Bill as Introduced

SB 147-FN – AS INTRODUCED

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

ANALYSIS

This bill requires the department of health and human services to establish a mandatory Medicaid managed care program for all Medicaid clients. Under this bill, the department shall develop a waiver to implement the program to present to the fiscal committee of the general court before seeking final approval from the federal Centers for Medicare and Medicaid Services to implement the program.

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

11-0215
01/10

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 Medicaid Managed Care Program.

I. The department of health and human services shall enter into a contractual agreement with one or more managed care organizations to provide managed care services for all Medicaid recipients, including the elderly, those meeting federal supplemental security income and state standards for disability, and those who are also currently enrolled in Medicare. Services provided pursuant to such contractual agreement may include, but not be limited to, care coordination, utilization management, disease management, pharmacy benefit management, provider network management, quality management, and customer services. To implement the requirements under this section, the department shall develop a Medicaid waiver to support the Medicaid managed care program for Medicaid clients. The department shall submit the appropriate waivers, state plan amendments and federal applications, including but not limited to, waiver requests authorized pursuant to sections 1115 and 1915 of the Federal Social Security Act, or successor provisions, as the department shall deem necessary to secure appropriate federal financial support for the cost of the program. The waivers, state plan amendments, and federal applications shall authorize mandatory managed care for 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. The department shall present the proposed waivers, state plan amendments and federal applications to the fiscal committee of the general court prior to submission for final approval of the federal Centers for Medicare and Medicaid Services (CMS). The department shall provide periodic reports to the fiscal committee of the general court throughout the waiver development, approval, and implementation processes. The department shall seek input from health care providers and the public in the course of developing the waiver.

II. For the purposes of this act, 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.

III. The department, in applying for a waiver, state plan amendment, or other federal authorization to implement the provisions of this act, shall request authority from the Secretary of Health and Human Services to combine Medicaid and Medicare funding for service delivery to

eligible individuals who are also eligible for Medicare. Implementation of these programs may begin without authority to include Medicare funding.

IV. The following categories of individuals shall not be required to enroll in the managed care program established under this act:

(a) An individual dually eligible for medical assistance and benefits under the federal Medicare program and enrolled in a Medicare managed care plan offered by an entity that is also a managed care organization;

(b) HIV positive individuals;

(c) Persons with serious mental illness and abused children and adolescents with serious emotional disturbances, as defined in RSA 169-C; and

V. Individuals determined to be eligible for nursing home services and residing in a nursing facility.

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.

SB 147-FN – AS AMENDED BY THE SENATE

03/16/11 0790s

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. 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.

CHAPTER 125
SB 147-FN – FINAL VERSION

03/16/11 0790s
03/23/11 1019s
27Mar2011... 1564h
27Mar2011... 1610h
05/18/11 1827eba

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 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.

- -

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.

CHAPTER 125
SB 147-FN - FINAL VERSION

03/16/11 0790s
03/23/11 1019s
27Mar2011... 1564h
27Mar2011... 1610h
05/18/11 1827eba

11-0215
01/10

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:

125:1 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 New Hampshire consistent with the provisions of 42 U.S.C. 1396u-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 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.

(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.

(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.

125:2 Effective Date. This act shall take effect upon its passage.

Approved: June 2, 2011
Effective Date: June 2, 2011

Amendments

Sen. Bradley, Dist. 3
February 17, 2011
2011-0384s
01/10

Amendment to SB 147-FN

Amend the bill by replacing all after the enacting clause with the following:

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 issue a 3-year request for proposal to enter into a contract with a managed care organization 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. Services provided pursuant to such contractual agreement shall include all mandatory Medicaid covered services and may include, but not be limited to, care coordination, utilization management, disease management, pharmacy benefit management, provider network management, quality management, and customer services. The commissioner shall establish a capitated rate for bids by managed care organizations for the contract that is full risk to the provider. Prior to any bidding for the contract, the capitated rate shall be approved by the fiscal committee of the general court. The managed care organization providing the Medicaid services shall establish medical homes and all Medicaid recipients shall receive their care through a medical home. After 3 years, the department may transition to an accountable care organization for the entire population of Medicaid recipients. 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 organization under contract with the department no later than 6 months after the contract is awarded to the managed care organization.

(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) 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 3 years, a "managed care organization" may include the department of health and human services,

with the approval of the fiscal committee.

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

2011-0384s

AMENDED ANALYSIS

This bill requires the commissioner of the department of health and human services to issue a 3-year request for proposal to enter into a contract with a managed care organization to provide for managed care services to the Medicaid population. Under this bill, after 3 years, the department may transition to an accountable care organization for the entire population of Medicaid recipients. The commissioner, in consultation with the fiscal committee, is granted rulemaking authority for the purposes of this bill.

Sen. Bradley, Dist. 3
March 8, 2011
2011-0712s
09/04

Amendment to SB 147-FN

Amend the bill by replacing all after the enacting clause with the following:

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, as approved by the oversight committee on health and human services as 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. After consultation with the oversight committee, the commissioner shall issue a 5-year request for proposals to enter into a contract with the vendor 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 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

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, 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 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.

Health and Human Services
March 10, 2011
2011-0790s
01/09

Amendment to SB 147-FN

Amend the bill by replacing all after the enacting clause with the following:

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. 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.

2011-0790s

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.

Committee Minutes

AMENDED

Printed: 02/10/2011 at 12:09 pm

SENATE CALENDAR NOTICE

HEALTH AND HUMAN SERVICES

Senator Jeb Bradley Chairman
Senator Tom De Blois V Chairman
Senator Molly Kelly
Senator Gary Lambert
Senator Andy Sanborn

For Use by Senate Clerk's Office ONLY

☐ Bill Status

☐ Docket

☐ Calendar

Proof: ☐ Calendar ☐ Bill Status

Date: February 10, 2011

HEARINGS

Thursday **2/17/2011**

(Name of Committee)	(Place)	(Time)
HEALTH AND HUMAN SERVICES	LOB 102	1:00 PM

EXECUTIVE SESSION MAY FOLLOW

Comments: Please note the addition of SB 151-FN.

1:00 PM SB147-FN relative to Medicaid managed care.

1:30 PM SB151-FN relative to contracts of the department of health and human services.

Sponsors:

SB147-FN

Sen. Jeb Bradley
Sen. John Gallus
Sen. Chuck Morse
Sen. John Barnes, Jr.
Sen. Tom De Blois
Sen. Fenton Groen
Sen. Bob Odell
Sen. David Boutin
Sen. Jeanie Forrester
Sen. Gary Lambert
Sen. Andy Sanborn
Sen. Sharon Carson
Sen. James Forsythe
Sen. Jim Luther
Sen. Raymond White

SB151-FN

Sen. Jeb Bradley
Sen. Tom De Blois
Sen. Fenton Groen
Sen. Raymond White
Rep. Gene Chandler
Sen. John Barnes, Jr.
Sen. Jeanie Forrester
Sen. Gary Lambert
Rep. Neal Kurk
Rep. David Bettencourt
Sen. David Boutin
Sen. James Forsythe
Sen. Jim Luther
Rep. Kenneth Weyler
Sen. Sharon Carson
Sen. John Gallus
Sen. Andy Sanborn
Rep. Pamela Tucker

Robyn Dangora 271-4154

Sen. Jeb Bradley

Chairman

Health and Human Services Committee

Hearing Report

TO: Members of the Senate

FROM: Robyn Dangora, Legislative Aide

RE: Hearing report on SB 147-FN – **relative to Medicaid managed care.**

HEARING DATE: February 17, 2011

MEMBERS OF THE COMMITTEE PRESENT: Senator Bradley, Senator De Blois, Senator Sanborn, Senator Kelly, Senator Lambert

MEMBERS OF THE COMMITTEE ABSENT: No one

Sponsor(s): 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

What the bill does: This bill requires the department of health and human services to establish a mandatory Medicaid managed care program for all Medicaid clients. Under this bill, the department shall develop a waiver to implement the program to present to the fiscal committee of the general court before seeking final approval from the federal Centers for Medicare and Medicaid Services to implement the program.

Who supports the bill: Sen. Barnes, Jr., Dist 17; Sen. White, Dist 9; Sen. Groen, Dist 6; Sen. Forrester, Dist 2; Sen. Luther, Dist 12; Sen. Boutin, Dist 16; Sen. Morse, Dist 22; Sen. Carson, Dist 14; Joe Moser, Medicaid Health Plans of America; Lisabritt Solsky, Department of Health and Human Services; Mark Trail, Former Medicaid Director in Georgia; John Stephen

Who opposes the bill: No one

Neutral/ Speaking to the bill: Doug McNutt, AARP; Jeff Dickinson, Granite State Independent Living; Leslie Melby, New Hampshire Hospital Association

Summary of testimony received:
Hearing opened at 1:00 PM

Senator Jeb E. Bradley, D. 3: Prime Sponsor
- This bill has been somewhat superseded by the Governor's budget address, in which he called for a full managed care program for all populations in New Hampshire at a capitated risk basis.
- The Department of Health and Human Services (DHHS) has been very involved in the Medicaid issue and legislation on this issue in the past
- Last year, similar legislation passed the Senate, but was deemed unnecessary by the House. After reviewing the RFIs, the Governor's address shows he has determined this initiative is worthwhile to pursue.
- Managed care has been implemented by over 30 states, both red and blue states
- Managed care has been implemented to better manage the Medicaid populations, especially those with chronic illness, and to maintain quality of services offered
- Medicaid is the single largest item in the New Hampshire budget and we must better manage the Medicaid population in order to balance the budget.
- In Washington, the passing of the Accountable Healthcare Act (ACA) calls for at least a doubling of the Medicaid population by 2014.
  - -Budget decisions will become increasingly difficult when the Medicaid population in New Hampshire doubles to about 250,000 eligible people.
- DHHS has been involved in drafting the language of the amendment prepared for this bill.
- Specific items within the amendment include:
  - -Line 5—The Commissioner shall request a 3-year request for proposal. The Governor asked for a 5-year proposal in his budget address, so I suspect we will change this, if DHHS agrees.
  - -The Governor called for all Medicaid populations be included, but the amendment wording reflects the concerns of Lisabritt Solsky of DHHS, that in some areas of the state it is not practicable to implement manage care, so the amendment allows for the continuation of the fee-for –service system where managed care is not possible.
  - -Line 8-9: ensures that all mandatory Medicaid services are covered (TANF, Women and Children, Developmental issues, Mental issues, Elderly)
  - -Line 11: The commissioner shall establish for a capitated rate for bids by managed care organizations (MCOs) to bid on. MCOs are privately run companies that will manage the Medicaid population. A capitated rate is an overall global rate and the MCO assumes any risk of the costs going above that rate
  - -The fiscal committee will approve the capitated rate

-DHHS asked for the right to transfer, after the initial contract, to an accountable care organization (ACO) model. The ACO model pays providers based on outcomes, not inputs. ACOs allow for a more holistic payment model for reimbursement. This will be subject to the fiscal committee adopting such rules.
-Line 19: DHHS must seek all necessary waivers from the Centers for Medicaid and Medicare in Washington to implement the managed care program
-Paragraph b, calls for implementing the program in a timely fashion. The amendment calls for this to be done, but that is not an absolute number, it is open to change. DHHS can help to establish a practical date.
    - The Governor is contemplating $33,000,000 in this biennium, so we would like to implement this expeditiously.
-One of the requests from the department is that in the future they have the opportunity to become the MCO
    - My concerns about that are (a) is it practical? (b) do they have the capability to do this?
    - This bill allows DHHS to make that case to potentially have the capability. This is similar to the Governor's wish to move Healthy Kids under DHHS

- Managed care is not a perfect solution, but it will be a major step forward in New Hampshire—ensuring quality, helping the state manage this very costly state program, and better position selves for the potential doubling of the population under ACA.

Doug McNutt, AARP

- Neutral, AARP supports initiatives that work to improve care and lower health care costs.
- The proposed amendment deals with some of the concerns AARP had with SB 147 as it was originally written.
- Concerns included:
    -The need for all populations to be included
    -Consumer choice—market competition will ensure good quality and adequacy
    -Long-term care issues—should provide incentives for coordination across care settings and providing least restrictive environment
    -Stability of care and care providers—residents of long-term care facilities should not be displaced for non-medical reasons, such as a new lowest bidder at the end of a contract. These residents develop a good relationship with the staff of their facilities.
- AARP prefers a medical home model of care.
- Provider networks should allow people to get care within their communities and allow for the maximum appropriate level of independence
- Senator Bradley said: As you addressed, the amendment calls for a medical home as DHHS suggested.

Jeff Dickinson, Granite State Independent Living

- Neutral, Granite State Independent Living (GSIL) is a 30-year running independent living center, providing the tools and resources to assist people with disabilities in living independently in the communities they desire.
- They ask that as DHHS and the legislature look at managed care that they focus on the importance of long-term care and choose an MCO that encourages community-based services.
- The amendment addresses one of the major concerns GSIL had with the bill, the "carve outs" in the bill that excluded nursing home residents from being covered under managed care.

