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MEDICAID MANAGED CARE

Implementing New Hampshire's Program

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TABLE OF CONTENTS

EXECUTIVE SUMMARY	1
1. INTRODUCTION	1
2. MEDICAID MANAGED CARE OVERVIEW	2
2.1 <i>NEW HAMPSHIRE'S EXPERIENCES</i>	2
2.1.1 <i>New Hampshire's Previous Programs</i>	2
2.1.2 <i>New Hampshire's Medicaid Managed Care Contract and Implementation Timeline</i>	3
2.2 <i>OTHER STATES' MEDICAID MANAGED CARE EXPERIENCES</i>	4
2.2.1 <i>History</i>	4
2.2.2 <i>New Hampshire's Program in Context</i>	4
2.2.3 <i>Other States' Cost Savings</i>	5
3. MEASURING THE EFFECTIVENESS OF MANAGED CARE	6
3.1 <i>NEW HAMPSHIRE'S CRITERIA FOR EVALUATION</i>	6
3.2 <i>BARRIERS TO DATA COLLECTION</i>	6
3.3 <i>FOLLOW-UP STATISTICAL ANALYSES</i>	7
4. NEW HAMPSHIRE'S UNIQUE MANAGED CARE PLAN	8
4.1 <i>LONG-TERM CARE COVERAGE FOR CHRONIC CONDITIONS</i>	8
4.1.1 <i>Structure of New Hampshire's Coverage</i>	8
4.1.2 <i>Potential Barriers to Success</i>	8
4.2 <i>COVERAGE FOR DEVELOPMENTAL DISABILITIES AND SEVERE MENTAL ILLNESS</i>	9
4.2.1 <i>Structure of New Hampshire's Coverage</i>	9
4.2.2 <i>Potential Barriers to Success</i>	10
4.2.3 <i>Arizona and Wisconsin: Opposite Ends of the Spectrum</i>	11
5. BARRIERS TO SUCCESS SPECIFIC TO NEW HAMPSHIRE	12
5.1 <i>IMPLEMENTATION TIMELINE</i>	12
5.2 <i>LIMITED MCO AND STATE EXPERIENCE WITH LONG-TERM CARE</i>	12
5.3 <i>DEMOGRAPHICS, NETWORK ADEQUACY, AND RATE NEGOTIATIONS</i>	13
5.4 <i>SYSTEMS CONSIDERATIONS</i>	14
5.5 <i>COST OF DSH PAYMENT CUTS</i>	14
5.6 <i>INCREASING SAVINGS WITHOUT DECREASING ACCESS</i>	15
5.7 <i>HOSPITAL LITIGATION AGAINST THE STATE</i>	15
6. CONCLUSION: KEYS TO IMPLEMENTATION SUCCESS	16
REFERENCES	17



EXECUTIVE SUMMARY

New Hampshire's Medicaid program began its transition to managed care on December 1, 2013. This shift to the managed care model of Medicaid represents an attempt to control costs and improve the coordination of health care. The shift to managed care is part of a national trend, as many states are looking at ways to control costs and establish predictability in their Medicaid budget. While Medicaid managed care has been in practice for several decades, it has primarily focused on low-cost patient populations such as young women and children. There is a very short track record of managed care plans that include disabled and long-term care populations. New Hampshire's Medicaid managed care plan has unique characteristics that include patient populations in the model that few other states have attempted to incorporate into capitated managed care programs. It is uncertain that the shift to managed care will produce any savings, especially in the short-term. If savings are found, they will likely be achieved in the long-term. The transition to managed care will present challenges, such as managing the needs of Medicaid patients without compromising access to care. Factors that may present challenges to New Hampshire's implementation of managed care include its rural demographics and its small Medicaid enrollment, which may make it difficult to maintain provider networks, as well as other policy challenges, such as setting appropriate capitation rates for patients with complex health conditions and its method of allocating federal funding for uncompensated care. To ensure that New Hampshire's transition to managed care is smooth and successful; the state should be cognizant of the concerns of all stakeholders involved in providing long-term care. Finally, careful, continuous statistical analysis will be important in tracking the effectiveness of this new program to address weaknesses early on in the implementation process.

1. INTRODUCTION

In an effort to control costs and promote predictability in planning state budgets, New Hampshire is shifting its Medicaid program from fee-for-service to managed care. Medicaid is the second largest item in the state budget, totaling \$1.4 billion in expenditures in fiscal year 2012.¹ The switch to Medicaid managed care has been estimated to save \$32 million in the first two years.² Medicaid provides health care to 166,000 New Hampshire residents, ten percent of the state's population.³ The shift to managed care began in 2011 when the state legislature passed SB 147 (Chapter 125, Laws of New Hampshire 2011)⁴ and federal officials approved New Hampshire's plan in August 2012.

