

Medicaid Managed Care Commission



NH Community
Behavioral Health
ASSOCIATION

2014 Managed Medicaid & Payment Reform



GOALS

PROTECT MENTAL HEALTH CONSUMERS

PAYMENT REFORM

REACH WORKABLE AGREEMENTS WITH THE
MANAGED CARE VENDORS

Protecting Consumers



- CMHCs are the designated safety net provider governed under RSA 135, services for individuals and families living with severe and persistent mental illness, serious emotional disturbance or experiencing a psychiatric emergency.
- CMHCs serve approximately 50,000 NH Consumers 25,000 Medicaid eligible and approximately another 25,000 non-Medicaid many of whom are uninsured or under insured.
- Medicaid accounts for 65% to 90% of revenues, depending on the Center

Payment Reform



Payment reform = finding a model different from our current fee for service payment system, that aligns quality of care and results in a more efficient delivery system

Payment Reform



- Payment reform must be done methodically and with a responsibility to sustain necessary services
- Non profit boards concerned with their fiduciary roles, particularly with such a heavy dependency on Medicaid revenue
- Goal is to convert to a new payment model without creating major disruption that will lead to an erosion of services or CMHC closure, current system is very economically fragile

MCO Engagement



- **Challenges:**
 - Potential Payment models only discussed conceptually by MCOs and were all different but all versions of models we had studied for over a decade
 - MCOs needed time to better understand our services, our mix of services and the design of our community mental health system
 - MCOs reported that they were not given sufficient funds to carry out the promise to INVEST in community mental health (e.g. structure of MCO payments did not clearly identify payment for a chronically mentally ill patient). Some adjustments were made to accommodate this concern

MCO Engagement^{cont'd}



● Other challenges....

- Contract language used from MCO experiences in other states needed to be modified
- What about membership? Evaluating 3 different payment models from MCOs without understanding which patients selected each MCO was challenging
- Timing – Changes to the MCO capitation rates were made to account for payment for Severely and Persistently Mentally Ill (SPMI) patients which added dollars for all services for this population, MCOs could not calculate tangible rate offers until that amendment occurred in mid 2013 – to date there are still issues in calculation of offers

MCO Engagement_{cont'd}



- Where are we today?
 - In the summer of 2013, CMHCs signed “Letters of Agreement” that preserved the then current payment system, and payment rules with a commitment to study new payment models after securing an independent actuary
 - This mechanism allowed us to facilitate a process that enables DHHS to move forward with managed care, while we better understand the MCO models and which patients choose which MCO
 - Those “LOA’s” expire June 30, 2014

MCOs What's Happened? Cont' d



- Working through the process of patient identification (which MCO chosen) and process of billing and collection
- Some implementation issues have resulted
 - ✦ Prior authorizations for maintenance drugs
 - ✦ Hospital admission authorizations
 - ✦ Patient engagement/confusion

DHHS Collaboration



- Recent meetings with DHHS identified several operational issues that we are collectively trying to resolve
- DHHS/Milliman actuarial meeting identified that while investments are being made by legislature and Governor, the MCOs have funds that already contemplate savings in “Care Management” – this means CMHCs and MCOs have a gap in current funding that is difficult to resolve before the end of the LOA’s

MCOs 2014 Tasks



- Working to get the payment system right and reaching new contractual agreements:
 1. Three MCOs, Three payment models (four with DHHS Fee for service) ten CMHCs for 25,000 lives – these are incredibly small numbers for fixed payment mechanisms
 2. Actuarial support – CMHCs and their boards will need independent actuarial support to consider any MCO offer – for any given CMHC this represents 65-90% of its total revenue and CMHCs are already economically fragile
 3. Coordinating investments in care contemplated by the Governor and State Legislature

MCOs in 2014_{cont' d}



Working to get the payment system right and reaching new contractual agreements: _{cont' d}

4. MCOs involvement in clinical activity may draw resource from a system lacking resource and can make patients wait times even greater

5. MCO economics – MCO need to cover their administrative costs and generate some surplus to survive. The challenge will be to find a payment model that supports that economic model but affords the opportunity for investment in services

How can you help?



- June 30 deadline is rapidly approaching, and many challenges still exist to get all parties to “yes”
- Can the Commission assist in that process , hear from other parties, request regular reporting on progress?