New Hampshire Fiscal Policy Institute

issue brief

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Key Questions to Consider in Implementing Medicaid Managed Care in New Hampshire

Earlier this year, the New Hampshire legislature approved changes in law to require the use of managed care for the state's Medicaid program. While managed care holds promise not only for reducing the costs the state incurs but also for improving the quality of care Medicaid members receive, other states' experiences in utilizing risk-based managed care models – and in placing all of their Medicaid members in them – vary significantly. Their experiences, coupled with New Hampshire's own past experiences with managed care, suggest that the state will face numerous challenges as it strives to implement such changes to its Medicaid program. As a result, the potential savings from Medicaid managed care in New Hampshire may be modest and require significant time to materialize.

Accordingly, this issue brief examines seven questions relating to the implementation of managed care in New Hampshire. Specifically, it explores:

1. What is managed care?
2. What is New Hampshire's experience with Medicaid managed care?
3. What are other states' experiences with Medicaid managed care?
4. What does the Medicaid managed care statute require?
5. What challenges might New Hampshire face in implementing managed care?
6. What might the consequences of managed care be for current and future Medicaid members?
7. Will Medicaid managed care in New Hampshire achieve anticipated savings?

What is Managed Care?

Managed care is a broad term that can be used in several ways. It can encompass different types of:

- health care payment and reimbursement arrangements, such as full-risk capitated payment plans or primary care case management;
- organizations, such as managed care organizations (also known as MCOs), and;
- techniques and tools to control the use of health care services, including limiting the number of services a member can utilize within a discrete period of time, requiring prior authorization of an expensive service, establishing best practices and preventive care for patients with particular diseases or conditions, or coordinating care across multiple settings.[i]

Nevertheless, the term managed care most frequently refers to payment and reimbursement arrangements. These arrangements are distinct from fee-for-service (FFS), the traditional method of reimbursement for health care services in the United States, in which a health care provider is paid a fee for every service rendered to every patient seen. In comparison, the two predominant managed care payment arrangements are risk-based payment plans and primary care case management.

Risk-Based Payment Plans

A risk-based payment plan (or capitated risk payment plan) is one in which a vendor[ii] is paid a fixed per member per month (PMPM) fee and assumes financial risk for delivering an agreed upon set of services.[iii] That is to say, the vendor bears the risk of managing the financial difference between the fixed PMPM fee and the actual cost of providing care to enrollees – should that cost exceed the PMPM – while still meeting quality of care and health outcomes targets. For example, if a vendor contracts to provide comprehensive medical inpatient and outpatient services for Patient A and Patient A never requires medical care, the vendor still receives its PMPM fee, but it does not incur any costs for that patient. However, if Patient A requires quadruple bypass surgery, the vendor must bear the cost of providing that care to Patient A without additional reimbursement, even if the PMPM fee for Patient A is insufficient to cover the cost of such surgery. A vendor may limit such risk by limiting the menu of services it agrees to cover, by trying to attract the healthiest enrollees, or by limiting the frequency with which some benefits are provided, such as capping the number of prescriptions that can be filled in a year or the number of hours that a home health aide can be covered per week.

The vendor and purchaser (in this instance, the state of New Hampshire) negotiate which services the vendor will provide and who the enrollees will be. The more comprehensive the set of services included in the contract and the higher the medical needs of the enrollees, the higher the financial risk is to the vendor.

Under a capitated risk payment plan, the challenge for the state is to negotiate, monitor, and enforce a contract that both obtains a PMPM fee that meets its financial target and requires the vendor to meet measurable and enforceable quality of care and health outcome targets.

Primary Care Case Management

Not all managed care payment arrangements are risk-based. Primary Care Case Management (PCCM) is a managed care arrangement that blends fee-for-service and conventional managed care in the provision of primary care and the coordination of any specialty care or other services. Under this arrangement, a primary care physician is paid a small case management fee per person per month to coordinate care for members. All other health care services are paid fee-for-service. In rural states, where population density and the limited availability of providers make MCOs less likely to operate, PCCM has historically been the predominant form of Medicaid managed care.[iv]

What is New Hampshire's Experience with Medicaid Managed Care?