New Hampshire's managed care plan will be executed by three managed care organizations that will receive a fee per month per enrollee from the state of New Hampshire. By enrolling these individuals, the managed care organizations assume full financial responsibility for their health care. This full capitated risk program is unique and one that few other states have tried to implement for their entire Medicaid program. Once it goes into effect, it will be one of the few Medicaid managed care plans to



incorporate long-term care for mental health and chronic conditions in a capitated model. Because these populations have complex conditions, they tend to incur high healthcare costs. The capitated model may have the potential for savings by reducing these costs through better coordination of care, but the data is limited because few states have attempted to cover disabled and long-term care patient populations in full-risk capitated models.⁵

In addition to the challenges of covering long-term care under a capitated model, other barriers may inhibit the success of New Hampshire's managed care program after it is implemented. The state's challenges include incorporating negotiations with stakeholders of disabled and mentally ill patients, finding savings despite that fact that Medicaid reimbursement rates are already one of the lowest in the country, as well as coping with the budgetary deficit Disproportionate Share Hospital (DSH) payment cuts will create. Additional challenges to the state may result from its small Medicaid enrollment and rural populations, which may hinder the ability to maintain adequate provider networks and weaken the ability to negotiate low rates. If dealt with proactively these challenges may be solved.

2. MEDICAID MANAGED CARE OVERVIEW

2.1 NEW HAMPSHIRE'S EXPERIENCES

Managed care is a broad term for a health care delivery model in which a health maintenance organization (HMO), a network of physicians, hospitals, and other providers deliver contractually agreed upon services for an enrolled population. The HMO is paid a capitation payment, which entails a monthly payment for each enrollee.

Medicaid has traditionally been a state administered fee-for-service system in New Hampshire, where health care providers are paid for every service such as a visit or test. Patients go to several different doctors and the New Hampshire Department of Health and Human Services (DHHS) pays doctors and hospitals directly. Managed care attempts to provide better quality and promote savings by coordinating care, promoting preventative care, and reducing unnecessary services that result from fragmented fee-for-service health care. Under managed care, Medicaid beneficiaries choose a health plan and select a primary care doctor or clinic from that health plan's network. The state of New Hampshire will pay a fee to the health plan for each beneficiary that is enrolled. The health plan coordinates care with beneficiaries and their doctors and pays doctors and hospitals. The Medicaid managed care model that New Hampshire is implementing is a Managed Care Organization (MCO) approach, which is a full risk capitated contract.⁶ This implies that if the MCO goes over the capitation payment, the state of New Hampshire is not responsible for the additional costs.

2.1.1 New Hampshire's Previous Programs

New Hampshire has limited prior experience with Medicaid managed care. New Hampshire's prior experiences include the Capitated Risk Payment Plan (1999-2003) and the Disease



Management Plan (2005-2009). Both programs were ended because they were unable to attain the projected savings. The Capitated Risk Payment Plan (1999-2003) was small in scope, voluntary for beneficiaries to enroll, and did not include long-term care. Additionally, the plan was primarily for young women and children, who tend to be the lowest cost patients. Only one of the original three contracted MCOs was still participating at the time of the plan's termination. Because the plan was voluntary and designed for low-cost individuals, it had small enrollment, did not result in any savings and was actually more expensive than traditional fee-for-service.⁷ The plan was also financially unsuccessful because the MCOs were unwilling or unable to negotiate lower rates. It is important that the lessons be learned from the previous unsuccessful managed care programs. To accumulate financial savings through managed care, MCOs will either need to improve the efficiency of care, or negotiate lower payments.

2.1.2 New Hampshire's Medicaid Managed Care Contract and Implementation Timeline

The state of New Hampshire signed a three-year contract with three MCOs to implement Medicaid managed care: Well Sense Health Plan (Boston Medical Center Health Plan), Granite Care-Meridian Health Plan of New Hampshire, and New Hampshire Healthy Families (Centene Corp).⁸ All three of these providers are out of state organizations. Boston Medical Center Health Plan is a not-for-profit organization,⁹ while the other two providers are for-profit. The plan will cost a total of \$2.2 billion over three years.¹⁰ Medicaid managed care is being implemented in three phases. Phase I includes acute care, Phase II includes long-term care, and Phase III includes the potential Medicaid expansion under the Affordable Care Act.¹¹ By Phase II, almost all Medicaid beneficiaries will be required to be enrolled in a MCO. Phase I was set to begin December 1, 2013. Phase II will take effect one year after Phase I is implemented.¹² New Hampshire's Medicaid managed care approach is unique in that it focuses on patient populations that are usually not covered by managed care in other states including individuals who are disabled and in long-term care, individuals with mental health needs, and dual eligibles (patients who qualify for Medicaid and Medicare).

New Hampshire's model is also unique because it includes wrap-around services as part of mental health and developmentally disabled treatment, covering services that include case management, job training and housing assistance.¹³ There is little previous experience among other states in covering patients with long-term needs under managed care. These patient populations have the highest costs and the most complex health care needs. Seniors and individuals with disabilities make up only 22 percent of New Hampshire's Medicaid population and account for 69 percent of Medicaid expenditures.¹⁴ Additionally, long-term services constitute the largest Medicaid spending category, totaling 51 percent of payments.¹⁵ In an attempt to find savings by including these high cost patients under the managed care model, it is essential that the health care needs of these populations still be met.

