs, whereas the state assumes this risk now. This incentivizes health plans to work with providers to keep people healthy and manage their conditions – care management is the hallmark of the Medicaid managed care business model. Transferring risk to health plans also creates predictable program expenditures on behalf of the state, which other states have reported is one of the most favorable aspects of this model. So, you see, this model realigns the incentives from delivering more services to delivering better care.

Provider Contracting and Improving Access

Medicaid health plans contract with a broad array of providers to ensure good access to care for their members, including many community and safety-net providers you would find in lower-income communities, such as public hospitals and community health centers. Provider contracting varies by plan, but generally rates are negotiated that are comparable to the state's Medicaid fee schedule. Rates can be and often are above the fee schedule, allowing health plan enrollees to enjoy better access to providers than those in traditional Medicaid. Anecdotal evidence suggests health plans also pay providers faster and more accurately than many state Medicaid programs. CMS reported that in 2008, payment error rates in Medicaid managed care were 0.1%, compared to 2.6% for traditional Medicaid.

Scope of Medicaid Managed Care

As I mentioned before, 36 states and the District of Columbia currently have some or all of their Medicaid and CHIP populations enrolled in health plans. Many more states are considering starting Medicaid managed care programs, or are in some stage of planning new programs including Montana and Louisiana. Other states are looking to expand the managed care programs they currently have into new populations, such as aged, blind and disabled beneficiaries or dual eligibles, or into new service areas of the state. Those states expanding their programs or considering expanding include California, Texas, Florida, Georgia, South Carolina, Pennsylvania, and Illinois.

There are a number of states with similar Medicaid enrollment numbers to New Hampshire (125,000) that have successful Medicaid managed care programs, including some in the New England and Mid-Atlantic regions that have some characteristics in common with New Hampshire. Rhode Island has 178,000 Medicaid enrollees and three competing plans. Delaware has 171,000 Medicaid enrollees and two plans. Nevada and the District of Columbia each have two plans and 213,000 and 154,000 enrollees, respectively. Each of these states have made a Medicaid managed care program with two or three competing private health plans work successfully with even a relatively small number of citizens on Medicaid.

Savings Potential

Other states have also experienced significant budget savings with implementing Medicaid managed care, although potential savings to New Hampshire should not be overstated and large savings may not materialize immediately. States with the largest savings have been those that have been vigilant in maintaining strong programs and committed for the long-term and display other best practices in the management of health plan contracts.

Savings varies depending on several factors. The potential for savings is greatest with the most difficult and costly populations – seniors, disabled and dual eligibles in

need of long-term care services. States have experienced savings in this population of about 8-11%. They often have multiple chronic conditions and are most in need of better coordinated care, making the savings potential proportionally greater. Children and pregnant women and low-income adults are cheaper to care for in general, and thus the potential for savings is less (generally around 4-7%).

Early savings to New Hampshire will depend on which populations are enrolled first, benefits included, and changes in provider and beneficiary behavior. Savings may be modest at first, but will accumulate over time as the program matures. The state is apparently already using some forms of care management and utilization management practices, which will limit the savings potential otherwise attributable to moving toward managed Medicaid than if the state did not have these mechanisms in place, and estimates of savings should account for these factors.

It is projected that New Hampshire's Medicaid enrollment will increase by as many as 62,000 enrollees if the Medicaid expansion in the federal health care reform law[1] takes effect starting in 2014, a 47% increase in enrollment[2]. The United Healthcare Center for Health Reform & Modernizations estimated this would cost the New Hampshire Medicaid program $2.1 billion between 2014 and 2019, with almost $2 billion of that coming from the federal government, and $135 million coming from state funds. The cost of the expansion to the state grows in the year 2020 and beyond, as the federal funding for newly eligible individuals falls to 90%. Undoubtedly, the federal health care reform law is going to raise the cost of the Medicaid program to the state significantly. To the extent you can implement these managed care solutions now and have your program mature before the full cost of the expansion hits the state, it will help you better manage these costs.

It is estimated that a more incremental, measured approach that gradually adds populations into the managed care program, starting with low-income adults and children (TANF population) in year one and including long-term care services for the disabled and elderly and mandatory enrollment of the dual eligibles in year two would result in $109 million in savings over the first three years.

