



# NH Department of Health and Human Services (DHHS)

Medicaid Care Management  
Information Meeting

June 14, 2012

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## NH Medicaid Care Management

- This evening's presentation is to let you know:
  - About upcoming changes to our Medicaid program
  - How the new program is different from what we have today
  - About the timelines for enrollment
- Give you the chance to ask questions



## What is Medicaid in NH?

- NH Medicaid is a safety net of health related services for people who meet certain income and eligibility requirements
- The program provides health care services and other supports for women and children and individuals who are elderly or disabled

## Why is NH's Medicaid Program Being Changed?



- Governor Lynch and NH Legislature passed new law establishing Medicaid care management program
  - Chapter Law 125, Laws of 2011 (SB 147)
- Law requires the Department of Health & Human Services (DHHS) to set up a managed care program
  - We call it **Care Management**
- The goal is to improve access to care, quality of care and overall health status, while at the same time improving cost effectiveness
- The Department is launching these sessions to begin to share information with those on Medicaid

# Care Management Program Implementation

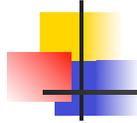


DHHS is implementing Care Management in three-steps:

- **Step 1** (This year):
  - The program includes everyone who is receiving Medicaid funded health care (with some exceptions)
- **Step 2** (Next year):
  - The program becomes mandatory for everyone receiving Medicaid (no opting out)
  - Medicaid Waiver and nursing home services are added
- **Step 3** (2014):
  - Affordable Care Act will expand Medicaid to include adults who fall below certain income levels
    - (~\$15,000/yr for single, ~\$30,000/yr for family of 4)

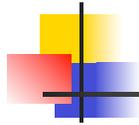
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The legislation stated that the program be implemented in a single phase. DHHS chose to present a plan that phases in services to assure enough time to include stakeholders in the process.



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We are here this evening  
to talk about Step 1



## Who is included in Step 1?



### **There are two groups in Step 1:**

- **Included:** Everyone using Medicaid
  
- **Can Opt-out during Step 1:**
  - Children in Foster Care
  - Children with special health care needs
  - Home care for children with severe disabilities-  
Katie Beckett
  - Children with Supplemental Security Income (SSI)
  - Dual Medicare and Medicaid eligible

May want to include ages in opt out bullets



## Who's excluded?

Individuals in the following categories:

- Spend-down
- Veterans Administration
- Qualified Medicare Beneficiaries (QMB)
- Special Low-Income Medicare Beneficiaries (SLMB)
- Qualified Disabled Working Individual (QDWI)

These programs remain the same as they are today.

# What services are included in Step 1?



- Doctors visits
- In-patient and out- patient hospital visits
- Prescriptions
- Mental health services
- Family planning
- Home health services
- Speech therapy
- Audiology services
- Durable Medical Equipment
- Physical therapy
- Occupational therapy
- Personal care services
- Private duty nursing
- Adult medical day care
- Ambulance services
- Wheelchair van
- Optometric services (eye glasses)
- Fluoride varnish by doctor for children

**Note: These services provided today with the exception of fluoride varnish by doctor for children**

What do me mean by step 1?

The whole program is rolling out in phases

# What is different or same?



## Now

- We (DHHS) handle Medicaid eligibility
- Standard set of services
- We issue Medicaid cards
- Individuals go to multiple places for care (uncoordinated)
- We pay doctors and hospitals directly

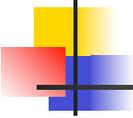
## Care Management

- We (DHHS) continue to handle Medicaid eligibility
- Standard services remain the same
- You pick a health plan. The managed care company also sends you a card
- You pick a primary care doctor or clinic from the company's provider list
- The managed care company coordinates your care in consultation with you and your doctor
- The company pays doctors and hospitals

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Say "no change" where appropriate

Primary care doctor includes: pediatricians, family practitioners, general practitioners, internists, OB/GYNs, physician assistants or Advanced Registered Nurse Practitioners.

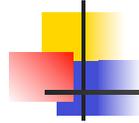


## What is a Managed Care Organization (MCO)?

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MCOs are companies that contract with doctors, nurses and other providers -who work together- to provide your health care. While often referred to as MCOs, we will refer to the companies as Health Plans.