Another characteristic that makes New Hampshire's Medicaid managed care program different from other states is the relatively high number of individuals who live in rural regions and the small number of Medicaid beneficiaries. The number of low-income New Hampshire residents who live in urban regions is ten percent below the national average.¹⁶



Additionally, New Hampshire has the smallest Medicaid enrollment of any state in New England.¹⁷ These will be important factors to consider when implementing the Medicaid managed care plan and building the provider networks. Safeguards could be put in place to ensure that rural networks have sufficient access to care.

2.2 OTHER STATES' MEDICAID MANAGED CARE EXPERIENCES

2.2.1 History

Medicaid managed care came into practice during the 1970s and gradually become more common to the point today where 74 percent of all Medicaid beneficiaries nationwide are enrolled in some form of managed care.¹⁸ Mandatory Medicaid managed care enrollment was primarily required for women and children because they have lower and more predictable health care costs than elderly and disabled populations.¹⁹ Enrollment in managed care includes both risk-capitated models and primary care case management (PCCM) models. PCCM is a hybrid of the capitated model and fee-for-service. Of all Medicaid beneficiaries nationwide, 47 percent are enrolled in capitated risk-based models.²⁰

Managed care developed a negative reputation during the 1990s. Patients often felt they were denied access to care and were frustrated by the administrative processes they had to go through to receive care.²¹ Too often the focus was on reducing costs, but not improving the quality and coordination of care. Managed care programs across the country have since undergone reforms to address these concerns by placing a greater emphasis on enhancing the coordination of care, employing pay-for-performance initiatives, and expanding access to preventative care.

2.2.2 New Hampshire's Program in Context

New Hampshire is one of the last states to make the transition to Medicaid managed care. Besides New Hampshire, only two other states, Alaska and Wyoming, do not use Medicaid managed care programs.²² Because New Hampshire is one of the last states to implement Medicaid managed care, there is the opportunity to examine and learn from the experiences of other states. The complicating factor when comparing Medicaid managed care is that every state has a different program with varying coverage models for different patient populations. Additionally few states have covered the patient populations that New Hampshire is planning to cover under the capitated model.

It is useful to consider the trends in other states, but also important to remember that New Hampshire's Medicaid managed care program is distinct, especially because of its focus on behavioral health and long-term care patients. New Hampshire officials can primarily observe the experiences of other states providing Medicaid managed care for acute care patients, but disabled, elderly, and mentally ill Medicaid patients have largely remained covered by PCCM or fee-for-service in other states. Only eleven other states currently cover



dual eligible beneficiaries in long-term managed care.²³ Additionally, only a minority of states cover behavioral health services under Medicaid managed care.²⁴

2.2.3 Other States' Cost Savings

Along with improving the integration of care, one of the main motivations for the transition to managed care is the opportunity for reducing health care costs and promoting predictability in state budgets. If managed care does produce savings, it is through either improving the coordination of health care and or through the negotiation of lower rates by the MCOs. The majority of peer-reviewed studies have found little savings from Medicaid managed care overall at the national level.²⁵

On an individual state basis, some states have actually seen an increase in costs after shifting to Medicaid managed care, while other states have been able to achieve savings.²⁶ One of the main indicators for a state's potential to reduce costs is the historical Medicaid physician reimbursement rate in the state.²⁷ States with high reimbursement rates reduce costs by implementing Medicaid managed care, while states with low reimbursement rates produce no savings or even see an increase in costs. Savings have mainly been produced by the negotiation of lower provider rates, rather than a reduction in the utilization of medical care.²⁸

This is significant for New Hampshire policymakers to recognize because New Hampshire has the 10th lowest Medicaid reimbursement rate in the nation,²⁹ a measure of each state's fee-for-service Medicaid physician fee. Because New Hampshire's reimbursement rate is already so low, this may make it difficult to find additional savings. Additionally, there is limited research regarding whether states have saved money by switching disabled and dual enrollee populations to managed care.³⁰

Much of the previous research on cost savings with Medicaid managed care has not included elderly and disabled populations, because these populations have traditionally not been enrolled in managed care. The few studies conducted that have focused on Medicaid managed care for disabled and long-term care populations have not found evidence of savings generated by switching from fee-for-service to managed care.³¹ Overall the potential for savings through Medicaid managed care is uncertain.

State Medicaid officials in states that have previously covered disabled populations in managed care have warned against using managed care to achieve short-term savings.³² More information may be available as more states begin to enroll disabled and long-term care Medicaid beneficiaries into managed care. New Hampshire officials should be cautious when projecting any savings, especially in the short-term. If savings are going to be achieved in New Hampshire, it will likely not be in the short-term, because the generated savings will have to come from structural changes to the health care delivery system, which will take time to develop.