Based on the factors specific to New Hampshire, such as state-specific claims data and the fact that the state is already using some care management tools, I would estimate total program savings of about 6-7 percent annually by moving to a Medicaid managed care approach once the program is fully operational.

This is in line with what we have observed in other states. Pennsylvania's Medicaid managed care program saved the state $2.7 billion between 2000-2004, or an

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[1] Patient Protection and Affordable Care Act of 2010, Public Law 111-148

[2] UnitedHealth Center for Health Reform & Modernization Working Paper 3, April 2010. Found at http://www.unitedhealthgroup.com/hrm/UNH_WorkingPaper3.pdf

estimated 10-20%[3]. Medicaid managed care was estimated to save Illinois 5%-11% in the SSI population[4], and 6.7% in Georgia's TANF population. Overall, a synthesis of 24 studies on the state cost-savings observed in Medicaid managed care programs in various states around the country showed between 2-19% state savings observed.[5]

Pharmacy

Because pharmacy benefits are such an important component of medicine now, it is vital that pharmacy benefits be included among the benefits provided by the health plans you contract with. Every health plan participating in Medicaid either has their own pharmacy benefit management operation, or contracts with a pharmacy benefit management organization to provide pharmacy benefits. Including pharmacy in health plan contracts allows plans to include pharmaceuticals among the tools they use to properly coordinate a person's health care, along with other medical services. Health plans need access to this pharmacy data, which they often lack access to when provided separately by third parties. Because health plans have an incentive to ensure proper utilization with pharmacy management techniques, health plans have 14.8% lower pharmacy costs than traditional Medicaid.[6] The generic utilization rate is 80% in Medicaid health plans, compared to 68% in traditional Medicaid. Because of these factors, the pharmacy benefits are an important part of how Medicaid managed care saves states money. The managed care model works best when pharmacy is included. Removing pharmacy benefits from Medicaid managed care contracts would reduce the savings potential from this program.

History of Medicaid Managed Care and Federal Standards

Medicaid managed care has its origins dating back to the early 1980s, with the first managed care solutions tried in New York and California. Enrollment in Medicaid managed care climbed from about 10% of Medicaid enrollees nationally in 1990, to 72% today. This includes about 25% who are enrolled in PCCM, and 47% who are enrolled in health plans. This growth was largely due to passage of the Balanced Budget Act of 1997 by Congress, which eliminated many of the barriers that prevented states from using Medicaid managed care solutions.

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[3] Comparative Evaluation of Pennsylvania's HealthChoices Program and Fee-for-Service Program. The Lewin Group, May 2005. Found at: http://www.lewin.com/content/publications/3178.pdf

[4] Assessment of Medicaid Managed Care Expansion Options in Illinois. The Lewin Group, May 2005. Found at: http://www.lewin.com/content/publications/3176.pdf

[5] Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies. The Lewin Group. Prepared for AHIP. July 2004. Updated March 2009. Found at: http://www.ahip.org/content/default.aspx?bc=39|341|319|27090

[6] Potential Federal and State-by-State Savings if Medicaid Pharmacy Programs were Optimally Managed. The Lewin Group, December 2010. Found at: http://www.lewin.com/content/publications/MedicaidPharmacySavingsReport_Rev.pdf

The Balanced Budget Act of 1997 (BBA) and subsequent regulations outline the parameters of today's Medicaid managed care programs[7]. States must have at least two competing plans in a single service area, unless the area qualifies for a rural exemption, in which case only one plan is required. Capitation rates must be actuarially sound, adequate to cover medical costs, administration, taxes and fees. CMS must review the rates and certify that the rates are actuarially sound. The actuarial soundness requirement in BBA 97 ensures that rates are appropriate based on actual cost experience, and that rates are neither too high nor too low so as to prevent underpayment or overpayment of plans. The stability of the Medicaid managed care program depends on these rates. If rates are inadequate to cover program costs because the state makes an arbitrary budget adjustment, it can have an impact on rates paid to providers and access to care, and inhibit innovative efforts the plans may engage in to improve quality. Inadequate rates in some states have even led to plans leaving the market, and, in certain states, the collapse of the managed care program entirely.