Leslie Melby, New Hampshire Hospital Association

- Neutral, representing New Hampshire's 32 acute care community and specialty hospitals.
- New Hampshire Hospital Association (NHHA) is in agreement on many of the provisions addressed in the amendment
- NHHA supports programs that allow more Medicaid patients to receive the right care the right place at the right time
- It is important to have a primary care medical home in the managed care system, which will avoid costly emergency room visits to treat conditions that only require a hospital visit
  - -The medical home is a fundamental building block of a managed care program
- NHHA suggested definitions and principles be included in the bill to address the type of managed care implemented and ways to ensure network adequacy and access in rural areas. Many of the definitions are included in the amendment
- NHHA will partner with the state to design a program focusing on quality and access to cost effective health care
- NHHA is happy to hear the amendment includes accountable care organizations (ACO). Five pilot ACO programs have been launched last summer, moving away from the fee-for-service model of care and instead gives providers incentives for spending more time with patients on preventive medicine
  - -The five pilot programs are in the areas surrounding Littleton, Plymouth, Keene, Exeter, and Nashua
- NHHA hopes this legislation achieves high quality and cost effective care

Joe Moser, Medicaid Health Plans of America

- In support, Medicaid Health Plans of America is a national trade association based in Washington, D.C., representing 26 health plans in 34 states and D.C.
- Member health plan providers cover over 14 million Medicaid and Children's Health Insurance Program beneficiaries
- Here to speak to other states' experiences with full-risk managed care Medicaid programs

-New Hampshire can improve deliver of care, quality of outcomes, and experience significant budget savings

- There are two recognized types of Medicaid managed care
  - -Of the 50 million managed care Medicaid beneficiaries, 47% are enrolled Medicaid health plans in and 25% are enrolled in primary care case management (PMCC) programs, which have some fee-for-service components
  - -28% are in tradition fee-for-service (FFS) models
  - -There are 36 states and D.C. with a managed care component in their Medicaid programs
- In 1994, only 23% of Medicaid beneficiaries where enrolled in managed care programs, in 2009 72% were enrolled
- States with comparable Medicaid enrollments to New Hampshire with successful Medicaid managed care programs:
  - -Nevada: two competing for-profit plans
  - -Rhode Island: three providers (non and for profit) compete for members
  - -Delaware: two competing plans
- These states pay the provider a per member per month capitated rate and the provider bear full-risk for financing care for enrollees
  - -Health care plans negotiate rates with providers and are accountable to the state
  - -This creates an incentive to contain costs and improve health quality
- Providers coordinate care to prevent chronic disease, prevent utilization of higher-cost services, and manage chronic conditions
- Benefits of a managed care model:
  - -better access to care and care coordination
  - -access to a medical home
  - -higher enrollee satisfaction
  - -quality insurance and improvement—stringent standards in statute
  - -delivery system innovation
  - -predictable costs to state
  - -cost savings
  - -reduced fraud and abuse
- Balanced Budget Act of 1997 governs most of the managed care market specific rules in federal law
  - -Medicaid health plans cannot deny people with pre-existing conditions
  - -Strict rules regarding grievances
  - -quality assurance requirements
  - -Marketing rules to prevent predatory
  - -Payment timeliness requirements
- There is a wide variation of players, some nonprofit and others for-profit, some Medicaid only and some with multiple lines of business
- A New York study showed that managed care HEDIS rates were statistically higher than FFS rates
- Proven Outcomes:

-Kentucky outreach children program improved well-child visits by 38% in population under 15 months old

-South Carolina Healthy Mom Babies Program resulted in a 73% reduction in recurring preterm births

- In 2008, Medicaid managed care had an error rate of only 0.1% compared to 2.6% for Medicaid FFS
- Potential Pharmacy Savings
  - -New Hampshire already has a partnership with Magellan resulting in savings; more savings are projected under managed care ($3.8 million in 2011 and $21 million over the next 10 years)
  - -Managed care health plans have 14.8% lower pharmacy than FFS plans
  - -Generic utilization rates are over 10% higher than FFS plans
  - -Under ACA there will be 62,440 newly-eligible Medicaid enrollees by 2019 (47% increase)
    - -This is an estimated cost of $2.1 Billion from 2011-2019
- Savings in other states who switched to managed care
  - -2-19% state savings
  - -5% average estimate of TANF savings
  - -8% lower average SSI savings
- Potential savings to New Hampshire is $465 Million over the next 9 years
- Program design recommendations
  - -Multiple Competing private plans, beneficiaries can choose plan
  - -Offer clear expectations in contracts with consistent state oversight
  - -Capitation plans must be rate adjusted with flexibility for innovation, such as pay-for-performance plans
- A Medical Loss Ratio is not necessary if the plan payment rates are actuarially sound

<u>Lisabritt Solsky, Deputy Medicaid Director, Department of Health and Human Services</u>

- In support, DHHS thanks Senator Bradley for his inclusive approach to drafting this bill and his leadership and openness throughout the process
- DHHS has not completed all the necessary research to conclude that a managed care capitated model id the best option for New Hampshire and the department continues to compare models on cost, quality, and efficiency
- DHHS had a brief experience in the 1990s with voluntary managed care programs, lessons from which inform DHHS's current direction
- New Hampshire's Medicaid program already utilizes many tools of managed care, such as prior authorization, service learning utilizations, bulk purchasing, and low reimbursement rates
  - -Therefore potential savings in New Hampshire are lower than in other states that switched to managed care
- DHHS sees managed care as an opportunity to harmonize services to complex patients in several populations

- Manage care would provide better coordinated and quality care to complex Medicaid populations and should include aging, blind, and disabled populations
- DHHS's past experience with managed care was with the lowest cost, low utilizers and now including high utilizers can help improve quality and efficiency and harmony of services
- DHHS concerns
  - -Setting the capitated rate before bidding.
    - It avoids the surety of better rate cells for each population (it should have a lower rate for lower utilizers)
    - DHHS prefers a rate cell model
    - Setting the rate mutes companies that could have come in at a lower price
    - Approving the rate in the fiscal committee adds time to the process
- The six month timeframe is profoundly aggressive, it needs to be softened or DHHS will fail.
- The fiscal note DHHS prepared includes "claims run-out" for the first 6 months of transition from fee-for-service to managed care. This was quantified to an estimated cost is $85 Million. We need this front loaded.
- Senator Kelly asked: In the 1990s did the state implement a managed care model?
  - -Response: Yes, it was voluntary and it targeted children. Savings seemed to be overpromised at that time, particularly because children are a healthier population and do not allow for as high a level of savings. We now want a mandatory model including other populations.
- Senator Kelly asked: Under fee-for-service, the state gets back half of what it puts in. Do you have any way to determine the amount of actual savings the state would take in?
  - -Response: DHHS has been working with a premiere actuary group to answer that question. Since New Hampshire has embraced some managed care programs, savings will be limited, but the efficiencies and harmonization will be advantageous.
- Senator Kelly asked: Managed care relies on outcomes not inputs; what is built into the managed care system to ensure desired outcomes of quality?
  - -Response: Title 19 of the Social Security Act imposes strict expectations on managed care models. DHHS must report quality assurance measures (HEDIS). DHHS has always held providers very accountable.
- Senator Kelly asked: Could you speak to the $85 Million upfront cost?
  - -DHHS would need that to pay FFS claims for services rendered before the switch. It could be better managed if this money is set aside specifically for that purpose.
- Senator Bradley: In terms of language of the amendment:
  - -You would like rate cells instead of one capitated rate—if we need a definition of that we would need your assistance.
  - -I agree we should soften the timeline.

-You would like the rate set after bidding, correct?
  - Response: DHHS would prefer a range for each population or for the whole, rather than one number.

<u>Mark Trail, Former Medicaid Director in Georgia</u>

- In support, Georgia switched to managed care in 2005, at which point Medicaid consumed 40% of revenue coming into the state and was projected to consume 60% by 2011
- Georgia implemented: member reduction, service reduction, price reduction, and utilization management—did not result in necessary savings
- Georgia switched to managed care
  - -Low income groups, Children: full risk mandatory system
  - -Disabled groups: enhanced PCCM, disease state management
  - -Others: administrative service organizations
- Only the fill risk manage care program still exists because the others did not provide the same level of savings
- Georgia broke into 6 regions served by 3 providers. All 3 serve the metro area and two providers serve the rural regions
- No matter what you do you will have a claims runout, but it was worth moving forward. Georgia ended up with savings in the first year
- Required the plans to cover all services the state covered in the plan
- Georgia had a full carve-in model including dental, pharmacy, and behavioral health
- Georgia managed care Medicaid has 1.1 million members. This does not yet include the disabled or elderly populations
- In 2002 Georgia's Medicaid cost was 27% above the national trend and in 2010 it was 43% below thanks to managed care
- Managed care not only resulted in cost savings in Georgia, but also increased access and quality on HEDIS measures. Many measures have doubled, such as prenatal care measures.
  - -By reducing the low birth weight babies by half, the state saved $70-80 thousand for each baby hospitalization avoided
  - -rates of diabetes admittance were one third of what it was under FFS
- I hope it seeing what other states have done helps your decision in New Hampshire
- Senator Sanborn asked: Could you walk us through the timeline for Georgia to get managed care online and functioning?
  - -Response: Georgia took an aggressive approach—nine months from contract completion to full implementation. The effort prior to contract completion, such as procurement and contract negotiations is where specifics should be addressed and that took 6 months for Georgia.

Hearing closed at 2:15 PM

Funding: See Fiscal Note

Action: Pending

RMD
[file: SB 147-FN report]
Date: 2/21/11

Speakers

Senate Health and Human Services Committee: Sign-In Sheet

Date: February 17, 2011 Time: 1:00 p.m. Public Hearing on SB 147-FN

SB 147-FN relative to Medicaid managed care.

Name	Representing			Please Check		
Sen. Barnes	District 17	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☑
Sen White	Dist 9	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☑
Sen Green	Dist 6	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☑
Sen Forrester	Dist 2	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☑
Sen Sutton	Dist 12	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☑
Sen. David Boutin	District 16	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☑
Sen Morse	District 22	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☑
Doug McNutt	AARP	Support ☐	Oppose ☐	Speaking?	Yes ☑	No ☐
JEFF DICKINSON	GRANITE STATE Ind. Living	Support ☐	Oppose ☐ Neutral ☒	Speaking?	Yes ☒	No ☐
LESLIE MELBY	NH HOSPITAL ASSN	Support ☐	Oppose ☐	Speaking?	Yes ☒	No ☐
Joe Moser	Medicaid Health Plans of America	Support ☑	Oppose ☐	Speaking?	Yes ☑	No ☐
Lisabritt Solsby	DHHS	Support ☒	Oppose ☐	Speaking?	Yes ☒	No ☐
MARK TEAIL	Former MCaid Dir	Support ☒	Oppose ☐	Speaking?	Yes ☒	No ☐
John Stephen	self	Support ☒	Oppose ☐	Speaking?	Yes ☒	No ☒
[illegible]	[illegible]	Support ☒	Oppose ☐	Speaking?	Yes ☐	No ☒
Jen Carson	District 14	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☑
		Support ☐	Oppose ☐	Speaking?	Yes ☐	No ☐
		Support ☐	Oppose ☐	Speaking?	Yes ☐	No ☐
		Support ☐	Oppose ☐	Speaking?	Yes ☐	No ☐

Testimony

147 Bradley

TOP STORY

FRIDAY, FEBRUARY 04, 2011

Crushed by Medicaid costs, states expand managed care

By Christine Vestal, Stateline Staff Writer

Last week, Illinois Governor Pat Quinn signed a health care reform bill that will dramatically change the way many Medicaid patients receive care. The bill aims to push half of Illinois' Medicaid caseload into the hands of managed care organizations by 2015. Illinois has a long way to go to reach that goal: Only 8 percent of Medicaid patients in the state receive care this way now.

When he signed the bill, Quinn promised the reforms would reduce the state's Medicaid costs by as much as $774 million over the next five years. The savings is supposed to come from shifting from a system in which the Illinois Medicaid program generally pays doctors for each service they provide, to one where the state pays insurers a set rate per year for each patient. Quinn also said Medicaid patients will see their health care services improve because insurers would be responsible for more carefully coordinating patient care to reduce avoidable hospitalizations and worsening of chronic conditions.

Health care in the states

Illinois is late to the managed care phenomenon — on average, states already have moved 46 percent of their Medicaid caseloads into managed care. But in a year of tight budgets and rising health care costs, Illinois is only one of many states turning to the managed care model to squeeze savings out of Medicaid, which now consumes 22 percent of state budgets. This year, at least a dozen states are expanding managed care for Medicaid, the state-run health insurance program for low income children, pregnant women, the disabled and frail elders.

For example, South Carolina is planning to require nearly all of its Medicaid beneficiaries to enroll in a managed care plan starting in April. Washington State is planning to increase its share of Medicaid recipients in managed care from 60 percent to 85 percent by 2014. Texas and Virginia also are weighing sizeable expansions of Medicaid managed care.

States have been using managed care to cut Medicaid costs for two decades. Up to now, however, the vast majority of plans covered only children and pregnant women — a large, but relatively healthy and inexpensive segment of the more than 60 million people covered by Medicaid.

What's different today is that states are beginning to target new populations for managed care. They include adults with disabilities and seniors who require long-term care, relatively small groups that nevertheless account for the lion's share of Medicaid costs. The hope is that more efficient care for Medicaid's sickest and most expensive patients will result in even greater savings.

Just yesterday (February 3), this approach received a nod of support from the federal government. In a letter to the nation's governors, U.S. Health and Human Services Secretary Kathleen Sebelius encouraged states to expand managed care to high-cost enrollees. "Just one percent of all Medicaid beneficiaries account for 25 percent of all expenditures," she wrote, noting that states don't need any special permission from Washington to cut costs by creating "initiatives that integrate acute and long-term care, strengthen systems for providing long-term care to people in the community, provide better primary and preventive care for children with significant health care needs, and lower the incidence of low-birth weight babies."

Managed care also has been a hot topic in discussions about reducing the federal debt. The Obama administration's National Commission on Fiscal Responsibility and Reform recommends enrolling about 9 million low-income senior citizens in managed care — the so-called "dual eligibles" who qualify for both Medicaid and Medicare. According to the commission, the change "would result in better care coordination and administrative simplicity," and save $44 billion by 2020. Another report, produced by the Debt Reduction Task Force, suggested the same idea, estimating the savings at $5 billion from 2012 through 2018.

