

**Joint Healthcare Reform Oversight Committee**  
**September 7, 2011**

**Overview of remarks**

- The Patient Protection and Affordable Care Act (ACA) has a number of key provisions that present both challenge and opportunity to the Department of Health and Human Services.
- The purpose of today's session:
- Provide the Oversight Committee with an update of DHHS related matters on the status of, issues with and options for several key provisions of the ACA.
- Understand the process and protocol for the Oversight Committee by which DHHS raises issues requiring rule changes to comply with or take advantage of ACA provisions and how these then tie into the Joint Legislative Committee on Administrative Rules.

**The ACA was signed into law in March of 2010 and has a roadmap of key provisions that will be implemented over the next several years.**

- A number of provisions impacting Insurance, Medicare, Medicaid and other areas have been implemented.
- A significant number of other provisions remain on the horizon, but DHHS has been investing significant time to respond to proposed Federal rules in several key areas:
- Medicaid Eligibility: Federal intent is to simplify Medicaid eligibility. Rules are proposed to calculate the Modified Adjusted Gross Income, however those rules will require changes in systems and policy.
- Waste, Fraud and Abuse Regulations: Federal intent is to step up efforts in this area and have proposed rules that have significant impacts on States and providers
- Health Insurance Exchanges or Health Benefit Exchange (HBE): Provisions of requirements, resources, options for States to plan, design, implement and manage the exchanges effective January 1, 2014

One item of note is that the Federal government has "re-branded" a number of existing programs and brought them under the ACA. These include:

- Prevention programs through public health
- Choices for Independence: home and community based care for long-term care populations

- Community Passport: nursing home transition program for long term care populations

**There are two critical areas where DHHS is focused:**

- Medicaid Expansion: effective on January 1, 2014, able bodied, childless adults with incomes below 133% of the Federal Poverty Level will become eligible
  - The first three years of eligibility, the costs of these newly eligible recipients will be borne by the Federal government and then phase that to a 90/10 funding by 2017
  - DHHS preliminary projections are for as many as 50,000 NH citizens will become eligible.
  - However, we do not know where these folks reside, when they are likely to enroll, what their disease burden is and what other needs or issues they may have.
  - We are presently exploring options on how to better quantify and qualify this population.
- Health Benefit Exchange: States must have an exchange: it is not optional.
  - States can choose one of two broad paths: development of an exchange directly or wait for a Federal Exchange to be implemented.
  - In either scenario, the State must have seamless integration between eligibility systems and the HBE
  - There is a requirement that once someone enters the HBE for coverage options, once all data is entered, the requirement is a response will be rendered within 15 minutes based on self-declaration of the recipient, with validation to follow.
  - A second level of integration is that the HBE must enable transitions for recipients who, based on circumstance, move from private to subsidized, to Medicaid to CHIP and associated permutations.
  - There are significant information technology impacts on the existing eligibility systems and how they will integrate with a State developed or Federal exchange. The State has no visibility to the Federal model(s) so it's not possible to do a fair comparison at this stage.
  - States must declare and have a comprehensive plan by January 1, 2013 as to which approach will be implemented
  - Any approach has inherent risks, but time is not our ally in mitigation of those risks.

### **The ACA and Care Management**

- Through SB 147, the Department is working on a Request for Proposal to implement a mandatory managed care system for the Medicaid population.
- Timeline and milestones require an implementation by July 1, 2012.
- The ACA provides models and resources for innovation in the health delivery system. Health Homes and Medical Homes are two delivery models that will be foundation for our care management program.
- The two core provisions of the ACA both have significant impact on the design, development and implementation of the Care Management program.
- The Department projects over 50,000 new Medicaid recipients beginning on January 1, 2014. These are childless adults with MAGI up to 133% of the FPL.
- The State expects to see a number of additional people into the health system via the subsidized insurance for people up to 400% of the FPL.
- Many of these people are being served by our health systems today, but not in a planned or efficient manner. They may forego preventive checkups and regular screenings until they are very sick and then go into the ER adding to the burden of UCC.
- The Health Benefit Exchange is the portal for these new recipients that provides some form of insurance enabling them to access the health delivery system.
- Under Care Management, we will also need to insure that those enrolled in one of the Care Management plans through an MCO are processed efficiently and timely.

### **Immediate issues for the Oversight Committee**

A number of lesser-known provisions of the ACA will require rule changes for State compliance. Two examples include:

- Pay for stand-alone birthing centers
- Prohibit payments for provider preventable conditions (same as Hospital Acquired Infections?)
- What is the protocol for addressing rule changes?

### **Next Steps**

- Provide regular updates to the Oversight Committee.