Executive Summary:

In 2009, the Legislature and then Governor Lynch of The State of New Hampshire (NH) established the Quality Council for those served by the NH Developmental Services System. The Quality Council grew out of recommendations contained in SB 138 report, Quality Improvement Committee Report, released in 2008. The mission of the Quality Council is to "Provide leadership and recommendations for consistent, systemic review and improvement of the developmental disability and acquired brain disorder services provided within New Hampshire's Developmental Services System."

When it was clear that the State of NH would be moving towards Commercial Managed Care for its Long-Term Services and Supports (LTSS) the Quality Council established a subcommittee to study this topic. In the spring of 2014, the Quality Council was asked by the Department of Health and Human Services (DHHS) to make systemic recommendations regarding the transition to Commercial Managed Care.

The full report formally adopted by the Quality Council on January 21, 2015 includes:

- Important aspects of the current NH Developmental Services System that must be maintained and included in a Commercial Managed Care environment; and
- Additional "must haves" for inclusion in any systemic changes are related to either:
    - Systemic Quality,
    - Individual Experience of Quality of Life, or
    - Caregiver Quality of Life.

The Managed Care Organizations (MCOs) delivering LTSS in NH shall be required to possess and demonstrate financing, administrative, programmatic, and care coordination capacity and infrastructures to enable it to comply with the terms of the contract.

The final report covers 20 topic areas and took nine months to complete. It is reflective of where NH is today and while the managed care system continues to evolve, the Quality Council may modify these initial recommendations. This list should not be considered exclusive and some subjects may have been inadvertently omitted. The Quality Council also researched how other states handled the transition to managed care for individuals with disabilities and incorporated some of the best practices into its recommendations. Some of these recommendations largely incorporate and summarize the following resources from the Centers for Medicare & Medicaid Services (CMS) and the National Senior Citizens Law Center (NSCLC):

1. Advocate's Library of Managed Long Term Services and Supports Contract Provisions, NSCLC; available at: http://www.nsclc.org/index.php/ltss-contracts-index-appeals-notices/
2. Long-Term Services and Supports: Beneficiary Protections in a Managed Care Environment, June 2012, Special Report by NSCLC and Disability Rights Education & Defense Fund, available at http://dualsdemoadvocacy.org/wp-content/uploads/2012/06/Special-Report-LTSS-June-2012-Final.pdf

3. Medicaid Managed Long-Term Services and Supports: A Review and Analysis of Recent CMS Waiver Approvals in New Jersey and New York, March 2013, Special Report by NSCLC, available at: http://www.nsclc.org/wp-content/uploads/2013/03/MLTSS-NY-NJ-Final-030113.pdf
4. Transitioning Long Term Services and Supports Providers Into Managed Care Programs, May 2013, Brian Burwell & Jessica Kasten, Prepared by Truven Health Analytics for CMS, available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/Transitioning-LTSS-.pdf
5. Summary - Essential Elements of Managed Long Term Services and Supports Programs, CMS, available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSS-Summary-Elements.pdf
6. Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs, May 20, 2013, available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf
7. Summary of CMS Guidance on Managed Long-Term Services and Supports, May 2013, NSCLC, available at: http://www.nsclc.org/wp-content/uploads/2013/05/MLTSS-Guidance-052313.pdf

In addition to the topic areas, there are considerations for DHHS to put into place prior to and during the implementation of Managed Care in NH. The 20 topic areas included in the final report are as follows:

1. Enrollment
2. Continuity of Care
3. Individualized Plans of Care
4. Services
5. Care Coordination/Service Coordination
6. Self-Direction
7. Coordination of Medicare Services for Dually Eligible Enrollees and Private Insurance
8. HCBS Benefit Packages/Required Services
9. Cultural Competence
10. Nursing Facility Diversion and Transition
11. Rebalancing Data
12. Qualified Providers
13. Quality Measurements, Data and Evaluation
14. Client Rights, Appeals, and Grievances
15. Advocacy Support for Enrollees
16. Meaningful Systemic Stakeholder Involvement
17. Civil Rights
18. Financing
19. Values
20. Caregiver Support and Quality of Life

For each of the topic areas, there are recommendations from the following perspectives: parents and/or individuals receiving services, providers, and oversight. The Committee looked at what is working well and needs to be preserved in the current system, what could be improved, and what needs to be maintained as the system and should the state evolve to a commercial managed care environment.