The federal health care reform law does not necessarily push states to use what is known as comprehensive or capitated managed care, in which insurance companies share risk with Medicaid programs by agreeing to serve enrollees health care needs for a set price. But it does offer hefty financial incentives for states that offer a type of managed care called "primary care case management," where doctors receive a monthly stipend for coordinating care for Medicaid patients, including preventive care, acute care and hospitalization. Under the Affordable Care Act, the federal government will pay 90 percent of the costs for so-called "health homes," a type of primary care coordination designed to help reduce the costs of caring for people with chronic conditions.

That, in addition to the huge expansion of Medicaid required by the law — 16 million more people are expected to be covered by 2014 — is making managed care an increasingly attractive option for many states.

Building momentum

In the past, states backed away from managed care solutions for people with disabilities or elderly people who required long-term care, says Stephen Zuckerman, health policy analyst with the Urban Institute. "They required more specialized care than people perceived managed care plans were prepared to provide."

But now, with more experience behind them, states are starting to put their costliest patients into managed care. "When you look at Medicaid spending, you have to look at those populations," Zuckerman says.

States are finding other ways to expand managed care, as well. Some are adding behavioral health services and prescription drugs to plans that previously excluded them. Others are extending the geographical reach of managed care within a state by extending it to new counties and metropolitan areas. And others are going from making managed care a voluntary option for Medicaid patients to mandatory.

In Illinois, where Medicaid spending swallows one-third of general revenues, the state is trying a mix of strategies. Traditional capitated managed care will be part of the mix, but the state also plans to experiment with other risk-based financial arrangements, as well as so-called "pay-for-performance" plans in which health care providers are rewarded for improving health outcomes. Other programs in the works would encourage the use of evidenced-based medical practices, electronic medical records and primary care coordination.

Will it work? Experience from other states suggests that the savings will come — although the size of the savings varies widely. A study by health care consultants The Lewin Group shows savings from 0.5 percent to 20 percent in states that have tried some form of managed care. Their research also shows that managed care savings were biggest when applied to disabled populations. In Arizona, for example, 60 percent of its managed care savings over an 8-year period came from this high-cost group of patients.

Not an easy change

But moving Medicaid recipients into managed care can be difficult. Illinois, in fact, has some experience with the problems.

Early in 2010, Quinn called on the state's Medicaid office to find private insurers that would provide managed care coverage for the state's more than 35,000 disabled, blind and elder Medicaid recipients in the suburbs of Chicago. By June, two companies were selected — Aetna and Centene. Services were scheduled to begin January 1 of this year.

But so far, the insurers have been unable to sign up enough doctors and hospitals willing to participate in the plan. It is unclear whether the fees Illinois set are too low or whether doctors and hospitals are objecting to other terms of the contract.

Getting health care providers to participate has been a hurdle for managed care in other states, too — particularly in rural areas. Setting so-called "capitation rates" that are generous enough to attract doctors and hospitals, but not so high that states end up losing money is a delicate balance to strike.

In addition, advocates for disabled and elderly people have generally opposed the move to managed care for these populations. They say that vulnerable people should not have their access to care restricted by managed care organizations concerned about their bottom lines.

But proponents see big pluses — and not just on the cost side. "There are many advantages to Medicaid managed care," says Margaret Murray, executive director of the Association for Community Affiliated Plans, a group of nonprofit insurers. "Greater care coordination, a focus on preventive and in-home care and less institutional care — all features of managed care — help explain why it is such a cost-effective system."

In fiscal year 2010, 13 states expanded Medicaid managed care, according to an annual survey conducted by the Kaiser Commission on Medicaid and the Uninsured. In the budget year that ends this June, 20 states expanded managed care plans. Eleven of them added disabled and elderly populations, six included long-term care, and six moved from optional to mandatory managed care.

The evolution of managed care has been a steady process since 1990 when about 3 million Medicaid recipients started receiving services under managed care plans. In 1997, Congress

passed a law making it easier for states to get federal permission to put Medicaid recipients under managed care. The momentum has continued, and Julia Paradise, associate director of the Kaiser commission, doesn't expect that to end anytime soon.

"Nobody likes the fact that we're spending as much as we are on health care and not getting better outcomes," Paradise says. "There's more and more commitment to policies aimed at spending our health care dollars as best we can to get good outcomes, better care and lower costs. The best managed care arrangements show that close management of chronic illnesses, coordinated care, and access to prompt care in appropriate settings can translate into gains in both health and spending."

See Related Stories:
Setting up health insurance exchanges, states face big decisions (1/26/2011)
Health care budgets in critical condition (1/14/2011)
Stitching Medicare and Medicaid together (12/13/2010)
Tennessee's bold leap in care for the aged and disabled (10/12/2010)
Hope for the long term (4/15/2010)

—Contact Christine Vestal at cvestal@stateline.org

Comment on this story in the space below by registering with Stateline.org.

COMMENTS (1)

Add a comment

Most Recent Comments

Article on Illinois Medicaid Reform
By Josh Evans on Feb 4, 2011 9:13:59 AM

It is frustrating that another article from a national newsgroup has not properly captured the Medicaid reform bill.

This bill does not necessarily move Illinois closer to managed care, what it does is establish a process for developing care coordination models, which are not limited to managed care companies earning a profit margin to manage utilization and restrict access to services.

Many members of Illinois' General Assembly are uncomfortable with expanding the managed care model in this state due to historical disasters with those models.

To the pilot with Centene and Aetna - if you research Medicaid payment rates - and maybe speek with our Medicaid agency - you will know Illinois does not pay rates that cover costs. This has been publicly stated. I suspect this rate inadequacy, as well as many basic questions on how the plans will coordinate long-term care services for the disabled and mentally ill, are at the core of why this program is slow to get off the ground.

Either this program will succeed when Medicaid expansion hits in 2014, or it will prove to be a great deflection technique by a state that has a history of ignoring the fact that it's not done enough on its own to foster the growth of nursing, dentists, psychiatrists, primary care physicians, etc.

Report as Offensive

Read More Comments

Medicaid
Health
Plans of
America

Medicaid Managed Care

Joe Moser

Director of Federal Affairs

February 17, 2011

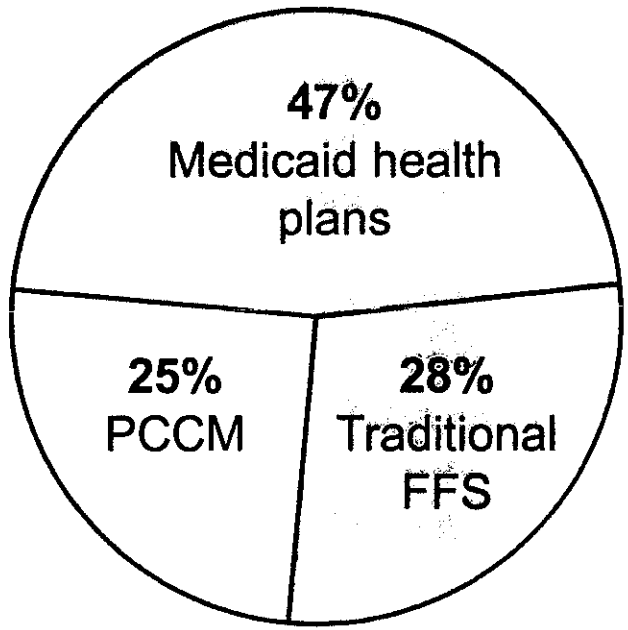
Highlights

- Industry Overview
- Outcomes & Quality
- Cost Savings
- Program Design

Medicaid Service Delivery Models

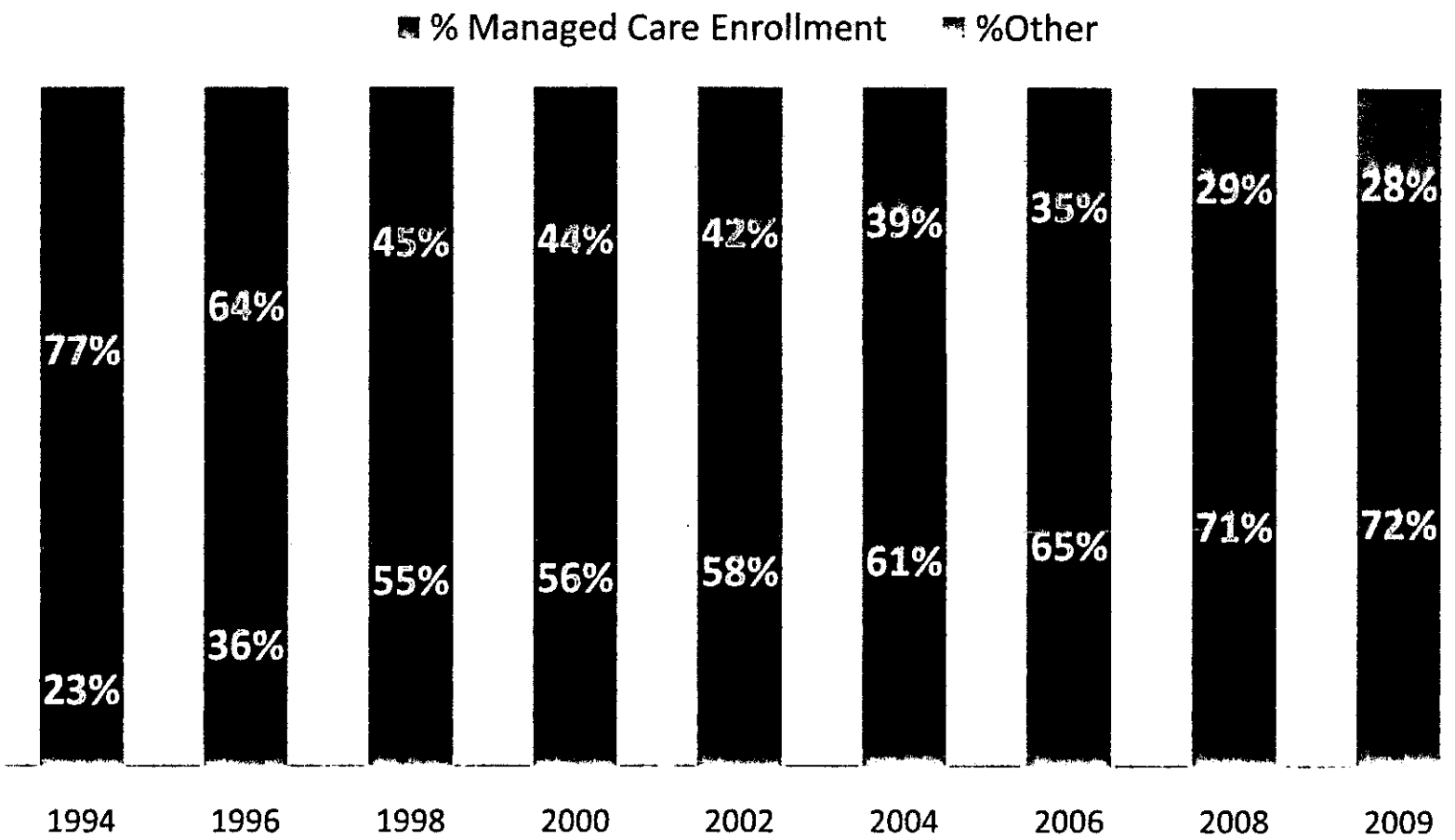
2009 Total Medicaid Enrollment

50 million beneficiaries



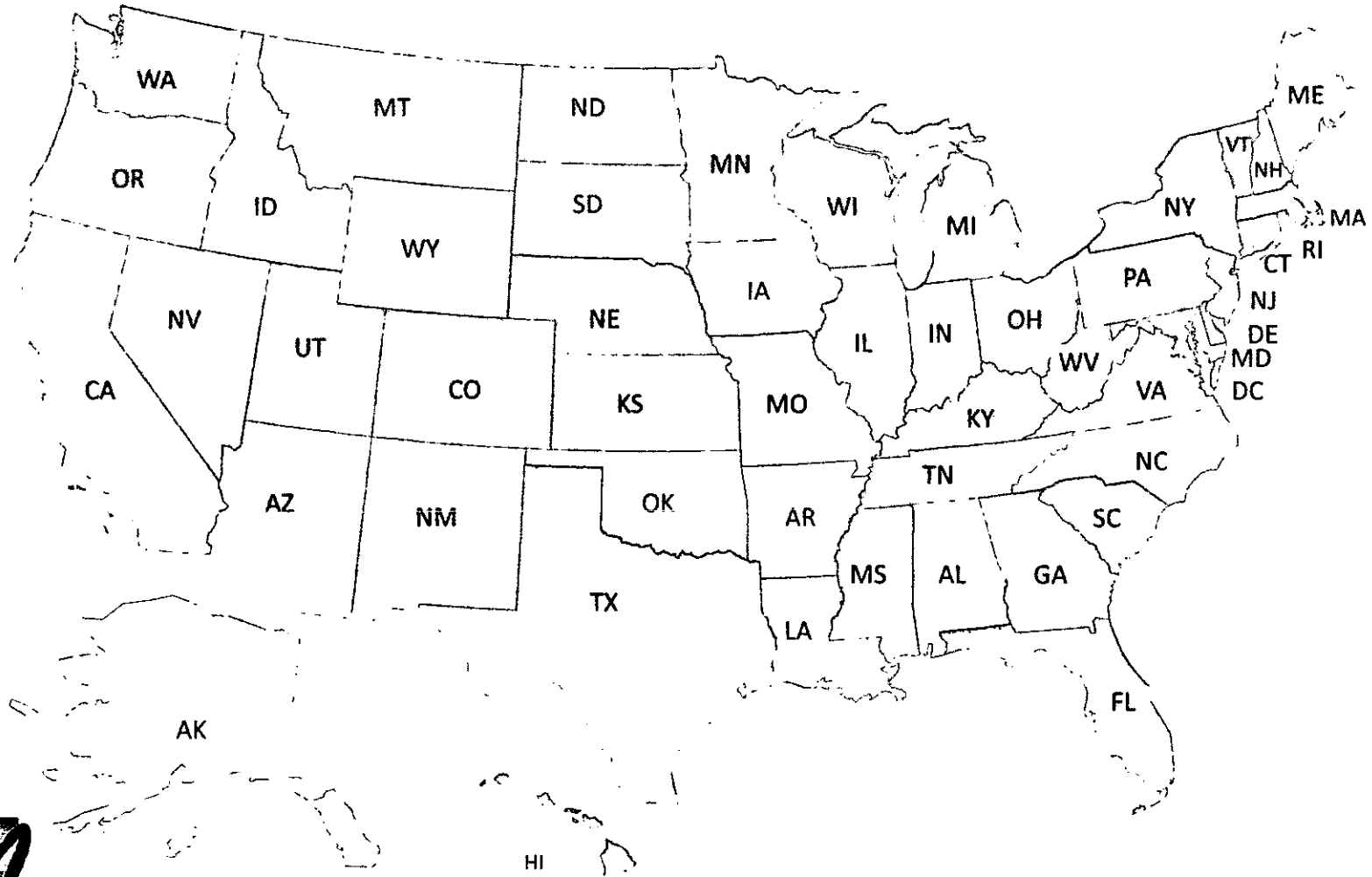
Data Source: 2009 CMS Medicaid Managed Care Enrollment Report
Medicaid Health Plan = CMS defined Commercial MCOs and Medicaid Only MCOs

