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# NH Department of Health and Human Services

Health and Human Services Oversight Committee

Nick Toumpas, Commissioner

August 19, 2011



# Agenda

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- Models for Care Management
- July 2011 Dashboard
  - Caseloads
  - Implications for SFY 12 budget
- Family Planning contracts update
- Update on ACO and Medical Home pilots



# Program Intent

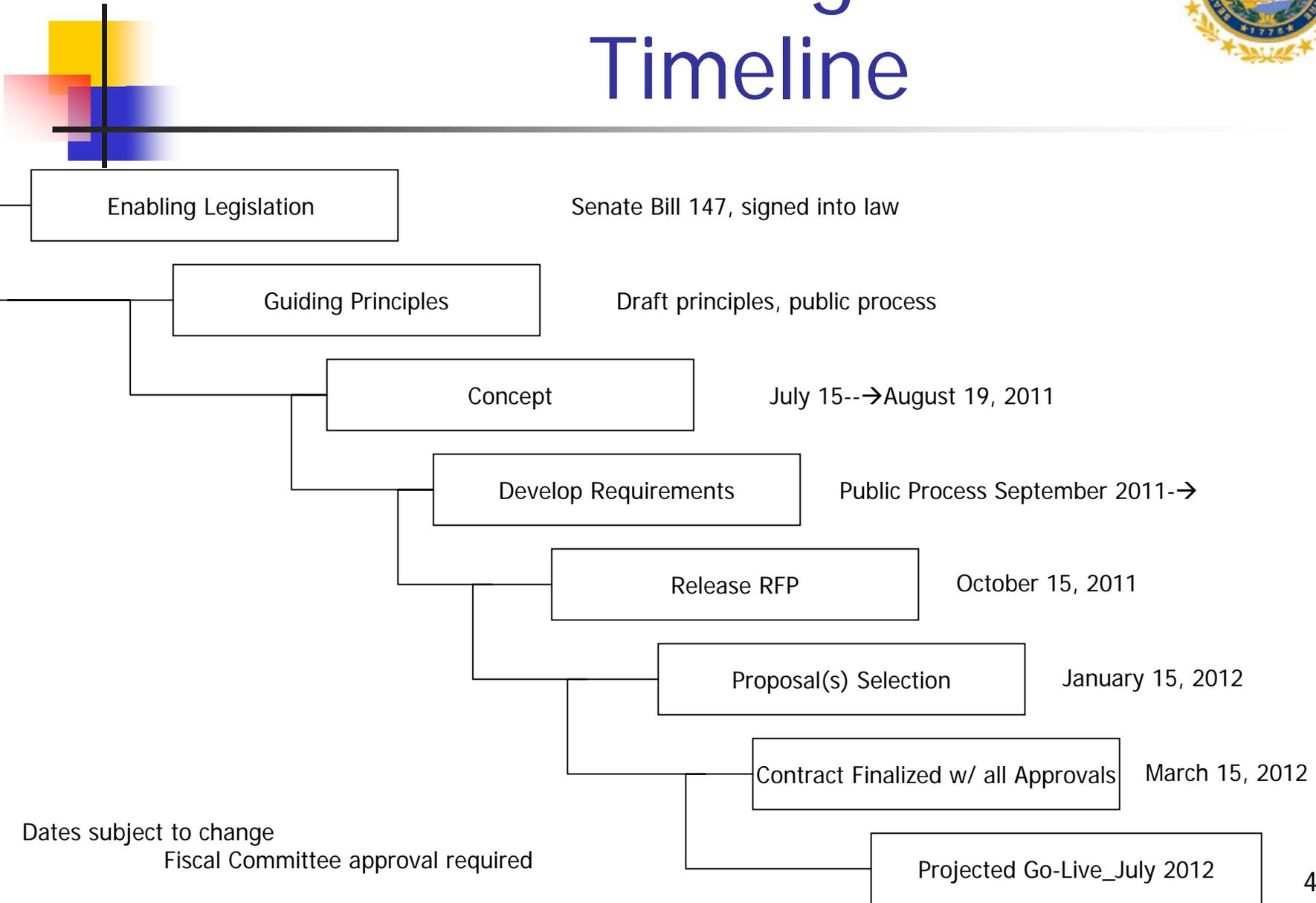
## Program Goals

- Improve beneficiary health
- Reimburse based upon outcomes
- Support continuity of care
- Ensure access to primary care and prevention
- Promote shared decision making
- Improve budget predictability
- Compliance with federal and state law
- Prepare for 2014 Medicaid expansion
- Achieve savings of \$16M in GF

## Source of Savings

- Increase timely access to primary care
- Implement single point of accountability for care coordination
- Better manage transitions between sites of care
- Reduce avoidable hospital admits and readmits
- Reduce emergency department use for primary care
- Improve compliance with recommended care
- Reduce duplication of tests
- Greater integration of public health

# Care Management Timeline



Dates subject to change  
Fiscal Committee approval required



# Model Overview

- Care Management program will be implemented via a three-phased approach
  - Process is consistent within the spirit and letter of SB 147
- Three phase strategy recognizes the issues of specialty services for vulnerable populations
- Plan takes into account federal health reform expansion population
  - The ACA is not just about the individual mandate



# Phase I

## ■ Populations

- All Medicaid/Children's Health Insurance Program populations, except
  - Third Party Liability (TPL) and Spend down populations will be excluded due to difficulty in estimating accurate per member per month costs.