NH has a long history of successful partnerships, beginning with the closure of the Laconia State School. Major systemic changes and evolutions included all: DHHS, the Area Agencies, providers, individuals and families. Stakeholder engagement and involvement has been a cornerstone of the NH Developmental Services System, to quote the Family Support Task Force of 1987, "nothing about us without us." NH families play a critical role in the service delivery system. Eighty percent of individuals live with their families. Families do this without an expectation of compensation because they love their son or daughter, are physically able to support their family member, and know that if they give a bit today, then another family can get some needed services. They do it because they are in partnership with the providers and the State of NH.

NH is all about local control, it is not a "cookie cutter" state. Each community has its own characteristics, resources, strengths and needs to which the community-based system has responded. The system has evolved and while there are always ways to improve what we are doing, NH has led the way for many other states. The NH Developmental Services System currently operates using many of the principles of a managed care environment. What concerns many of the families and those sitting on the Quality Council is involving another party in the delivery system, specifically, the Commercial Managed Care Organization. It has not been clearly articulated as to whether adding another entity in the provision of LTSS will increase efficiency, improve outcomes, and not result in budget reductions. It is the intent of these recommendations to preserve what is working well if NH does move to a commercial managed care environment.

Above all, the NH Quality Council is concerned about what values the Managed Care Organizations will bring to the New Hampshire Developmental Services System as it begins to become involved with the delivery of LTSS. Historically, NH has placed a very high priority and emphasis on supporting people to have the best possible quality of life and to make their own choices about how to spend their lives. We are deeply concerned that this absolutely must continue to be the perspective which is taken.

Introduction:

This report is divided in two sections, the first are the requirements that the State of New Hampshire (NH), through its Department of Health and Human Services (DHHS), shall have in place as it transitions to a Managed Care system for its citizen's with developmental disabilities and/or acquired brain disorders. The second section focuses on contract requirements for the Managed Care Organizations (MCOs) as they begin to deliver Long-Term Services and Supports (LTSS) to NH's most vulnerable citizens.

Care Coordination shall be provided so that the care coordinator has an ongoing relationship with the individual/family and who is able and willing to meet the family/individual at their home and in the community, and not just on the phone or other electronic means.

MCOs shall provide services in accordance with the values and principles of Medicaid, federal law (including the "state plan portion" and the requirements of the "Waivers") and state law (e.g. for persons with developmental disabilities RSA 171-A). This includes but is not limited to adherence to individualized and person centered planning and services, use of highly competent staff in all roles, community inclusion and participation, and local/regionally based Individual Service Agreement development and implementation.

DHHS Requirements, prior to the Implementation of DD/ABD LTSS in Managed Care:

- DHHS shall proactively identify members with significant or complex needs prior to enrollment and monitor their status with particular care to ensure that appropriate services are provided throughout a transition to managed care and thereafter.
- LTSS care plans shall not be changed except in accordance with applicable federal and state laws and regulations.
- DHHS shall provide the MCOs with copies of prior assessments of enrollee's health condition and service needs (SIS, HRST, and/or other evaluations or assessments).
- Any existing grounds for state exemptions from mandatory managed care enrollment and the procedures for pursuing such exemptions shall continue to be honored and made available, and enrollees shall be notified about how to obtain an exemption.
- The inclusion of details on how care coordination services will not be disrupted for the individual/family if conflict-free case management is implemented. If one entity performs one of the key functions and also provides a direct service, a conflict of interest can potentially arise, so appropriate firewalls and guidelines shall be developed by DHHS and adopted by the MCOs and the Area Agencies/Private Providers, so that one entity can continue to provide both.
- DHHS shall engage the NH DD/ABD Quality Council (NH DD/ABD QC) to define and implement conflict-free case management in the NH Developmental Services System.
- The MCOs shall not provide Service Coordination.
- DHHS shall provide a strong support system for Self-Direction that includes: training; counseling; assistance with financial and logistical issues, including an Internal Revenue Service (IRS) approved fiscal/employer agent who acts as the enrollees' agent for payroll and other employer responsibilities should the individual/their representative not wish to assume payroll

responsibilities themselves; support broker assistance; and assistance with technical capacity to bill an MCO for individual service providers.