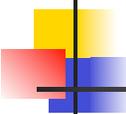
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Let's look at some examples of individual situations to better understand Care Management and its potential benefits

# Adult with Mental Health needs



- 55 year old experiencing severe anxiety and depression
  - Her primary care physician began to prescribe medications for her anxiety and depression
- Has high blood pressure, high cholesterol, and been struggling with severe weight problems
- Began to see a private independent psychotherapist who referred her to an independent psychiatrist
- The psychiatrist took over prescribing the medications for symptoms of anxiety and depression.
  - The primary care doctor continued to prescribe the same medications
- Experienced serious medical and cognitive complications from overuse of the medication and was admitted to inpatient care



# Adult with BH/MH needs under Care Management



- The **care manager** will reach out to the person to assist with referral and linkage to appropriate care providers
- The care manager will have the ability to review all standing orders for treatment and medications
- The care manager will have seen the request for payment on the duplicate prescriptions
- The care manager is expected to have contacted the primary care and pharmacy to terminate the duplicate psychiatric medication order



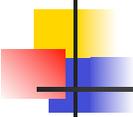
## Child with chronic health issues

- An eight-year-old boy with poorly controlled asthma
- Does not have a regular primary care physician
- On medication for treatment of his asthma, including inhalers
  - But does not use them correctly
- Lives with his single father in an old, carpeted, poorly ventilated apartment
- In the last year he has had four emergency room visits, requiring emergency treatment for breathing difficulties

# Child with chronic health issues under Care Management



- Care management would identify and connect the family with a **primary care provider (PCP)**
- Review current medications and father's level of understanding about asthma treatment
- Evaluate asthma triggers within the home and provide education to father
- Asthma **plan of care** outlines responsibilities of all involved care partners
  - Including family, school, child care providers, health care providers and other community resources, such recreation programs
  - Improving overall **care coordination**



# Teen with Autism



- 15-year-old with autism and anxiety
- Recently started having seizures
- Evaluated by a neurologist in Boston and started on seizure meds
  - Took three months for the appointment with the neurologist.
- Was not responsive to the first trial of seizure medications and had a prolonged seizure at school.
  - The school was not aware that she had a medication order from the neurologist to be used on an as needed basis, which would have stopped the seizure
  - She was taken to the emergency room by ambulance
  - Neurologist made a change in seizure medications, which resulted in increased anxiety
- Her school attendance and performance has suffered as a result and her parents have missed several days at work

# Teen with Autism under Care Management



- **Coordination between primary care physician and specialist** for management of anxiety
  - Making sure neurologist is aware of diagnosis of Autism and issues around anxiety to facilitate informed choice of seizure medications to avoid negative interactions
- Ensure communication with the school regarding treatment
- Increased co-management between primary care physician and specialist could have resulted in family not needing to wait for the neurological appointment or travel as far
- **Seizure treatment plan** outlines responsibilities for all involved care partners including family, school, health care providers and other community resources

## Woman with Developmental Disability (DD)/Intellectual Disability (ID)



- Fifty year-old woman with Down Syndrome
  - Has a thyroid disorder and is overweight
- She has recently become irritable and forgetful and has stopped wanting to go to work or participate in her walking group
- Has not received regular health and wellness screenings appropriate for women her age
- She has been to see her primary care physician who told her mother that these symptoms are not unusual for an older woman with Down Syndrome.

# Woman with DD/ID under Care Management



- Care management would offer standard medical evaluation
  - Ensure full complement of **typical health and wellness screenings** such as mammogram, colonoscopy, gynecologic screenings
- Treatment of thyroid condition
- Depression screening
- After ruling out medical causes for recent changes in function and mental status, consider neurological evaluation to identify possibility of early onset dementia



## Elderly with medical issues

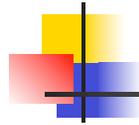
- 87-year-old woman with advanced Multiple Sclerosis
- Utilizes a combination of services to live in her home by herself
- Developed many medical complications due to inconsistent care provided through paid and unpaid caregivers
  - Inpatient admissions for management and resolution of medical problems

## Elderly with medical issues under Care Management



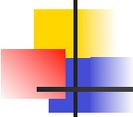
- Better **coordination** of services could lead to her care being provided in a more consistent manner
- Would decrease or eliminate the now frequent acute care needs and inpatient stays
- Coordination would include the development of a comprehensive **service plan** with provisions for safety/emergency so that she can safely remain in the community

# Critical Elements of Care Management



## ■ Care Coordination

- Across all need areas (physical health, mental health, social)
- Across all providers (getting all providers to communicate and collaborate with each other)
- Facilitating accessing of services and achieving outcomes
- Link people with other state, local, and community programs that may provide or assist with related health and social services
- Helping individuals to acquire self-care skills
- Supporting care-giving families



# Critical Elements of Care Management



## ▪ **Patient-Centered Medical Homes**

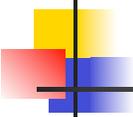
- Connection to a Primary Care Provider (PCP)
- Person's needs are the focus of the care
- Screenings and assessments to identify person's health care needs
- Monitoring and reassessing needs
- Evidence-based practices (using proven successful methods of care)
- Integration of primary care and mental health services

# Critical Elements of Care Management



## ▪ Chronic Care and High Risk Management Programs

- Assist individuals in the management of their chronic diseases
  - Diabetes, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Asthma, Coronary Artery Disease, Obesity, and Mental Illness
- Use “whole person” approach to ensure that the person’s physical, behavioral, developmental, and psychosocial needs are comprehensively addressed