3. MEASURING THE EFFECTIVENESS OF MANAGED CARE

3.1 NEW HAMPSHIRE'S CRITERIA FOR EVALUATION

New Hampshire selected a number of statistical markers to monitor the success of the managed care program. The markers for the Quality Incentive Program will be determined by the Department of Health and Human Services on an annual basis. Financial incentives are in place for the MCO's to meet each of the measures. The most recent list of measures are described in the Medicaid Managed Care Quality Strategy.³³ Four of the key early markers are described here. One measure, adolescent well care visits, will track the percentage of enrollees age 12 to 21 who utilized a primary care physician or obstetrician/gynecologist. Second, New Hampshire will examine the thirty- and eighty-day hospital readmission rates. Additionally, the state has established "Getting Needed Care Composite Rates" using the Quality Compass for Medicaid Managed Care Programs. The Quality Compass survey given to each enrollee assesses questions including "How often was it easy to get appointments with specialists? How often was it easy to get the care, tests, or treatment you thought you needed through your health plan?" For New Hampshire, answers of "usually" and "always" indicate success in these categories. Additionally, New Hampshire wants to increase the percentage of pregnant women who quit smoking. The current rate of pregnant women who quit smoking is 21 percent, and the state hopes to increase this figure to 26-28 percent.³⁴

While New Hampshire initially employed a limited number of data sources for its statistical analysis of managed care relative to other states,³⁵ the list has been expanded to include others such as physician and emergency room utilization. New Hampshire can employ a more widespread collection of data to establish accurate capitation rates. These statistical analyses will be crucial in determining whether managed care is reducing costs while improving access to and quality of care. For example, two-thirds of states with established managed care programs that responded to the Kaiser Family Foundation's survey reported a decrease in access to care among enrollees in their health plans.³⁶ Data collection and evaluation will be critical in determining whether and why not specific aspects of Medicaid managed care would fail in New Hampshire. Finally, given that the managed care program will increase the size of the covered population under Medicaid, statistical analyses about health and access outcomes when managed care is enacted will need to account for any changes in the population size served by Medicaid.

3.2 BARRIERS TO DATA COLLECTION

Several obstacles might prevent New Hampshire from obtaining reliable data to make Medicaid policy decisions. Ideally, data would compare populations from fee-for-service models and various types of managed care programs nationwide to identify successful trends and the compare effectiveness of different plans.³⁷ However, Medicaid programs vary significantly from state to state and have different methods of data collection. New Hampshire could benefit from collaborating with similarly sized states, including Maine,



Vermont, and Rhode Island, to collect similar benchmarks and pool data.

Currently, most states employ one of two established assessment models, the Health Plan Employer Data and Information Set (HPEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS). However, these models focus on clinical measures related to acute care, and lacks specificity with regard to children and adolescents as well as individuals with developmental or physical disabilities, chronic conditions, or mental health issues.³⁸ The Centers for Medicare & Medicaid Services has, as of January 2012, acknowledged that there is a lack of established measures to evaluate chronic care patients.³⁹ Because the aforementioned populations (i.e., children and adolescents, chronic care patients and mental health patients) represent a significant portion of New Hampshire's Medicaid population, the state might get more useful results by creating its own model for analysis that addresses the quality of life of those specific populations.

3.3 FOLLOW-UP STATISTICAL ANALYSES

In addition to specific data markers, it is important for the state to effectively interpret the program data and reinforce the standards expected of the managed care organizations. Having a coordinated and comprehensive mechanism for review of managed care is as important as having a coordinated and comprehensive managed care health plan; states that have neglected the follow-up to managed care organizations waste significant opportunities for continued improvement. Additionally, review and analysis is important to ensure that capitation rates are sufficient without being excessive to maximize the economic benefits of managed care.⁴⁰

The New Hampshire DHHS plans to contract with an external quality review organization for this follow-up analysis. To comply with federal regulations, the organization will assess the quality performances outcomes from the Quality Incentive Projects and Managed Care Quality Strategy, and prepare a technical report. Questions remain about what to do if the outcomes do not meet pre-established quality standards. Other states have found success by following a 'threaten first, then act' approach towards the managed care companies in this case. Possible ramifications used in other states include fines, freezing the enrollment or, eventually, terminating the contract. States have had success both performing the statistical analysis and evaluation within the state, and by contracting out to private organizations.⁴¹



4. NEW HAMPSHIRE'S UNIQUE MANAGED CARE PROGRAM

4.1 LONG-TERM CARE COVERAGE FOR CHRONIC CONDITIONS

4.1.1 Structure of New Hampshire's Coverage

New Hampshire's unique managed care program covers long-term care for chronic conditions. Few states cover long-term care under a capitated model, such as New Hampshire's, because it is difficult to predict the monthly cost of patients with complicated conditions. In fact, most states actively "carve out" coverage for long-term care, although New Hampshire has only "carved-out" dental benefits from its managed care plan. States that have successfully integrated long-term care in their managed care models opted for a Primary Care Case Management (PCCM) model, rather than a capitated model.⁴²

New Hampshire elected the capitated model because it has greater potential for cost savings, though it will require careful implementation and assessment to be successful. Additionally, the PCCM model is typically the type utilized by rural states, because it is more difficult to get managed health organizations to commit to providing capitated managed care. Careful implementation and analysis of the long-term care aspect of New Hampshire's managed care plan is critical to determine whether the capitated model is, in fact, the best option for New Hampshire.