The Balanced Budget Act and regulations also include very specific requirements for network adequacy, to ensure that health plans contract with an adequate number of providers, including safety-net providers. This ensures enrollees have access to providers that are close to their homes or within reasonable distances from their homes. BBA also requires plans and the state to have specific procedures in place for beneficiaries to file grievances and appeals. Medicaid managed care is a guaranteed issue product. That is, no one can be turned down because of age, gender, or health status. Cost-sharing cannot exceed that allowable under the traditional Medicaid program, which typically has no premiums and very low copayments ($1-$3 per service). The BBA also allowed states to move toward mandatory managed care enrollment through State Plan Amendment instead of a waiver for all populations, except for 1) children with special health care needs, 2) dual eligibles, and 3) American Indians. These populations can be required to be enrolled in managed care by obtaining a waiver from CMS. Any marketing material distributed by plans must be approved by the state to avoid predatory marketing practices. Medicaid managed care is a highly regulated market, and in these respects differ from other types of managed care such as Medicare and commercial plans.

State Partnership

Medicaid managed care programs work best when states and participating Medicaid health plans have a strong partnership, work together to solve problems and communicate clearly and regularly with one another. Michigan is a good example of how health plans and the state have a collaborative relationship, with the state accepting input from plans on the rate-setting process and negotiating final rates with plans. The state shares assumptions that its actuaries use to propose rates, and provides opportunities for plans to present further data and challenge assumptions. Health plans have partnered with the state officials in other states to help the state solve budget problems.

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[7] Balanced Budget Act of 1997, Public Law 105-33 and managed care regulations at 42 CFR 438

Quality Assurance

One of the most significant benefits of Medicaid health plans is quality measurement and improvement. Federal regulations require annual quality reviews of Medicaid health plans and specify state oversight expectations. Most states conduct additional reviews of Medicaid health plans to ensure that they meet state rules and regulations in areas such as utilization review and grievances and appeals. The state and federal rules provide additional consumer protections for Medicaid health plans, such as network adequacy and the provision of culturally and linguistically appropriate services, that are unique from commercial health insurance plans.

Medicaid health plans are required to report performance measures, such as HEDIS, to the state. Performance measures provide valuable data to health plans, states, researchers and policymakers for demonstrating the quality of care in Medicaid programs, identifying gaps in care, and creating quality improvement projects. Through performance measurement, the quality of care in Medicaid health plans has improved.

Many states also field the Consumer Assessment of Health Plans Survey (CAHPS) that assesses patient satisfaction with their experience of care. Studies have shown that Medicaid enrollees are more satisfied with the quality and experience of care received through managed care than in fee-for-service.

About 25% of Medicaid health plans have achieved accreditation by the National Committee for Quality Assurance, meeting a nationally recognized standard for demonstrating the delivery of high quality care. Additional Medicaid health plans are accredited by other organizations.

Supporting the Safety Net

Medicaid health plans are dedicated to a strong safety net. We take positions that support a stronger, sustainable Medicaid program that ensures access to health care for low-income Americans. Medicaid has served an important purpose as the health insurance program for low-income children, pregnant women, disabled and elderly Americans since 1965. MHPA chairs a coalition of Medicaid provider organizations in Washington called the Partnership for Medicaid, a group of stakeholders that includes the American Academy of Pediatrics, National Association of Community Health Centers, National Association of Public Hospitals, and National Association of Children's Hospitals. MHPA works with these organizations to advocate for more federal funding and policies that improve the Medicaid program and preserve the safety net. The Partnership for Medicaid was instrumental in securing the temporary Federal Medical Assistance Percentage (FMAP) increase in the American Recovery and Reinvestment Act, or Stimulus Act, and the extension, that provided New Hampshire with an additional $309 million in federal funding over the baseline in the last two years. The Partnership works to ensure that the less fortunate, and those that provide care for them, and states, have the resources necessary to delivery quality health care and support services.

In conclusion, let me say that Medicaid Health Plans of America fully supports Senator Bradley's bill and efforts outlined in Governor Lynch's budget this week to move to a comprehensive Medicaid managed care delivery system. Based on what has been observed in other states, we do have suggestions on the best way to structure your program. We look forward to working with you and DHHS officials to provide advice or technical assistance as needed. Using managed care solutions already used in most other states will improve New Hampshire's Medicaid program and save the state significant dollars. Given the federally-mandated Medicaid expansion beginning in 2014, I don't know how the state can afford not to move in this direction.