- Dental Services be provided for those on the Home and Community-Based Services (HCBS) waiver.
- Provide an expectation to the MCOs for reimbursement methods for reimbursing family, friends, and/or caregivers for transportation in a timely manner and without undue documentation requirements.
- That DHHS work with housing service agencies (federal and state) to develop options for affordable housing for individuals with disabilities and their families, if applicable, so the individual can remain as independent as possible, with services provided in their home. These options shall include grants, increased housing stipends, or low/no-interest loans. Money shall also be available for additions to home (in-law suites, additions) to facilitate natural supports and enhanced quality of life for the individual.
- That DHHS develop low interest or no interest loan and/or grant programs for the purchase of accessible vehicles.
- That dedicated funds be set aside for the continuation of vehicle and home modifications for accessibility, as currently provided under the HCBS wavier.
- DHHS establish an independent certification and workforce development board by statute. The board shall be inclusive of the LTSS Provider System, including individuals with disabilities, their representatives and/or their families, and members of the workforce.
- That DHHS continue to publish quarterly employment reports.
- That DHHS have contract expectations with the MCOs regarding employment outcomes.
- That DHHS have expectations for the MCOs to hire people with disabilities.
- DHHS shall undertake a comprehensive LTSS needs and capacity assessment and update it annually. The needs assessment shall provide information on such areas as community health needs, health disparities, existing resources, typical patterns of health care utilization, and barriers to beneficiaries living and working safely and independently in the community.
- Prior to implementation, DHHS shall implement an outreach program to LTSS providers to facilitate their transition to Managed Long-Term Services and Supports (MLTSS). This shall not create a significant added paperwork or accounting burden.
- DHHS shall provide technical support available to small LTSS providers in negotiations with MCOs.
- DHHS shall ensure that enrollee access to providers does not decrease over time.
- DHHS shall reward MCOs for increasing their HCBS provider capacity, with extra incentives attached to doing so in rural contexts.
- DHHS shall develop and implement a comprehensive managed care quality strategy that includes MLTSS, is integrated with any existing state quality strategies and provides for continuous quality improvement. The design and implementation of a quality improvement strategy shall be transparent and appropriately tailored to address the needs of the MLTSS population.
- DHHS shall utilize the external quality review process to assess and validate quality elements related to MLTSS, see Appendix A for NH DD/ABD QC's recommendation.

- The State maintains ultimate responsibility for the quality of MLTSS programs and shall not delegate this responsibility.
- DHHS shall have adequate resources to carry out numerous quality-related activities, including the development and implementation of MLTSS performance improvement projects/corrective actions and the solicitation and analysis of consumer feedback all to ensure that deficiencies are corrected and standards and performance measures are being met.
- DHHS shall develop managed care reports in such critical areas of MLTSS as "network adequacy; timeliness of assessments, Individual Service Agreements and Individual Service Agreement revisions; disenrollment; utilization data; denial rates for DD/ABD specifically; call monitoring; quality of care performance measures; fraud and abuse reporting; participant health and functional status; [and] complaint and appeal actions." The contract shall specify the relevant reporting requirements.
- The contract shall require DHHS to develop "report cards" that can be used by the public to evaluate and choose a managed care plan.
- DHHS, MCOs and contractors shall measure key experience and quality of life indicators for all MLTSS participants and require the State to make survey results available to stakeholder advisory groups for discussion, and post the results on the State website.
- DHHS shall establish an independent certification and workforce development board by statute. The board shall be inclusive of the LTSS Provider System, including individuals with disabilities, their representatives and/or their families, and members of the workforce.
- An external oversight mechanism shall be established, as recommended by the NH DD/ABD QC in October 2013. As an interim measure, DHHS shall contract with a nationally recognized consultant group to develop performance measures for the provision of long-term DD/ABD to assist the DHHS to develop the measures, metrics and standards that MCOs have to meet. See Appendix A.
- DHHS shall immediately hire staff with expertise in overseeing, monitoring and contracting with MCOs, including specific expertise in MLTSS.
- DHHS shall create an oversight and monitoring plan that clarifies what role each of the relevant agencies will play.
- Plan shall include activities to monitor MCO performance over time as well as activities that can quickly identify and resolve current problems.
- DHHS shall utilize stakeholder groups and independent ombudsman in its monitoring and oversight plan.
- Plan shall include specific activities for overseeing and monitoring delivery. Examples include, but are not limited to:
    1. A dashboard that monitors the delivery of HCBS.
    2. Secret shopper surveys that test the adequacy of LTSS networks.
    3. Audits of MCO operations related to LTSS delivery, general management rates, and amount of corporate profit.
    4. Review and analysis of LTSS encounter data submitted by MCOs.
- The data collected by DHHS regarding MCO performance and quality data shall be fully validated and transparent and unedited, and made publicly available in a timely manner.