4.1.2 Potential Barriers to Success

The ability to provide adequate care outside of the hospital is important in maximizing the access, cost and quality of managed care for patients with long-term health care needs. New Hampshire has excluded several benefits from its managed care plan that could benefit long-term care patients, including In Home Supports Home and Community Based Services as well as skilled nursing facilities. Figure 1 provides a comprehensive list of New Hampshire's excluded services.

However, the state should monitor closely to determine whether patients can sufficiently access these or similar resources without managed care. If patients are seeking care in hospitals to replace the services offered by the excluded services, the health care costs associated with their care will most likely increase. Finally, further research should also examine the unique nursing home system in New Hampshire and its effects on the integration of long-term care and providers outside of the hospital system.



Figure 1. Services Excluded from New Hampshire’s Medicaid Managed Care Model

Excluded
Dental Benefit Services
Intermediate Care Facility MR
Medicaid to Schools Services
Excluded Until Step 2
Acquired Brain Disorder Waiver Services
Developmentally Disabled Waiver Services
Choices for Independence Waiver Services
In Home Supports Waiver Service
Skilled Nursing Facility
Skilled Nursing Facility Atypical Care
Inpatient Hospital Swing Beds, SNF
Intermediate Care Facility Nursing Home
Intermediate Care Facility Atypical Care
Inpatient Hospital Swing Beds, ICF
Glenclyff Home
Developmental Services Early Supports and Services
New Substance Abuse Benefit Allowing MLDACs
Services only offered to children involved with DCYF
Home Based Therapy–DCYF
Child Health Support Service–DCYF
Intensive Home and Community Services–DCYF
Placement Services–DCYF
Private Non-Medical Institutional For Children–DCYF
Crisis Intervention – DCYF

Source: New Hampshire Medicaid Managed Care Contract

If the long-term care facilities in place are not sufficient to meet the health needs of enrollees, the Patient Protection and Affordable Care Act offers states the option to create home health organizations targeted at people with chronic conditions. States that implement this option will receive a 90 percent federal match for the first eight months.⁴³ New Hampshire could consider utilizing this option if their long-term care model is unsuccessful, and if they have the funds to invest up front in a program that might need several years to maintain a profit.⁴⁴

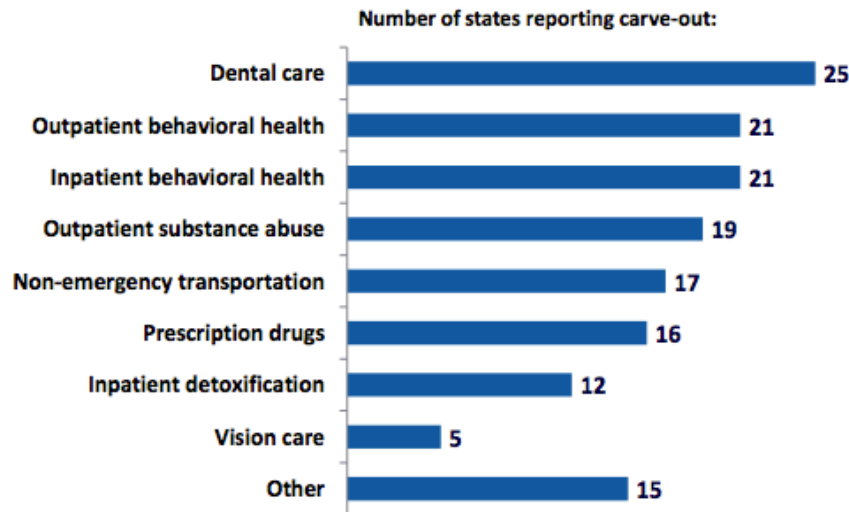
4.2 COVERAGE FOR DEVELOPMENTAL DISABILITIES AND SEVERE MENTAL ILLNESS

4.2.1 Structure of New Hampshire’s Coverage

New Hampshire’s managed care model also covers care for mental health and developmental disabilities, many in Step 2. In most states, mental health coverage is another “carve-out” not included in capitated managed care programs. In many ways, the approach to mental health care implementation and evaluation is analogous to the implementation of long-term health services. Figure 2 displays the frequency with which various benefits have been carved-out in other states’ Medicaid managed care plans.