New Hampshire has utilized formal capitated risk payment plans in the past and currently employs other managed care techniques and tools to control costs. However, these past experiences have been somewhat limited, as they were voluntary in nature and did not include long-term care. Perhaps as a result, they did not achieve anticipated levels of savings.[v]

Capitated Risk Payment Plan: 1999-2003

New Hampshire had a voluntary capitated risk payment program from 1999 through2003. The enrollees who participated were children and low-income women – generally the least expensive Medicaid members. The state initially began the program with three different health insurance companies; however, by 2003, only one health insurance company was still willing to participate.[vi] The program ended in 2003 after an evaluation by an independent actuary revealed that managed care contract costs were higher than adjusted fee-for-service costs and that it would cost the state less to administer the same services itself. The fact that the program neither required all Medicaid members to be enrolled nor controlled costs for higher-need populations – such as individuals requiring long-term care – may have affected any savings the state achieved. According to public testimony by Department of Health and Humans Services officials, ending the program resulted in $8 million in savings in fiscal year 2003.[vii]

Disease Management Plan: 2005-2009

New Hampshire Medicaid also had a disease management program from 2005 through 2009 which provided specific self-management skills for Medicaid clients with chronic illnesses, including, but not limited to, asthma, diabetes, coronary artery disease, and chronic kidney disease. According to public testimony of Department of Health and Human Services officials, this contract was not renewed because there was little savings left that had not been achieved through it already.[viii]

Current Tools

Currently, New Hampshire employs a pharmacy benefit manager to slow cost growth in pharmacy benefits, utilization management tools such as prior authorization, service limits, and inpatient review, and discharge planning. However, these tools do not appear to have affected effectiveness of care. According to public testimony by Department of Health and Human Services officials, New Hampshire Medicaid had higher effectiveness of care measures scores than national Medicaid managed care program scores for all measured categories.[ix]

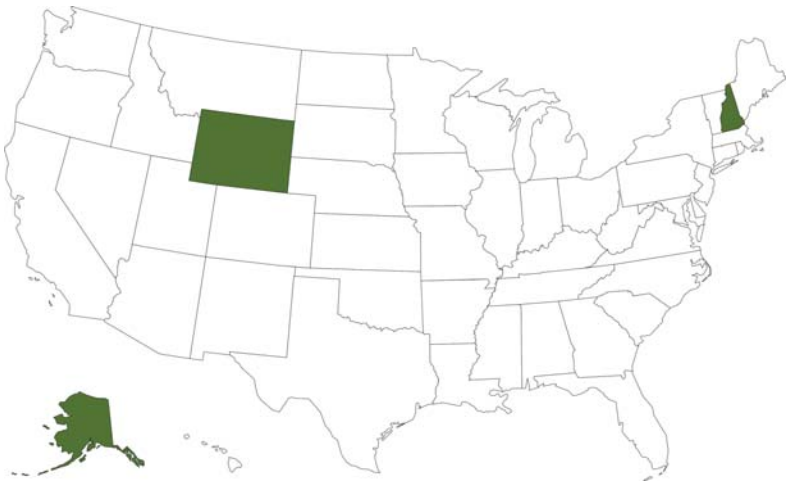
What Are Other States' Experiences with Medicaid Managed Care?

According to the Kaiser Family Foundation, managed care is the "dominant form of health care delivery among Medicaid programs."[x] Forty-seven states utilize managed care payment arrangements in their Medicaid programs; as Figure 1 indicates, only New Hampshire, Alaska, and Wyoming do not currently do so.[xi] Moreover, as Figure 2 illustrates, states collectively have more than half of their Medicaid enrollees in managed care payment arrangements.[xii]