- The contract shall require that the NH DD/ABD QC or other legislatively created independent authority duly will serve as oversight and decision-making entity for DD/ABD LTSS Managed Care. DHHS shall provide full funding to the NH DD/ABD QC to hire a full-time employee.
- DHHS shall work with the MCOs, the Area Agency/Provider System to establish, maintain, and fund a permanent system of professional development for all DSP's, DSP's supervisors, and Service Coordinators, across all LTSS. See Appendix B for the NH DD/ABD QC's recommendation.
- DHHS shall create a uniform notice of action form that MCOs are required to use related to enrollee appeals.
- DHHS shall be required to contract with an outside entity to provide training, information, support and assistance to individuals and families regarding the appeal and grievance process.
- DHHS shall establish and fund independent advocacy entities to provide MCO enrollees with support in obtaining services, negotiating, and pursing grievances and appeals and to formally represent enrollees as necessary.
- DHHS shall establish safeguards to ensure that participant health and welfare is assured within the MLTSS program.
- DHHS shall only allow auto-assignment to a plan when a person does not make an affirmative-choice, and any assignment shall follow an intelligent process that takes into account the person's current LTSS providers.
- Within 60 days of the receipt of this report, DHHS shall create a statewide managed care advisory committee. The committee shall be comprised of persons impacted by the program and their advocates, including one member of the NH DD/ABD QC. The committee's recommendations shall be required to be heard and acted upon by the State and MCOs. At a minimum, the State shall consider and respond in writing to the committee's recommendations.
- Ongoing, DHHS shall have a stakeholder advisory board that includes Medicaid-eligible beneficiaries, including a representative of the NH DD/ABD QC, to advise it on all aspects of the planning, implementation and operation of the managed care program. The advisory board shall continue through program implementation. Individuals with a range of LTSS service needs and their representatives and advocates shall be included.
- DHHS shall participate in quarterly meetings, convened by the MCOs with its members to document fully all grievances raised by individuals at the meetings, to keep comprehensive minutes of all member meetings that are made available to all individuals, and to provide written responses to all articulated grievances prior to the convening of the next member meeting.
- There shall be transparency at the State and plan level. Agreements between and among the Centers for Medicare and Medicaid Services (CMS), the State and the MCO shall be made public. Results of readiness reviews, evaluations and quality measures shall also be made public. MCOs, as they are performing a State function, shall be subject to State freedom of information act laws.
- The State shall have an affirmative plan, with data requirements, periodic monitoring obligations, and enforcement measures, to ensure that MCOs are in compliance with all relevant civil right laws.
- The State shall design its payment structures to support the goals and objectives of the MLTSS program.

- State shall reward MCOs for activities such as providing supports to aid in achieving competitive employment, provision of services in the most integrated setting, and consumer satisfaction. The contract with the MCOs shall be explicit in what sanctions and rewards will be used, how they will be used and how they will achieve program goals.
- DHHS shall develop mechanisms to evaluate the efficiency of all payment structure procedures.
- Each Family Support Council receives direct funding from DHHS and have input and control over how those Funds are used and managed. There shall be no reduction of Family Support Councils or Family Support funding.
- DHHS shall fully fund an Annual Family Support Conference, Direct Support Conference, and People First of NH Conference each year. Each shall have liberal subsidies available for respite, necessary support, transportation, and accommodations. Conference program planning and content will remain under the jurisdiction of the appropriate body, i.e.: State Family Support Council, People First of NH, and Direct Support Professional Planning Committee.
- DHHS shall ensure that NH has a Medical Loss Ratio of no more than 85% for the general population and not more than 6% for the LTSS Population.