Medicaid Managed Care Enrollment Trends



Data Sources: 2009 CMS Medicaid Managed Care Enrollment Report; NASHP Medicaid Managed Care, June 2005

The Majority of States Have Medicaid Health Plans



Data Source: 2009 CMS Medicaid Managed Care Enrollment Report
Medicaid Health Plan = CMS defined Commercial MCOs and Medicaid Only MCOs

States with Comparable Medicaid Enrollment

Medicaid Enrollment Rank	State	Medicaid Enrollment (09)	Medicaid Health Plan enrollment	% in Medicaid health plans	# Medicaid health plans
40	Nevada	213,440	106,302	50%	2
41	Idaho	198,000	0	0%	0
42	Rhode Island	177,981	120,243	68%	3
43	Delaware	170,562	117,602	69%	2
44	Vermont	156,503	137,385	88%	1
45	Dist. of Columbia	153,779	96,639	63%	3
46	New Hampshire	124,498	0	0%	0

The Health Plan Model

- Under capitation, health plans
  - Are paid a per member per month capitation payment
  - Bear financial risk for financing care for enrollees
  - Negotiate rates with providers to build networks
  - Are accountable to state contracts and federal regulations
- Creates the incentive to contain costs though reducing costs and improving health quality
- Enrollees are assigned or choose a primary care provider
- Providers coordinate care to prevent chronic disease, prevent utilization of higher-cost services, and manage chronic conditions

Why Medicaid Managed Care?

- Better access to care and care coordination
- Access to a medical home
- Higher enrollee satisfaction
- Quality assurance and improvement
- Delivery System Innovation
- Predictable costs
- Cost savings
- Reduced fraud and abuse

Medicaid Delivery System Comparison

	Health Plan	PCCM	FFS
Benefits to Members			
Identification card proving coverage	✓	✓	✓
A designated primary care physician	✓	✓	
Case management of primary care services	✓	✓	
Disease management	✓	✓	
Comprehensive case management	✓		
Quality standards and continuous quality improvement programs	✓		
National accreditation	✓		
Cost Containment			
Claims analysis	✓		
Utilization review	✓		
Improved generic utilization	✓		
Using lower cost service where available	✓		
Cost predictability	✓		

Federal Rules

- Consumer protections
  - Anti-discrimination, grievance procedures, provider-enrollee communication
- Quality assurance requirements
  - Access to providers, credentialing of providers, network adequacy, performance measurement reporting
- Fraud and abuse protections
  - Marketing Restrictions, sanctions for non-compliance
- Payment timeliness requirements

Non Profit Plans

For Profit Plans

Medicaid only

Single State

Multi-State

Single State

Multi-State

Multiple Lines of Business

Comparative Profits

1.	Network and Communications Equipment	20.4%
2.	Internet Services and Retailing	19.4%
3.	Pharmaceuticals	19.3%
4.	Medical Products and Equipment	16.3%
5.	Railroads	12.6%
6.	Financial Data Services	11.7%
7.	Mining, Crude-Oil Production	11.5%
8.	Securities	10.7%
9.	Oil and Gas Equipment, Services	10.2%
35.	Health Insurance and Managed Care	2.2%

Fortune Magazine 2009 list of most profitable industries: 2008 profits as a % of revenues

Better Quality

- Health plan resources and federal quality improvement requirements facilitate care coordination, case management and disease management
- A study of New York Medicaid found that managed care HEDIS rates were statistically higher than FFS rates*

*Roohan, et al. Quality measurement in medicaid managed care and fee-for-service: the New York State experience.

Best Practices

Passport Health Plan (Kentucky): Early Periodic Screening Diagnosis and Treatment (EPSDT) Program

Health Plan outreach to providers and parents for children who did not receive EPSDT screenings resulted in

Performance Measure	Percentage Point Increase
Annual dental visits	14.88
Well Child Visits (>15m)	38.19
Well Child Visits (3-6y)	22.92
Well Child Visits (adolescents)	28.55

Best Practices

Select Health of South Carolina

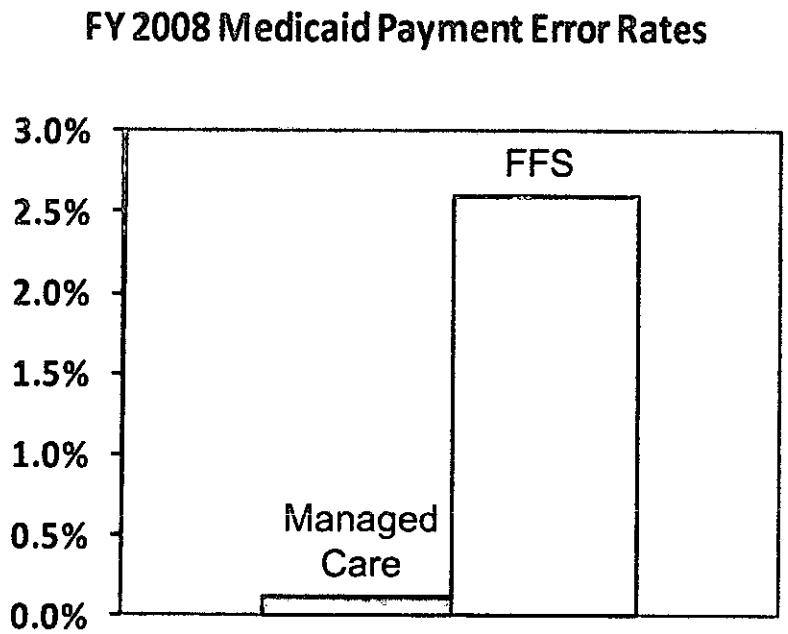
Healthy Moms and Babies Program

- Improved rates for Timeliness of Prenatal Care; Postpartum Care; and Frequency of Ongoing Prenatal Care

Reducing the Risk of Recurring Preterm Births

- Experienced a 73% reduction in recurring preterm births

Better Performance



CMS reported that in FY 2008 payment error rates for Medicaid managed care were 0.1% compared to 2.6% for Medicaid fee-for-service.

Pharmacy Savings

- Health plans have 14.8% lower pharmacy costs than traditional Medicaid
- Generic utilization rate is 80% in Medicaid health plans, compared to 68% in traditional Medicaid
- Health plans ensure proper utilization with pharmacy management techniques
- Estimated $3.8 million savings for New Hampshire in 2011 and $21 million over next ten years

The Lewin Group: Potential Federal and State-by-State Savings if Medicaid Pharmacy Programs were Optimally Managed, December 2010

New Hampshire and Medicaid Expansion

- 62,440 newly-eligible Medicaid enrollees with health reform by 2019 (47% increase)
- Estimated cost of $2.1 billion 2011-2019
  - $1.96 billion federal
  - $135 million state

Studies on Savings Potential

- 2%-19% State savings realized through health plans

  [synthesis of 14 studies by Lewin for AHIP, 2004]

- 10%-20% Savings in Pennsylvania = $2.7 billion 2000-2004
- 5% Average estimate of TANF capitation savings

  [Lewin Group Capitation Savings for MHPA & ACAP, 2006]

- 8% Average Estimate of SSI capitation savings

  [Lewin Group Capitation Savings for MHPA & ACAP, 2006]

- 5%-11% Estimated Savings for Illinois SSI population
- 6.7% Savings for Georgia TANF population

Estimated Health Plan Savings New Hampshire 2011-2019

	Existing Population	Expansion Population	Total
Federal	$170 million	$115 million	$285 million
State	$170 million	$10 million	$180 million
Total	**$340 million**	**$125 million**	**$465 million**

UnitedHealth Center for Health Reform & Modernization: Coverage for Consumers, Savings for States: Options for Modernizing Medicaid; Working Paper 3, April 2010.

Program Design

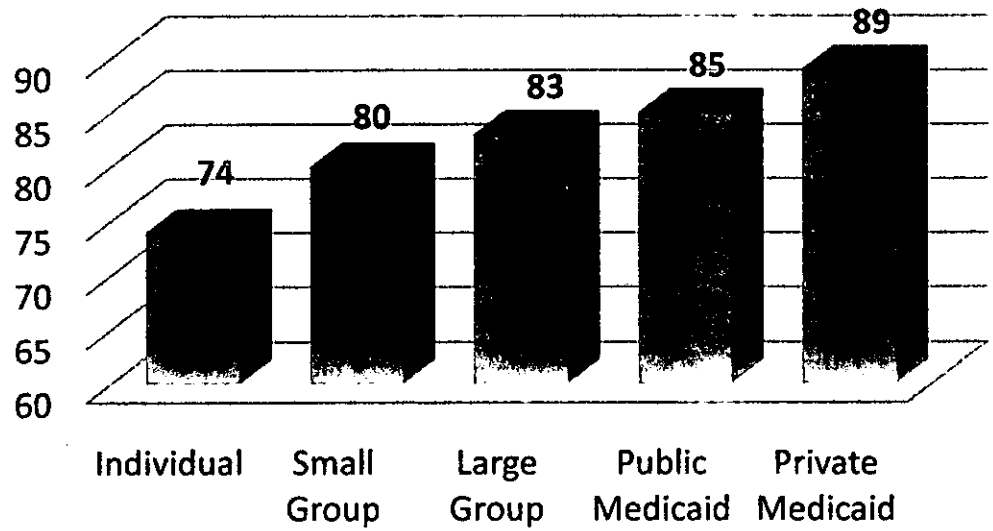
- Competing private plans
- Beneficiary choice of plans
- Communicate clear expectations of plans
- Consistent oversight
- Actuarially sound rates
- Risk adjustment
- Give plans flexibility to innovate
- Incentives to improve quality

Medical Loss Ratio

A Medical Loss Ratio is not needed if plan payment rates are actuarially sound.

- Medicaid = Higher medical costs, less marketing

2009 MLR



Information compiled by MHPA staff from Oppenheimer and U.S. Senate Commerce Committee reports from 2009 regulatory filings.

Questions

Joe Moser

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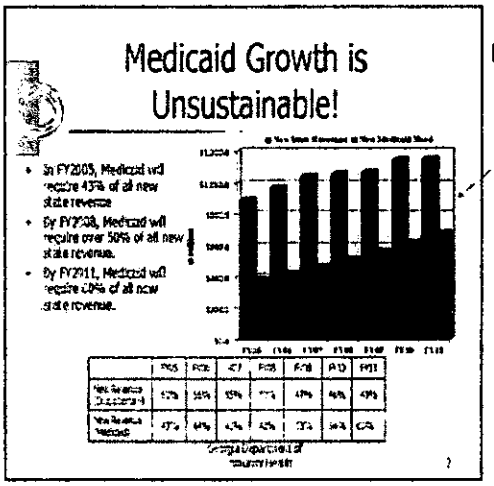
GEORGIA MANAGED CARE EXPERIENCE

NEW HAMPSHIRE LEGISLATIVE BRIEFING

FEBRUARY 17, 2011

Mark Trail, Healthcare Consultant
Former Georgia Medicaid Director

Why Managed Care?



Managing under an PCCM Program

FY 2005 Projections indicated that by FY2011 Medicaid would require 60% of all new state revenue.

Health Care Cost Drivers Addressed by Managed Care:

- Utilization
- Unit Price
- Lack of a medical home
- Limited knowledge on how to access appropriate care

* Source: Department of Community Health FY 2005 Presentation

2

Typical Cost Saving Strategies

- Member Reduction
  - GA implemented several strategies in 2005 & 2006
    - Citizenship & medical necessity for Emergency Medicaid and TEFRA
  - Now held to levels & regulations in place - 2008
- Service Reduction
  - Minimal opportunity in most states
- Price Reduction
  - State still has to maintain access
- Utilization Management
  - Managed care techniques

3

Georgia Medicaid Benefit Management

- Managed Care – Full Risk - Mandatory
  - Low Income Medicaid
  - Breast & Cervical Cancer
  - PeachCare for Kids
- Disease State Management (Enhanced PCCM)
  - SSI Adults – Voluntary opt-out
  - SSI Children – Voluntary opt-in
- Administrative Services Organization
  - All others
    - Dually Eligible, SSI not in DSM, Katie Beckett, Waivers, etc.