Thank you again for the opportunity to provide written testimony before your committee.

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SB147
Rep. Keene

Repetitive Thomas Keane
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I would ask the committee to consider adopting HB2's version of managed Medicaid.

The House and the Senate versions of Managed Medicaid differ in only four areas.

1. HB2 deletes the phrases AS MUCH and AS PARACTIABLE found in the first sentence of the Senate bill. I believe existing federal regulations expresses the intent of the two phrases and thus they are unnecessary.

2. The House and Senate differ on which committee should have oversight of the project. The Senate refers to the committee on Health and Human Services while the House refers the matter to the Joint Fiscal Committee. The House felt that managed care had such a large impact upon the budget that the Fiscal Committee should be the oversight committee with input from the policy committee.

3. In the fourth sentence HB2 adds the words "but not limited to" when referring to which services are to be included in the managed care proposal. This language allows the Department to add services if such additions would enhance the possibilities for additional bidders.

4. There is a slight variance in the projects schedule. In the first deadline the Senate refers to a June 15, 2011 but the law does not take effect until July 1, 2011 so HB2 changed the date was changed to July 15, 2011. This caused the other dates to be moved as well. The RFP moved from October 1, to December 1, and the final contract moved from December 1 to March 1, 2012.

   Although I personally liked the face pace proposed in the Senate bill, in the end I was convinced that HB2 time lines are more realistic.

In conclusion, as the former Director of the Division of Behavioral Health and as person who has spent a life time as the CEO of private sector companies providing Medicaid services, I unequivocally support moving to a private managed care model for New Hampshire's Medicaid Services.

SB147 File Copy
SB147
Leslie Melby

New Hampshire Hospital Association

HOUSE WAYS & MEANS COMMITTEE
April 12, 2011

SB 147-FN
Relative to Medicaid Managed Care

Testimony

Good afternoon, Mr. Chairman and members of the Committee. My name is Leslie Melby and I am the Vice President for State Government Relations at the New Hampshire Hospital Association, representing the state's 32 acute care community and specialty hospitals.

New Hampshire's hospitals support programs that allow more Medicaid patients to receive the right care at the right time and in the right place....every time. In particular, we believe every Medicaid beneficiary must have access to a primary care medical home to ensure that quality, coordinated care is accessible, thus avoiding long standing patterns among Medicaid patients of inappropriate and costly use of hospital emergency rooms to treat conditions that only require an office visit. The medical home is the fundamental building block of an effective managed care program.

The bill, as amended by the Senate, instructs DHHS to employ a managed care model for all Medicaid clients that demonstrates the "greatest ability to satisfy the state's need for value, quality, efficiency, innovation and savings..." That is surely something on which we can all agree. The reality is that New Hampshire pays extraordinarily low rates to its Medicaid providers. Projected savings therefore, cannot simply be the result of even lower payment rates, but rather on tools such as utilization management and disease management.

As you know, managed care works when participants are highly incentivized to curtail their utilization of unnecessary services through high deductibles, co-insurances, and co-payments. However, these are tools that cannot be imposed on low-income Medicaid recipients. Therefore, when patients in a managed care system use those services over which providers have no control, such as hospital emergency rooms, providers will be at full risk for the cost of those services through no fault of their own.

We suggest that further details are needed in the bill, such as principles that ensure network adequacy and access. We also suggest that rulemaking be required to implement the managed care program. The bill merely permits the Commissioner to adopt rules if necessary, to implement the managed care program. We urge you to amend the bill to require rulemaking because it only makes senses that any organization that administers such a large program as Medicaid must be subject to regulations that address, for example,

quality-related issues, network adequacy issues, appeals processes, as well as billing-related issues such as timely adjudication of claims.

If this proposal is about designing a program to achieve better coordination of care for Medicaid patients with a focus on quality, access and cost effective health care delivery, hospitals would support such a program and would partner with the state to be part of it. On the other hand, this program must not be designed merely to spend less on health care for Medicaid patients. As our colleagues around the country have observed, several other states' Medicaid managed programs have focused solely on limiting access to services and payment denials.