The contract between the State of NH and the MCOs, shall require, at a minimum:

- The MCOs delivering LTSS in NH shall be required to possess and demonstrate financing, administrative, programmatic, and care coordination capacity and infrastructures to enable it to comply with the terms of this contract.
- MCOs providing LTSS shall have leadership, management, and programmatic roles dedicated solely to LTSS that are filled by personnel with demonstrated experience and expertise in LTSS management and systems issues with at least 10 years' experience serving this population including possession of the values, knowledge and skills to enable them to carry out their respective roles and responsibilities in accordance with the terms of this contract. This includes but is not limited to personnel making service authorization decisions. Such experience and expertise should not be limited to necessary medical and clinical experience, but include all aspects of service delivery under applicable federal and state law. It should also include the necessary experience and expertise in understanding the complex and distinct needs of sub-populations of LTSS beneficiaries.
- MCOs shall have interdisciplinary care teams composed of individuals with expertise in the availability, provision and coordination of LTSS, including the aforementioned experience, knowledge and skills.
- MCOs shall have LTSS specialists in their Provider Relations departments available 24/7.
- MCOs shall have required structures and procedural safeguards to ensure that enrollee's procedural and substantive rights are protected
- MCOs shall include 2 members of each of the LTSS systems in NH (including DD, ABD and CFI systems) on their governing board as full voting members. The members from the DD and ABD systems shall be at least one individual receiving services. They shall be chosen through the governing board process of People First of NH. Any family member shall be chosen by the State Family Support Council.

- MCOs shall maintain and further develop and support existing LTSS provider networks that are already integrated within beneficiary communities to ensure no one need change their trusted providers.
- When an MCO subcontracts duties, the MCO retains responsibility.
- MCO shall provide services consistent with NH values as outlined in Section 19, including, but not limited to the localized and individualized control of service delivery. Each community, agency, service has challenges unique to them and their populations, this needs to be acknowledged, accepted, and supported.
- Retention of the regional Area Agencies and the Private Provider system of delivering services in accordance with RSA 171-A:18 and He-M 505.
- Individual Service Agreement in accordance with 171-A and He-M 503 and other applicable regulations.
- MCO Staff shall be trained in Social Role Valorization (SRV) by a trainer from the SRV Implementation Project.
- MCO Staff shall become versed in the usage of Person Centered Language as well as the concept of "presumed competency."
- 100% of MCO surplus/profits from DD/ABD services shall go back into the DD/ABD service delivery system and used for continual improvement and enhancement of those services.
- DHHS shall create and MCOs, Area Agencies and Private Providers shall adopt uniform documentation. Such documentation shall be meaningful in tracking preferred outcomes, such as, but not limited to: employment and community participation.
- MCOs shall adopt a mission-based approach to LTSS for DD/ABD rather than a profit-based approach.
- MCO shall ensure that Salaries/Compensation and Benefits of providers and their staff are sufficient to attract and retain competent personnel for all necessary direct support , supervisory, clinical, administrative and management positions in the networks. DHHS, MCOs and providers shall cooperate to phase in over a five year period the Direct Support Professional (DSP) and Enhanced Family Care (EFC) compensation recommendations that the NH DD/ABD QC approved at its November 13, 2012 Meeting. A copy of the recommendations are attached as Appendix C. Note "Section I A and B were approved as well as cost of living increases for EFC providers.

The following recommendations are additional requirements in specific areas that should be in any contract with the MCOs by the State of NH:

1. Enrollment:

Enrollment into MLTSS shall be voluntary and those that choose to opt-out will remain in a fee-for-service system. If the MCOs offer a truly person-centered experience and can demonstrate improvements, individuals will enroll without being forced to do so. However, if mandatory enrollment occurs, the contract shall:

- Allow enrollees a 60-day period to evaluate the available plans and make an informed selection.
- Include the specific conditions under which disenrollment could be allowed "for cause", which includes when the termination of a provider from their MLTSS network would result in a disruption in their residence or employment.
- Require that any auto-assignment takes into account the person's current LTSS providers and allow for cross-network or out-of-network choices.

