

RESEARCH REPORT

Risk-Based Managed Care in New Hampshire's Medicaid Program

A Qualitative Assessment of Implementation and Beneficiary Experiences in Year One

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Executive Summary

This is the first report in a series that will be prepared during a three-year evaluation of the statewide implementation of risk-based managed care in New Hampshire's Medicaid program. With support from the Endowment for Health, Urban Institute researchers and researchers from the University of New Hampshire Institute for Health Policy and Practice are evaluating the transition to Medicaid managed care using both qualitative and quantitative methods. The Endowment for Health convened an advisory group for the evaluation team, including representatives from key provider groups, advocates, and state officials, which first met in December 2012 and will meet annually as the evaluation proceeds.

In June 2011, the New Hampshire legislature passed SB 147, which directed the New Hampshire Department of Health and Human Services to develop a comprehensive statewide Medicaid managed care program for all Medicaid enrollees. At its conception, the Medicaid Care Management program was designed to be implemented in three steps beginning in July 2012. Step 1 was to include a transition to managed care coverage of acute care services for the majority of beneficiaries. One year later, Step 2 would add long-term services and supports (LTSS), and Step 3 in 2014 would bring in the Affordable Care Act Medicaid expansion population. Ultimately, however, Step 1 was implemented in December 2013 and Step 3, now known as the New Hampshire Health Protection Program, began in August 2014. Step 2 of the transition, which will include those who are currently voluntarily enrolled in Medicaid managed care and several waiver populations, is scheduled to begin enrollment in July 2015; coverage will begin in September 2015.

In this report, we provide an overview of managed care implementation in New Hampshire as of mid-2014. This report thus examines early experience with the implementation of managed care for Medicaid acute care services. We drew upon a case study conducted about seven months after the state began enrolling Medicaid beneficiaries in risk-based managed care. The case study includes a review of such documents as the state quality strategy and quality reports, newspaper articles and other reports, New Hampshire Medicaid Care Management focus group findings produced by the external quality review organization, and materials presented to the Governor's Commission on Medicaid Care Management. We also interviewed key stakeholders including representatives from the state and their managed care contractors (Well Sense and New Hampshire Healthy Families), providers, and advocates. Three focus groups were conducted to provide a beneficiary perspective on the first year of Medicaid managed care implementation in the state. The major findings that emerged are summarized here.

Initial implementation of managed care in New Hampshire's Medicaid program went relatively smoothly. A successful transition to managed care depends on a smooth enrollment process for beneficiaries, development of robust provider networks by the managed care plans, continuity of care for beneficiaries, and provider readiness for the transition. The enrollment process saw few reports of problems and a relatively high rate of self-selection of a managed care plan by beneficiaries, which likely reflect the state's extensive efforts to educate beneficiaries and providers about the transition. There was also little evidence of provider networks diminishing because of managed care, and focus group participants noted they found it easy to make an appointment for primary or specialty care. Providers also reported a smooth transition when it came to implementation issues such as credentialing, claims submission, and payment procedures. By most accounts, communication among the key stakeholders was good, and when problems arose, efforts were made to address them and track the issue.

Staff at the New Hampshire Department of Health and Human Services see managed care as an opportunity to develop additional quality improvement processes within the Medicaid program, and they have taken an active oversight role as implementation has progressed. The state developed an ambitious quality strategy and sophisticated data collection and analysis plans for the program going forward. This includes monitoring of over 400 quality indicators on the New Hampshire Medicaid Quality Indicators web site, annual Quality Improvement Projects, chosen by the state, and Performance Improvement Projects, chosen by each health plan, and external quality review organization activities, including all optional activities outlined in federal regulations. Though it is too early to observe the effects of managed care implementation, the state has released a quality indicator report each month since August 2014. Each report provides key indicators in 10 domains: access and use, customer experience, provider experience, utilization management, grievances and appeals, preventive care, chronic medical care, behavioral health care, substance use disorder care, and general quality. The report will continue to be released each month and provide up-to-date information for each indicator, allowing the state to track program performance over time.

Both providers and Medicaid beneficiaries reported significant problems with prior authorization processes, particularly for pharmacy services. The provider community was clear in their dissatisfaction with the new prior authorization requirements imposed by the managed care plans. Across types and locations, providers agreed the requirements had added considerable administrative burden to their practice and in some cases had jeopardized beneficiary care. Focus group participants confirmed delays in care caused by the prior authorization process and noted particular difficulty receiving needed prescriptions. The state has recognized that prior authorization processes are the biggest issue in New

Hampshire Medicaid managed care and has been meeting with the managed care plans to address these issues.

Much uncertainty exists about Step 2 implementation. Though some stakeholders suggested potential benefits of managed care for the Step 2 population, most advocates for the developmentally disabled and other populations receiving LTSS expressed serious concerns about the ability of the managed care plans to serve these populations. The state recently conducted public forums to generate feedback on Step 2 implementation and found that stakeholders have concerns about provider networks, prior authorization processes for pharmacy and therapy services, and the general ability of the managed care plans to understand and meet the complex needs of the LTSS population. With enrollment for some Step 2 populations now scheduled to start in July 2015, it will be important to monitor negotiations between health plans and LTSS providers as well as the continued feedback from the advocacy community.

As Medicaid managed care continues to evolve, the evaluation team will be monitoring several issues to assess its evolution and sustainability. With the greatest concerns around the initial phase of implementation of managed care stemming from prior authorization requirements, this area will receive ongoing scrutiny from the evaluation team. The state desires to address these issues and ease the burden on providers, but these processes are an important care management tool for managed care plans, so the ultimate outcome remains to be seen. A related issue is the adequacy of the provider networks under managed care. Currently, the networks appear to be meeting beneficiary needs, but if provider dissatisfaction with the administrative burden of managed care continues, some providers could discontinue their participation with the managed care plans. Analysis of provider networks will also require additional attention as Step 2 is implemented because these beneficiaries tend to have more complex needs and see a wider variety of providers.

In addition, the community mental health centers operated under letters of agreement with the managed care plans during the first year of the care management program, though they did contract with Well Sense/Beacon Health Strategies on November 1, 2014. Because these providers appear to be an important component of state efforts to provide more community-based mental health services, the contracting process between the community mental health centers and managed care plans is another area that will be closely monitored as the program evolves.

Another key component of the managed care model is the use of case management programs. At the time of our interviews, both managed care plans had functioning case management programs, but they were small and seemed not fully developed. These programs are closely associated with managed

care's promise to provide better care coordination for enrollees and better health outcomes. Thus, particularly as the more complex Step 2 populations transition from a fee-for-service model into a managed care model, it will be important to track the development of case management.

As noted, the state has extensive plans for monitoring and evaluating the transition to managed care, but the current set of quality indicators are only available for the period since managed care has been implemented. The state plans to generate a consistent set of quality indicators using fee-for-service data, which will be necessary to fully assess the managed care program's effects on beneficiaries. As the evaluation team begins its quantitative analysis, it will be important to understand any challenges that arise in creating consistent measures in the pre- and post-managed care period.

Finally, one important goal of the transition to managed care was to generate cost savings for the state. New Hampshire is a small state with a modest-size Medicaid program that has been dominated by a population of relatively healthy parents and children. Though the budgetary implications of Step 1 implementation are not yet known, further opportunities for care management and cost savings may be realized by implementing Step 2, which is small in enrollment but represents a disproportionate share of the program costs. The delayed implementation of Step 2 gives the state and managed care plans an opportunity to better prepare for this transition and to minimize disruption of care for these vulnerable individuals, but the delayed implementation may hamper state goals for cost savings.

Background

In June 2011, the New Hampshire legislature passed SB 147, which directed the New Hampshire Department of Health and Human Services (DHHS) to develop a comprehensive statewide Medicaid managed care program for all Medicaid enrollees. At its conception, the Medicaid Care Management (MCM) program was designed to be implemented in three steps beginning in July 2012. Step 1 was to include a transition to managed care coverage of acute care services for the majority of beneficiaries. One year later, Step 2 would add long-term services and supports (LTSS), and Step 3 would bring in the Affordable Care Act (ACA) Medicaid expansion population in 2014. Ultimately, however, Step 1 was implemented in December 2013 and Step 3, now known as the New Hampshire Health Protection Program, began in August 2014. Step 2 of the transition, which will include those who are currently voluntarily enrolled in Medicaid managed care and several waiver populations, is scheduled to begin enrollment in July 2015, with coverage beginning in September 2015.

New Hampshire was one of the last states to adopt capitated managed care for its Medicaid population. Though the state had made earlier attempts to implement managed care for some of its Medicaid population, these efforts were not as comprehensive as the current plan and were discontinued because projected savings did not materialize (Agredo et al. 2013). A major difference between earlier programs and the MCM program is the latter's focus on providing LTSS under risk-based managed care.