## ■ Delivery

- Medical Homes for every enrollee
- Health Homes will be established for those populations who meet the criteria

## ■ Payment

- Full risk, capitated model

## ■ Services

- All State Plan medical services for example hospital, physician services, etc.
  - Not included are Home and Community Based Care Support services and services via institutions
- Prescription drug services are currently under a Pharmacy Benefit Management contract
  - State can evaluate value of inclusion in new contract or maintaining existing successful contract
- Under consideration is an outpatient substance abuse basic benefit consistent with a "whole person" strategy
- Specialty behavioral health services will be part of a Prepaid Ambulatory Health Plan for those diagnosed with Severe and Persistent Mental Illness, Severe Mental Illness and Severe Emotional Disturbance through 1915(b)waiver.



# Subsequent Phases

## ■ Phase II

- Specialty services for the long-term care populations
  - Home and community based care services and supports for all long-term care populations
    - Note that medical services for these populations in Phase I
- Affordable Care Act expansion population
  - Estimated 50,000 additional Medicaid-eligible individuals

## ■ Phase III

- Exercise state option for the management of both Medicare and Medicaid financing for services for the "Dual Eligible" recipients
  - Note that all medical services for these populations in Phase I
- Nursing home per diem services (non-medical)



# Actions to Date: Summary

- DHHS continues with Medicaid related cost savings initiatives
- Securing technical assistance resources
  - Priority is RFP and contract development
- Convened a cross functional “design team” to evaluate possible models, other states experiences
  - Draft implementation plan that factors in all Medicaid populations and services
- Drafting the Stakeholder Engagement Plan
  - Includes regional forums and focus groups planned for September
    - Dates time and locations to be posted on DHHS website.
  - Briefings for Medical Care Advisory Committee, State Committee on Aging, DHHS Stakeholder Councils and others (pending)
- Assessing information systems readiness
  - Finalizing contract for assessment of system per HB 2
- Developed “guiding principles” draft document
- Refining a 5-phase project plan
- Working with CMS to identify technical resources, identify required approvals
- Developing contingency plans to insure targeted savings are achieved



# Key Considerations

Consideration	Mitigation Strategy
Estimated \$85M in claims lag-runoff	Address in contract negotiations
MMIS/systems readiness	HB 2 requires an assessment for system readiness for core operations and for support of a managed care model
Resources for quality and outcomes review	Prepare separate requests for proposals to secure External Quality Review Organization
Enrollment services and other business functions not currently conducted by DHHS	Exploring options as to how the business functions will be performed and by who
CMS approval process	Involving CMS in development stages to ensure Federal approvals in timely manner
Adherence to Federal rate requirements	Address provider payments in request for proposals...must be "actuarially sound"
Federal regulations require at least 2 vendors where capitated model(s) employed	Crafting of RFP to get innovative and cost effective proposals



# Key Considerations

Consideration	Mitigation Strategy
Meeting targeted budget savings	Developing contingency plans should savings not be achieved from managed care within timeframe
Vendor(s) start up timetable to design, develop and implement program is assumed to be 6 months from contract execution	Work closely to ensure selected vendor can meet deadlines while balancing need for smooth transition for enrollees
DSH audit	Potential for budget reductions to address
Regional variances	Include requirements that permit innovative approaches especially in North Country
Pending and current litigation/liabilities impact on implementation	Work with Legislature, Governor's Office to understand implications
Impacts of expected reductions in Federal appropriations	Monitoring and preparing contingency plans
Affordable Care Act Medicaid expansion	Address in Phase II



# Next Steps

- Draft and finalize Fiscal Information Item
  - Present to Fiscal Committee on September 23<sup>rd</sup>
- Stakeholder Council meeting on August 29<sup>th</sup>, 2:00PM @ Hazen Drive
- Initiate public process on or around September 12<sup>th</sup>
- Finalize and secure technical assistance resources
  - RFP and contract development technical assistance is critical
- Continue to detail requirements to include in the request for proposals
  - Continued work on implementation of the behavioral health payment reform program
  - Continued work on concept for disabled and elderly services, expansion population, dual eligibles
- Refine and execute mitigation strategies to address key considerations



# Additional Updates

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Dashboard\_July 2011  
Family Planning Update  
ACO and Medical Home pilots