Figure 1

Managed Care is the Norm for Medicaid Programs Nationwide

States without formalized managed care programs shown in green



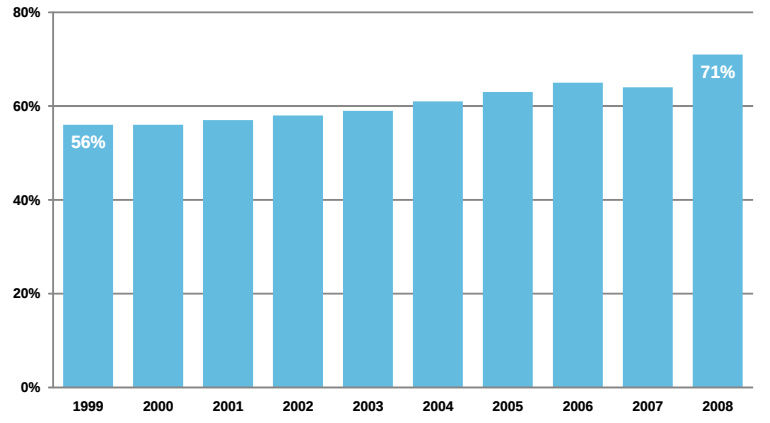
Source: Kaiser Commission on Medicaid and the Uninsured, September 2011

Importantly though, not all managed care payment arrangements are risk-based. In fact, less than 50 percent of Medicaid members are enrolled in risk-based managed care arrangements, meaning the other half are in primary care case management or some other model of care.[xiii] Further, nationwide, managed care spending as a share of total Medicaid spending on services is low compared to the roughly two-thirds of beneficiaries enrolled in managed care. This reflects the fact that managed care enrollment is dominated by families and children, whose costs tend to be low, and that many of the highest-cost beneficiaries (seniors and people with disabilities) and services they use (frequently long-term care) primarily remain reimbursed in fee-for-service arrangements.[xiv] Indeed, some estimates suggest that as much as 94 percent of Medicaid's long-term care beneficiaries are in unmanaged fee-for-service payment arrangements nationwide.[xv]

Figure 2

Managed Care Enrollment has Increased Steadily Over the Last Decade

Percent of Medicaid Beneficiaries Enrolled in Managed Care Plans Nationwide, 1999 - 2008



Source: Kaiser Commission on Medicaid and the Uninsured, February 2010

Similarly, while more than a quarter of all Medicaid enrollees with disabilities are enrolled in comprehensive risk-based managed care, the percentage of this group's enrollment in such arrangements varies significantly by state according to the

Medicaid and CHIP Payment and Access Commission, from less than 1 percent of such enrollees in Connecticut to over 90 percent in Tennessee.[xvi] These figures suggest that a uniform type of managed care payment arrangement in which to enroll Medicaid members – especially those members with special needs – may not exist within individual states.

In general, these figures demonstrate that states have little experience enrolling all of their Medicaid populations, and all of their specialized services, into a single type of managed care arrangement. Designing a program that meets the needs of special populations, while also meeting the financial goals of the state and a full-risk vendor, may be a challenge. Some states enroll members in an array of different care management programs depending on their particular attributes, the availability of providers, and other factors.[xvii] For instance, some states include aged blind and disabled (ABD) populations in programs that are available to all Medicaid eligibility groups, while others have developed programs solely for these groups.

Accordingly, enrolling all Medicaid members into managed care may require New Hampshire to adopt a variety of plan models and purchasing strategies. For example, in Pennsylvania, the state uses multiple purchasing strategies to tailor programs to the care and needs of special populations in different parts of the state. In some counties, enrollment in managed care is mandatory for aged blind and disabled (ABD) members; in others, they can choose between full-risk managed care plans and PCCM plans. In still other counties, PCCM is mandatory if a member remains in a FFS system. Throughout Pennsylvania, dual-eligible adults and nursing home residents are exempt from being mandatorily enrolled in any form of managed care.[xviii]

Finding an effective managed care model for special populations is especially relevant because the majority of costs in New Hampshire Medicaid are driven by seniors and people with disabilities – those most likely to receive specialty, institutional, and other long-term care. Seniors and people with disabilities comprise only 22 percent of New Hampshire's Medicaid population, but constitute 69 percent of the expenditures for the program.[xix] Put another way, long-term care services (consisting of home and community based care, nursing facility care, and some other intensive care for children) are the single largest category of spending for New Hampshire Medicaid, comprising 51 percent of provider payments in FY 2010 and representing services for 22,000 Medicaid members.[xx]

What Does the Medicaid Managed Care Statute Require?