Over the past decade, Medicaid programs have increasingly relied on risk-based capitated managed care arrangements to deliver care to disabled populations (Howell, Palmer, and Adams 2012). For example, the number of states with managed LTSS programs grew from 8 in 2004 to 16 in 2012, and the number of people enrolled in these programs grew from 105,000 to 389,000 (Saucier et al. 2012). States cite many reasons for expanding Medicaid managed care programs (such as reduced uncertainty in spending and the potential for improvements in care through greater case management, care coordination, and focus on prevention), but the evidence on improvements to access, quality, and cost is mixed (Goodell and Sparer 2012). The current managed care program in New Hampshire was projected to save \$32 million per biennium.¹

With support from the Endowment for Health, the Urban Institute is evaluating New Hampshire's transition to Medicaid managed care using both qualitative and quantitative methods. The qualitative component provides insights about how managed care is implemented across the state and assesses changes in beneficiary care that will inform the quantitative analysis, which assesses impacts. This report provides a qualitative assessment of stakeholder experiences with the MCM program through

early July 2014, seven months after program enrollment began. The next section describes our case study methods and is followed by a discussion of the major themes that emerged from our analysis. We conclude with a discussion of key findings based on our assessment of the early implementation period and suggestions of issues to monitor as managed care implementation evolves.

Methods

This year-one implementation report is based on a review of documents, including newspaper articles, state quality strategy and quality reports, New Hampshire Medicaid Care Management focus group findings produced by the external quality review organization (EQRO), and materials presented to the Governor’s Commission on Medicaid Care Management. Also, we conducted 23 interviews with stakeholders and three focus groups with Medicaid managed care members in the Concord-Manchester region of the state to assess early experiences with Medicaid managed care implementation. We use multiple sources to identify themes that emerge across types of information and informants. This process is called “saturation” in qualitative research, and it is achieved when the same themes are heard repeatedly. We do not assess the accuracy of stakeholders’ opinions. We received Institutional Review Board approval for the qualitative work in this report.

Case Study Interviews

Most stakeholder interviews were held in person in New Hampshire during the week of July 14, 2014. Additional interviews were held by phone from July through September 2014. Table 1 shows the number of interviews of each type, and appendix A lists the specific organizations and people with whom we spoke. Interviewees included state Medicaid staff and their contractors, representatives of Well Sense and New Hampshire Healthy Families, providers and provider associations, and advocates for populations using LTSS and mental health services. Provider informants were drawn from the Concord-Manchester region and the “north country” (roughly the northern third of the state) and included provider association staff, chief executive officers of community health centers, and providers. We spoke with providers of acute care services and LTSS. A semistructured interview protocol guided each interview and was tailored to each respondent. The topics covered in the interview guides are noted in table 2. Interview notes were transcribed using a recording of the interview and coded using NVIVO qualitative research software.

TABLE 1

Number of Interviews by Type

Interview type	Number of interviewees
State official or state partner	5
Health plan	2
Provider or provider association (acute care)	8
Provider or provider association (LTSS)	3
Mental health provider or advocate	2
LTSS advocate	3

Source: Urban Institute evaluation of New Hampshire Medicaid managed care case study data.

Note: LTSS = long-term services and supports.

TABLE 2

Interview Topics by Stakeholder Type

Topic	State	Health plan	Advocate	Provider
State organization and oversight	X			
Plan selection	X			
Credentialing and contracting		X		X
Prior authorization				X
Coding and billing				X
Denials and appeals				X
Education and enrollment	X	X	X	X
Provider networks	X	X	X	X
Continuity of care	X	X	X	X
Quality and access	X	X	X	X
Case management	X	X	X	X

Source: Urban Institute evaluation of New Hampshire Medicaid managed care case study data.

Focus Groups

To obtain beneficiaries' perspectives on Medicaid managed care implementation and on access to care, focus groups were conducted during the week of July 14, 2014. These groups were conducted with three discrete groups of individuals: parents of children enrolled in Medicaid managed care, adults accessing LTSS who were enrolled with a managed care plan for their acute care services, and adults accessing the mental health system.

Parents of children were chosen because children are the largest group that transitioned to managed care in December 2013. Moreover, because they are generally healthy, their experiences and perceptions are likely different from the other two groups, which tend to have significant and complex care needs. Those accessing the mental health system were chosen because of the special interest in this population in New Hampshire. Adults accessing LTSS were chosen because of the potential lessons for the subsequent expansion of managed care to encompass these services.

TABLE 3

Focus Group Participants by Type

Focus group type	Region	Number of participants
Parents of healthy children	Concord-Manchester	7
Using mental health system	Concord-Manchester	6
Long-term services and supports	Concord-Manchester	3

Source: Urban Institute evaluation of New Hampshire Medicaid managed care case study data.

Recruitment was designed in consultation with New Hampshire stakeholders and was intended to attract participants representing varied experiences with Medicaid managed care. For example, we did not want to recruit only beneficiaries who had a particularly good or bad experience. The recruitment strategy used was different for each of the three groups and is detailed in appendix B. Focus group notes were transcribed by a professional service and coded using NVIVO qualitative research software. Respondents were assured of anonymity and encouraged to provide honest opinions about their experience with Medicaid managed care.

Limitations

The results presented in this report have two main limitations. First, the findings primarily reflect the experiences of major stakeholders in the first seven months of the managed care program in New Hampshire. The program has evolved since July 2014 and will continue to evolve. Though we have updated this report with current information where possible, the analysis focuses mainly on the early implementation period and therefore does not necessarily reflect the current environment in New Hampshire. Second, the focus group findings are based on a small sample of Medicaid enrollees. These

findings are meant to illuminate issues that Medicaid beneficiaries may be experiencing, but they are not meant to be broadly representative of the New Hampshire Medicaid population and should not be interpreted as such.

Findings

We start this section with a discussion of the implementation time line, managed care plan participation and enrollment, and state oversight; we then distill findings on provider and beneficiary experiences.

We also discuss case management programs and their development in the state. We close with a discussion of implications for the implementation of Step 2.

Evolution of the Implementation Timeline and Managed Care Plan Participation

At its conception, the MCM program was designed to be implemented in three steps beginning in July 2012. Step 1 was to include a transition to managed care coverage of state plan services for the majority of beneficiaries. One year later, Step 2 would add LTSS, and Step 3 would bring in the ACA Medicaid expansion population in 2014. There has been considerable change in this timeline, however, which has affected the implementation experience for all stakeholders.

A request for proposals was released in October 2011, and six managed care plans submitted bids for New Hampshire's business; the state signed contracts with three managed care organizations (MCOs). Well Sense Health Plan (operated by Boston Medical Center Health Plan), Granite State (operated by Meridian Health Plan), and New Hampshire Healthy Families (operated by Centene) were contracted to provide health care services for the New Hampshire Medicaid population on a capitated basis. Step 1 of the transition, which would require most Medicaid enrollees to receive state plan services through a managed care plan, was scheduled to start on July 1, 2012.²

Implementation of the MCM program stalled because of the health plans' difficulty establishing the appropriate provider networks. This was caused in large part by a preexisting conflict between the hospitals and the state regarding payment for Medicaid services. In 2011, a lawsuit filed by 10 hospitals stated that budget cuts reducing Medicaid payments to hospitals put the state out of compliance with federal guidelines to ensure access to care for Medicaid beneficiaries.³ This took place during ongoing conflict with hospitals over payment issues, which began with cases challenging rate reductions as early as 2008.⁴ Hospitals were unwilling to negotiate with the managed care plans while lawsuits were pending, and with the majority of primary care practices in the state owned by a hospital, the managed care plans were not able to establish the necessary networks. Ultimately, the hospitals agreed to

contract with at least one of the health plans in exchange for improved disproportionate share hospital payments.

After the hospitals signed on, implementation of the MCM program resumed. Beneficiaries began enrolling with managed care plans in September 2013 and coverage of acute care services for all nonoptional populations began December 1, 2013. Currently the timeline for implementing Step 2, which will incorporate waiver and nursing home services as well voluntary population groups (such as children in foster care, children with disabilities and Medicare-Medicaid dual eligibles), has been revised (Toumpas 2014). Beginning July 1, 2015, voluntary groups will be enrolled in the MCM program, and coverage for them and for some individuals in need of LTSS, specifically those using the Choices for Independence waiver and those in nursing facilities,⁵ will begin September 1, 2015. Those using the developmental disabilities waiver,⁶ the acquired brain disorder waiver,⁷ and the in-home supports waiver⁸ do not yet have a definite enrollment date in managed care.