# Dashboard\_July 2011

Persons Enrolled for period July 31 in Fiscal Years 09-12

	2009	2010	2011	2012
Unduplicated Persons	125,236	140,420	150,572	153,928
		12.12%	7.23%	2.23%
Medicaid Persons	103,667	113,861	118,831	119,814
		9.83%	4.36%	0.83%
Long Term Care-Seniors	6,954	7,613	7,443	7,418
		9.48%	-2.23%	-0.34%
FANF Persons	10,539	13,377	13,920	12,046
		26.93%	4.06%	-13.46%
APTD Persons	6,905	7855	8,617	9,031
		13.76%	9.70%	4.80%

Growth from prior year

Budget changes including  
Elimination of 2-parent program

Vacancy rate on June 30 stood at 581 or 17.4%

Vacancy rate on July 31 is 237 or 7.9%

Reflects elimination of 354 positions

Not reflected in above is SNAP program whose population doubled

Since July 2008 from 64,961 to 113,984 this year

while a 100% Federal benefit, requires significant staff resources

# Dashboard\_July 2011 SFY 12 Budget Update



- Projected Appropriation Shortfalls (\$000's)
  - DOIT budget error
  - MMIS contract enhancements
  - SSI/APTD legislation
  - SSP Earned Income Disregard
- Contingency for DSH disallowance
- Projected Program Shortfalls
- Projected net savings from initiatives
  
- Total Projected Shortfall for SFY 12

\$613

Legislation  
drafted

\$993

File for  
reconsideration  
by 9/12

\$7,897

\$412

Early  
projections...  
monitoring

\$35,400

\$7,260

\$14,644

# of planned  
change  
initiatives

\$67,219



# Family Planning

- 10 contracts for Title X family planning funding approved by G&C on June 22<sup>nd</sup>
  - One contract, PPNNE, was rejected and would have covered 56% of the approximately 26,000 clients
  - For many of the targeted clients, the services via these contracts are the only healthcare services available to them
- DHHS sought alternative approaches to assure statewide service provision...a key provision of Title X funding
- Communicated to Federal agency on August 2<sup>nd</sup> that we do not have a plan (at this time) for statewide access
  - Additional discussions to determine options to get coverage for balance of calendar year 11



# Medical Home Update

- Medical Home pilots through Citizens Health Initiative
  - Two-year pilot ended on 6/30/11 but extended for six months by all carriers...Medicaid is not part of the pilot
  - 9 sites are involved in the pilot
    - Include FQHC's, private and hospital owned PCP's
  - The average results for the 9 sites did better than peer group
    - The PMPM cost increase lower than peer group and suggests success in cutting inappropriate use of ER, inappropriate readmissions, better care for chronic illnesses, better coordination of care, etc.
    - Final results expected by early 2012
      - Evaluation involves interviews and assessment of clinical outcomes and costs
      - <http://www.youtube.com/user/nhpcmh2011>
- Hitchcock system results with Cigna and Medicare show promising results with the 22 participating primary care groups

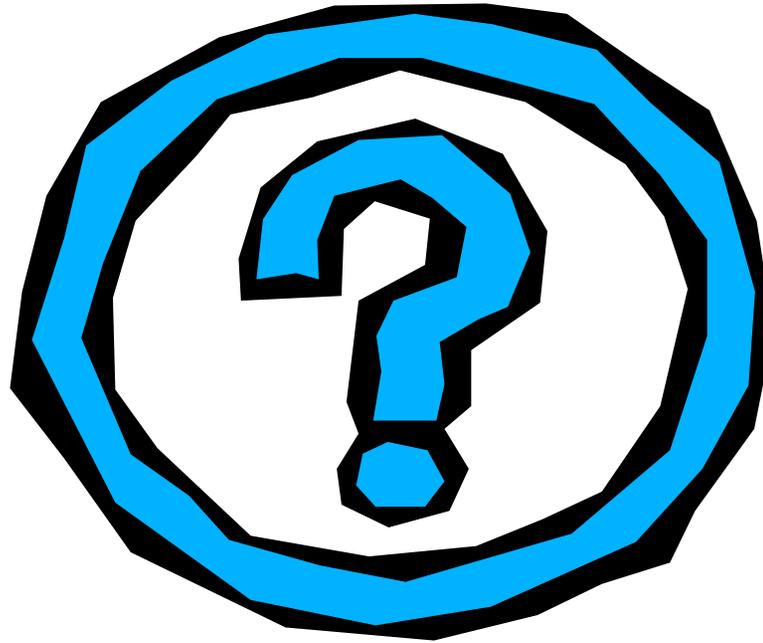


# ACO Project Update

- Overall focus for ACO is to better manage the health of a specific population for which you are responsible and not just managing illness and disease on a reactive basis
- Finalizing first year ("planning year")
  - 5 groups are involved
- Developing baseline for groups to negotiate with carriers and includes
  - Clinical, budget and risk profiles
  - All major carriers in the State are engaged
- Strong and active participation through regular updates, conference calls
- Key is how the groups evolve from a planning mode to implementation and execution



Thank You



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