The recently enacted Medicaid managed care statute requires mandatory enrollment in managed care for anyone eligible for Medicaid in New Hampshire, including seniors and people with disabilities. However, federal regulations require waivers before some Medicaid populations can be mandatorily enrolled in managed care arrangements; perhaps as a result, New Hampshire's Department of Health and Human Services has indicated it may exempt some Medicaid populations in the initial phase.[xxi]

The Department may choose from a selection of managed care models, as described here, or a combination of models, so long as those choices offer the best "value, quality assurance and efficiency, [maximize] the potential for savings and [present] the most innovative approach compared to externally administered models."[xxii] Whatever model or combination of models is chosen must employ a so-called "medical home" approach through which each Medicaid member will receive care. While there is no definition of what constitutes a medical home in the statute – and while there are several definitions of what constitutes a medical home in health policy circles, one way in which it could be defined is as a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes.[xxiii] At a minimum, under the new statute, all "mandatory" Medicaid services – those that New Hampshire is required to provide under federal law, as detailed in Figure 3 – must be covered through a managed care arrangement. The Department is also required by the reform statute to ensure that current quality of care is not diminished for members.

Figure 1

Mandatory Medicaid Benefits in New Hampshire

Physician services
Laboratory and X-rays
Outpatient hospital
Inpatient hospital
Federally qualified health clinic
Rural health clinic
Intermediate care facilities
Nursing care facilities for individuals age 21 and older
Home health care for those entitled to nursing facility care
Nurse midwife services
Pediatric and family nurse practitioner services
Family planning services and supplies

Source: New Hampshire Medicaid Annual Report, FY 2009

The timeline for developing and implementing managed care is laid out in the statute. A five year Request for Proposals to enter into contracts with vendors is to be released no later than October 15, 2011. Vendors are to be selected no later than January 15, 2012, with final contracts submitted to the Governor and the Executive Council no later than March 15, 2012. The target date for implementation of the contract is July 1, 2012. All eligible Medicaid members are to be enrolled no later than 12 months after the contract is awarded.

The Department of Health and Human Services has indicated it will implement Medicaid managed care in three phases. In Phase 1, all Medicaid populations' state "medical services" will be contracted for through a full-risk, capitated program. It appears that the Department will include all mandatory Medicaid services and some optional Medicaid services in its definition of "medical services," but will exclude home and community based care services and services provided in a nursing home.[xxiv] The state is also considering including an outpatient substance abuse basic benefit and a prepaid behavioral health benefit in Phase 1 as well. Phases 2 and 3 will address home and community based care services, those who are newly eligible for Medicaid in 2014 pursuant to the Affordable Care Act, integrated care and financing for dually eligible members, and nursing home non-medical services.

Moreover, the Department has clarified that, in addition to medical homes, Medicaid beneficiaries could be enrolled in health homes, a medical home pilot available under the Affordable Care Act, for Medicaid members with chronic conditions.[xxv] Under the Affordable Care Act, a Medicaid program may be eligible for additional federal funding for constructing health homes for those Medicaid members with chronic and complex conditions. Medicaid members who are eligible for health home are those with: 1) two or more identified chronic conditions; 2) one chronic condition and are at risk for a second; or 3) serious and persistent mental illness. Eligible chronic conditions include mental illness, substance abuse, asthma, diabetes, heart disease, and obesity. Additional chronic conditions can be added at the discretion of the Secretary of the US Department of Health and Human Services. A health home must provide comprehensive care management, care coordination, health promotion, comprehensive transitional care and follow-up, patient and family support, and referral to community and social support services. Several different types of providers are eligible to serve as health homes.

Phase 1 also includes the initiation of a Stakeholder Engagement Process that will consist of 6 regional forums and 11 focus groups, to be held during the latter half of September 2011. The regional forums, which are open to the public, have been described by the Department as "facilitated, interactive events that will allow for participants to provide input about their expectations, concerns and needs using a mixture of small-group and large-group discussions."[xxvi] The planned focus groups will involve 10 to 12 consumers or care givers each and are divided among different Medicaid population groups and will be held in different parts of the state. Three sessions will focus on low-income members, two will focus on members with developmental disabilities, one will focus on members with physical disabilities, three will focus on seniors, and two will focus on members with mental health and/or substance abuse issues.

What Challenges Might New Hampshire Face in Implementing Managed Care?

New Hampshire's and other states' experiences, as well as the requirements of the new state statute, present challenges for the successful implementation of Medicaid managed care.

A small Medicaid population and significant rural regions may make attracting full-risk vendors challenging.