Step 3 of the original MCM implementation plan was to include the ACA Medicaid expansion population (individuals with income below 138 percent of the federal poverty level who were not eligible for Medicaid before the ACA but who meet the immigration requirements). In June 2012, a US Supreme Court ruling gave states the power to decide whether to adopt the ACA expansion. New Hampshire chose to implement the ACA Medicaid expansion and has submitted a waiver application to provide premium support for the Medicaid expansion population to purchase coverage in an Exchange plan. In July 2014, New Hampshire began enrolling the expansion population in the New Hampshire Health Protection Program. Those with access to employer sponsored coverage are required to take that coverage if it is cost effective and receive a subsidy; those without access to employer sponsored coverage can enroll with a Medicaid managed care plan through the Bridge Program offered by the New Hampshire Health Protection Program. If the state's waiver is approved, the latter group will be transitioned to an Exchange plan by 2016.⁹

The complexity of the implementation plan and the continued evolution of the timeline for Steps 2 and 3 provide important context for understanding the experiences of different stakeholders throughout the early implementation process. The implementation delay may have had at least one advantage: it allowed the state more time to educate beneficiaries and providers and thus smoothed the transition process. These efforts are discussed in more detail in the next section.

Though the state initially contracted with three health plans to serve the Medicaid market in New Hampshire, Meridian Health Plan announced their withdrawal on June 30, 2014, and the plan ended all

services in New Hampshire on July 31, 2014.¹⁰ The remaining two plans began serving all former Meridian enrollees as of August 1, 2014.

Total enrollment in MCM has grown since the program's inception: enrollment numbers rose from 104,284 in December 2013 (when the program began) to 137,030 in November 2014. Enrollment in Well Sense and New Hampshire Healthy Families has also grown every month, and both plans recently had more than twice the enrollment that Meridian had at its peak in June 2014. As of November 2014, Well Sense had 74,331 insured in New Hampshire and New Hampshire Healthy Families had 62,699 insured (Toumpas 2014). These numbers will fluctuate as Step 2 and 3 implementation evolves.

Enrollment into Medicaid Managed Care

New Hampshire offered an intensive, multicomponent education and enrollment process. New Hampshire officials created two major education channels: one for beneficiaries and one for the providers who would likely be fielding questions from those beneficiaries. They also developed four methods for beneficiaries to enroll in managed care and choose a health plan. Key informants generally agreed these efforts led to a relatively smooth enrollment process as indicated by a high share of beneficiaries actively choosing their plan and enrolling on their own rather than relying on the state's automatic assignment algorithm.

Educating Beneficiaries

The state's process for educating beneficiaries about the change from a fee-for-service Medicaid system to a managed care system included community-level information sessions during open enrollment, information posted on the MCM web site, and four written communications to beneficiaries. First, the state sent a letter explaining the MCM program. Second, the state mailed each beneficiary a packet that explained the beneficiary's health plan choices and suggested how to choose among the plans. For example, the packet explained that the beneficiary may want to determine which health plan or plans had a contract with their primary care provider. The packet also contained a document providing information about the special benefits offered by each plan. For example, some plans included free car seats, diabetes education, or pregnancy classes. Third, the state sent everyone who had not signed up a reminder letter when they still had 30 days left to choose a health plan. Fourth,

beneficiaries received a confirmation letter informing them of their health plan assignment regardless of whether they self-enrolled or were automatically assigned.

Education and Self-Selection

As reported by informants with experience working in other states, these processes together led to a high degree of beneficiary self-selection of a health plan. The state reports that data from the New HEIGHTS eligibility system from the week of December 6, 2013, showed that 60 percent of those eligible for MCM self-selected or opted out.

In focus groups, we heard that beneficiaries often selected their own plan based on their provider network, and this was an aspect of plan selection that was emphasized in state educational materials. We also learned that those who called MAXIMUS, the state's enrollment broker, were likely to be encouraged to consider additional benefits offered by the health plans when making their plan selection.

Automatic Assignment

Those who did not self-select a health plan within the allotted 60-day period were automatically assigned to a plan based on the following factors: (1) an assessment of the plan contracts with the beneficiary's primary care provider (as determined through claims analysis), (2) selection of a particular health plan by a family or case member, (3) previous membership in a health plan (this criterion will be more applicable as the program gains more history), and (4) random assignment (using a formula that provided Well Sense, the plan that had the highest technical score as determined by their proposal, with 50 percent of the membership and divided the remaining 50 percent between New Hampshire Healthy Families and Meridian).¹¹ This algorithm will stay in place following Meridian's departure, with each of the two remaining health plans receiving 50 percent of the random automatic assignments.

State Oversight Experience

Medicaid managed care programs require many different staffing and oversight structures compared with fee-for-service programs. In New Hampshire, state officials see managed care as an opportunity to

build and develop their oversight structure and are adding internal staff while also contracting out some responsibilities to the health plans, the EQRO, and MAXIMUS.

State officials reported that there were impediments to developing a robust state infrastructure for quality improvement and oversight in the absence of managed care. The increased infrastructure available through the health plans was described as a benefit of managed care and a potential step toward greater influence on population health by creating a vehicle through which the state can influence such health issues as smoking and obesity. The health plans are overseen by the New Hampshire DHHS through the deputy Medicaid director, a bureau chief, and account managers for each MCO.

“By hiring an MCO, their administrative cost is much higher than ours... And that is going toward things like having people to manage provider relations, and having quality people... If you wanted to do an intensive education program to try to get people to stop smoking, there’s no [infrastructure to do it under fee-for-service].” –State informant

In addition to expanding its focus on quality oversight through managed care, the state received an Adult Medicaid Quality grant from the Centers for Medicare and Medicaid Services (CMS) to build quality infrastructure and expand resources for data analysis on Medicaid quality measures. One such expansion includes the improvement of a dedicated web site, which currently provides historical quality data for the fee-for-service program, to provide quality information that can be compared across managed care plans.¹² The grant also allowed the addition of four new employees focused on quality measurement and improvement. The state will continue to fund these positions beyond the period of the grant.

Under Medicaid managed care, CMS also requires the creation of a comprehensive quality strategy. The state’s quality strategy describes its four quality incentive projects (which both health plans must undertake), four performance improvement projects (which are different for each plan, based on the plans’ goals), and other quality improvement activities (including population-based measurement and reporting, health plan operations and contract compliance reporting, and annual surveys of members and providers). This public document was updated throughout 2013 and 2014 to reflect the evolving

goals of New Hampshire Medicaid staff. The most recent version was released August 29, 2014 (New Hampshire Department of Health and Human Services 2014).

“We imposed a certain rigor in our approach to things.... One of the things... in this procurement process is that [the health plans] will report out on a boatload of things and we are not backing down... it means the contract and its language is not just a shell to make CMS happy. It’s real.” –State informant

The state’s quality strategy is ambitious and requests a large amount of data and metrics from the health plans. The state has established with the health plans that the information they collect could become public. A state web site will allow select data to be displayed, compared across plans, and compared to benchmarks to increase transparency and accountability. The data will be provided quarterly.

“We survey, think often, and interview some of the folks around here to see what’s being done to come up with a recommendation that not only weaves together the different facets of Medicaid under the New Hampshire DHHS roof, but also to look at it from a broader, statewide perspective.” –State informant

Quality reporting is still beginning, and it is not yet possible to decipher changes in quality metrics because of managed care. The state’s monthly data reports currently contain a limited set of the measures that it ultimately plans to cover and no fee-for-service data are included for reference.¹³ Moreover, at the time of our interviews, claims and encounter data had not yet been obtained by the EQRO; this was partially attributable to a change in the Medicaid Management Information System on April 1, 2013. We were told that the change slowed the state’s reception of aggregate data.¹⁴

Provider Experiences with Medicaid Managed Care

Provider Notification and Transition to Medicaid Managed Care

The delay in implementation of managed care also allowed the state to conduct more outreach and education with providers regarding (1) how they could help educate and enroll beneficiaries into managed care, and (2) the managed care processes that they would encounter once the program was implemented. As it was developing training materials for providers, the state sought input directly through provider surveys. The state also created a web site that providers could use to track the types of materials that beneficiaries were receiving from the state and held 12 community-level sessions around the state during open enrollment. The state held four provider sessions focused on how to assist beneficiaries with understanding managed care and their health plan choice. One objective of these sessions was to help providers understand what happened when a beneficiary called the enrollment broker. Providers were also educated about assisting beneficiaries with the enrollment process through an online portal called NH Easy. Additional provider sessions focused on business processes and related issues. For example, they discussed reimbursement under managed care, managing business processes, and where and how to submit claims. These sessions may have eased some of the burden of transitioning to Medicaid managed care as providers and provider organizations interviewed in the case study did not often complain about contracting, credentialing, or timely payment of claims. Provider informants noted that prior authorization was the most burdensome new process under managed care and that the appeals process caused by claims denials was also burdensome. These issues are discussed further in “Prior Authorization” later in this section.

Contracting

The contracting process between managed care plans and providers went smoothly according to both parties, except for the contracts with the community mental health centers (CMHCs), who operated under a letter of agreement during year one. One informant suggested that Medicaid managed care was more significant for CMHCs than other providers, which led CMHC representatives to take great care in negotiating their contracts. For example, an informant reported that CMHCs rely on Medicaid for between 65 and 90 percent of their financing, though a hospital system may rely on Medicaid for less than 10 percent of its financing. A CMHC representative reported that covered services were a primary concern with the contracts.