There are currently five pilot programs around the state launched this past year that are aimed at improving quality and lowering costs. The Accountable Care Organization (ACO) program is designed to encourage health care providers to collaborate and focus more on prevention and disease management, so that patients are healthier and the growth in health care costs is reduced. This pilot program moves away from the fee-for-service model and instead gives health care providers incentives to spend more time with their patients, to work with their patients to prevent new illnesses and better manage existing illnesses, and to collaborate with other health care providers. The five locations participating in this model are in Littleton region, the Plymouth area, Keene, Exeter and Nashua. This is a managed care model we support. We think it makes sense for Medicaid to partner with these ACOs in the future as one possible approach to "managed care."

We hope this legislation achieves what's in the best interest of the patients we serve – high quality, cost effective care provided in the right place at the right time.

Thank you.

Doug McNutt SB147 File Copy

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Testimony SB 147

AARP has long been an active supporter of initiatives to make health care more coordinated, integrated, and consumer- and outcome-oriented. We support efforts to control health care costs through greater efficiency or systems changes that foster better care (e.g., reducing medical error and hospital readmissions, duplication of tests, and use of community care when it is more appropriate).

At this time we are not taking a position on this bill; however we do wish to address several aspects we believe are important in a managed care system.

First and foremost we believe the assessment of a managed care system in New Hampshire should include all those served by the Medicaid system including children, families, disabled Adults and the Elderly. Each proposed system and its component elements must be closely examined. Combining improved care management and cost containment can best be achieved by careful balancing to ensure quality and patient protection.

Consumer Choice is a paramount feature. Those directly affected are best able to gauge the adequacy, quality and customer service provided by a health care system. Market competition provides a direct and immediate way of ensuring good quality that, from the consumer's perspective, is far superior to government oversight and retrospective review.

There are a variety of **Service Delivery Models.** At its core, managed care is about managing care more than managing costs. This can be done through a primary care case management system (PCCM) or medical home, health home or accountable care organization that provides primary care as well as overall coordination for specialty services rendered by other health care providers. These systems can be structured to create and coordinate a care plan based solely on the best medical interests of the patient, but may also be required to consider costs.

In the context of long-term care (LTC), appropriate managed care needs to include incentives to ensure that care is well coordinated across various care settings and that is provided in the least restrictive environment. Stability of care and care providers over multiple years is another important factor. Appropriate managed care systems should ensure that residents of LTC facilities are not displaced for non-medical reasons, such as a change in the networks roster of providers. The most vulnerable, residents of LTC facilities, often have deep connections with staff, other residents and the local community

and any changes can be devastating. They should not be forced to move to new facilities simply because their current facility is no longer the lowest bidder.

In the LTC context, we favor managed care based on a medical home model with care managed and coordinated by a physician or medical group practice allowing for consumer direction, operating independently from providers of LTC, and with the mission of coordinating care across all providers and settings (physicians, hospitals, clinics, residential settings, nursing homes, home care, etc.) to provide the individual with the best care in the setting that ensures the maximum appropriate level of independence. Provider networks should be constructed based on objective data on quality and should be broad enough to ensure that individuals are able to obtain appropriate care within their own communities.

If the Committee does approve of a managed care option we believe it is critical that stakeholders have an opportunity to participate meaningfully in the development of that system in order to ensure that the system that is developed promotes the provision of quality services to all populations.

We would like the Committee to consider the above mentioned guidelines in the development of a Medicaid managed care plan for New Hampshire.

Douglas McNutt
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Granite State Independent Living
gsil
Tools for Living
Life on Your Terms

SB147 File Copy

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April 12, 2011

House Ways and Means Committee
NH State House
107 N. Main Street
Concord, NH 03301

Dear members of the House Ways and Means Committee:

I am writing on behalf of Granite State Independent Living (GSIL) regarding SB147 relative to instituting Medicaid Managed Care in New Hampshire. For 30 years GSIL has been NH's statewide Independent Living Center, providing tools and resources to assist people with disabilities in living independently in their communities.

In general GSIL does not oppose Medicaid Managed Care as long as it meets the needs of those who rely on it for healthcare coverage so they can be healthy, engaged, and productive. Our specific area of focus is on Medicaid coverage for the provision of home and community based services to those with long term care needs. We ask this legislature and DHHS that as the state moves forward with Medicaid Managed Care it ensure that NH's citizens with disabilities and seniors continue to be able to receive quality long term care services in their communities. As the Governor stated in his budget address earlier this year, not only is home and community based care the preference of most NH citizens, it is also a far more economical model than institutional based care.