Figure 3 describes the specific types of carved-in and carved-out mental health plans. New Hampshire is employing the model described in the left-hand column. In New Hampshire, it will be important for all three managed care organizations, in partnership with the state, to rely consistently on the definitions of developmental disability and severe and persistent mental illness to ensure similar coverage across the three MCOs.⁴⁵

Figure 2. Acute-Care Benefit Carve-Outs in Medicaid MCOs



Note: 36 states contract with MCOs.
 SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

Figure 3. Subsets of Mental Health Managed Care Plans

Mental Health Carve-in (Integrated Plan)	Mental Health Subcontracted (Subcontracted Plan)	Mental Health Carve-out (Separate Plan)
A managed care plan manages both mental health and other medical benefits.	A managed care plan is responsible for both mental health and other medical benefits but subcontracts management of mental health benefits to another entity, often one that specializes in providing mental health benefits.	Mental health benefits are provided on a fee-for-service basis or are provided by a separate managed care plan that is not responsible for other medical benefits.

Source: National Alliance on Mental Illness

4.2.2 Potential Barriers to Success

New Hampshire has a variety of third-party organizations that handle mental health care needs. To successfully integrate care for mental health and developmental disabilities, managed care organizations should consider the input of these key stakeholders and secondary care providers.⁴⁶ Specifically, individuals with mental health needs are 25 percent more likely to have three or more chronic conditions as a result of the complex



physical and behavioral needs.⁴⁷ Without the support and commitment of the stakeholders, managed care for mental health and developmental disabilities is unlikely to increase the quality of and access to care, or to reduce costs. Electronic medical records would also help with this transition, by allowing for better communication between third party organizations.⁴⁸

Because many of these organizations operate with a small budget, they will likely have trouble managing the upfront costs associated with redesigning their administrative procedures to fit with the new infrastructure of managed care. Specifically, each of the three managed care organizations in New Hampshire has different coverage and payment options, and consolidating these variations in managed care into a shared electronic system will reduce administrative costs and improve care integration.⁴⁹

Similar to managed care plans for long-term care, New Hampshire's managed care plan for mental health and developmental disabilities excludes many services until Step 2. Effectively incorporating mental health and developmental disability services appears to be instrumental in the success in other states. New Hampshire may benefit from considering the experiences and goals of these states' managed care programs.

4.2.3 Arizona and Wisconsin: Opposite Ends of the Spectrum

Wisconsin and Arizona are two states that have both enacted capitated managed care plans to cover mental health needs. However, these states fell at opposite ends of the spectrum with regard to the success of their managed care plans. Arizona — the first state to adopt a statewide managed Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS) — has been very successful, primarily because the managed care organizations employ case managers to coordinate the care of each enrollee with mental health needs.⁵⁰ The state also carefully monitored capitation rates to ensure their accuracy and sufficiency.⁵¹ Additionally, Arizona took steps to address a lack of qualified caregivers to treat patients with chronic disease in a home-based setting by paying family members of those patients to become certified and deliver the necessary care to their loved one.⁵²

Ultimately, the Arizona model was successful because it did three things: first, it selected leaders who had the required skills to implement and manage the program (i.e., finding senior leadership for AHCCCS with direct experience in assuring and monitoring care delivery for Medicaid services).⁵³ Second, the state took on extensive management responsibilities (i.e., financial management, planning to estimate future costs of program continuation and modification, monitoring utilization and access to services, and coordination with other states to develop common procedures and shared evaluation criteria).⁵⁴ Third, the program fostered working relationships with the governor, key legislators and the media to gain support and sufficient allocation of resources.⁵⁵



Wisconsin was less successful in using capitated managed care to cover mental health needs. This is due to the fact that the state did not update capitation rates, so although they had extensive home-based health care organizations in place to improve long-term care, the managed care organizations were underpaid and the state's overall plan was unsuccessful. Wisconsin's managed care organizations were very inexperienced with regard to long-term care enrollees, and the lack of financial oversight led to budget deficits. Wisconsin has attempted to restore the financial status of its programs by establishing separate capitation rates for the physically disabled, elderly, and individuals with intellectual and developmental disabilities. New Hampshire should closely examine the successes and failures of these two states to avoid pitfalls associated with offering a full-risk capitation plan for long-term care.⁵⁶

5. BARRIERS TO SUCCESS SPECIFIC TO NEW HAMPSHIRE

Once managed care is implemented in the state of New Hampshire, it faces additional challenges. These challenges are unique to the state of New Hampshire, and they include the state's population demographics, and operational structure (i.e., allocation of Disproportionate Share Hospital (DSH) payments).

5.1 IMPLEMENTATION TIMELINE

The prescribed timeline for implementation of managed care in the state of New Hampshire was aggressive from the start. A driving force in this is the estimated \$32 million in savings during the first year of implementation is equal to 2.5 percent of the state's current Medicaid budget. With each month the implementation of managed care is delayed, it costs the state approximately \$1.5 million in potential savings.⁵⁷

While a tight budget does require cost savings at all levels, it is more important to sacrifice short-term savings for long-term success. Gathering input from stakeholders and establishing a solid framework for the management of care will prove to be more effective in the long run, especially as each contracted MCO has limited experience with the disabled and elderly long-term care populations that NH is targeting. This is particularly important in the situation of New Hampshire implementing a plan that is unique to managed care, and new to many of the contracted MCOs as well.