“We need to be mindful that we can’t be managed in such a way that we can’t provide the level of services that [we are] mandated to provide.” –Provider informant

Most providers that we spoke with reported that they initially contracted with all three of the plans (Well Sense, New Hampshire Healthy Families, and Meridian). One informant reported that their practice considered contract negotiations with local hospitals and specialists before deciding to contract with a plan; this ensured that there would be places to which to refer beneficiaries.

Plans reported that the contracting process with providers began long before managed care went live in December 2013, and that the process became more hurried after the fiscal year 2014–15 budget negotiations.

“Even when things were held up, we were still working on drafts of the contract with the hospital, even though no one was going to sign it. Stuff was still happening. And we were contracting with lots of other providers over the course of that year.” –Plan informant

Perhaps because of the compressed contracting process, some provider informants reported surprise at some of the clauses that were in the contracts they had signed, particularly concerning payment. A few provider informants noted they would like to spend more time on contracting in future years.

“Now we are negotiating for year two because of all the issues that we learned about after the first year.” –Provider informant

Credentialing

Most provider informants noted that the credentialing process with the new plans presented no major problems. Some provider informants noted initial problems that interfered with their timely payment, but these problems had been largely resolved by the time of our interviews. Problems included confusing guidance from the plans about whether the provider needed to go through the credentialing process, different processes for each of the plans, and incorrect provider credentialing by the plans.

Prior Authorization

Provider informants reported that their biggest problems with Medicaid managed care were related to the newly implemented prior authorization processes that accompanied the transition. Every provider informant reported that prior authorization was problematic. Concerns centered on the intensive administrative process needed to receive prior authorization (a process that was different for each plan), as well as the slow time frame for receiving authorizations from the plans.

In particular, providers were concerned about the effect on beneficiaries of the prior authorization processes in place for pharmacy. Multiple provider informants reported that the prior authorization process often required beneficiaries to repeat trials of cheaper pharmaceuticals that may have been ineffective for the beneficiary in the past. In addition, the prior authorization processes do not allow for changes to a prescription within 30 days even in cases where the prescribed medication proved ineffective.

“If you were started on something on August 1, and they realize about 10 days in that you either need a new level of dosing or a new medication, you can’t get a second prescription in the same class in 30 days, [the health plans] won’t cover it.” –Provider informant

“You just have to keep fighting it, and sending more documentation and showing what’s been done with history. The providers are refusing. They don’t want to put the patients through that. The problem is patients can’t have a delay in medication” –Provider informant

“You have to prove that you’ve tried A and B.... So what you’re saying to the patient is ‘This drug that you have been on for the past three years, which has worked every month, I now have to ask again if you are going to be allowed to take this drug.’ It’s not particularly logical. There are delays in the authorization, so there were delays for people staying on their medication.... Appropriate authorizations that were already in the system should have been carried over.” –Provider informant

“We have a period of time where the patient doesn’t have meds for their pain, they’re dying of cancer, and we have to wait for the appeals process so we can get that approved. That’s not what we want for patient care.” –Provider informant

Beyond the delays that the prior authorization processes could cause for beneficiaries, providers were concerned also about the amount of staff time that prior authorization required; they also reported frustration that the forms were not designed to minimize provider burden (e.g., each managed care plan had different policies and forms). Many provider informants noted that the additional time required for prior authorization meant additional expense for the provider, and a few noted that additional staff had been hired to work exclusively on administrative work caused by managed care.

“I went from two hours (a week) doing authorization for medication to now 16 hours a week. And most are denied, which means we have to appeal.” –Provider informant

“The form is a generic form that is used for all medications, so (we) completely fill it out and get it back saying that [the health plan can’t] approve because it’s missing x, y and z information... but there’s no room on the generic form to fill that information in. (We) have called and asked for the medication specific forms and (the health plans) don’t have them. So [we] try to remember from patient to patient which information is requested for which medication.” –Provider informant

“Instead of my nurse manager spending an hour on this, now she’s four hours into this and she’s still working on it and we’re calling the patient saying, ‘Sorry we don’t have anything to give you.’”-Provider informant

“It really takes [a registered nurse] to understand the medications and everything. It’s expensive time. It’s not just a clerk on the phone. You have to go into the record, show them all the medications that did not work, why we’re going into the formulary, all the allergies, talk about all medications and dosage, what’s been tried, what’s failed and why we’re at this point.” –Provider informant

Providers reported that the administrative burden was exacerbated by the repeated need for prior authorization even for treatment of chronic conditions, noting particular frustration that the process was necessary for beneficiaries with conditions that weren’t expected to change. Birth control was a common medication that providers suggested should be authorized on a less frequent basis. This complaint was also heard often among those serving patients in need of LTSS.

“Every 30 days we have to get birth control approval. We’re telling patients ‘call us in two weeks.’ Every two weeks they’re calling us so we can make sure they get their birth control.” – Provider informant

“[We] have a kid with cystic fibrosis who is on some special medication and we’ve got to prior authorize it every month. The only reason he is not going to be on that medication is if the child dies. You don’t get better from cystic fibrosis.” –Provider informant

“We’re used to doing [prior authorization for medications for private managed care plans]. They don’t do it as much. It seems like Medicaid is doing it for every single medication.” – Provider informant

Some provider informants also reported that they didn’t feel the contracts between the managed care plans and the state provided a realistic prior authorization guideline for beneficiaries and providers. It was reported that the managed care contracts dictate that a response within 7 to 14 days was adequate, but some provider informants felt contractual guidelines should be more nuanced and dependent on the condition of the beneficiary and federal guidelines. Though the 14-day limit reflects federal guidelines, DHHS shortened the response time to five days in response to this feedback.

“Federal regulations would be a good place to start [when developing the contract provisions for the managed care plans]. Because if [we] are held to those, theoretically the managed care plans should be as well. It’s not fair to be held to a higher standard that we can’t avoid as a provider.” –Provider informant

Some providers are looking for creative ways to participate in managed care without taking on the administrative burden caused by prior authorization. For example, CMHCs are hoping to negotiate a capitated rate with the health plans that would enable them to be paid by beneficiary instead of service. This would also ease the administrative burden of prior authorization and allow the MCOs to fulfill obligations to DHHS around payment reform.

The state is aware of the problems providers are having because of prior authorization and noted that it would have liked to receive more guidance on this issue from other states when they were planning for Medicaid managed care.

“There are some providers who have come to the Care Management Commission and complained about prior authorization, and we went back to all the providers and asked for the names of patients so we could track this.” –State informant

Denials

Provider informants reported that the number of claim denials had gone up because of Medicaid managed care. Informants gave mixed responses regarding how much information they had about the reasons for claim denial.

“They give you information as to why they denied something, but if it’s something they should be covering, you need to go back to your manual and [get the correct person to approve it.]” –Provider informant

“They’re clerks. They’re looking at a screen and saying ‘denied.’ They don’t even tell us [why]. They send us a sheet that says ‘unable to authorize’ and give their five sentences about how to go through the appeal process.” –Provider informant

“People don’t know what is required. They just get these rejections.... There is no communication.... Instead of saying ‘What I’m missing is a note from Dr. Smith’—it’s not like that, they simply say ‘no.’” –Provider informant

Length of time before submitting a claim and miscommunication between a managed care plan and their behavioral health subcontractor were the most common reasons that provider informants gave for claim denials. Prenatal care claims were reportedly particularly difficult to submit expeditiously because the claims were to be submitted based on the total number of prenatal care visits rather than submitted every time a pregnant woman was seen. Some women were seen early in their pregnancy and did not return for prenatal care later in their pregnancy. Reportedly, it was hard to avoid submitting these claims late.

Problems with behavioral health claims were commonly caused by confusion about how to categorize a claim. It is unclear whether the confusion was the provider’s or was between the managed care plan and their subcontractor.

*“If someone comes in for a visit and the primary care provider happens to do some kind of behavioral health talk with them, is that all of a sudden just a regular visit or is it a behavioral health visit? [The managed care plan] couldn’t give us clear guidelines.... We had a patient here who ended up being admitted by a psychologist. We had to write off the claim.”
–Provider informant*

Claims Submission and Payment

Provider informants did not consistently express concern about issues of claims submission and payment. The problems mentioned can be grouped in three areas: (1) issues of providers not having all the correct identifying information and information about plan assignment to properly submit claims; (2) issues pertaining to providers with unique billing and coding arrangements before implementation of managed care; and (3) issues with Medicare claims.

Information Gaps

Providers noted that their access to beneficiary information, such as what plan the beneficiary was enrolled with, limited their initial ability to bill the Medicaid managed care plans for services rendered. However, providers suggested that this issue occurred early in implementation and had been resolved by the time of our site visit in July 2014. Providers also reported problems with the beneficiary information that was available, noting those problems made billing difficult.