2. <u>Continuity of Care:</u>

To ensure continuity of care, the contract shall require:

- Protections to apply to all provider categories, including but not limited to personal attendant care, home health services, DSP's, EFC providers, and durable medical equipment.
- The MCOs to automatically extend out-of-network payment to a new enrollee's existing providers for up to one year or until a transition satisfactory to the individual has been affected to ensure that the transition to the MCOs does not jeopardize the new enrollee's health, security, comfort or capacity for independent living in the community.
- For situations in which providers are unwilling to accept payment from the plan, the State shall establish a mechanism for paying providers during the transition period, and the contract shall require the MCOs to establish procedures for effectively fulfilling out-of-network providers' medically necessary prescription, specialist, durable medical equipment or other treatment referrals.
- MCOs to pay the pre-existing provider a rate at least equal to what the provider received previously in a fee for service structure with DHHS.
- An MCO to honor all existing authorizations for services or supplies for a minimum of 120 days from enrollment of a new member, and shall not terminate such an authorized service or supply without due process notice to the enrollee, and an individualized plan to transition the beneficiary to other services or supports as needed is in place. In the event an appeal is filed to maintain existing services, the contract shall require continued payment pending until a final decision is issued in the appeal even if the prior authorization period for the services has ended.
- The MCOs to give due process notice to both the enrollee and the provider and to DHHS when refusing to make payment to an out-of-network provider who has provided services to the enrollee, or when refusing to authorize such provider to provide services to the enrollee.
- Because enrollment in an MCO shall never require a person to move, the contract shall require the MCOs to make payment available to any appropriately certified nursing facility or assisted living facility, EFC home, or any other living arrangement, in which the enrollee is living at the time of enrollment, for services provided to that enrollee. The contract shall require the MCOs to provide payment at the network rate if that rate is higher than the standard Medicaid rate.
- Permit enrollees to retain existing physicians, and other health practitioners, and/or providers who are willing to adhere to plan rules and payment schedules regardless if the provider is a member of the MCO network or not.

- That ample notice of any proposed new plan of care before it becomes effective and final approval of plan must remain with the individual served, their family or legal guardian.
- MCOs to contract and make reimbursement available to existing LTSS providers so long as the provider meets appropriate standards of quality, as defined in the contract between DHHS and the MCO.
- MCOs to offer network admission to the provider, or allow out-of-network access for the enrollee to a provider that has been providing services to an individual currently being enrolled into an MCO and the provider is not already part of the MCOs provider network but meets the DHHS standards.
- MCOs to work with smaller LTSS providers to help them develop the infrastructure and/or provide support so they are able to participate in the plan network.

3. <u>Individualized Plans of Care:</u>

The contract shall contain a definition of planning that include the person and their family at the center. Each enrollee receiving LTSS shall have an Individual Service Agreement, updated at least annually.

The contract shall require:

- All Individual Service Agreements shall:
  - Be a personalized and ongoing process to plan, develop, review and evaluate the enrollees' services and include environments, as identified by the enrollee, their guardian and/or family, and service providers of those environments that will promote the individual's health, welfare, and quality of life.
  - Final approval of the plan lies with the enrollee and/or their representative.
  - Service agreements in place at the time of the initiation of managed care LTSS shall be honored and continue as is until the next annual review or unless changed in accordance with the applicable rules He-M 503, 522, 510.
- The contract shall include DHHS-established requirements for the individualized Service Agreement, such as, but not limited to:
  - Integration of all elements of needed medical, clinical, and community living supports.
  - Be prepared in person-first singular language and be understandable to the consumer and/or representative.
  - Shall initially document the positive attributes of the individual, to be strengths based.
  - Shall identify risks and the measures taken to reduce risks without restricting the individual's autonomy to undertake risks in order to achieve goals.
  - Shall include and document goals stated in the individual's and/or representative's own words, with clarity about the amount, duration, and scope of services and supports that will be provided to assist the individual to achieve his/her goals.
  - Specify person(s) and/or any provider agency (ies) responsible for delivering services and supports.