4

Planning and Preparation

- Did not require legislation
  - Savings recognized in the appropriation process
- Claims Run-Out
  - GA had been operating Medicaid on a cash basis
  - Recognized that any prospective change require run-out due to claims filing lag
- GA had the plans bid both design & rates
  - Savings were realized in the first year

5

Georgia Families

- State - 6 Regions
- State served by 3 plans
  - Competitively selected – Quality & Price
- Metro served by all 3 plans
- Each of the 5 Rural Regions served by only 2 plans
  - Plans have to serve entire Region
- Contracting Model
- State Plan - Benefit
- Full Risk – Carve–In
  - Behavioral Health, Pharmacy and Dental Carved-In
    - Improved Coordination and Outcomes of Care

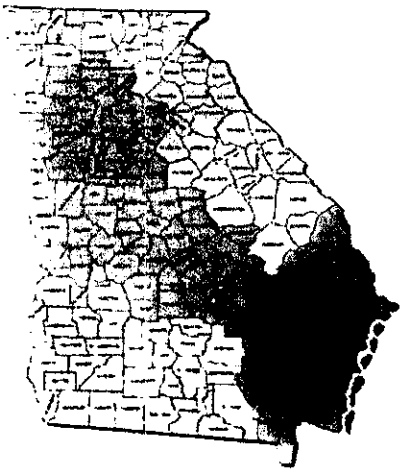
6

Georgia Families: Care Management Organizations

3 CMOs: Amerigroup,
Peach State Health Plan (Centene),
and WellCare

Competition in 6 Regions:
- All 3 in Atlanta
- 2 in each of the other 5

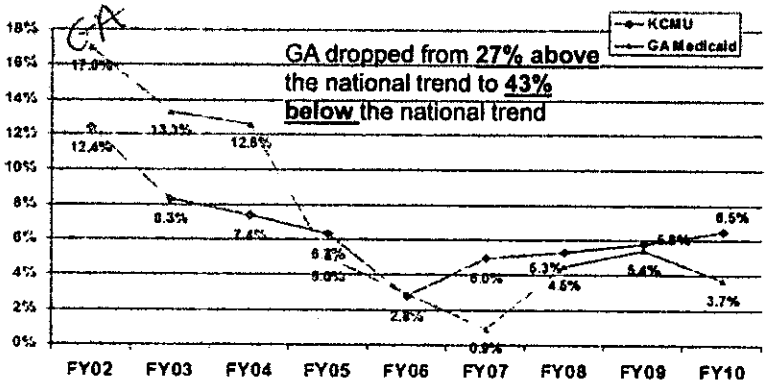
Manage over 1.1 million members in Medicaid and PeachCare:
- 85% are children
- 15% are pregnant women and low income parents
- Aged, blind and disabled are covered in fee for service



7

GA vs. National Medicaid Trends

Annual Increases in Medicaid Benefit Expenditures



Source: The Kaiser Commission on Medicaid and the Uninsured, *The Crunch Continues: Medicaid Spending, Coverage, and Policy in the Midst of a Recession: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2003 and 2010*, September 2003.

8

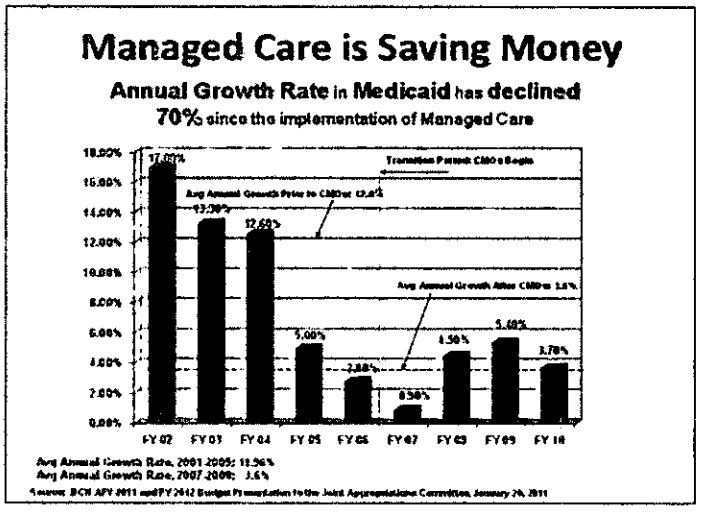
Cost Savings

" When I came into office, Medicaid was growing annually at rates as high as 17 percent. Over the last four years, growth averaged just 3.4 percent, saving the state a staggering $4.7 billion. Those are numbers that any business would envy."

Governor Sonny Perdue
"State of the State"
January 14th, 2009

9

Cost Savings



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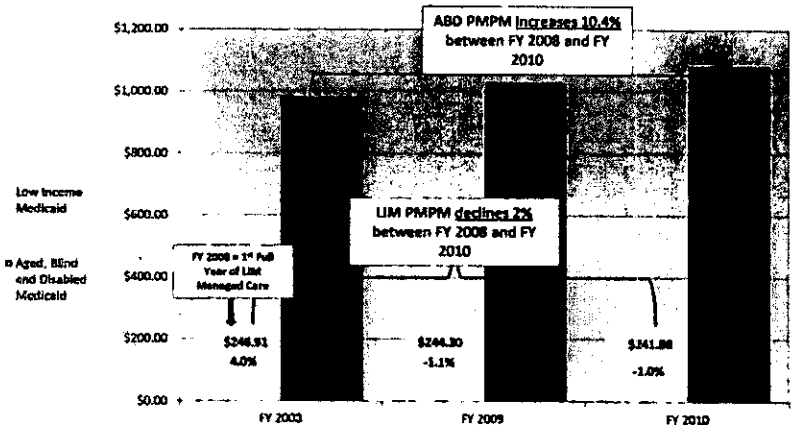
ABD and LIM PMPM Trend: FY '08 – FY '10



LIM Trend:
1. LIM includes CMO members and LIM FFS members (foster children and CMO eligible in their plan choice period).

ABD Trend:
1. ABD is covered under FFS. 2. The ABD members in this analysis exclude dual eligible that are covered in Medicare or as a Qualified Medicare Beneficiary. Some SSI members included in this estimate may be dually eligible (also covered under Medicare).

Unaudited

11

Increased Access and Quality

Measure	GA Families	Medicaid FFS
Adult Access - Preventive Care	85.2%	75.1%
Annual Dental Visits	55.9%	49.5%
Cervical Cancer Screening	66.7%	30.0%
Diabetes Care – HbA1c	70.5%	43.0%
Diabetes Care – LDL-C	61.0%	36.5%
Prenatal Care Timeliness	53.5%	44.2%
Cesarean Delivery Rate	30.1%	35.1%
Rate of Low Birth Weight Babies	6.5	14.1
Asthma Admit Rate per 100K	151.5	385.3
Diabetes Admits – short term complication rate per 100K	32	90.4

Source: DCH 2009 and 2010 Performance Measure Report

12

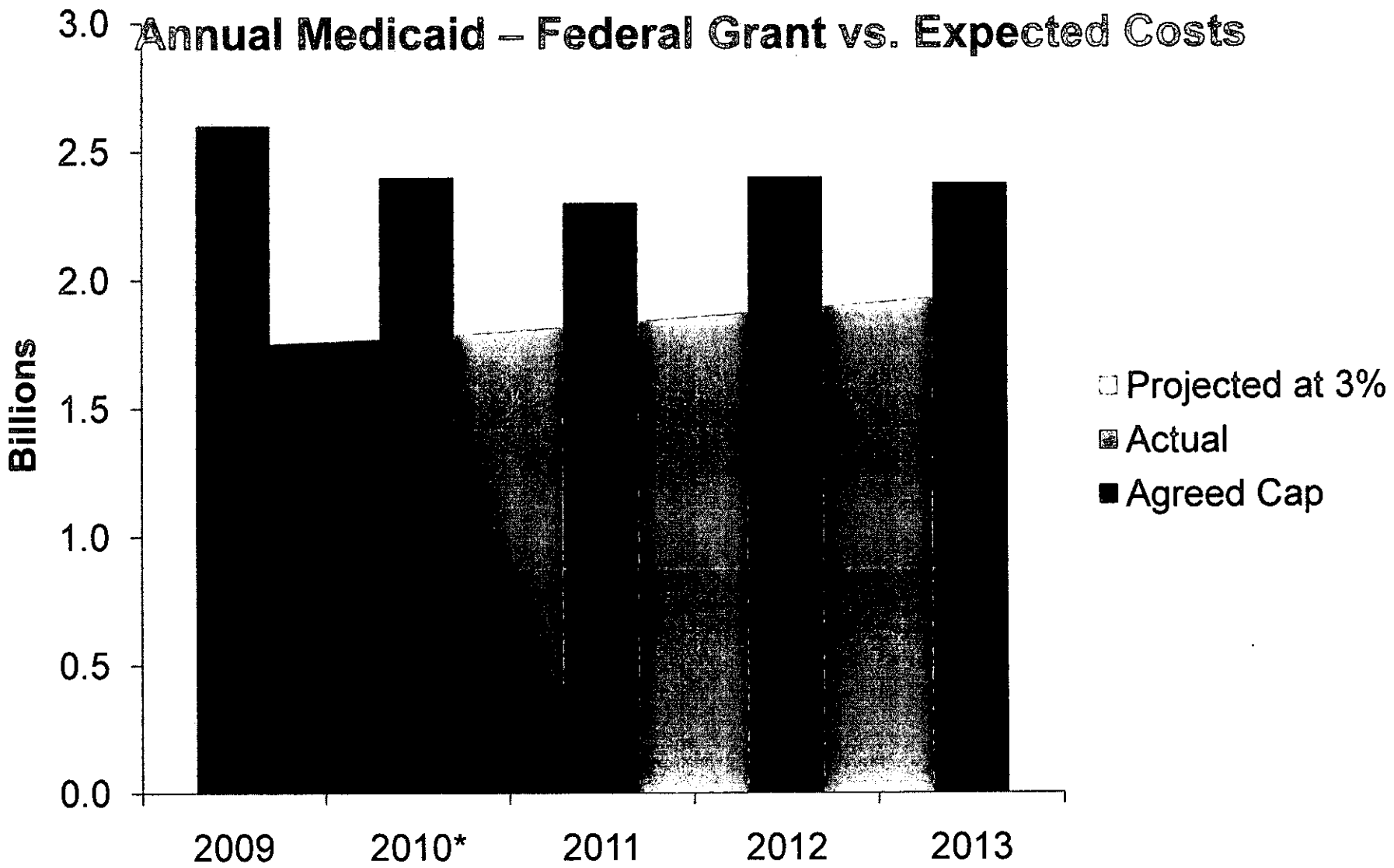
Stephen

Lucas Group Partners

Rhode Island Global Medicaid Waiver

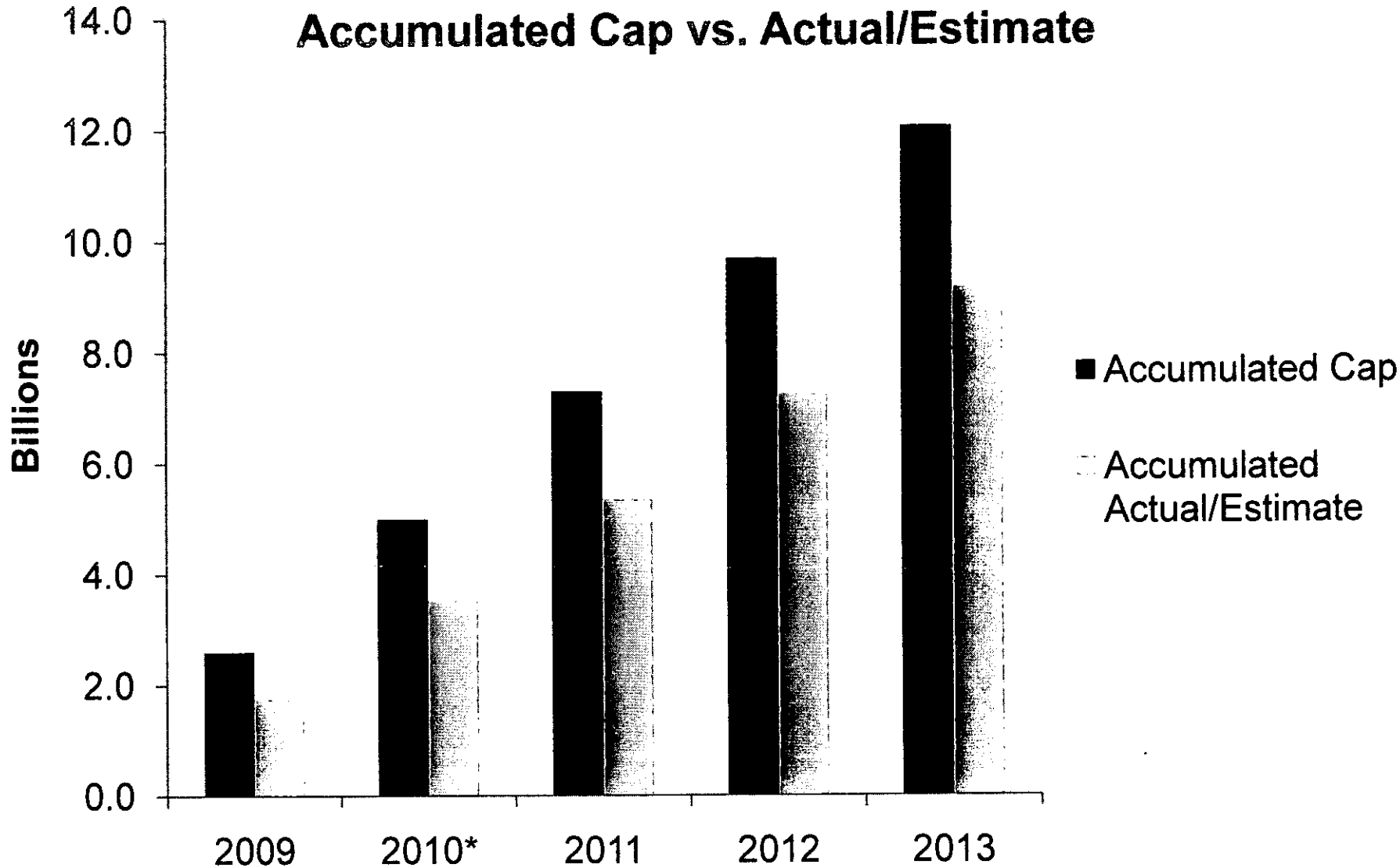
Early Results Prove Lucas Group's Efforts May Save RI Taxpayers $2.9 Billion over Five Years