GSIL is happy that the amendment to SB147 removed the "carve outs" toward the end of the originally introduced bill that would have excluded "individuals determined eligible for nursing home level of care and residing in a nursing facility" from being covered under managed care. We did not understand this exclusion and nor did we agree with it. If other types of long term care such as home and community based services are to be included, so too should institutional care. Given that it is the preference of most folks and costs 1/3 what institutional care does, we would ideally like to see the state shift more toward home and community based services and away from institutional services. Please do not allow these "carve outs" to be put back into the bill as it moves forward.

Thank you for taking the time to read our comments and for your service to New Hampshire.

Sincerely,

Jeff Dickinson

Jeff Dickinson
Advocacy Coordinator

SB147 File Copy
Tom Bunnell

NEW HAMPSHIRE VOICES FOR HEALTH

House Ways and Means Committee
April 12, 2011

NH VOICES for HEALTH TESTIMONY

SB 147: Relative to Medicaid Managed Care

Mister Chairman, members of the committee, good afternoon and thank you for this opportunity to provide testimony on Senate Bill 147.

My name is Tom Bunnell, and I am offering very brief testimony today on behalf of NH Voices for Health. NH Voices for Health ("Voices") is a statewide network of individuals, small businesses, and advocacy organizations committed to ensuring a strong, high quality, affordable health system for families and businesses in our state. Voices has over 40 partner organizations and, together, represents more than 200,000 people across the Granite State.

Moving NH's Medicaid program to managed care is a prospect and opportunity that appears to have great promise. But independent of and including Medicaid, our health system and its cost-drivers are a complex matrix. Converting our Medicaid program – currently providing coverage and care to more than 140,000 people annually – to an overarching managed care system will doubtless require not just hard science but some artful balancing and process.

And so, as you deliberate on and continue to shape this opportunity in collaboration with the NH Department of Health & Human Services, there are two matters that NH Voices for Health is respectfully asking you to consider:

First, while we are cognizant and respectful of the tight deliverable timelines in this legislation, please consider a provision that would have the NH Department of Health & Human Services utilize a stakeholder advisory committee, such as its existing Medical Care Advisory Committee or a subcommittee thereof, to be consulted in the development, implementation, and oversight of Medicaid managed care in and for NH.

The idea is to help ensure that the Department has a mechanism for some meaningful and pragmatic input and feedback from stakeholders, who can help to assure that the emerging and new systems change can and does work for consumers and providers.

And second, we urge you to continue to be reasonable and pragmatic concerning any proposed savings target for this measure, in order to help avoid any risk of jeopardizing health care quality, access to care (particularly in rural areas of our state), or health outcomes in the context of this very significant systems change.

We welcome the opportunity to engage in additional dialogue with you about these considerations as you move forward.

I would happy to answer any questions from members of the Committee.

Thank you.

Voting Sheets

HOUSE COMMITTEE ON WAYS AND MEANS

EXECUTIVE SESSION on SB 147-FN

BILL TITLE: **relative to Medicaid managed care.**

DATE: April 21, 2011

LOB ROOM: 202

Amendments:

Sponsor: Rep. Major	OLS Document #:	2011	1506h
Sponsor: Rep. Almy	OLS Document #:	2011	1445h Withdrawn
Sponsor: Rep.	OLS Document #:		

Motions: (OTP), OTP/A, ITL, Interim Study (Please circle one.) Vote on amendment change.

Moved by Rep. Major

Seconded by Rep. Almy

Vote: 21-0 Hand Vote (Please attach record of roll call vote.)

Motions: OTP (OTP/A), ITL, Interim Study (Please circle one.)