“The biggest issue with submitting claims in Medicaid is that demographic information is incorrect. People have names misspelled on their card, and then you spell it correctly. If you came in and your name was misspelled and then we submitted something where we spelled it correctly, they would reject your correct name because the incorrect name is in the system.” –Provider informant

“Determining who has what insurance... initially there was a lot of confusion because patients often didn’t have their cards and they’d have to search to figure out who they have insurance with.” –Provider informant

“It took a few months [to know which plan people were enrolled with]. By the time they got the information on the web we could see the information [if they forgot their card, or if they moved, for example]. But it took a while for that to happen. So we had quite a few on-hold claims until we could access the information. Once we could access it, then we could process the claims.” –Provider informant

Unique Billing and Coding Arrangements

Federally qualified health centers (and freestanding rural health centers) are paid under a cost-based reimbursement structure. They noted that some of their services required the use of a billing and coding

structure with which the managed care plans did not seem familiar and which often could not be accommodated in the forms used by the managed care plans. Providers suggested that these coding problems were often specific to particular entities and were not sure where the breakdown in communication was. Providers did not know how much information managed care plans had been given about specific coding situations.

“The state should have done a lot more thinking into all of the weird codes and weird situations for facilities that are offering unique or limited services. They have some services and programs that only have one vendor...so they have some codes that only they use.” – Provider informant

“FQHCs bill a ‘T’ code, that’s presented a number of problems because the forms (we) are given to complete can’t read it.” –Provider informant

Medicare Claims

Finally, providers reported payment issues under managed care for dual eligibles who did not sign up for Medicare Part B. Because Medicare is supposed to be the primary payer for dual eligibles, and because Medicaid pays the remaining amount after Medicare payment has been rendered, it was reported that one managed care plan was not paying claims for dual eligibles who could have signed up for Medicare Part B and did not, because it claimed to be a secondary payer. This issue has reportedly been resolved.

Providers also reported administrative issues with dual eligibles’ claims. In the past, these claims were submitted to Medicare and then were crossed over electronically to Medicaid. However, we were told that the claim now must be submitted to both Medicare and the Medicaid managed care plan directly and that providers were not given good guidance from the plans regarding the process for submitting these claims to them directly. The state is working with the plans and hospitals on this.

Resolution of Provider Issues

Many informants reported that communication with senior members of the state and health plan staff was more fruitful than communication with junior staff and that health plan provider representatives were not particularly helpful to providers. Reportedly, high turnover among the health plan's provider representatives made it difficult to establish a relationship. Providers noted that when the provider representative proved ineffective, they would turn to their provider association for help getting issues resolved.

"[How helpful they are] depends on who your provider rep is. The problem is they are all pretty powerless and these things have to go up the chain." -Provider informant

"The representatives at the provider service level seem to be very uninformed about their own policies." -Provider informant

"The provider rep for [health plan] has been pleasant, but the first one we had was really ineffective. She didn't understand the issues... it took 5 months to get what I thought were simple things fixed." -Provider informant

"[The Department is] not always responsive. Sometimes it takes a long time to get answers from them about why things are happening.... There was a disconnect between higher-ups and the people who answer the phone to try to solve problems.... The issue is the same at the MCOs." -Provider informant

Providers reported that the health plans were not particularly well-staffed or well-prepared for the implementation of Medicaid managed care, but they also noted that this issue has improved over time. For example, one provider representative reported that plans were employing staff outside New

Hampshire to answer phones and these individuals could not answer their questions. Another provider noted that staff weren't available outside of normal business hours, which seemed necessary in some cases.

"I'm not saying that it makes sense to have to call someone on a Friday night at 8 o'clock. It makes a lot more sense to have a contract with a pharmacy, so we can just give [the patient] a prescription and send them there, but that didn't occur." –Provider informant

Provider Networks under Managed Care

Despite providers' concerns, we heard few reports of Medicaid managed care hampering access to needed providers. Providers did not report new problems referring beneficiaries to specialists except cases in which a provider needed to consult a provider directory to find a specialist that participated in a particular plan. We were told by one association representative that the availability of this information in provider directories was "abysmal." Informants agreed that provider networks under Medicaid managed care suffered from a few weak spots, largely in the northern part of the state, which has historically suffered from more limited provider capacity, but they also agreed that these were issues that had existed under the Medicaid fee-for-service model. One informant mentioned a dearth of oral surgeons in northern New Hampshire; two others noted the difficulty of finding child psychiatrists in the northern region. One way that plans have addressed these weak points in the provider network is by contracting child psychiatrists in other parts of the state to come up to northern New Hampshire to serve beneficiaries for a day or two a week.

The state requires quarterly and annual reports from the health plan showing that it meets provider network standards. Beginning in August 2014, the state has also released monthly reports that evaluate the plans using network adequacy metrics (Medicaid Quality Program 2014). In the first quarter of 2014, the reports show a low rate of calls asking for assistance accessing primary care providers (12.3 per 1,000 members) and specialists (10.7 per 1,000 members); these rates had fallen further in the second quarter. The state also requires the plans to regularly survey providers to ensure timely access. Plans also get notifications of provider termination. The state's provider network standards were

developed to satisfy federal requirements and were developed in consultation with other states that had experience with managed care.

Though provider networks currently appear adequate, provider dissatisfaction with both Medicaid rates and the administrative burden caused by managed care was palpable. Though concern over low Medicaid reimbursement rates existed under the fee-for-service system in New Hampshire, providers expressed renewed frustration because of the new administrative burdens associated with managed care. Many provider informants claimed that provision of care to Medicaid beneficiaries was not a rational choice from a business perspective but said that they continued to provide services to Medicaid beneficiaries out of a sense of loyalty to beneficiaries. Though providers expressed concerns about the adequacy of Medicaid reimbursement, that so many physicians in the state are employed by hospitals means factors other than reimbursement for physician care may drive providers' decisions to provide care to Medicaid beneficiaries.

“Providers aren’t going to do this.... We’re being paid poorly, and we lose money on every single encounter. They’ve added additional administrative costs (through managed care). There isn’t another business, a rational business, which would work under this model of care.” –Provider informant

“We have to do this [for our patients]. But, for someone in private practice, what would [Medicaid managed care] give them?” –Provider informant

“I don’t think there is anyone making money on Medicaid. They have to be losing.” –Provider informant

Though agreements with the hospitals that provided additional disproportionate share hospital funding have helped secure providers' participation in the managed care networks, low payment rates seem to be affecting health plans' ability to ensure access to providers that some families consider

important. Notably, Meridian was the only health plan to contract with Boston Children’s Hospital. Since Meridian exited the market, New Hampshire Medicaid beneficiaries do not have in-network access to this provider.

“We were able to get a lot of the providers along the borders, but the tertiary hospitals have been less engaged—partly because they believe the rates are too low. This is the trouble we are having with Boston Children’s [Hospital].” –Plan informant

Case Management under Managed Care

Much of the promise of managed care is in the potential to better manage and coordinate care for enrollees with complex needs. Both Well Sense and New Hampshire Healthy Families have developed general case management programs that target members with complex health conditions and provide them with support depending on the beneficiary’s need. At the time of our site visit (about seven months into program operations), these programs were relatively small. For example, one plan reported that it had about 500 members in case management (less than 1 percent of membership) at the time of our interview.¹⁵ A state informant reported that the plans were not supplied with claims history data expeditiously, and this inhibited the MCOs from using their predictive modeling software to identify high-cost and high-risk patients. Plan informants confirmed that, at the time of the interviews, the labor required to identify all members who could benefit from case management was high at the time of our interview, and not all members had been administered a risk assessment. One plan reported some trouble hiring the number of case managers it desired for the program, but another reported that it had hired the expected number of case managers for the acute care population. Case management is currently provided by phone in most instances.

“It is very labor intensive. Case managers have to have certain certifications... and contact high, medium or low strata and define how many times they contact them once they are identified. It is very labor intensive and that is usually where plans have difficulty—getting enough people to handle the population that needs to be case managed.” –State informant

Both plans had active case management programs available to pregnant women and seemed to have a heavy focus on this population at the time of our interview. One reason this population may be receiving a higher level of case management services than other populations at this early stage is because its members are easy to identify.

“Once a notification of pregnancy has been received, there’s a risk number associated with that. So if the member is deemed high risk, those are the priority.” –Plan informant

Though the two existing plans insisted that their case management programs were fully operational, both suggested that their programs were still maturing. Also, neither plan reported much cost savings from their case management programs at this early stage. Targets for case management beyond pregnant women included those who use the emergency room for nonurgent care and those utilizing LTSS. The state also holds interest in using case management to address health behaviors and the social determinants of health, such as smoking, obesity, and childhood trauma.