Rhode Island Has Already Saved Approximately $1.5 Billion in the First Two Years of its 1115 Waiver



Source: Lucas Group analysis of date from RI DHS
* 2010 annualized from data through September

Rhode Island's Waiver On Path To Save $2.9 billion over 5 Years



Stephen

How MMC Programs Improve Healthcare Costs

Improving access to preventive and primary health care by requiring participating doctors and hospitals to meet standards for hours of operation, availability of services, and acceptance of new patients

Investing in enrollee outreach and education initiatives designed to promote utilization of preventive services and healthy behaviors

Providing a "medical home" to an individual and utilizing a physician's expertise to refer patients to the appropriate place in the system (as opposed to relying on the patient's ability to self-refer appropriately)

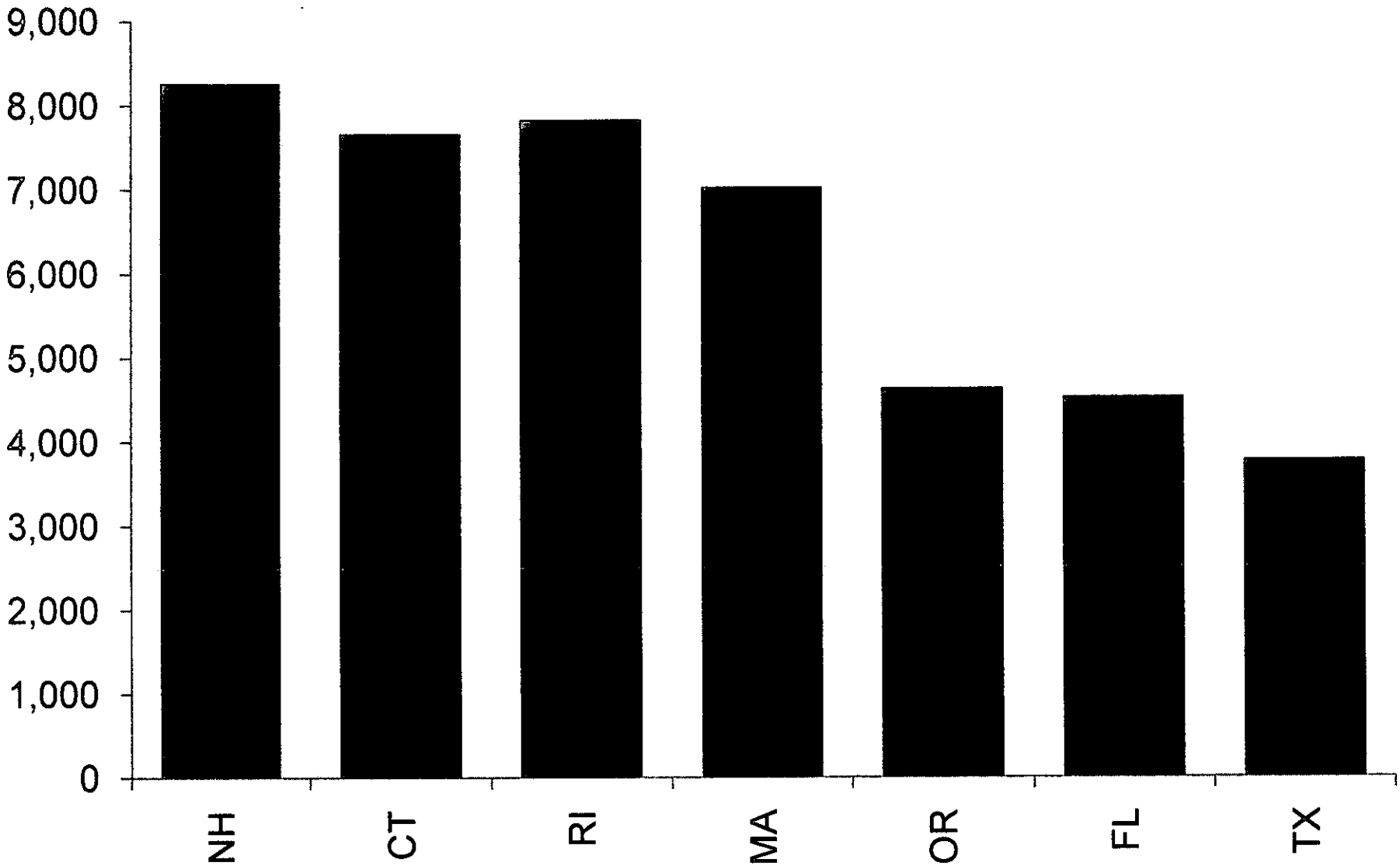
Providing individualized case management services and disease management services

Channeling care to providers who practice in a cost-effective manner

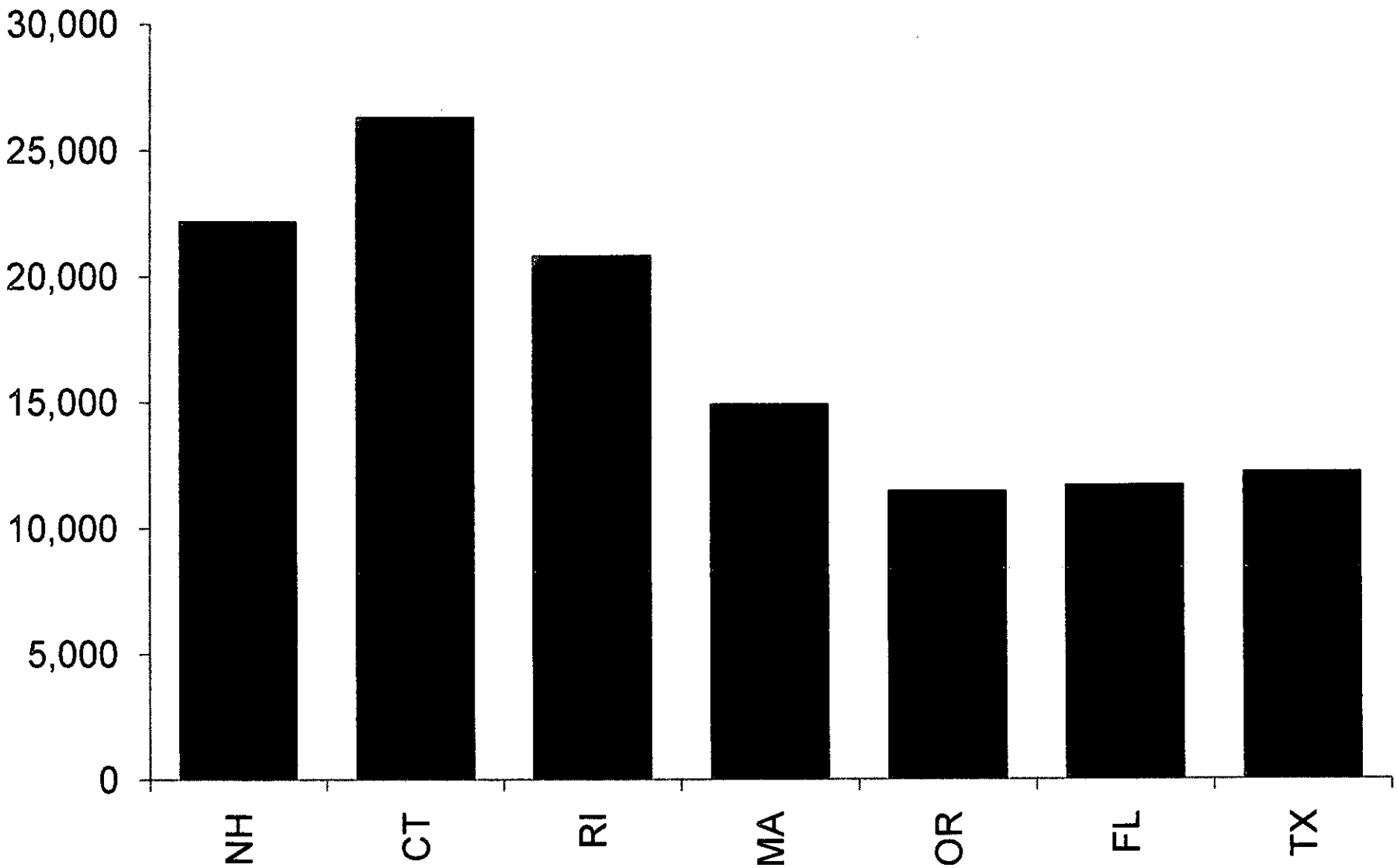
Using lower cost services and products where such services and products are available and clinically appropriate (in lieu of higher-cost alternatives)

Conducting provider profiling and enhancing provider accountability for quality and cost-effectiveness

Comparing Individual States – All Medicaid

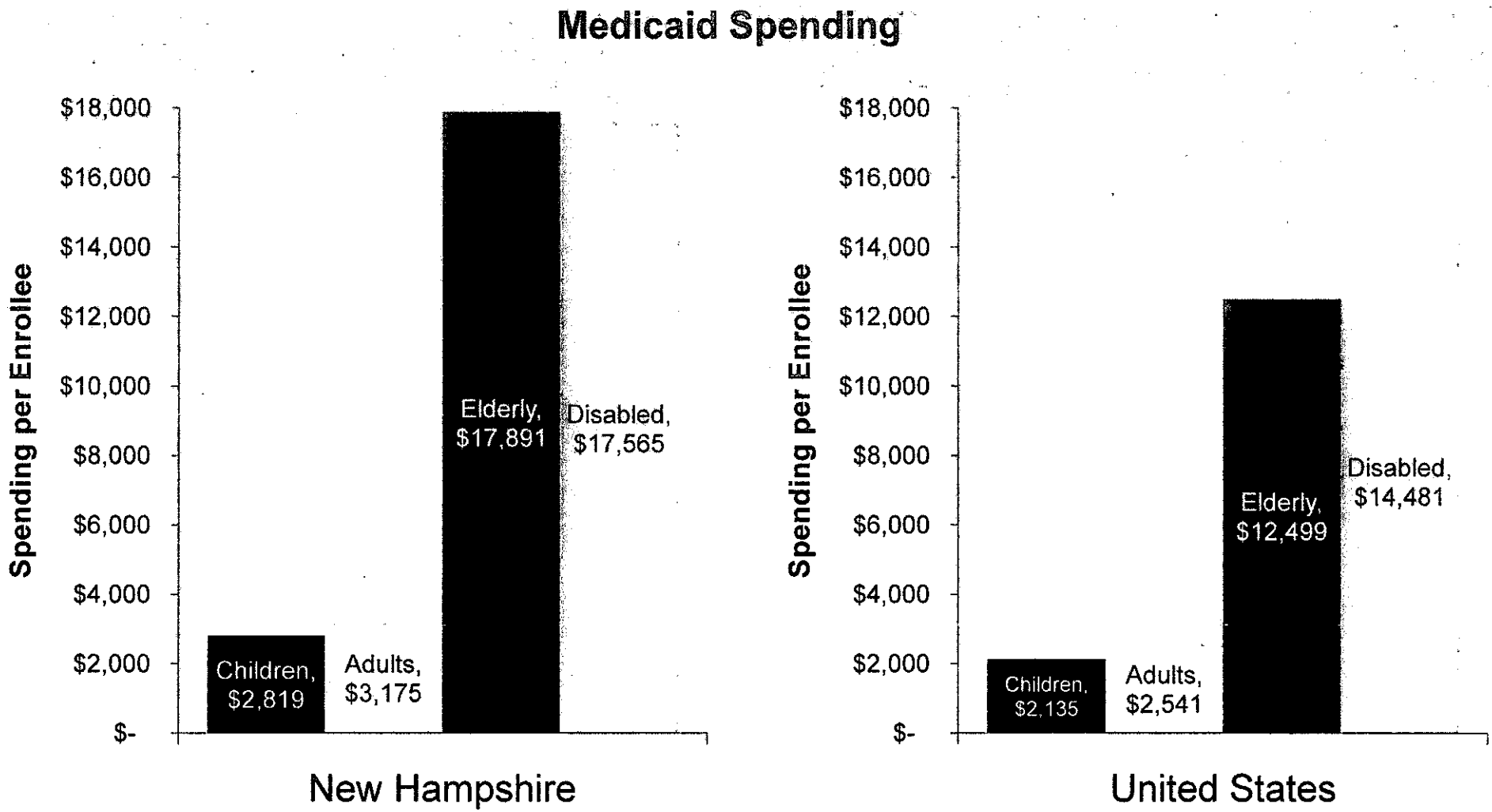


Comparing Individual States – Aged, Blind & Disabled



Stephen

Medicaid Spending in NH Higher than US Average



If New Hampshire Medicaid spending were at US average, NH would save approximately $230 million each year ($115 million state portion at 50% FMAP)

Source: Kaiser Statehealthfacts.org 2007 data

Testimony for the Record

Submitted by

Joe Moser

Director of Federal Affairs

Medicaid Health Plans of America

Public Hearing

Senate Bill 147: An Act on Medicaid Managed Care

Health and Human Services Committee

New Hampshire State Senate

February 17, 2011

Chairman Bradley, 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 criticisms of this approach are that it comes with an additional add-on payment, doesn't actually replace the fee-for-service model with its perverse incentives, is limited in scope to selected services, and does little to curb inpatient utilization and costs. The evidence of overall program savings under this approach is mixed.