# Critical Elements of Care Management



- **Wellness and Prevention programs**
  - Provide individuals with general health information
  - Provide services to help people make informed decisions about their health care needs
  - Encourage individuals to take an active role in shared decision making about their care
  - Develop and implement programs designed to address childhood and adult obesity, smoking cessation, and other similar type wellness and prevention programs
  - Encourage individuals to complete an annual health risk assessment

## Critical Elements of Care Management



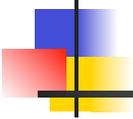
These elements are not options.  
They are contractual requirements  
to which the Health Plans will be  
held accountable to by the State.



## Who are the three Health Plans?

- Boston Medical Center Health Plan
- Granite Care-Meridian Health Plan of New Hampshire
- Granite State Health Plan (Centene Corp)

All three MCOs will have staff in NH--many from NH



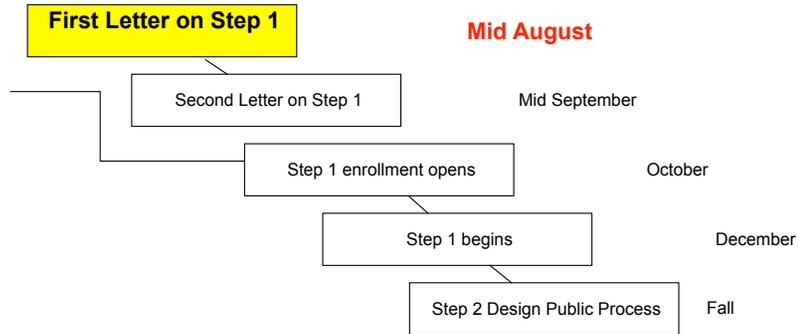
# Care Management

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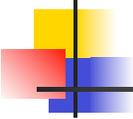


## Timeline for Step 1 2012

# Care Management Timeline 2012



Dates subject to change pending  
Centers for Medicare & Medicaid Approval



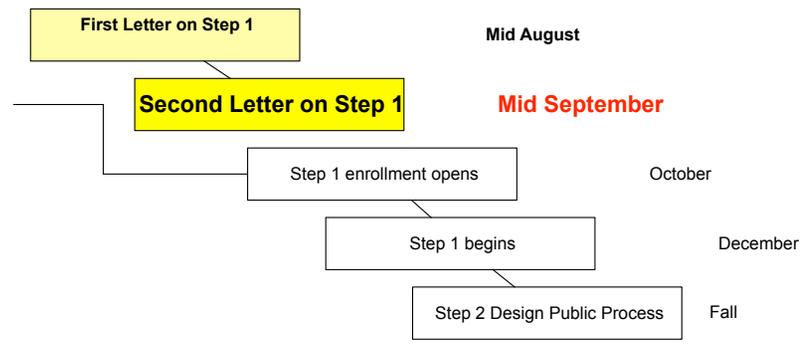
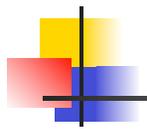
## We send you a letter in Mid-August on Step 1

- **Does not require you to take any action**
- Informs you of upcoming changes to the Medicaid program
- Provides information on next steps
- Provides how to get more information

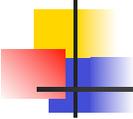
Rural areas – PCCM

Small Medicaid Population – together could be a challenge.

# Care Management Timeline 2012



Dates subject to change  
Centers for Medicare & Medicaid Approval



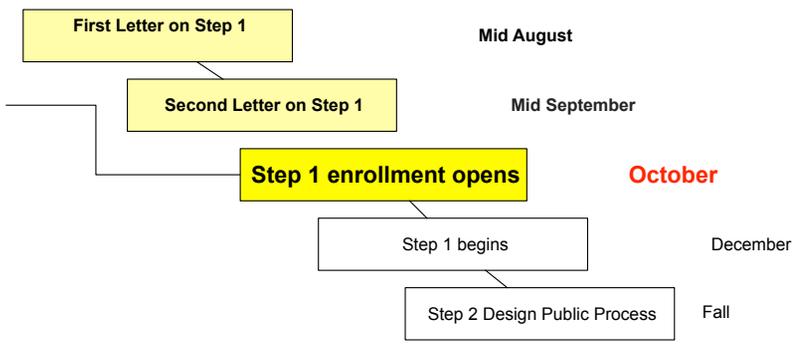
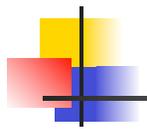
## We send a second letter on September 1: Mid-September

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- Provides information about the three managed care companies
- Provides more detailed information about when and how to pick a managed care company
- Gives updated information on the timeline
- Provides contact information to get help

# Care Management Timeline 2012



Dates subject to change  
Centers for Medicare & Medicaid Approval



## Enrollment begins: October

**Action Required: You will need to pick a managed care company. If you don't, we will pick one for you.**

- Everyone who uses Medicaid begins to pick among the three managed care companies via mail, NH Easy, telephone
- We (the Department) will provide information about the three companies to help you pick one.
- When you choose a company, the company will send you a card that you will use when you go to a doctor or clinic for health services to use along with your Medicaid card.