Because New Hampshire is mandating managed care enrollment, it is required under federal regulations to give members a choice of no fewer than two managed care entities.[xxvii] Given the relatively small size of New Hampshire's Medicaid population, it may be difficult to attract two full-risk managed care organizations to the state. The New Hampshire Medicaid enrollment on any given day is approximately 130,000 - the smallest monthly Medicaid enrollment of any New England state. Maine, Vermont, and Rhode Island all have larger Medicaid enrollments, even though their overall populations are close to or smaller than New Hampshire's.[xxviii] If the state were unable to secure two managed care organizations, it would have to reconsider the models of

managed care it is envisioning or pursue federal waivers to suspend the choice of vendor requirement.

Rhode Island and Vermont both employ risk-based managed care models for their Medicaid populations. However, both states also have been granted demonstration waivers by the Centers for Medicare and Medicaid Services (CMS). Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to waive provisions of major health and welfare programs authorized under the Act, including certain requirements of Medicaid and CHIP. Under Section 1115, the Secretary can allow states to use federal Medicaid and CHIP funds in ways that are not otherwise allowed under federal rules. The Secretary's waiver authority is very broad.[xxix] These waivers have given these small states the flexibility they require to institute Medicaid managed care. Maine also utilizes Medicaid managed care with a relatively small Medicaid population. However, Maine relies on primary care case management, which also requires a federal waiver.

Another concern for New Hampshire is its significant rural regions. Rural regions have historically not performed as well under full-risk capitated programs, in large part because managed care organizations cannot use patient volume to negotiate reimbursement rates down.[xxx] Under federal regulations, in rural regions, the state is permitted to contract with only one managed care organization, but must give members a choice of more than one provider.[xxxi]

Some New England states have developed ways to work around the challenges posed by rural regions. Maine and Vermont both ended their fully capitated Medicaid programs in the 1990s and began pursuing primary care case management models by 2001.[xxxii] Maine returned to examining full-risk contracts for its Medicaid population, but those plans were abandoned in 2011. Instead, Maine currently uses primary care case management to organize the delivery of its Medicaid managed care system, which allows it to avoid the need to attract a sufficient number of managed care organizations to serve its rural regions. Vermont was granted a demonstration waiver in 2005 that allowed it to consolidate funding for all of the state's Medicaid programs – except for CHIP and long-term care – and to convert the state's Medicaid organization into a Medicaid managed care organization. Vermont has an additional waiver focused on the delivery of long-term care services. Moreover, Vermont is actively exploring developing a single-payer, government-financed health insurance program that would be available to all state residents. Massachusetts returned to a primary care case management model in two of its nonmetropolitan counties when HMOs in those markets pulled out.[xxxiii]

New Hampshire's small patient population and rural regions make it unlikely that the state will be able to rely exclusively on a capitated risk payment system as it implements managed care. The final managed care design for New Hampshire will likely combine different approaches, pairing risk-based capitated payment arrangements along with strategies that focus on care coordination, such as primary care case management. These models will theoretically drive reimbursement that is based on improving health outcomes and efficiencies, rather than the number of units of service provided.

New Hampshire Medicaid has low provider reimbursement rates.

New Hampshire has relatively low provider reimbursement rates and a managed care organization may not be able to lower them further as a negotiating tool, particularly in light of existing and proposed federal restrictions on such changes. According to Kaiser State Health Facts, New Hampshire has the 36th lowest reimbursement rates for Medicaid in the nation.[xxxiv] Under federal regulation, CMS requires that capitated payment rates for Medicaid be actuarially sound.[xxxv] Moreover, CMS proposed a rule in May of 2011 that appears to require states to monitor the adequacy of current Medicaid payment rates and to provide significantly more information to CMS about any proposed payment rate reductions.[xxxvi] If this rule were implemented as drafted, it may preclude further reductions to provider payments in the future. In any event, it signals that CMS may view future provider reimbursement reductions as limitations on patient access and therefore may lead the agency to take a much more active role in monitoring the adequacy of provider reimbursement. Managed care organizations frequently leverage discounts in physician fees in return for guaranteeing patient volume. Given the already low provider reimbursement rates, small Medicaid population with significant rural regions, and CMS actively monitoring reimbursement rate reductions, a managed care organization may not be able to achieve additional savings through provider reimbursement rate reductions in New Hampshire.