Another difficulty that the plans face in operationalizing their case management programs is that some of their beneficiaries are already receiving case management services from a provider in the state. For example, the CMHCs are expected to offer case management services to anyone who meets certain eligibility criteria. Providers and managed care plans are discussing how to implement case management without duplicating each other’s work. Advocates and providers for the Step 2 population expressed concern about having the plans manage this population because providers have historically taken on this function. However, one advocate did report that there may be opportunity for the plans to manage the Step 2 population on the acute care side, noting that the specialized health needs for this

population can be so dominant that such preventive services as colonoscopies and mammograms can be overlooked.

“If people haven’t had those things, then your costs are going to increase because you are going to have more people that have preventive medicine, but in the long run it’s going to prevent medical issues.” –Advocate

Beneficiary Experience under Managed Care¹⁶

Education and Enrollment

In focus groups, participants reported they primarily heard about the transition to Medicaid managed care from letters they received from the state. Though most focus group participants said the letters were helpful and informative, a few participants noted that communities of less educated Medicaid enrollees and enrollees who don’t speak English may have had trouble understanding the transition to managed care.

“In our community [there are] many uneducated people. If you send some letter in the mail, they can’t understand it. [My parents] took our letter to their friend’s house and they said ‘I got this letter. What is written in this letter? Can you explain it to me?’” –Focus group participant

Most focus group participants reported that they chose their managed care plan by determining which plan(s) their primary care provider participated in, though some parents reported that they chose based on extra incentives offered. In the LTSS group, beneficiaries expressed frustration with the lack of information available to them to choose a plan. Some participants expressed frustration that they

were encouraged to consider incentives that didn't apply to them, such as free diapers, and wanted better access to information about how their loved ones' care would be affected based on their health plan choice. Participants expressed concern about having poorer access to the durable medical equipment and specialists they might need, though no beneficiary had experienced these barriers.

"The only thing you had for an informed choice for the three was one said you could have free helmets, one said you could have... free diapers... all that stuff. None of it applied. And if you called [the plans] to get more specifics, there was no answer. We could not find out who they had for durable medical equipment." –Focus group participant

"I didn't get any information. I wasn't sure what to do, so I just let them choose. I don't know which [plan] is best for my mom and for my parents." –Focus group participant

Most participants noted the enrollment process was easy and straightforward and that there were multiple options for enrollment. Focus group participants experienced few problems enrolling in a plan.

"My case manager helped me and it was all done online. It was very, very simple." –Focus group participant

Primary Care

The majority of focus group participants noted they found it easy to get an appointment for primary care and they remained satisfied with the primary care they received following Medicaid managed care implementation. The only change focus group participants noted to their primary care was the assignment of a primary care physician by the health plan. This was sometimes a source of confusion because some focus group participants were assigned to a provider other than the person they

considered to be their current primary care provider. However, most participants reported they were able to call and get it changed if they wanted. Only one participant reported difficulty changing to the primary care provider she wanted.

Specialty Care

Focus group participants also noted that, with the exception of care needed from Boston Children's Hospital (which is not in either health plan's provider network), obtaining appointments for needed specialty care was not a problem. A few participants noted that the process could be slow, but participants felt confident they would get their needed care.

"I have a seizure disorder, so I see a neurologist. I also see a urologist... and I am continuing to see a psycho-therapist who I started seeing after my wife passed away. Thankfully, I'm not having any difficulty getting any of these appointments, even now being on managed care." – Focus group participant

Focus group participants noted the more problematic areas were (1) receiving prior authorizations from their health plans for the specialty care they need and (2) receiving denials for care that their doctors prescribed. A few participants reported that specific services weren't covered by one of the two plans, which led to plan switching.

"When they put in for my injections I got denied. I had to put in an appeal in order to get my injection approved. It was like starting all over to get it approved." –Focus group participant

“I have to wait longer to get the approval, so it takes longer to get the appointment... they have to schedule my appointments like two to three weeks in advance to be sure that there’s going to be enough time with [plan] that it’s going to be approved.” –Focus group participant

“You have to wait for preauthorization of....occupational therapy and speech therapy.” – Focus group participant

“When he has to go for his MRIs they usually have to put it in at least two to three weeks...for it to get approved.” –Focus group participant

Prescriptions

Concern about prescription drugs was most commonly voiced by focus group participants. Participants reported that the prior authorization process and subsequent denials of medications caused delays in receiving needed care. Delays were caused by the beneficiaries planning poorly or being unaware of the requirements to receive a prior authorization, or by waiting periods imposed by plan procedures.

“The doctor said she needed a different kind of injection... he doesn’t know if [the health plan] will cover it or not. So, they sent all the paperwork... and they say she needs to wait for ten days. Why does my mom have to be in pain for ten whole days without medication?” – Focus group participant

“A lot of my peers that are coming into the mental health center do not have their medications because some of them forget to call [to get the prior authorization].... They’re suffering because of this.” –Focus group participant

Delays caused by the prior authorization process were exacerbated by a requirement to refresh the prior authorization each month. Focus group participants noted that this caused more work for them and their providers.

“For a while [the plans] were insisting on getting an entire [prior authorization] process like on a monthly basis. You couldn’t just carry the prescription over. You would have to do the whole process over again.” –Focus group participant

“Every month I go in, whereas before it was just one preauth... every six months or year.” – Focus group participant

“[The doctor] ordered an antispasmodic for her bladder, and it was denied. It was denied! And we waited two weeks for that one, too.” –Focus group participant

Other focus group participants felt that the prior authorization process caused decisions about their care to be incongruent with what their doctors prescribed or their medical history. For example, one focus group participant described trying to obtain prior authorization for a medication to stop her daughter’s seizures. The child had a history of taking the medication effectively and had taken 10 medications that had not been effective before finding the effective one:

“After you get all the prior authorizations... the [health plan] still says no. We want you to try this [other] medicine. Well, they don’t have the knowledge that my daughter’s doctor has as to what all of her disabilities are, and they interact with a seizure... I found another doctor that said, yes, this is what she needs to be on. And then it was authorized.” –Focus group participant

Transportation

In two of the three focus groups, participants noted problems accessing the transportation they needed to keep their appointments. Problems included the prior authorization process, not knowing whether the transportation would be approved, and the transportation company being unreliable.

“They told [me] that I need to do [prior authorization] paperwork, and [they] don’t know whether [the ride] will be approved or not.... I didn’t have a concrete answer whether they would provide [a ride] or not. If they didn’t I would have to find another person to help to get the ride. ... But they just said, ‘Maybe. We don’t know.’” –Focus group participant

“They said if you want a ride just wait until you get approved. And I said my appointment is earlier than that. And they said, reschedule the appointment.” –Focus group participant

“I first started riding after CTS [a company authorizing transportation services under managed care] took over, the first four or five times I was supposed to go to my physical therapy appointments my ride was not there. CTS dropped the ball.” –Focus group participant

Translation Services

Two of three focus group participants in the LTSS group thought that translation was an issue for Medicaid beneficiaries. These participants were caretakers of non-English-speaking parents. These two participants often acted as a translator for their parents when they interacted with the health care system. Both reported that in-person translators worked well for their parents but translation phone lines were problematic. Both said that their parent’s education level was such that the most basic words were necessary and the phone translation often used more complicated words. One participant noted that acting as a translator on her mother’s behalf had become more problematic under Medicaid managed care, which may have been related to her lacking power of attorney for her mother.

“[I] was able to interpret for [my] mother with Medicaid... but when [I] went, [the provider] said ‘because you are with Well Sense, you cannot do that.’” –Focus group participant

Case Management

Some focus group participants in all three groups had access to case management. Those in the mental health group primarily had case management through their CMHC. Those in the LTSS group primarily had case management through Heritage Case Management, a company hired by the state to provide case management services. Parents of healthy children were the only focus group participants who reported that they had a case manager through their health plan. They described the case management as being telephonic and often consisting of a couple of phone calls to check in. One woman reported she received a letter indicating that she would be in case management.

“They said something about breathing and things like that. I don’t really have breathing problems. But it said that a case worker or someone would call me.” –Focus group participant

Another woman reported that she received post-partum case management that ended abruptly.

*“I had a case manager when I enrolled my son after he was born. But then a month ago she decided to end the case management, because everything was going fine.... She’s like, well, we’re going to end case management today. I’m going to close your case management case.”
–Focus group participant*

Implications for Phase-in of LTSS

Expansion of Community Based Services and Upcoming Changes for LTSS

The expected changes in the delivery of LTSS caused by managed care will take place among other LTSS delivery changes. The state is participating in several federal initiatives, including the Balancing Incentive Program and Money Follows the Person, which encourage development of community supports for individuals in need of LTSS. Other initiatives, such as New Hampshire's State Innovation Model, are also designed to transform the LTSS model in the state (New Hampshire Department of Health and Human Services 2013). A major focus of the State Innovation Model is better coordination of care for those in need of LTSS and prevention for those who have not yet reached the highest levels of need.

These initiatives are designed to affect two groups: the elderly, who are often referred to as the "choices population" in reference to the Choices for Independence waiver, and those with developmental disabilities. The two groups are served by separate delivery systems and tend to be represented by different advocacy groups. According to one informant, about 4,500 people are covered by the developmental disabilities waiver and less than 20 percent of them have consumer-directed services. Those with consumer-directed services may hire their own providers and develop their own care schedule.

