Medicaid Managed Care in New Hampshire

A recent legislative history and timeline

By Alex Koutroubas

January 2010

SB 343, **relative to Medicaid managed care** is introduced in the State Senate**.** This bill required the commissioner of the department of health and human services to release a request for information (RFI) soliciting information regarding the feasibility of contracting with a managed care organization for risk-based managed care for all Medicaid recipients.

Sen. Bradley the prime sponsor of the bill says the rationale for the legislation is to begin the exploration moving the state's Medicaid program into a managed care system.

March 2010

SB 343 passes the State Senate on a voice vote.

March 11th

The House Health and Human Services Committee conducted a public hearing on **SB 343**. Katie Dunn, State Medicaid Director, speaks against the legislation and states the State of New Hampshire looked at this issue several years ago. Following an analysis it was determined New Hampshire was already utilizing many "Managed Care" principals and any new savings would be minimal. In addition, the department was already requesting an RFI as part of a directive from Governor Lynch. (It would later be determined that the responses to the RFI were not useful and were not used)

April 2010

NH House kills SB 343, **relative to Medicaid managed care** on a vote of **241-108**

January 2011

Sen. Bradley now chairman of the Senate HHS Committee and Senate Majority leader introduces a new Medicaid Managed care bill, SB 147, **relative to Medicaid managed care.** This bill requires the commissioner of the department of health and human services to issue a 5-year request for proposals to enter into contracts with vendors of a managed care model to provide for managed care services to the Medicaid population. The bill states all mandatory Medicaid covered services must be included.

February 2011

Senate public hearing on **SB 147** takes place on February 17.

It becomes clear through discussion and the public hearing on **SB 147** that the legislation was written by a group of: Senator Bradley, Governor's Lynch's office and DHHS (primarily by Lisabritt Solsky).

DHHS speaks very broadly about what managed care would look like at the public hearing, including speaking about improving beneficiary health, providing reimbursements based on outcomes and supporting continuity of care.

When asked about including waiver services such as developmental services and acquired brain disorders, the response from DHHS is that we are already utilizing managed care in those areas but we will look at all options, however, the focus will be on acute care. There is no opposition to the legislation at the public hearing.

February 15th

Governor Lynch introduces his budget. It contains the policy of moving New Hampshire into Medicaid Managed Care (language similar to **SB 147** is contained in **HB 2**)

March 2011

SB 147 passes the State Senate on a voice vote.

During their review of the DHHS budget, House Finance Committee Division III asks many questions about Medicaid Managed Care. The department continues to be very vague. When speaking about waiver services, DHHS states that no other state has moved those services into managed care.

April 2011

NH House conducts public hearing on **SB 147** in the Ways and Means Committee on April 12. There is no opposition to the legislation at the public hearing. The Committee makes minor changes and quickly, the bill is sent to the House floor and passes unanimously on April 27 by a voice vote.

June 2011

During the State budget Committee of Conference negotiations, former Commissioner John Stephen provides Rep. Kurk with an amendment to **HB 2**.

This amendment contains much stricter language on Medicaid Managed Care including requiring Developmental Services to be moved into a "capitated rate cell." The Senate and HHS objects and the amendment failed to be included into the budget.

June 2011

SB 147 is signed by the Governor on June 2.

Governor Lynch lets **HB 1** and **HB 2** become law without his signature on June 29.

As it was signed into law, **SB 147** requires all mandatory Medicaid covered services to be included in a managed care program. The legislation further states that all Medicaid populations throughout NH shall be included. However, the law does not state that all Medicaid funded services must be included in managed care.

End of Legislative Session

July 2011

At the July meeting of the Fiscal Committee, Commissioner Toumpas fails to present the various models or combination of models with a recommendation for the best managed care model for New Hampshire as required by the new law. He tells the Committee he needs more time.

August 2011

Health and Human Services Oversight Committee holds a meeting. Commissioner Toumpas unveils his "Phased Approach" to managed care.

- Phase 1: Medical Services for all populations (State plan Medicaid Services)
- Phase 2: Long Term Care, Waivered Services
- Phase 3: Dual Eligible population

The Senate expresses support for the phased approach. The Commissioner says the initial RFP will include Phase 1 only. Toumpas says there is absolutely no time table for phases 2 and 3.