The timeline required in law may make effective implementation difficult.

As noted above, the timeline for development and implementation of managed care is laid out in the statute. The very short amount of time to draft the request for proposals (RFP) makes conducting vital needs assessments – which necessarily requires meaningful stakeholder involvement and data analysis – difficult.

Under DHHS' proposed implementation plan, Phase 1 includes a Stakeholder Engagement Process comprised of 6 regional forums and 11 focus groups. The short amount of time between the regional forums and the focus groups and the release of the RFP makes it challenging to incorporate the knowledge gathered from those processes into the RFP. Without robust stakeholder involvement, the state may have difficulty developing an assessment of the current system – including gaps in service – that will be vital to attracting vendors with the appropriate systems to rationalize and to improve care delivery.[xxxvii]

Literature related to Medicaid managed care makes clear that involvement from the full spectrum of stakeholders – consumers, providers, plans, and partner agencies - are key to developing effective managed care models, especially when designing managed care that includes special populations.[xxxviii] Consumers can be involved to describe what is and is not working well in the current delivery system. Providers who care for people with special health care needs are also a good source of information about the inefficiencies in an existing system.[xxxix] The development of responsive provider networks requires a knowledge of the service needs of the population and a careful analysis of the existing fee-for-service delivery system.[xl]

One of the other keys to success with respect to implementing managed care will be whether the state understands the current utilization and cost patterns of its members so that it knows how to rationalize and improve care delivery.[xli] Consequently, conducting an analysis of such patterns prior to the development of the RFP will also be critical to the success of the program. The aggressive schedule for implementation makes these assessment steps difficult to accomplish within a timeframe in which they would be effective.

What Might the Consequences of Managed Care Be for Current and Future Medicaid Members?

Moving from an unstructured fee-for-service system to a managed care arrangement can be an enormous change for Medicaid members. Critics frequently charge that quality of care and access to care suffer within a managed care setting, because the managed care organization prioritizes limiting financial risk over providing high quality access and services. The findings of a recent 50 state survey by the Kaiser Commission on Medicaid and the Uninsured indicate that Medicaid MCO enrollees in many but not all states reportedly face some access problems. Key areas of concern were dental care, pediatric and specialty care, and mental health care. However, in states in which access problems were reported, such problems may parallel similar problems encountered by people with forms of health care coverage other than Medicaid. Moreover, improved access to care was the most frequently cited perceived benefit of managed care relative to fee-for-service.[xlii]

The findings of other studies on this question are mixed and relatively little work has been published regarding the consequences of implementing Medicaid managed care in rural settings. However, there is some evidence to suggest that Medicaid managed care neither improves nor detracts from heath care access or quality for rural residents. At the same time, there is some evidence that Medicaid managed care has improved access to care for people with disabilities, but that those improvements are largely limited to urban areas and that any gains in access were not evident in rural regions.[xliii] While questions regarding access or quality of care in rural areas or for special populations will be especially relevant as New Hampshire moves to incorporate all of its populations – including people with disabilities, seniors, and others with specialized health care needs – into mandatory managed care arrangements, there are some steps that can be taken to mitigate potential deficits in quality and access.

Develop responsive provider networks.

Managed care strictly for medical services for all Medicaid populations will force the question of whether providers in any network have adequate experience and sufficient skill in treating patients with chronic or complex conditions. One possible consequence for Medicaid members is that the network of providers available to them will not be experienced or accessible to them due to their specific condition. Network providers will need to have experience providing primary care to people with physical or developmental disabilities and have offices, equipment, and staff that can accommodate people with disabilities, including those with a variety of cognitive and

physical impairments. Without responsive provider network, members may have difficulty accessing basic care.