5.2 LIMITED MCO AND STATE EXPERIENCE WITH LONG-TERM CARE

The provision of services to populations with disabilities and long-term care needs may be difficult because the contracted managed care organizations have limited experience serving populations with such needs. According to James Cotton, CEO of Meridian, one of the MCOs that New Hampshire has contracted with, his company does not deal directly with long-term care or disabilities in a holistic fashion. Scott O'Gorman, president of Boston Medical Center Plan, reported that only 2.5 percent of its 200,000 caseload is developmentally disabled. Centene provides care to 12.5 percent of its 1.8



million members and is in the process of developing long-term care in Illinois and Texas.⁵⁸ Each has some experience in dealing with these specific populations, but none have had experience managing their care. Nevertheless, it is promising that New Hampshire received a State Innovation Model (SIM) Design grant from the Centers for Medicare & Medicaid Services that may foster new involvement with stakeholders in the long-term care service community.

Recent litigation raises further concern about New Hampshire's ability to provide care to populations with disabilities and complex long-term care needs. In 2012, a lawsuit was filed against the state arguing that New Hampshire fails to provide appropriate community mental health services to people with disabilities. The provision of services to those populations may be in violation of the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973. The case will go to the U.S. District Court with the Bazelon Center for Mental Health Law, the Center for Public Representation and the New Hampshire Disabilities Rights Center as plaintiffs.⁵⁹

Similar concerns have arisen surrounding the expansion of Medicaid, outlined in Phase 3 of the contracts. Many fear that, in the absence of Medicaid expansion and the subsequent 25 percent increase in revenue, one or more MCO will leave the state and cause New Hampshire to violate federal requirements to provide 2+ provider choices.⁶⁰ However, consider the Medicaid population in New Hampshire relative to other states; it is the size of the Bronx, one borough of New York City. New Hampshire is not the lone source of revenue for these companies and a 25 percent change in revenue will not have a significant effect on their livelihood. Additionally, growth is not determined solely by profit but includes expansion to a new state as well.⁶¹

5.3 DEMOGRAPHICS, NETWORK ADEQUACY, AND RATE NEGOTIATIONS

A substantial proportion of New Hampshire's residents live in rural areas—approximately 40 percent, compared to 20 percent of all U.S. residents—which introduces challenges to the management and coordination of care. In northern New Hampshire, Grafton County's population density is 52 per square mile, while Hillsborough County's is 450 per square mile.⁶² Additionally, the state's Medicaid population is relatively small at seven percent of its 1.3 million residents.⁶³ Due to New Hampshire's low population density and small eligible populations, MCOs cannot be physically present in all parts of the state, increasing the risk of gaps in coverage areas. Results of a study conducted by The Urban Institute demonstrated that only urban areas with full capitated risk payments showed a significant increase in access to care; conversely, primary care case management and rural areas saw little significant effect after implementation.⁶⁴

Price negotiation strategies might also be limited by New Hampshire's population size. With such small percentages eligible in a state with total population 1.3 million, it may be difficult for MCOs to negotiate low rates when Medicaid reimbursement rates are already



low compared to other payers and patient volume cannot be used as leverage power.⁶⁵ This limitation could be problematic for New Hampshire due to the high cost of care and complex needs of many of its Medicaid participants.

5.4 SYSTEMS CONSIDERATIONS

Medicaid Managed Information Systems (MMIS) are used by each state to track process Medicaid claims to health care providers and track eligibility of Medicaid enrollees. With the implementation of Medicaid managed care, the role of the MMIS becomes even more critical. Electronic Data Systems (EDS) was New Hampshire's initial MMIS provider. A contract was approved in December 2005 with Xerox State Healthcare. This contract included two years for the design and implementation of the system, a three-year operational phase to commence in January 2008, and a streamlined way to track claims, providers, conform to federal requirements, and provide better data to the state regarding its Medicaid program. The implementation of the new system has faced continued delays and in December of 2012, another extension of the project was granted. The transition to the Xerox system is expected to begin on April 1, 2013 and the estimated completion of the project is March 31, 2018. EDS stopped processing claims in March of 2013.

5.5 COST OF DSH PAYMENT CUTS

New Hampshire's managed care implementation might also be influenced by future reductions in Medicaid Disproportionate Share Hospital (DSH) payments. Medicaid DSH payments are given to hospitals to help pay for uncompensated care to the uninsured and differences between Medicaid reimbursements and actual costs of care to program participants. DSH payments are the largest source of federal funding for uncompensated care.⁶⁶ In FY 2011 New Hampshire received \$160 million in DSH federal funding.⁶⁷ However, these payments will be reduced under the PPACA, which could limit managed care's efforts to increase access and quality of care.