At the August Meeting of the Fiscal Committee, Commissioner Toumpas again speaks about the "Phased Approach" to managed care and repeats that, the initial RFP will include Phase 1 only and that there is no time table for phases 2 and 3.

On August 29 the Commissioner holds a meeting of various stakeholders. When asked directly if the initial RFP would include phase 1 only, the Commissioner says "yes."

September 2011

NH House introduces legislation to create a Managed Care Commission. This is largely due to the failure of DHHS to meet the July 15 deadline in **SB 147**.

During the discussion on the Managed Care Commission legislation, House members Neal Kurk and Tom Keane admonish the Commissioner for “too many carve outs” in the phased approach to managed care.

September 23rd

At the September Fiscal and Health and Human Services Oversight Committee meetings, the message from Commissioner Toumpas continues to be a Phased approached and separate RFP’s for each phase.

October 2011

The Community Mental Health Centers receive a letter from Commissioner Toumpas stating they are now included in Phase 1.

In a meeting with CSNI, Commissioner Toumpas fails to answer any questions or concerns the area agencies have about Medicaid Managed Care. CSNI is told the RFP process will answer specific questions. The Commissioner for the first time, states there will be only be one RFP for Medicaid Managed Care.

The single RFP will contain all phases now called “Steps.” Step 2 (long term care/waivers), will be implemented one year following the implementation of step 1. Commissioner Toumpas states that the one and only RFP will contain all of area agency funded services.

DDHS releases Medicaid Managed Care RFP with a date certain for “Step 2” implementation of July 1, 2013. The RFP itself states: ***“*DHHS recognizes that there are many challenges around coordinating services for waivered services, both for non-dual and dual eligible members and that moving to a capitated managed care model for these services and populations will require significant planning, stakeholder involvement, and provider and service re-alignment.” For these reasons, Step Two has not been fully developed to date.”**

November 2011

DHHS releases answers to questions from bidders. The answers relative to step 2 continue to be very vague.

DHHS releases “Databook” with key financial and technical information for potential bidders. DD/ABD community support services are not contained in the databook.

December 2011

A total of 6 bids were submitted on or before December 15, 2011. The companies many believe submitted proposals are: Anthem, Aetna, Centene Corporation, Network Health, BMC Healthnet Plan and Meridian Health Plan.

January 2012

DHHS has selected and notified the three insurance companies that they will negotiate with relative to the Medicaid Manage Care contract.

The company names will not be released by the department until an agreement is finalized.

The department has received permission to hire an "out of state law firm" to assist with the negotiations because too many in state firms have "conflicts of interest."

The MCO's are pushing hard for a firm 5 year contract rather than the three year agreement with 1 year extensions that exists now.

The goal is to have this contract ratified on the March 28, 2012 Executive Council Meeting.

The department has stated the full contract language will only be available for public examination three or four days before the contract is voted on by the Executive Council.

March 2012

March 9th
Joint Fiscal Committee approves the DHHS recommended capitated rates for the Medicaid Managed Care program.

March 23rd
The Medicaid Managed Care contracts and the bidding organizations selected by the state are officially released to the public. The 3 selected bidders are: Centene Corporation, BMC Healthnet Plan and Meridian Health Plan.

BMC Healthnet Plan receives the highest score and is the only not-for-profit selected.

March 28th
The Executive Council votes to table the Medicaid Managed Care Contract.

April 2012

April 13th
The Governor and Executive Council hold a special meeting regarding the tabled Medicaid Managed Care Contract.

April 18th
The Executive Council leaves the Medicaid Managed Care Contract on the table at their sole April meeting.

May 2012

May 9th
Governor and Executive Council approve the Medicaid Managed Care Contract on a vote of 3-2.

May 11th
DHHS submits State Plan Amendment (SPA) and Medicaid Managed Care contract to CMS for review.

June 2012

June 28th
CMS (responding to the DHHS submitted SPA) transmits a three page letter to DHHS informing the department that the SPA has not been approved and that CMS requires more detailed information before a decision can be rendered.

August

August 7th
DHHS responds to CMS's June 28th letter requesting additional information about NH's plan for Medicaid managed care and specifically the SPA.

August 24th
CMS approves the SPA and submits a letter to DHHS that states the capitated rates and Medicaid managed care contract are still under federal review.