Among the upcoming expected changes to the LTSS programs, LTSS providers were most concerned about the MCM program. Concerns were multifaceted and stemmed from both experiences with Step 1 of managed care and concerns about the role the managed care plans will play in the LTSS system. One concern was that few states have experience overseeing Medicaid managed care programs for this population, though this may reflect some misperception among providers and advocates because state interest in administering managed LTSS programs has grown in recent years. For example, in 2012, eight states included adults with intellectual or developmental disabilities in their Medicaid managed care programs (Saucier et al. 2012). Providers and advocates also expressed sheer fear of the unknown.

“The unknown is what is scaring us all to be honest. We don’t have anything to compare this to. We don’t even know what we’re getting ourselves into, and this is the bread and butter of our whole operation.” –Provider informant

Provider Concerns about Implementation of Step 2

Based on their experiences with Step 1, providers reported concerns about issues of billing, coding, and prior authorization they foresee for Step 2. The pattern of concern was similar to that for acute care, with prior authorization being the aspect of managed care that providers discussed most often.

Providers of LTSS reported that some services, such as physical therapy and occupational therapy, are covered in Step 1 and that the prior authorization processes for providing these services is inefficient. One informant thought that the managed care plans were treating these services as acute care services and were not considering that some people accessing these services have longer-term needs that aren’t expected to change regularly.

“They’ve imposed prior authorization requirements based on an acute care model [for patients with longer-term needs]... they might authorize physical therapy for two weeks... and the prior authorization would take 30 days or 60 days. These kids depend daily on these therapies and you can’t wait 30 days.” –Provider informant

“Right now we get a year authorization [for LTSS patients].... These patients are clinically not changing from year to year, there are no changes in their plan of care. If MCOs require the same authorization process... that’s going to increase the administrative burden significantly.” –Provider informant

Both disabled beneficiaries and their advocates also expressed concern that disabled populations will not have the information they need to make an informed health plan choice. Disabled populations often rely on many specialized providers for their care and often develop a long-term relationship with providers, which greatly contributes to their treatment success. Because of the nature of managed care and the establishment of provider networks, advocates and beneficiaries expressed concern that, for example, the constellation of providers used by beneficiaries with multiple health problems may not be contained within the same network, which could inhibit their continuity of care. Focus group participants also expressed concern that it could be difficult for beneficiaries to understand which of their providers was contained in each health plan's provider network.

“[For people with autism or communication disorders or behavioral issues] the family doctor knows to get them to the exam room right away and the nurses know how to handle [these issues]... knowing the provider and staying with the same provider is really so critical.” - Advocate

One major concern articulated by informants was that the managed care plans do not have sufficient experience working with LTSS populations. There is also concern that the plans will diminish the amount of control providers have over offered care. A primary reason for this concern was the perception that the managed care plans would become part of the delivery system solely to save money.

“I’d rather have the state just say to the DD system [the system in place for the developmentally disabled] ‘save this amount of money and continue to provide services to people with developmental disabilities.... We continue to look at ways that we can save money, standardize our practices and collect data... those are the kinds of things a managed care company might come in and try to do, but if a managed care company is put on top of the area agency, they’re going to take a cut and (that cut) comes from services and supports.” -Provider informant

Of the two plans currently serving New Hampshire Medicaid, only New Hampshire Healthy Families (operated by Centene) has experience serving beneficiaries in need of LTSS in other states. In 2012, Centene was a leading national health plan in this market, operating in programs in Arizona, Florida, and Texas (Saucier et al. 2012). The plan expressed that, to some extent, it would build its New Hampshire program from the ground up by engaging state LTSS providers directly to learn more about the New Hampshire system. Both New Hampshire Healthy Families and Well Sense had begun this process at the time of our interviews and had found other ways of leveraging New Hampshire LTSS experience. For example, one of the plans hired a high-level person from the New Hampshire Bureau of Developmental Services to supplement their expertise.

“Understanding the infrastructure and how it sustains itself today and comparing that to our experience in other states that we can apply in New Hampshire in a thoughtful way has been our goal.” –Plan informant

Potential Benefits of Managed Care for LTSS Populations

Some provider informants remained hopeful about Medicaid managed care for the LTSS population, noting the potential to improve certain aspects of care, such as coordination of their acute services. However, most provider informants expressed that they did not see advantages to moving LTSS to a managed care arrangement; only the downsides were apparent to them.

“We understand that there may be better care coordination. There may be people getting services that they don’t need. Or supposedly there will be more communications between the MCOs and people to get them the services they need and that kind of stuff. But for the nursing homes, it’s very different because we already have all of these things... and we are monitored by CMS. We have quality standards that have to be met at all times and we have surveys in place to monitor those...” –Provider informant

Conclusions

Initial implementation of managed care in New Hampshire's Medicaid program went relatively smoothly. A successful transition to managed care depends on a smooth enrollment process for beneficiaries, development of robust provider networks by the managed care plans, continuity of care for beneficiaries, and provider readiness for the transition. The enrollment process saw few reports of problems and a relatively high rate of self-selection of a managed care plan by beneficiaries, which likely reflect the state's extensive efforts to educate beneficiaries and providers about the transition. There was also little evidence of provider networks diminishing because of managed care, and focus group participants noted they found it easy to make an appointment for primary or specialty care. Providers also reported a smooth transition when it came to implementation issues such as credentialing, claims submission, and payment procedures. By most accounts, communication among the key stakeholders was good, and when problems arose, efforts were made to address them and track the issue.

Staff at DHHS see managed care as an opportunity to develop additional quality improvement processes within the Medicaid program, and they have taken an active oversight role as implementation has progressed. The state developed an ambitious quality strategy and sophisticated data collection and analysis plans for the program going forward. This includes monitoring of over 400 quality indicators on the NH Medicaid Quality Indicators web site, annual Quality Improvement Projects, chosen by the state, and Performance Improvement Projects, chosen by each health plan, and EQRO activities, including all optional activities outlined in federal regulations. Though it is too early to observe effects of managed care implementation, the state has released a quality indicator report each month since August 2014. Each report provides key indicators in 10 domains: access and use, customer experience, provider experience, utilization management, grievances and appeals, preventive care, chronic medical care, behavioral health care, substance use disorder care, and general quality. The report will continue to be released each month and provide up-to-date information for each indicator, allowing the state to track program performance over time.

Both providers and Medicaid beneficiaries reported significant problems with prior authorization processes, particularly for pharmacy services. The provider community was clear in their dissatisfaction with the new prior authorization requirements imposed by the managed care plans. Across types and locations, providers agreed the requirements had added considerable administrative burden to their practice and in some cases had jeopardized beneficiary care. Focus group participants confirmed delays in care caused by the prior authorization process and noted particular difficulty receiving needed prescriptions. The state has recognized that prior authorization processes are the

biggest issue in New Hampshire Medicaid managed care and has been meeting with the managed care plans to address these issues.

Much uncertainty exists about Step 2 implementation. Though some stakeholders suggested potential benefits of managed care for the Step 2 population, most advocates for the developmentally disabled and other populations receiving LTSS expressed serious concerns about the ability of the managed care plans to serve these populations. The state recently conducted public forums to generate feedback on Step 2 implementation and found that stakeholders have concerns about provider networks, prior authorization processes for pharmacy and therapy services, and the general ability of the managed care plans to understand and meet the complex needs of the LTSS population. With enrollment for some Step 2 populations now scheduled to start in July 2015, it will be important to monitor negotiations between health plans and LTSS providers as well as the continued feedback from the advocacy community.

As Medicaid managed care continues to evolve, the evaluation team will be monitoring several issues to assess its evolution and sustainability. With the greatest concerns around the initial phase of implementation of managed care stemming from prior authorization requirements, this area will receive ongoing scrutiny from the evaluation team. The state desires to address these issues and ease the burden on providers, but these processes are an important care management tool for managed care plans, so the ultimate outcome remains to be seen. A related issue is the adequacy of the provider networks under managed care. Currently, the networks appear to be meeting beneficiary needs, but if provider dissatisfaction with the administrative burden of managed care continues, some providers could discontinue their participation with the managed care plans. Analysis of provider networks will also require additional attention as Step 2 is implemented because these beneficiaries tend to have more complex needs and see a wider variety of providers.

In addition, the CMHCs operated under letters of agreement with the managed care plans during the first year of the care management program, though they did contract with Well Sense/Beacon Health Strategies on November 1, 2014. Because these providers appear to be an important component of state efforts to provide more community-based mental health services, the contracting process between the CMHCs and managed care plans is another area that will be closely monitored as the program evolves.