## How do I choose a Managed Care Plan?

All three companies cover the same basic services.

- Do you want to keep your current doctor or clinic?
- Do you see a specialty doctor?  
Are doctors and clinics close to where you live?
- Are there services or benefits offered by one company and not another that are appealing to you?
- Check to see if they are on a managed care company's list.
- Check to see if they are on a company's list.
- This is important to look at on the companies' lists.
- This may make one company more appealing than another – if other parts are the same.

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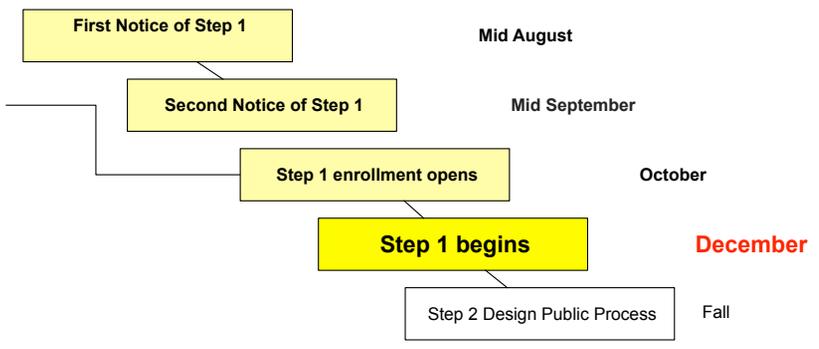
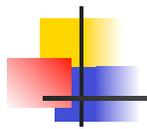
You may want to give examples of what one company would offer versus another—perhaps focused on wellness programs.



## Will I choose my primary care doctor?

- Yes. You will be able to choose your doctor from the managed care company's group of health care providers.
  - Some providers may be in more than one plan.
- Your primary care doctor is your personal doctor
- Some people who have needs for specialty services will coordinate the services with their doctor and managed care company.
- You have to use providers listed in your managed care plan
  - Primary care doctors, clinics, pharmacies, hospitals, mental health providers, etc.

# Care Management Timeline 2012



Dates subject to change  
Centers for Medicare & Medicaid Approval

# Program projected to begin in December



- The managed care companies help you see the right provider when you need to
  - Through their network of doctors, clinics, pharmacies, mental health providers, etc.
- All Medicaid populations enrolled in program (with some exceptions)



## Step 2

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- Specific elements of Step 2 have not been identified yet
  - DHHS has started working on this
- This fall DHHS will begin to reach out to all stakeholders for input on design of Step 2



# What services are in Step 2?



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<b>Community-Based Medicaid Waiver Services</b>	<b>Long Term Care Services such as Nursing Homes</b>
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The design of Step 2 is under development. Step 2 services remain in the fee for service Medicaid program (stay the same as today)



## 2012 Timeline Recap

- **August:** You'll get a letter from DHHS
- **September:** You'll get detailed managed care company information from us
- **October:** You can choose a health plan. If you don't choose a plan, we will pick one for you.
- **December:** The new program projected to begin

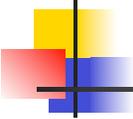
Note: If there are any changes to the timeline, DHHS will make announcements and provide updates

## What if I want to change health plans



- If you are not happy with your company, you can switch to another within the first 90 days
- There will be annual open enrollment periods

At any point w/in first 90 days of initial enrollment you can switch w/o cause.  
After that open enrollment annually.  
Exceptions like your PC or specialists drops out of the plan



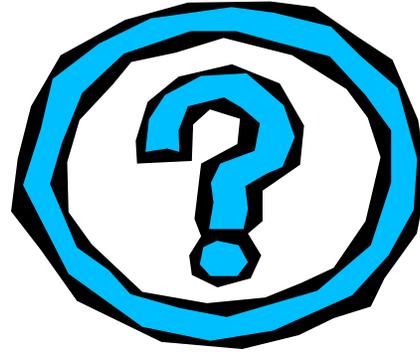
## What will I do if I have a problem with the Health Plan (MCO)?



You will be given information when you enroll with the company about your rights and what to do should you have a problem.



# Questions





## For More Information

- Visit <http://www.dhhs.nh.gov/ocom/care-management.htm> for updates and this presentation
- Submit questions to:  
nhmedicaidcaremanagement@dhhs.state.nh.us
- Website and toll free telephone number will be established in the coming months