NH's Managed Care Strategy for People with Developmental Disabilities & Acquired Brain Disorders

Prepared by Community Support Network Inc. (CSNI), a not for profit organization that works in support of the 10 Area Agencies throughout the state of New Hampshire that provide services to individuals with developmental disabilities and acquired brain injury and their families.

Is Managed Care the right model for those with developmental disabilities and acquired brain disorders?

CSNI's member area agencies urge New Hampshire to thoughtfully consider any delivery system redesign relative to these goals:

- Increase consumer access to services by increasing waiver slots
- Promote high quality care
- Encourage and allow for consumer choice and direction
- Deliver services in a cost-efficient manner
- Prevent unnecessary institutionalization
- Allow for coordinated care across service delivery systems and
- Take full advantage of the current infrastructure

Member area agencies are concerned that a rapid privatized managed care deployment and dismantling of the current community based Area Agency (AA) service delivery system will cost a significant amount of state dollars up front and the state should consider pilot operations, in collaboration with the area agencies, for implementing managed care programs locally. Until further collaboration and thoughtful planning can be undertaken, the area agencies support a separate approach for NH's Medicaid Reform (managed care) for long term care programs that serve individuals with developmental disabilities (DD) and acquired brain disorders (ABD). *Let's not place ourselves in the position of "trying to fix something that is not broken."*

Why Managed Care now?

New Hampshire is looking to adopt a managed care model to improve accountability and measurement of quality care, health status, and outcomes. The state is also looking to reduce per member costs, make expenditures more predictable, and align incentives of payers, providers, and members. NH is looking to achieve $16M in general fund savings and prepare for 2014 Medicaid expansion.

Where is the state at?

In a February 17, 2011 report to NH's Senate Finance Committee, Katie Dunn, NH Medicaid Director, revealed that managed care programs implemented throughout the United States often:

- do not include all eligibility groups, and are not comprehensive in services included
- even with managed care, states continue to wrap around coverage and "carve out" services for separate management
- result in less use of institutional services among people with long term support needs
- engage stakeholders early and continuously
- MCO administration overhead costs at 11-15%

On August 19, 2011, Department of Health and Human Services (DHHS) Commissioner Toumpas noted to the Health and Human Services Oversight Committee, that Senate Bill 147 has been signed into law and that NH "shall employ a managed care model for administering the Medicaid program and its' enrollees … for all Medicaid populations throughout New Hampshire." Public input process will begin in September 2011 with the Request for Proposals (RFP) being issued October 15, 2011 and a contract finalized with all approvals by March 15, 2012. Toumpas stated that "a robust stakeholder engagement process is vital to success" and that "NH's rates for services are low." He made it clear that timelines for approvals and oversight are tight and that the Care Management program will be implemented in three phases "recognizing the issues of specialty services for vulnerable populations." He noted that Phase II will include "home and community based care services and supports for all long term care populations." Medical

services for these populations will be included in Phase I. Next steps (September to October 15) will include detailing requirements to include in the RFP for a "concept for disabled and elderly services, expansion population, and dual eligibles."

If NH has a plan to save money and improve services, why support a separate approach?

1.) *Disruption of High Quality Care at Low Cost* -- NH's 10 AA system is a cost effective community based system that is continuously transforming and moving to less expensive support models like Consumer Directed Services (CDS). It delivers DD/ABD supports at the lowest average cost of any New England state while ranking 34th in the country in terms of fiscal effort. NH ranks number three nationally in a recently published study of Medicaid services in four key outcome measures for people with DD. Quality indicators nationally and statewide note satisfaction with services with little to no fraudulent billing. NH is efficiently managing the cost of DD/ABD care and has strict laws governing increases. The model is predictable and manageable. State policy, along with Federal regulation, demands scrutiny for eligibility.

2.) *No Proven Models -- DD/ABD Inclusion in Managed Care May Not Have Significant Fiscal Impact* – Managed care implementations to date in the US for long term care for those with DD/ABD do not indicate that savings are achievable. Vermont, Wisconsin, Arizona, and Michigan, the pioneer states, have adopted managed care for this specialized population to varying degrees of success. In all four cases, managed care was adopted to move to a community based service system which NH has already cost effectively established. Wisconsin has run into several issues including the fact that several managed care organizations (MCOs) have incurred operating deficits and three of the organizations have been identified as an increased risk for insolvency. NH should consider, like Florida, New York, and Texas are currently studying, what the upfront cost will be for implementing managed care for this specialized population and should consider pilot operations like those conducted in the 4 pioneer states. Transfer to a managed care system may simply not be worth the disruption to an established system that works well and is taking care of the needs of severely impacted individuals cost effectively.

3.) *Privatized Managed Care Organizations (MCOs) Run at 20% GM* – MCOs typically use 20% or more of their funding revenues for program administration which would likely mean a reduction in service dollars that are available. Also, many privatized Health Maintenance Organizations (HMOs), which act as managed care contractors, are publicly traded entities that are faced with the goal of increasing profits quarter over quarter. An HMO managed care model, with its triage assessment of needs, capped rates, and its overriding cost containment practices, would likely diminish the quality of care now available to DD/ABD recipients. NH's AA system operates at 8.4% GM and is mission driven with direction from Family Support Councils and Boards.

4.) *Program Requirements* -- DD/ABD services are regulated by the Federal government through program requirements. Cost savings are unlikely unless Federal requirements are lowered.

5.) Expand Community Based Supports – The AA system has proven that community based care is cost effective and far less costly than care provided through nursing homes or institutions. We encourage the state to move care for seniors to a community based model supported by the AA system allowing for economies of scale and improved quality supports.

Has any other state considered a separate approach?

On May 8, 2011, Florida passed managed care, but exempted persons with disabilities from the reform effort. Florida's Office of Program Policy Analysis and Government Accountability (OPPAGA) reported "Little data is yet available on whether Medicaid reform has produced cost savings or is more cost-effective that traditional Medicaid. We recommend that the legislature not expand Medicaid Reform until more information is available to evaluate success … expanding would be costly to the state at a time when revenues are experiencing significant shortfalls."