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 here today, 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 Maine, 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.

The United Healthcare paper cited above estimates $340 million in savings from 2011-2019 for your current Medicaid program by implementing a Medicaid managed care program that includes all populations immediately, with $170 million of that savings accruing to the state government, and $170 million accruing to the federal government. They estimate an additional $125 million in savings if the Medicaid expansion goes into place, with $115 million being federal savings and $10 million being state savings.

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

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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

(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 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.

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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

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.

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.

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

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.

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 testify before your committee today. I look forward to answering any questions you may have.

Stephen

Managed Care ABD Approaches

Disease Management	• System of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. Helps patients to adhere to medication regimens to develop healthy lifestyle choices, and to seek regular professional monitoring of their symptoms
Care Coordination	• Assessing the needs of a client and effectively planning, arranging, coordinating and following-up on services that most appropriately meet the identified needs of the client. States have used care coordination (for Medicaid recipients) to improve the quality of care that they receive.
Primary Care Case Management	• Medical care model in which patients are assigned to a primary care physician who is responsible for managing the quality, appropriateness, and efficiency of the care they receive. Many states use PCCM in their Medicaid programs, either as the sole delivery system or in conjunction with managed care systems.
Mandatory Full-Risk Capitated Managed Care	• System where providers are paid on a per member per month basis and thus assume the risk in caring for each patient. Care is coordinated proactively to anticipate problems, and address them before issues arise.

Populations Included	SSI-PD Only	SSI-PD 1915(c) Waiver	SSI-PD 1915(c) Waiver Nursing Home Behavioral Health	SSI-PD 1915 (c) Waiver Nursing Home Behavioral Health ICF-MR

Disease Management Programs for Chronically Ill-ABD

Defined as a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant.

- Chronic diseases such as diabetes, obesity, congestive heart failure, and untreated or under-treated asthma can lead to unnecessary hospitalizations and/or necessitate the need for Long-Term Care services.
- States have begun aggressive campaigns to monitor and prevent complications through care that includes helping patients to adhere to medication regimens to develop healthy lifestyle choices, and to seek regular professional monitoring of their symptoms.
- At this time, at least 12 states have Disease Management programs that apply to their Long-Term Care settings, and numerous other states indicated that they are developing programs. Some of the states report limiting their DM program to participants with certain chronic conditions or certain plans. Several additional states indicated that it was a requirement that the Managed Care plans that they contract with have Disease Management components.

Disease Management Programs in Other States

- **Idaho**
  - Targets specific diseases of all participants. Long-Term Care participants receive their Disease Management services from their acute care provider even if they reside in a Long-Term Care setting.
- **New Jersey**
  - Awarded a three-year federal grant (Empowering Older People to Take More Control of their Health through Evidence-Based Prevention Programs)
  - Among 16 states selected to implement low-cost, community-based disease and disability prevention programs that have proven to reduce the risk of disease and disability among older adult participants
  - Establishing the Chronic Disease Self-Management (CDSM) Program and Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) program
- **North Dakota**
  - Implements Disease Management for all Medicaid recipients that have asthma, diabetes, Chronic Obstructive Pulmonary Disease (COPD), and Chronic Heart Failure (CHF)
- **Tennessee**
  - Disease management is applied across the board to its entire Medicaid population, including those who receive Long-Term Care services.
- **Texas**
  - HMOs must provide, or arrange to have provided to members, comprehensive Disease Management services consistent with state statutes and regulations.
  - HMOs must develop and maintain screening and evaluation procedures for the early detection, prevention, treatment, or referral of participants at risk for or diagnosed with chronic conditions such as asthma, diabetes, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, or other chronic diseases based upon an evaluation of the prevalence of a disease within HMO's membership. The HMO must ensure that all members identified for DM are enrolled into a DM Program with the opportunity to opt out of these services within 30 days while still maintaining to access to all other covered services.

Source: State websites

Care Coordination

Care coordination is a process that includes assessing the needs of a client and effectively planning, arranging, coordinating and following-up on services that most appropriately meet the identified needs of the client. States have used care coordination (for Medicaid recipients) to improve the quality of care that they receive.

- One of the strongest trends identified in this survey was the use of care coordination to assist in the improvement and integration of care.
- At this time, at least 21 states have created some form of a care coordination model.
- The goal of these models is to improve and integrate care and each state has adopted unique features to cater to states individual needs

State ABD Care Coordination Programs

New Hampshire: Enhanced Care Coordination

- Medicaid initiative that offers comprehensive, patient-centered medical management and care coordination. The program works with Medicaid recipients who are Medicaid eligible through the Temporary Assistance to Needy Families (TANF) and Aid to the Permanently and Totally Disabled (APTD) categories of assistance and existing DHHS funded community based case managers. fostering the concept of a medical home, reducing hospital readmissions and emergency room use, provider outreach and support, including convening case conferences as needed. No waiver necessary. Program is voluntary.

Mississippi: Full Risk Pre-Paid Capitation Coordinated Care

- Recently issued an RFP for MississippiCAN in 2009. The goal was to improve efficiencies and cost effectiveness by connecting targeted beneficiaries with a medical home, increasing access to providers and improving the beneficiaries use of primary and preventative care services. This is intended to be accomplished by providing systems and supportive services, including disease state management and other programs that will allow beneficiaries to take increased responsibility for their health care. The plan is to contract with Coordinated Care Organizations on a full-risk prepaid capitated basis to provide comprehensive services through efficient, cost-effective system of care.

Arizona

- serves people who are developmentally disabled, physically disabled, and/or elderly and who are at risk of an institutional level of care. All members are assigned a case manager to assist with the coordination of care. Members can move between HCBS and institutional settings as needed. The only restriction on HCBS is that the cost of care must be no more than the Medicaid cost of institutional care.

California

- Care coordination for individuals with chronic conditions who are seriously ill. The goal of the state's new program is to enhance the coordination of care, improve health outcomes, and decrease the long-term costs of chronically ill populations by using a holistic approach. Interventions will include intensive case management and Disease Management strategies including: referrals to improve mobility and provide needed financial and social support, disease self-management education, development of individualized care plans using evidence-based practice guidelines, and promotion of the use of disease/patient registries to share data.

Massachusetts

- Special care coordination plan for pediatric patients. Under the Massachusetts model, all Medicaid cases for children with complex care are managed by a care coordinator.

Source: State websites

State ABD Care Coordination Programs

Idaho

- Coordinates and integrates benefits for individuals eligible for both Medicare and Medicaid. It is one of the three benefit packages that comprise Idaho's Medicaid Modernization plan. Individuals who opt into the Medicare/Medicaid Coordinated Plan will receive an integrated benefits program offered by a participating Medicare Advantage Organization (MAO). Medicaid will pay the premium for the integrated Medicare Advantage Plan offered by a participating MAO. The integrated Medicare Advantage Plan will cover some services usually covered by Medicaid, such as primary care case management, prescribed drugs not covered by Medicare Part D, and dentures.

Minnesota

- comprehensive care coordination model for seniors and people with disabilities that applies to enrollees in all settings (nursing home, waiver, and other community settings regardless of level of need). All enrollees are screened within 30 days of enrollment and are assigned a care coordinator or health service coordinator. The staff assists in coordinating all aspects of care, including access to primary and specialty care, chronic care conditions, as well as to Long-Term Care, social and community support services. Most aspects of this care coordination are also found in the Minnesota Senior Care Plus (MSC+) program, which is a separate, mandatory managed care program that includes Medicaid wrap-around services and Long-Term Care but is not integrated with Medicare.

New Jersey

- A part of the state's GO for LTC program, the Nursing Home Transition initiative, implemented an interdisciplinary team approach to coordinate discharge planning for nursing home residents whose level of service needs can be supported with HCBS.

Rhode Island

- Covers adults and elders with very high utilization in key diagnostic groups. The program was be significantly expanded effective September 1, 2007, by offering nurse care manager services to moderate and high-risk clients in primary care practice settings regardless of diagnosis.

Vermont

- Chronic Care Program (CCP) focuses on Medicaid's highest utilizers with chronic conditions. The CCP emphasizes evidenced-based planned and collaborative care for Medicaid beneficiaries. A registered nurse and a medical social worker team will be regionally based and work with care coordination clients and primary care providers directly.

Source: State websites

Hawaii: Quest Expanded Access (QExA)

Basics

- Sec. 1115 Waiver
- Managed health care plan integrating its Medicaid members who are either aged (65+), blind, or disabled (ABD)
- Enables these populations to access primary, acute, behavioral health, and LTC services
- Covers approximately 39,000 ABD
- Started February 1, 2009
- Mandatory enrollment

Eligible Populations

- ABD individuals living at home
- ABD individuals residing in long-term care institutions
- ABD individuals enrolled in an existing home- and community-based services program and residing in the community setting
- Other relatively small, specialized ABD populations

Carve-Outs

- DD/MR (Developmentally Disabled/Mentally Retarded) waiver clients use their QExA health plan for acute and primary care services ONLY. They receive Medicaid waiver services (case management, etc.) as they do now.
- Behavioral health services for enrollees with serious mental illness (SMI) or children with serious emotional disturbances (SED)

Providers

- 'Ohana Health Plan (via WellCare Healthplans Inc. – 2.3 MM members nationwide)
- Evercare (via UnitedHealth Group – 70 MM members nationwide)

Source: State website

Oregon: Oregon Health Plan (OHP) Plus

Basics

- Covering approximately 62,000 members of the ABD population, which is about 62% of the total eligible ABD population.
- Enrollment is mandatory if MCOs in the community have the capacity to handle everyone who is eligible in a given area. Services Covered

Eligible Populations

- The OHP Plus program is for people who are aged, blind, disabled, under age 19, pregnant or receiving Temporary Assistance for Needy Families benefits.
  - The Aid to the Blind (AB) and Aid to the Disabled (AD) eligibility categories cover people with disabilities who meet federal criteria. Seniors (individuals 65 and older) are covered in the Old Age Assistance categories (OAA). Most individuals in this group have Part A and/or Part B Medicare. Some of these individuals are also covered by Medicare. Individuals who have both Medicare and Medicaid (such as OHP) are known as "dual eligibles"

History

- First applied for Medicaid waiver in 1991. It was initially denied due to possible violations of the Americans with Disabilities Act.
- The waiver application was revised and resubmitted in 1992 and approved in 1993
- In 1994, Oregon started enrolling the first Oregonians into the Oregon Health Plan.
- The ABD population was added in 1995 and a gradual expansion of coverage for mental health services and chemical dependency services began.
- Began pharmacy management program and disease management program in 2002
- In 2003, the OHP Basic plan is renamed to OHP Plus. Eligibility and services do not change, just the name. OHP Standard is created which offers reduced benefits, higher copayments and requires premiums but is open to people who are typically not eligible for public insurance options.

Services

- OHP Plus covers medical, dental, mental health and chemical dependency services plus: Hearing services, hearing aids and batteries Home health Hospital stays Physical, occupational and speech therapy Private duty nursing, Routine vision testing and eyeglasses, transportation to health care services

Providers

- 12 different providers, including Kaiser Permanente

Source: State website

New Jersey: New Jersey Care 2000+

Basics

- 1915 (b) waiver
- Approximately 95,000 of the 200,000 people in New Jersey who meet the eligibility standard for being "aged, blind or disabled" and receive New Jersey Medicaid are being moved from traditional Medicaid to managed care
- Some New Jersey Medicaid beneficiaries, including those who reside in institutions and those who receive both Medicare and Medicaid benefits, continue to receive traditional "fee-for-service" Medicaid.

Eligible Populations

- All non-dually eligible (Medicaid, no Medicare) ABD beneficiaries, and clients of the Division of Developmental Disabilities (DDD), including individuals enrolled in DDD's Community Care Waiver, enroll in an HMO to receive their Medicaid benefits

History

- Division of Medical Assistance and Health Services (DMAHS) has been providing mandatory managed care services for the AFDC/TANF and NJ KidCare/FamilyCare populations since 1995 and 1998, respectively, through the New Jersey Care 2000 program.
- On October 1, 2000, the program was expanded to move the Aged, Blind and Disabled (ABD) populations into mandatory managed care.

Carve-outs

- Pharmaceutical services for ABD Beneficiaries (Non-dual eligibles) PT, OT, Speech
- Some transportation
- Mental health & substance abuse for non-DDD clients
- Some blood products

Providers

- AmeriChoice
- AMERIGROUP NJ
- Horizon NJ Health
- Health Net of New Jersey, Inc.
- University Health Plans

Source: State website

Ohio: Managed Care for the Aged, Blind & Disabled

Basics

- Has 8 managed care plans that cover 1.2 million members and 108,000 ABD
- $4 Billion Medicaid managed care program
- Finished roll out of its regional ABD system in 2007
- Approximately 125,000 of these elderly or disabled individuals will be transitioned into arrangements in which they will receive medically necessary Medicaid covered services through managed care plans (MCPs)
- State sets Medicaid rates separately for the CFC and ABD populations

Eligible Populations

- Non-dual eligible ABDs not enrolled in a Medicaid HCBS waiver

Value-Added Services

- 24 hour hotline for medical advice & direction. Provider directory, Member handbook, Grievance resolution system, Provider network management, Member services, Preventive care reminders, Health education materials & activities, Expanded benefits including: transportation, vision, and incentives (varies among MCPs), Extended office hours (varies amount MCPs)

Carve-outs

- Approximately two-thirds of ABD consumers in Ohio are exempt from Medicaid managed care and will continue to receive their services via the traditional fee for service system. ABD consumers who will be excluded from Medicaid managed care include:
  - People with both Medicaid and Medicare coverage ("dual eligibles").
  - Children 20 years of age and under.
  - Consumers enrolled in a Medicaid Home and Community-Based Waiver.
  - People residing in a nursing home or an intermediate care facility for the mentally retarded (ICF-MR).
  - Consumers who must "spend down" some of their income each month before they meet the financial eligibility for Medicaid.