Moved by Rep. Abrami

Seconded by Rep. Azarian

Vote: Postponed until 4/26/11 (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE:

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Russell Ober, Clerk

Russell J. Ober

HOUSE COMMITTEE ON WAYS AND MEANS

EXECUTIVE SESSION on SB 147-FN

BILL TITLE: **relative to Medicaid managed care.**

DATE: 4/21/2011

LOB ROOM: 202

Amendments:

Sponsor: Rep. Major — OLS Document #: 2011-1506h

Sponsor: Rep. Almy — OLS Document #: 2011-1445h → withdrawn

Sponsor: Rep. — OLS Document #:

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. Major

Seconded by Rep. Almy

Vote: 21-0 (Please attach record of ~~roll call~~ hand vote.)

vote on amendment change (new amendment)

21-0

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. Abrami

Seconded by Rep. Czaraa

Vote: (Please attach record of roll call vote.)

postponed until Tues next

CONSENT CALENDAR VOTE:

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Russell Ober, Clerk

OFFICE OF THE HOUSE CLERK 2011 SESSION

WAYS AND MEANS

Bill #: SB 149-FN Title: relative to Medicaid managed care

PH Date: 4 / 12 / 2011 Exec Session Date: 4 / 21 / 11

Motion: OTP/A Amendment #: 2011/1506h

MEMBER	YEAS	NAYS
Stepanek, Stephen B, Chairman		
Major, Norman L, V Chairman		
Griffin, Mary E		
~~Hess~~, David W Baldasaro		
Sapareto, Frank V		
Ulery, Jordan G		
Osgood, Joe		
Ober, Russell T, Clerk		
Abrami, Patrick F		
Azarian, Gary S		
Daugherty, Duffy		
McDonnell, John J		
Murphy, Keith		
Ohm, Bill		
Sanborn, Laurie J		
~~Shuler~~, Wyman E Renzullo		
Almy, Susan W		
Hamm, Christine C		
Butynski, William		
Hatch, William A		
Cooney, Mary R		
TOTAL VOTE:		

Printed: 1/19/2011

HOUSE COMMITTEE ON WAYS AND MEANS
RECONVENED, RECESSED FROM 4/21/2011
EXECUTIVE SESSION on SB 147-FN

BILL TITLE: **relative to Medicaid managed care.**

DATE: April 26, 2011

LOB ROOM: 202

Amendments:

Sponsor: Rep. Major	OLS Document #:	2011	1564h
Sponsor: Rep.	OLS Document #:		
Sponsor: Rep.	OLS Document #:		

Motions: (OTP) OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. Major

Seconded by Rep. Azarian

Vote: 20-0 HAND VOTE (Please attach record of roll call vote.)

Motions: OTP (OTP/A), ITL, Interim Study (Please circle one.)

Moved by Rep. Abrami

Seconded by Rep. Azarian

Vote: 20-0 (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE:

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Russell Ober, Clerk

Russell J. Ober

HOUSE COMMITTEE ON WAYS AND MEANS
RECONVENED, RECESSED FROM 4/21/2011
EXECUTIVE SESSION on SB 147-FN

BILL TITLE: **relative to Medicaid managed care.**

DATE: April 26, 2011

LOB ROOM: 202

Amendments:

Sponsor: Rep. Major — OLS Document #: 2011-1564h

Sponsor: Rep. — OLS Document #:

Sponsor: Rep. — OLS Document #:

Motions: (OTP) OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. ~~Abramson~~ Major

Seconded by Rep. Azarian

Vote: 20-0 (Please attach record of roll call vote.) hand

Regular Calendar

Motions: OTP, (OTP/A), ITL, Interim Study (Please circle one.)

Moved by Rep. Alexander

Seconded by Rep. Azarian

Vote: (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE:

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Russell Ober, Clerk

OFFICE OF THE HOUSE CLERK 2011 SESSION

WAYS AND MEANS

Bill #: SB 147-FN Title: relative to Medicaid managed care.

PH Date: 4/12/2011 Exec Session Date: 4/26/2011

Motion: OTP/A Amendment #: 2011-1564L

MEMBER	YEAS	NAYS
Stepanek, Stephen B, Chairman	✓	
Major, Norman L, V Chairman	✓	
Griffin, Mary E	✓	
Hess, David W	✓	
Sapareto, Frank V	✓	
Ulery, Jordan G	✓	
~~Osgood~~, Joe		
Ober, Russell T, Clerk	✓	
Abrami, Patrick F	✓	
Azarian, Gary S	✓	
Daugherty, Duffy	✓	
McDonnell, John J	✓	
Murphy, Keith	✓	
Ohm, Bill	✓	
Sanborn, Laurie J	✓	
Shuler, Wyman E	✓	
Almy, Susan W	✓	
Hamm, Christine C	✓	
Butynski, William	✓	
Hatch, William A	✓	
Cooney, Mary R	✓	
	20.0	
TOTAL VOTE:		

Printed: 1/19/2011

Committee Report

REGULAR CALENDAR

April 27, 2011

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Committee on WAYS AND MEANS to which was referred SB147-FN,

AN ACT relative to Medicaid managed care. Having considered the same, report the same with the following amendment, and the recommendation that the bill OUGHT TO PASS WITH AMENDMENT.