  - Include a discussion of acute care preferences and anticipate care transitions needed for a return to the community from any temporary emergency room, hospitalization, or nursing home admission, as well as transitions requested by any individual who desires and is capable of a less restrictive community placement.
  - Document other non-paid supports and items needed to achieve the individual's goals. The plan shall include the signatures of all people with responsibility for its implementation, including the individual and/or representative, and a timeline for plan review.
  - Identify the person and/or entity responsible for monitoring the plan and everyone involved (including the beneficiary) shall receive a copy of the plan.
  - Include strategies for resolving conflict or disagreement within the process, and include clear conflict-of-interest guidelines for all planning participants, as well as a method for the enrollee to request revision of a plan, or appeal the denial, termination, or reduction of a service.
  - The MCOs to provide information that allows individuals to understand and make informed decisions about service options, including providing information about Olmstead rights to all who use LTSS.
  - That the individual/their representative approve any proposed changes to the Individual Service Agreement well in advance, at a minimum of 30 days prior to any changes.
- The MCOs to have procedures in place to monitor and follow up implementation of an enrollee's individualized plan. This process shall include:
  - Mechanisms to ensure that paid and unpaid services and supports are delivered.
  - That integrated care teams monitor progress toward achieving individuals' goals.
  - That MCOs review the care plan according to the established timeline.
  - That the MCOs implement a feedback mechanism, to report on progress, issues and problems, to the individual/their representative.
- Individuals having the right to choose to designate someone, including but not limited to: a trusted family member or friend, to serve as their representative for a range of purposes or time periods.
- Care planning meetings shall be held at a time and place that is convenient and accessible to the individual. The individual shall have available communication supports, such as interpreters or other assistive devices.
- Individuals to have choices about the extent of involvement of their DSP's in their Individual Service Agreement process.
- The contract shall prohibit any penalty or reduction in benefits when an individual/their representative exercises their freedom of choice.
- The contract shall have an incentive and increased reimbursement for person-centered planning. Person-centered planning is a strength based, capacity focused way of looking at a person who experiences disabilities. All supports and relationships flow from this viewpoint with the intended outcomes to improve the quality of life for the focus person in the areas of home, work, volunteerism, recreation, etc., in the context of community settings.
- DHHS and the MCOs to incorporate person-centered principles, defined above in their policy, mission/vision statements and operations documents.

- MCO staff and leadership to receive training in the principles of person-centered planning by a nationally-certified trainer.
- MCOs to ensure that each member has a meaningful opportunity to participate in the initial development of, and updating of, his/her service agreement.

4. <u>Services:</u>

The contract shall ensure that:

- As outlined in RSA 171- A:1 " that persons with developmental disabilities and their families be provided services that emphasize community living and programs to support individuals and families, beginning with early intervention, and that such services and programs shall be based on the following:
  - Participation of people with developmental disabilities and their families in decisions concerning necessary, desirable, and appropriate services, recognizing that they are best able to determine their own needs.
  - Services that offer comprehensive, responsive, and flexible support as individual and family needs evolve over time.
  - Individual and family services based on full participation in the community, sharing ordinary places, developing meaningful relationships, and learning things that are useful, as well as enhancing the social and economic status of persons served.
  - Services that are relevant to the individual's age, abilities, and life goals, including support for gainful employment that maximizes the individual's potential for self-sufficiency and independence.
  - Services based on individual choice, satisfaction, safety, and positive outcomes.
  - Services provided by competent, appropriately trained and compensated staff; and with the service guarantees as outlined in RSA 171-A: 13 "Every developmentally disabled client has a right to adequate and humane habilitation and treatment including such psychological, medical, vocational, social, educational or rehabilitative services as his condition requires to bring about an improvement in condition within the limits of modern knowledge."
- Community Participation Services shall be:
  - Individualized, based on goals and aspirations.
  - Community based; ordinary experiences.
  - Age appropriate.
  - Flexible.
  - Follow the recommendations of the Developmental Services Employment Committee, Considerations for Employment Services in Care Management and the similar recommendations of the NH DD/ABD QC on Employment. Copies of these recommendations attached as Appendices D and E, respectively.
  - Include transportation, necessary supports and/or staff, and funding to events and activities, including evening and weekend hours.
  - Include training for employers/volunteer sites. Provide support for families to understand the importance of meaningful employment when appropriate natural supports fostered and supported in the workplace have flexible funding. The staffing patterns shall accommodate

work schedules of the individual and of the family or primary caregiver(s) (including nights and weekends), collaboration with employers, vocational rehabilitation, schools, provider agencies, individuals and families is essential.