Another key component of the managed care model is the use of case management programs. At the time of our interviews, both managed care plans had functioning case management programs, but they were small and seemed not fully developed. These programs are closely associated with managed

care's promise to provide better care coordination for enrollees and better health outcomes. Thus, particularly as the more complex Step 2 populations transition from a fee-for-service model into a managed care model, it will be important to track the development of case management.

As noted, the state has extensive plans for monitoring and evaluating the transition to managed care, but the current set of quality indicators are only available for the period since managed care has been implemented. The state plans to generate a consistent set of quality indicators using fee-for-service data, which will be necessary to fully assess the managed care program's effects on beneficiaries. As the evaluation team begins its quantitative analysis, it will be important to understand any challenges that arise in creating consistent measures in the pre- and post-managed care period.

Finally, one important goal of the transition to managed care was to generate cost savings for the state. New Hampshire is a small state with a modestly sized Medicaid program that has been dominated by a population of relatively healthy parents and children. Though the budgetary implications of Step 1 implementation are not yet known, further opportunities for care management and cost savings may be realized by implementing Step 2, which is small in enrollment but represents a disproportionate share of the program costs. The delayed implementation of Step 2 gives the state and managed care plans an opportunity to better prepare for this transition and to minimize disruption of care for these vulnerable individuals, but the delayed implementation may hamper state goals for cost savings.

Appendix A. Interviewee List

TABLE A.1

Interviewee List

Organization	Name	Title
New Hampshire Department of Health and Human Services	Dr. Doris Lotz	Medicaid medical director
	Andrew Chalsma	Chief, Bureau of Data and Systems Management
New Hampshire Department of Health and Human Services	Katie Dunn	Associate commissioner
New Hampshire Department of Health and Human Services	Christine Shannon	Chief, Bureau of Health Care Research
MAXIMUS	Adeline Pierre	Manager, Contracts Administration
Health Services advisory group	Debra Chotkevys	Director, Professional Services
Well Sense	Sarah Scott	Senior contract and program manager
New Hampshire Healthy Families	Dr. Karen Boudreau	Chief medical officer
	Laurie Doran	Chief financial officer
	Suzanne Cassidy	Product implementation director
	Stefanie Svoboda	Senior director, Compliance
	Scott Westover	Executive director
	Jay Gonzalez	Plan president and chief executive officer
	Suzanne Peterson	Vice president, Network Development and Contracting
	Jennifer Weigand	Chief operating officer
	Dr. Samuel DiCapua	Chief medical director
	Andrea Matkowski	Manager, Utilization Management
Bi-State Primary Care Association	Jonathan Morello	Manager, Case Management
	Jamie Matozzo	Director, Clinical-Behavioral Health
	Kristine Stoddard	Director of public policy
	James Zibailo	New Hampshire community development and financial services coordinator
	Scott Colby	Executive director
New Hampshire Medical Society	Paula Minnehan	Vice president of finance and rural hospitals
New Hampshire Hospital Association	Celeste Pitts	Chief financial officer
Weeks Medical Center	Dr. Steve Paris	Medical director
Dartmouth-Hitchcock Medical Center	Gina Balkus	Chief executive officer
Home Care Association of New Hampshire	Violet Rounds	Chief financial officer
Concord Regional Visiting Nurse Association		
Rockingham County Rehabilitation and Nursing Center	Amy Guillou	President
Ammonoosuc Community Health Services	Steven Woods	
Coos County Family Health Services	Ed Shanshala	Chief executive officer
Manchester Community Health Center	Adele Woods	Chief executive officer
	Patty Couture	Chief operating officer
Community Support Network	Kris McCracken	President and chief executive officer
Granite State Independent Living	Dotty Treisner	Executive director
New Hampshire Disability Rights Center	Clyde Terry	Chief executive officer
NAMI New Hampshire	Cindy Robertson	Senior staff attorney
New Hampshire Community Behavioral Health Association	Ken Norton	Executive director
	Jay Couture	President
	Jill Abbott	Discrete targeted case manager for children

Source: Urban Institute evaluation of New Hampshire Medicaid managed care case study data.

Appendix B. Study Focus Group Details

TABLE B.1

Study Focus Group Details

Focus group	Group managing recruitment	Recruitment strategy	Number of participants
Parents of healthy children	Women, Infants, and Children (WIC)	WIC clients were given a flier introducing them to the focus group when they came to the WIC office to meet with a nutritionist. The flier instructed them to call the Urban Institute, who screened them for eligibility for the group.	7
People accessing the mental health system	National Alliance on Mental Illness (NAMI)	An announcement of the focus group was put on the NAMI Facebook page and in the NAMI newsletter. People were directed to call the Urban Institute if they were interested in participating, and the Urban Institute screened them for eligibility.	6
Those using long-term services and supports	Urban Institute	The Urban Institute was provided a list of everyone in Merrimack County identified as needing long-term services and supports and who was enrolled in a managed care plan. A representative from the Urban Institute called everyone on the list and solicited caretakers to participate in the group. The list was received from a state representative and was limited to those eligible for the “Choices” waiver and enrolled in managed care for acute care.	3

Source: Urban Institute evaluation of New Hampshire Medicaid managed care case study data.

Notes

1. Ben Leubsdorf, "Council Okays Managed Care: 3 Private Firms to Be Paid \$2.2 Billion," *Concord Monitor*, May 10, 2012, <http://www.concordmonitor.com/news/4396952-95/medicaid-executivecouncil-medicaidmanagedcare>.
2. Certain populations were permitted to opt out, including children in foster care, children with disabilities (those receiving assistance through Supplemental Security Income or the Katie Beckett program), and Medicare-Medicaid dual eligibles.
3. Jim Haddadin, "Feds Still Reviewing NH Medicaid Care Management Plan," *Fosters.com*, August 22, 2012, http://www.fosters.com/apps/pbcs.dll/article?AID=/20120822/GJNEWS_01/708229936.
4. Office of New Hampshire Governor Maggie Hassan, "Governor Hassan Announces Agreement with 25 Hospitals to Settle Court Cases Challenging MET, Medicaid Rate Reductions," press release, May 29, 2014, <http://www.governor.nh.gov/media/news/2014/pr-2014-05-29-met.htm>.
5. The Choices for Independence waiver provides seniors and adults with disabilities community-based services to allow them to postpone or avoid institutional placement.
6. The developmental disabilities waiver provides home- and community-based services to individuals with developmental disabilities and their families who choose to remain in community settings in lieu of institutionalization.
7. The acquired brain disorder waiver provides home- and community-based services to individuals with traumatic brain injuries or neurological disorders who choose to remain in community settings in lieu of institutionalization.
8. The in-home supports waiver provides in-home support to children with severe disabilities living at home with their families.
9. Even at full phase-in, the following populations will remain in fee-for-service Medicaid: those with VA benefits; those with only family-planning benefits; those in the Qualified Medicare Beneficiary program, the Specified Low-Income Medicare Beneficiary program, and the Qualified Disabled Working Individuals program; and spend-down populations. Office of New Hampshire Governor Maggie Hassan, "Governor Hassan Announces Agreement with 25 Hospitals to Settle Court Cases Challenging MET, Medicaid Rate Reductions," press release, May 29, 2014, <http://www.governor.nh.gov/media/news/2014/pr-2014-05-29-met.htm>; Ryan Lessard, "Informational Campaign for NH's Expanded Medicaid Kicks Off," *New Hampshire Public Radio*, June 11, 2014, <http://nhpr.org/post/informational-campaign-nhs-expanded-medicaid-kicks>.
10. New Hampshire Department of Health and Human Services, "Changes Coming to MCM Program; Meridian Health Plan Announces Departure," press release, June 3, 2014, <http://www.dhhs.state.nh.us/media/pr/2014/06-jun/06032014-mcm.htm>.
11. After Meridian left the market, this algorithm was altered to offer both plans equal membership.
12. "NH Medicaid Quality Indicators," New Hampshire Department of Health and Human Services, accessed June 7, 2015, <http://nhmedicaidquality.org/>.
13. DHHS notes that it is working to provide comparison data for select measures. It also notes that the web site the state is developing has the functionality to store goals, contract standards, and benchmarks, as well as to provide comparison data in report output.
14. The EQRO was looking at health plan coding to ensure that quality measures would be reported in a valid and reliable way. They had conducted a contract compliance review of each health plan, ensuring that provider contracts contained the necessary requirements; they had also reviewed each plan to ensure that Balanced Budget Act and state requirements were being met. This review primarily looked at health plan policies and procedures and 14 different areas were investigated, including grievances and appeals.
15. One plan reported on December 12, 2014, that its case management program had grown to about 3,700 individuals, or about 7 percent of membership. This exceeded the planning assumption that 5 percent of total membership would use case management services. The plan pointed out that 5 percent is a common industry

assumption in programs built around a medical model. It also pointed out that Care Management services that will be offered to the Step 2 population will not be based on a medical model; rather, services will be weighted toward nonmedical needs.

16. Note that this section of findings is derived from our focus groups, which included 16 participants. These findings should not be extrapolated to the entire New Hampshire population.

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