New Hampshire allocates its DSH funding through a Medicaid Enhancement Tax (MET) levied over all hospitals. This tax is returned to hospitals, with a 50 percent equivalent paid by federal funds. In recent years, New Hampshire has modified this formula so that net revenue remains the same but only 26 percent of the MET is reimbursed to Critical Access Hospitals.⁶⁸ Critical Access Hospitals are rural community hospitals that receive cost-based reimbursement. As a share of 2009 patient revenue, 2010 DSH payments comprised 27 percent of Medicaid patient services reimbursement and 5.6 percent of net patient services reimbursement for non-critical access hospitals. Additionally, under the Patient Protection and Affordable Care Act (PPACA) these payments will be cut, in addition to already having been distributed differently.⁶⁹

Reductions in DSH funding could create incentives for hospitals to alter their behavior, including increased management of care, higher costs, or more limited provision of care to Medicaid patients.⁷⁰ Alternatively, several factors might also reduce such incentives. If



New Hampshire expands Medicaid to include residents earning up to 138 percent of the federal poverty line, the volume of uncompensated care should decrease, thereby reducing hospitals' reliance on DSH funds. In general, changes in DSH funding have significant potential to alter New Hampshire hospitals' behavior.

5.6 INCREASING SAVINGS WITHOUT DECREASING ACCESS

Many best practices and cost-saving methodologies seen in Medicaid programs have already been implemented in New Hampshire. Inpatient utilization and pharmacy cost reductions are two of the biggest savings in managed care models, but these methods are already in existence in New Hampshire. Already the utilization of certain services is limited, requiring review or prior authorization.⁷¹ MCOs may have opportunities to reduce costs by incentivizing specific types of participant behavior, including compliance with a care plan or even fitness center attendance. However, to decrease service utilization further would be difficult, and probably violate the federal Medicaid requirement that capitation rates be "actuarially sound" in that they are not prohibiting the provision of services (access and care) to Medicaid enrollees. Thus, managed care may not have as significant an impact on the cost of services covered under Phase 1 as it would on Phase 2 services.

Additionally, the current managed care contract caps MCO payment to \$382 million in FY 2013, while the cost of acute care services totaled \$408 million in FY 2010.⁷² Although care costs may have been higher in FY 2010 due to recessionary factors, a \$26 million difference appears substantial at first glance. To the extent that future care costs are higher than MCO payments, providers may seek to reduce costs through greater care management or reduced services to Medicaid patients.⁷³

5.7 HOSPITAL LITIGATION AGAINST THE STATE

In July 2011, ten of the state's biggest hospitals sued the state for compensation for millions of dollars in inadequate Medicaid reimbursement as a result of cuts enacted in 2008. Those cuts, prompted by state budget shortfalls, reduced outpatient Medicaid payments by 33 percent and inpatient payments by 10 percent at those hospitals. The hospitals' lawsuit additionally claims that the 2010 state legislature further burdened hospitals by eliminating returns on the Medicaid Enhancement Tax (MET), which had been a source of money that the state returned to hospitals as DSH payments (see Section 5.5).

In December 2012, federal Medicaid officials weighed in on the lawsuit by concluding that despite the reduced payments to hospitals, Medicaid patients in New Hampshire retained access to care, and that the state's motives for reducing Medicaid payments in 2008 due to budget shortfalls that year were irrelevant as long as access to care remained guaranteed.⁷⁴ However, federal officials did not rule out hospitals' right to pursue relief for losses from cuts experienced in the period 2008-2010. Therefore, that issue remains



open and has the potential to complicate Medicaid managed care implementation.

6. CONCLUSION: KEYS TO IMPLEMENTATION SUCCESS

There are several key considerations for policymakers moving forward with implementation. In projecting cost savings in the shift to Medicaid managed care, policymakers are best served by being cautious. Because New Hampshire's physician reimbursement rate for Medicaid services is already low, it may be difficult to find short-term savings. Savings might be produced over a longer time frame, but policymakers will need to be patient because savings are likely to depend on structural changes resulting from improved care coordination and efficiency.

To ensure a smooth transition for providers, New Hampshire and its managed care organizations can collaborate closely with all stakeholders involved in providing long-term care relating to mental health and disabilities. This collaboration would ensure stakeholders' commitment to the program and support throughout its implementation. Because major changes are being implemented to long-term and disabled care under a short implementation phase, policymakers will benefit from being responsive to any concerns that the stakeholder organizations may have regarding the transition to managed care. Capitation rates for long-term care patients are best set carefully and adjusted when necessary to make certain that access to care is not compromised. Rural networks might also be structured in such a way that access to care is not compromised.

The move to Medicaid managed care in New Hampshire is a major transformation with many uncertainties and potential challenges. Medicaid managed care has the ability to improve the efficiency of care, but the transition must be conducted in a careful and diligent manner.



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