*Provide adequate benefit design for special populations***.**

Commercial carriers typically insure populations that are generally well and need medical services intermittently. Consequently, their benefit plans reflect an assumption that illness or injury is temporary and can and will be rehabilitated. In turn, a commercial insurer may offer the same benefits as a public program, but the scope and duration of benefits they offer may be limited because they anticipate a return to full functionality or wellness. Certain Medicaid populations, particularly those with chronic conditions require ongoing services that focus on optimizing functionality and health. For example, a person with a physical disability may require permanent and perpetual access to physical therapy to maintain muscle tone or to prevent the deterioration of muscle tone – whereas an otherwise healthy person with an injury would receive physical therapy only for a discrete number of sessions until sufficient mobility or strength was regained. Ensuring that the carriers involved have an adequate benefit design for all populations is critical to ensuring that members can continue to receive the services they need to remain in their communities and in their homes.

Will Medicaid Managed Care in New Hampshire Achieve Anticipated Savings?

The fiscal year 2012-2013 budget approved by the New Hampshire legislature in June assumed that the implementation of Medicaid managed care will save $32 million in total funds over the course of the biennium. This cost saving estimate is equivalent to an overall Medicaid program cost reduction of 2.5 percent. Yet, there are several reasons to think these savings projections may not be achieved within this timeframe.

Savings from managed care programs take time to materialize.

This initial savings target appears to be very aggressive for the first year of a managed care system. Most managed care systems need maturing to achieve savings. According to the Center for Health Care Strategies, "Short term savings are difficult to achieve due to high initial utilization, difficulty in setting accurate capitation rates, and up front administrative costs. Longer-term savings are achievable through more effective clinical management and care coordination programs."[xliv]

Savings from managed care programs are unpredictable.

A report by the Lewin Group, a national health care and human services consulting firm, which summarizes more than 24 studies regarding the relative success of risk-based Medicaid managed care in other states, acknowledges that savings from managed care programs are hard to predict accurately.[xlv] In the various studies examined by Lewin, estimates of savings within Medicaid programs ranged from 2 to 19 percent, but those savings were projected against what the fee-for-service cost of the Medicaid program *would have been* in the absence of managed care arrangements and does not reflect per se bottom line savings that accrue to the

state.[xlvi] Savings generally will be higher in states that have not managed care and cost for their population previously. The Lewin report also notes that in some states health plans have abandoned managed care programs and that not all states that implemented managed care achieved savings.[xlvii]

There are examples of New England states in which some managed care programs have been abandoned or savings were not realized through risk-based capitated arrangements in Medicaid. Connecticut has recently chosen to end its full-risk capitated program, claiming that it could save tens of millions of dollars by doing so; it will instead be moving forward with medical home and primary care case management models in 2012.[xlviii] Massachusetts has lost two HMOs from its nonmetropolitan markets and New Hampshire achieved savings after it ended its voluntary managed care contract in 2003.

New Hampshire already employs some managed care tools and techniques.

It is possible that savings from implementing managed care will not be as high for New Hampshire as other states may have experienced because New Hampshire already employs managed care tools in its Medicaid program. For instance, New Hampshire already employs prior authorization, utilization review, and a pharmacy benefit manager to manage costs. As a result, according to public testimony by Department of Health and Human Services officials, an unpublished evaluation of New Hampshire Medicaid and managed care conducted by Milliman – one of the world's largest independent actuarial and consulting firms – suggests that if New Hampshire only included its low-income Medicaid population in a managed care arrangement it would obtain no additional savings.[xlix] However, if the Medicaid managed care arrangement included long-term care and mental health care – traditionally very expensive services that are frequently carved out of managed care arrangements – the state could potentially see savings of 3 to 5 percent over time once the program has matured.[l] Placing home and community based care services and long-term care services in the later phases of implementation – which may be warranted to ensure that the managed care model selected effectively serves the people who rely on those services – means that savings produced by management of those programs will come later as well.

The three phase model may make integration and coordination of care more difficult.

Effective coordination of care is a key determinant of potential cost savings. The three phase approach the New Hampshire Department of Health and Human Services intends to follow – with the apparent bifurcation of medical services from specialty and long- term care services – may affect integration and coordination of care and thus reduce savings. Whether entities that will provide long-term care services or home and community based care are the same as those vendors that contract to provide medical services and how well they coordinate or integrate care for high need beneficiaries will affect savings. The manner in which medical homes and health homes are defined and how effectively they are implemented will also be a factor in determining the degree of budgetary savings from managed care.