Providers

- Plans that participate: AmeriGroup, Centene Corp, Buckeye Community Health Plan, Molina Healthcare, Paramount Advantage, Unison, WellCare.

Source: State website

Texas: Star+Plus Mandatory Managed Care for ABD (County) SSI

Basics

- 1915(b) that combines the 1915(c) Waiver for Community-Based Alternative Services
- As of February 2008, this program had more than 155,000 Medicaid clients enrolled (55,268 aged; 1,736 blind; and 98,239 people with disabilities).
- Combines traditional health care (such as doctor visits) and long-term services and support, such as providing help in your home with daily activities, home modifications, respite care (short-term supervision) and personal assistance.
- Service coordination is the main feature of STAR+PLUS. Medicaid clients, their family and providers work together to help clients coordinate health, long-term and other community support services.

History

- Began as a pilot program in Harris County (Houston) in 1998. The program had 65,000 enrollees in that county by the time the state announced an expansion to four additional regions (29 counties) in January 2007, with enrollment beginning in February 2007.
- Several provider and staff problems arose in the first few months of 2007, however. At one point, too few physicians were willing to accept new patients in the Austin area, and there were not enough trained staff in the San Antonio service area to complete LTC needs assessments in a timely manner.

Carve-Outs

- Excludes those enrolled in another Managed Care Program, dual eligibles, those participating in HCBS Waiver and those in nursing facilities or ICF/MR

Providers

- Aetna Amerigroup (STAR)
- Community Health Choice Cook Children's
- Driscoll El Paso First Premier
- First Care Molina (STAR)
- Parkland Community Health Plan Superior HealthPlan (STAR)
- Texas Children's Health Plan Unicare
- United

Outcomes

- Compared 3,226 SSI in Star Plus with 13,160 SSI in PCCM. Results, lower inpatient and ER use in Star Plus program. Total savings $145.8 mm
- SSI – blind and disabled 89.1% savings v TANF 4.8% Early indications were that it promoted wellness and avoided high costs.
- As of December 31, 2007, more than 39,800 people were on an "interest list" (waiting list) in Texas for HCBS waiver services; about 8,800 of them are in counties served by STAR+PLUS. The Texas legislature appropriated an additional $71.5 million for waitlist reduction in 2007; however, this funding is projected to reduce the waiting list by only 10 percent

Source: State website

New York ABD Managed Care

Basics

- 1115 Waiver extended in 2009, first Operating since 1997
- Mandatory Medicaid managed care program in 37 counties and all areas of New York City.
- Voluntary Medicaid managed care programs operate in 13 additional counties.
- Statewide, Medicaid managed care enrollment has grown from approximately 650,000 in July 1997 to more than 2.3 million as of February 2009.
- As of February 2009, more than 250,000 SSI and SSI-related individuals were enrolled in Medicaid managed care statewide, representing almost 64 percent of the total eligible to enroll.
- Medicaid Advantage: Managed care for dual-eligibles, Individuals voluntarily enroll in an approved Medicare Advantage plan that also has a Medicaid managed care product to receive most of their Medicare and Medicaid benefits. Enrollment began in April 2005; nearly 5,000 individuals are enrolled in 15 Medicaid Advantage plans as of February 2009.

Eligible Populations

- Dual-eligibles
- Medicaid recipients with both SSI and serious mental illness

History

- In December 2004, CMS approved an amendment to the 1115 waiver that permits enrollment of dually-eligible individuals in a program known as Medicaid Advantage.
- For New York City Medicaid recipients with both SSI and serious mental illness, mandatory managed care enrollment began in March 2007
- For those residing in non-New York City counties, including those with serious mental illness, mandatory managed care enrollment began in the fall of 2007
- By the fall of 2008, 37 counties plus New York City had implemented mandatory SSI programs

Incentives

- Since 2001, the Department has provided a financial reward to Medicaid managed care plans that do well on a defined set of quality and member satisfaction measures. In the most recent cycle, more than $60 million was awarded to over 20 qualifying plans. The State has also made the decision to auto-assign individuals only to plans that meet the requirements for earning a Quality Incentive reward.

Source: State website

Massachusetts: MassHealth

Basics

- Public health insurance program for low and medium-income residents of Massachusetts.
- Most people who are approved for MassHealth must choose a either a primary care clinician (PCC) plan, or a MassHealth MCO managed care plan
- 17 percent of state's population
- Mandatory and optional populations, mandatory and optional benefits

Services

- Inpatient care at hospitals or other medical facilities,
- Outpatient care in doctor's offices, clinics, hospitals
- Tests, medical equipment, and medical services
- Well-child services for children under 21,
- Mental health and substance abuse treatment
- Dental services
- Prescription drugs for non-Medicare recipients
- Tobacco cessation services

Carve-outs

- MassHealth Standard is the only coverage type that pays for long-term care in a medical facility such as a nursing home (for low-income Massachusetts residents including eligible parents with children under 19 years of age, pregnant women, children up to 19 years of age, the elderly, the disabled, and women needing treatment for breast or cervical cancer)

Providers

- Boston Medical Center (BMC) HealthNet Plan
- Fallon Community Health Plan (FCHP)
- Neighborhood Health Plan (NHP)
- Network Health

Behavioral Health Partnership

- Established in 1996, the Massachusetts Behavioral Health Partnership (MBHP) was contracted by MassHealth to manage the mental health and substance abuse services for MassHealth Members who select the Primary Care Clinician (PCC) Plan.
- provides healthcare services to about 300,000 Members

Source: State website, Center for PAS analysis of CMS Form 372 waiver data.

New Mexico: Coordination of Long Term Services (CoLTS)

Basics

- Joint initiative of the New Mexico Aging and Long-Term Services Department and the New Mexico Human Services Department
- Covers primary, acute, and long-term services in one coordinated and integrated program that will incorporate Medicare and Medicaid services
- Will serve an estimated 38,000 Medicaid recipients in New Mexico
- Enrollment began in July 2008

Eligible Populations

- Those currently enrolled in New Mexico's CoLTS C waiver program (formerly knows as the Disabled and Elderly (D&E) waiver program);
- Adults receiving personal care services from the Medicaid Personal Care Option (PCO) program;
- Residents of nursing facilities;
- Individuals who are fully eligible for both Medicare and Medicaid, but who have not yet accessed the system of long-term services in the state; and
- Certain qualified individuals with brain injuries.

History

- Waiver applications for CoLTS were submitted in early July 2007 Enrollment for clients in 6 counties began in July 2008 and clients started receiving services on August 1, 2008.
- Over the past year, clients in 27 additional counties have begun receiving services.

Services

- Doctor visits, hospital, emergency and other health services, and home and community-based and long-term services

Carve-Outs

- Individuals currently enrolled in the Development Disabilities (DD), Medically Fragile (MF) and AIDS Waivers
- Behavioral health services

Providers

- Amerigroup
- Evercare

Source: State website, Center for PAS analysis of CMS Form 372 waiver data.

New Hampshire Hospital Association

SENATE HEALTH & HUMAN SERVICES COMMITTEE
February 17, 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, 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 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 introduced, instructs DHHS to apply for a waiver from the federal Centers for Medicare and Medicaid Services (CMS) to support a Medicaid managed care program for Medicaid clients. And the bill calls for a managed care program that is implemented statewide for most individuals enrolled in the Medicaid program. However, we suggest that further details are needed in the bill such as definitions and principles as to what type of managed care model is intended, and how to ensure network adequacy and access in rural areas, to name just a few issues to be addressed.

So 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.

before amendment

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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 Mediciad 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, 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.

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
ARP New Hampshire

Granite State Independent Living
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Life on Your Terms

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February 16, 2011

Senate Health & Human Services Committee
Statehouse Room 302
107 N. Main Street
Concord, NH 03301

Dear members of the Senate Health & Human Services 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 continue to be able to receive quality long term care services in their communities. As the Governor stated in his budget address earlier this week, 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 has particular concern about one of the "carve outs" toward the end of this bill that would exclude "individuals determined eligible for nursing home level of care and residing in a nursing facility" from being covered under managed care. We do not understand this exclusion and nor do 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 bias shift toward home and community based services and away from institutional services. At the very least home and community based services should be on equal footing with nursing homes. Please remove this "carve out" for nursing homes from SB147.

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

Sincerely,

Jeff Dickinson

Jeff Dickinson
Advocacy Coordinator

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date: March 10, 2011

THE COMMITTEE ON Health and Human Services

to which was referred Senate Bill 147-FN

AN ACT relative to Medicaid managed care.

Having considered the same, the committee recommends that the Bill:

OUGHT TO PASS WITH AMENDMENT

BY A VOTE OF: 5-0

AMENDMENT # 0790s

Senator Jeb E. Bradley
For the Committee

Robyn Dangora 271-7585

New Hampshire General Court - Bill Status System

Docket of SB147

Docket Abbreviations

Bill Title: relative to Medicaid managed care.

Official Docket of **SB147**:

Date	Body	Description
1/19/2011	S	Introduced and Referred to Health and Human Services, **SJ 3**, Pg.38
2/3/2011	S	Hearing: 2/17/11, Room 102, LOB, 1:00 p.m.; **SC10**
3/10/2011	S	Committee Report: Ought to Pass with Amendment **#2011-0790s**, Session Date: 3/16/11; **SC15**
3/16/2011	S	Committee Amendment 0790s, AA, VV
3/16/2011	S	Ought to Pass with Amendment 0790s, MA, VV; Refer to Finance Rule 4-3
3/17/2011	S	Committee Report: Ought to Pass, 3/23/2011; **SC16**
3/23/2011	S	Sen. Bradley Floor Amendment **#2011-1019s**, AA, VV; **SJ 10**, Pg.178
3/23/2011	S	Ought to Pass with Amendment 1019s, MA, VV; OT3rdg; **SJ 10**, Pg.178
3/23/2011	S	Passed by Third Reading Resolution; **SJ 10**, Pg.187
3/28/2011	H	Introduced and Referred to Ways and Means [3/17/2011]; **HJ 30**, PG.1037
4/6/2011	H	Public Hearing: 4/12/2011 1:00 PM LOB 202
4/13/2011	H	Executive Session: 4/21/2011 12:30 PM LOB 202
4/19/2011	H	Continued Executive Session: 4/26/2011 10:00 AM LOB 202 If Needed
4/26/2011	H	Committee Report: Ought to Pass with Amendment #1564h for April 27 (Vote 20-0; RC); **HC 33A**, PG.1085
4/26/2011	H	Proposed Committee Amendment **#2011-1564h**; **HC 33A**, PG.1087-1088
4/27/2011	H	Amendment #1564h Adopted, VV; **HJ 40**, PG.1382
4/27/2011	H	Floor Amendment **#2011-1610h** (Rep Hess) Adopted, VV; **HJ 40**, PG.1382-1383
4/27/2011	H	Ought to Pass with Amendments #1564h and #1610h: MA VV; **HJ 40**, PG.1382-1383
4/27/2011	H	Reconsideration (Rep Hess): MF VV; **HJ 40**, PG.1383
5/4/2011	S	Sen. Bradley Concurs with House Amendments #1564h and #1610h, MA, VV; **SJ 15**, Pg.311
5/4/2011	H	Enrolled Bill Amendment #1827e Adopted; **HJ 42**, PG.1492
5/18/2011	S	Enrolled Bill Amendment **#2011-1827e** Adopted
5/25/2011	H	Enrolled; **HJ 46**, PG.1609
5/25/2011	S	Enrolled
6/8/2011	S	Signed by the Governor on 06/02/2011; Effective 06/02/2011; Chapter 0125

NH House NH Senate

Other Referrals

COMMITTEE REPORT FILE INVENTORY

SB 147 ORIGINAL REFERRAL _____ RE-REFERRAL

1. THIS INVENTORY IS TO BE SIGNED AND DATED BY THE COMMITTEE AIDE AND PLACED INSIDE THE FOLDER AS THE FIRST ITEM IN THE COMMITTEE FILE.
2. PLACE ALL DOCUMENTS IN THE FOLDER FOLLOWING THE INVENTORY IN THE ORDER LISTED.
3. THE DOCUMENTS WHICH HAVE AN "X" BESIDE THEM ARE CONFIRMED AS BEING IN THE FOLDER.
4. THE COMPLETED FILE IS THEN DELIVERED TO THE CALENDAR CLERK.

✓ DOCKET (Submit only the latest docket found in Bill Status)

✓ COMMITTEE REPORT

✓ CALENDAR NOTICE

✓ HEARING REPORT

✓ HANDOUTS FROM THE PUBLIC HEARING

✓ PREPARED TESTIMONY AND OTHER SUBMISSIONS

✓ SIGN-UP SHEET(S)

ALL AMENDMENTS (passed or not) CONSIDERED BY COMMITTEE:

✓ - AMENDMENT # 7905 ✓ - AMENDMENT # 7125

✓ - AMENDMENT # 3845 ___ - AMENDMENT # _____

ALL AVAILABLE VERSIONS OF THE BILL:

✓ AS INTRODUCED ___ AS AMENDED BY THE HOUSE

✓ FINAL VERSION ✓ AS AMENDED BY THE SENATE

___ OTHER (Anything else deemed important but not listed above, such as amended fiscal notes): _____

IF YOU HAVE A RE-REFERRED BILL, YOU ARE GOING TO MAKE UP A DUPLICATE FILE FOLDER

DATE DELIVERED TO SENATE CLERK 8/11/11 Robyn (by Susan)

BY COMMITTEE AIDE

Revised 2011