Rep. Patrick F Abrami

FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

COMMITTEE REPORT

Committee:	**WAYS AND MEANS**
Bill Number:	**SB147-FN**
Title:	**relative to Medicaid managed care.**
Date:	**April 26, 2011**
Consent Calendar:	**NO**
Recommendation:	**OUGHT TO PASS WITH AMENDMENT**

STATEMENT OF INTENT

Currently the Medicaid program is structured predominantly as a fee-for-service program. It has been determined that this is a costly model to the state. This bill calls for the state to move to a less costly managed care model. In addition, this bill requires the commissioner of the department of health and human services to issue a 5-year request for proposal to enter into contracts with vendors who can support a managed care model. The committee unanimously endorsed the concept of moving our Medicaid program to a managed care model.

Vote 20-0.

Rep. Patrick F Abrami
FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

REGULAR CALENDAR

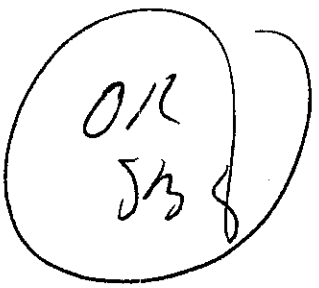
WAYS AND MEANS

SB147-FN, relative to Medicaid managed care. **OUGHT TO PASS WITH AMENDMENT.** Rep. Patrick F Abrami for WAYS AND MEANS. Currently the Medicaid program is structured predominantly as a fee-for-service program. It has been determined that this is a costly model to the state. This bill calls for the state to move to a less costly managed care model. In addition, this bill requires the commissioner of the department of health and human services to issue a 5-year request for proposal to enter into contracts with vendors who can support a managed care model. The committee unanimously endorsed the concept of moving our Medicaid program to a managed care model. **Vote 20-0.**

Original: House Clerk
Cc: Committee Bill File

SB 147-FN P. Abrami OTP/A (1564h) 20-0 RC

Currently the Medicaid program is structured predominantly as a fee-for-service program. It has been determined that this is a costly model to the state. This bill calls for the state to move to a less costly managed care model. In addition, this bill requires the commissioner of the department of health and human services to issue a 5-year request for proposal to enter into contracts with vendors who can support a managed care model. The committee unanimously endorsed the concept of moving our Medicaid program to a managed care model.



SB 147-FN with Amendment

Representative Patrick F. Abrami for Ways & Means: Currently the Medicaid program is structured predominantly as a fee-for-service program. It has been determined that this is a costly model to the state. This bill calls for the state to move to a less costly managed care model. In addition, this bill requires the commissioner of the Department of Health and Human Services to issue a 5-year request for proposal to enter into ~~a~~ contract~~s~~ with ~~a~~ vendors who can support a managed care model. The committee unanimously endorsed the concept of moving our Medicaid program to a managed care model.

OK
SBS

COMMITTEE REPORT

COMMITTEE: Ways + Means

BILL NUMBER: SB 147-FN

TITLE: relative to Medicaid managed care

DATE: 4/26/11 CONSENT CALENDAR: YES ☐ NO ☑

☐ OUGHT TO PASS

☑ OUGHT TO PASS W/ AMENDMENT

☐ INEXPEDIENT TO LEGISLATE

☐ INTERIM STUDY (Available only 2nd year of biennium)

Amendment No. 2011-1564h

STATEMENT OF INTENT:

see attached

COMMITTEE VOTE: 20-0

OK SB

RESPECTFULLY SUBMITTED,

Rep. (Patrick Abrami)

For the Committee

- Copy to Committee Bill File
- Use Another Report for Minority Report

Rev. 02/01/07 - Yellow