Conclusion

While managed care may hold promise for containing costs and improving care, other states' experience with placing all of its Medicaid populations, including high-cost beneficiaries, such as seniors and people with disabilities, into risk-based managed care models is varied. Finding effective managed care models and savings for these populations may be challenging. Overall, New Hampshire's past experiences with managed care, as well as the experiences of other states, suggest the potential savings from such reforms may be modest and will require significant time to be realized.

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[i] For a helpful glossary of managed care terminology, see http://www.pohly.com/terms.html.
[ii] A vendor is traditionally a managed care organization that manages risk, contracts with providers, is paid by another entity, and handles claims processing
[iii] *Medicaid Managed Care: Key Data, Trends, and Issues*, Kaiser Commission on Medicaid and Uninsured, February 2010, p. 2-3.
[iv] Ibid.
[v] Ibid.
[vi] New Hampshire Department of Health and Human Services Office of Medicaid Business and Policy, Presentation to House Finance Division III, Medicaid Overview, February 3, 2011, p. 46.
[vii] Ibid.
[viii] Ibid.
[ix] Ibid at 49.
[x] *Medicaid Managed Care: Key Data, Trends, and Issues*, Kaiser Commission on Medicaid and Uninsured, Februar 2010, p. 2.
[xi] Medicaid Managed Care Enrollment as of December 31, 2009, accessed at https://www.cms.gov/MedicaidDataSourcesGenInfo/downloads/09December31f.pdf
[xii] Ibid.

[xiii] MACPAC Report to Congress on Medicaid and CHIP, Table 2 in MAC Stats, March 2011.
[xiv] *Medicaid Managed Care: Key Data, Trends, and Issues, Kaiser Commission on Medicaid and Uninsured*, Feb 2010, p. 2-3.
[xv]Center for Health Care Strategies, "Medicaid by the Numbers: Opportunities to Improve Quality and Control Costs," September 2010, p. 1. P. Saucier, "Overview of Medicaid Managed Long-Term Care." Presented at the National Health Policy Forum on Medicaid Managed Long-Term Care, April 25, 2008.
[xvi] MACPAC report to the Congress, The Evolution of Managed Care in Medicaid, June 2011, p. 102, 164-165.
[xvii] Bella, M., Shearer, C., Llanos, K., and Somers, S., "Purchasing Strategies to Improve Care Managements for Complex Populations, A National Scan of State Purchasers, Center for Health Care Strategies, March 2008, p. 9.
[xviii]Ibid.
[xix]Office of Medicaid Business and Policy, New Hampshire Department of Health and Human Services, "New Hampshire Medicaid Annual Report, State Fiscal Year 2010," April 20, 2011, Table 4, p. 9.
[xx] Office of Medicaid Business and Policy, New Hampshire Department of Health and Human Services, "New Hampshire Medicaid Annual Report, State Fiscal Year 2010," April 20, 2011, Table 5, p. 12,13.
[xxi]42 CFR 438.5(d) prohibits a state from mandatorily enrolling dually eligible members and certain children, among others, in managed care arrangements, though waivers can be obtained to move these members into managed care arrangements. Moreover, the Department has publicly stated that Medicaid members with third party liability coverage and those in a spend-down category will be exempted from the initial phase.
[xxii] RSA 126-A:5 XIX(a)
[xxiii] See http://www.ncqa.org/LinkClick.aspx?fileticket=3vQKgtlkp7g%3D&tabid=631&mid=2435 for the key principles of National Committee for Quality Assurance's medical home definition; see also "New Hampshire Multi-Stakeholder Medical Home Handbook Version 2.0" accessed at: http://citizenshealthinitiative.org/medical-home-project.
[xxiv] Health and Human Services Oversight Commissioner's Presentation 8-19-2011(18 pages).pdf.
[xxv] Section 2703 of the Affordable Care Act allows Medicaid programs to draw down 90 percent FMAP for the cost of six health home services over a two year period for Medicaid members with chronic and complex conditions.
[xxvi] http://www.dhhs.nh.gov/media/pr/09152011care.htm
[xxvii] 42 CFR 438.52(a)
[xxviii] Kaiser Family Foundation, State Health Facts, accessed at http://www.statehealthfacts.org/index.jsp
[xxix] Kaiser Commission on Medicaid and the Uninsured, *The role of section 1115 waivers in Medicaid and CHIP*, March 2009, p. 1.
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