- Choice in services and models, such as:
  - Real choice from among all available options "within the limits of modern knowledge."
  - Choice of any qualified provider both within or out-of-network.
  - Choice of schedule and usage of individual's time.
  - Choice of whether or not to participate; can opt-out of Commercial Managed Care or Self-Direction.
  - Choice of support staff without undue regulatory burdens and/or restrictions; can choose friends, family members, neighbors, etc.

5. <u>Care Coordination/Service Coordination:</u>

The contract shall require:

- The MCO assign a team to work with individuals/families with experience in DD/ABD. The caseload of each team shall not exceed 30 individuals.
- MCOs to acknowledge that individuals have the right to engage the services of an independent case manager/service coordinator if he/she chooses, consistent with current NH law.
- That the service coordinator shall:
  1. Be fully knowledgeable of local, regional and statewide specialized and generic supports and services, be available locally and meet with the member locally on a monthly basis or more frequently if needed or requested.
  2. Advocate on behalf of individuals for services to be provided, in accordance with He-M 503.08.
  3. Be a person-chosen or approved by the individual or guardian and approved by the Area Agency, provided that the Area Agency shall retain ultimate responsibility for service coordination.
  4. Coordinate the Individual Service Agreement process.
  5. Describe to the individual or guardian service provision options.
  6. Monitor and document services provided to the individual.
  7. Ensure continuity and quality of services provided.
  8. Ensure that service documentation is maintained.
  9. Determine and implement necessary action and document resolution when goals are not being addressed, support services are not being provided in accordance with the service agreement, or when health or safety issues have arisen.
  10. Convene Individual Service Agreement meetings at least annually and whenever:
      a. The individual or guardian is not satisfied with the services received;
      b. There is no progress on the goals after follow-up interventions;
      c. The individual's needs change; or
      d. There is a need for a new provider.
  11. Provide guidance and assistance during a crisis.

6. <u>Self-Direction:</u>

The contract shall require:

- The MCOs retain the services allowed under He-M 525 and He-M 524 so that individuals/their representatives/families have continued Participant Directed and Managed/Person-Centered control of all funds and program decisions.
- The utilization of Self-Direction as an option in order to give the enrollees the opportunity to have choice and control over how services are provided and who provides the services. Self-Direction may be performed by a non-legal representative freely chosen by the enrollee if they are not a provider of the service.
- The individual has Employer Authority, including, but not limited to:
  - recruiting,
  - hiring,
  - setting pay rate,
  - developing job description,
  - verifying employees' qualifications and ability to perform the job,
  - evaluating,
  - verifying time worked,
  - discharging as necessary, scheduling,
  - providing all tax reporting and payroll responsibilities directly,
  - maintaining employee insurance requirements, obtaining criminal history or background investigation; and
  - Specifying additional staff qualifications based on the enrollees' needs and preferences.
- Budget authority
  - Authority over the approved budget with some significant discretion as to how the money is used.
  - Members shall have flexibility to negotiate provider rates within their allocated budgets and budgets shall be adequate to offer DSP's competitive wages, benefits, and health insurance.
- The MCO cannot require a member to hire providers from the MCOs network or otherwise restrict the choice of workers.
- In this model, the MCOs shall not dictate educational or other requirements for employment of DSP's, but shall support and encourage members and families to utilize people that are appropriately trained and/or certified.
- The creation of a service budget to explain how the enrollee shall make changes to the budget and how the enrollee might reserve funds to purchase items that increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for the human assistance.
- That an individual have the ability to leave the self-directed model and receive HCBS services without interruption.

- That the option of Self-Direction be available to all individuals regardless of age, disability, functional limitations, or cognitive abilities, provided they are able to self-direct or have a representative who is willing to assist on their behalf.
- Individuals be free to choose to hire family and friends as HCBS providers and require the MCOs to support flexible hiring, training, and worker qualifications that respect Self-Direction and help to expand the long-term service work force.
- That individuals have the right to take risks and the responsibility to develop or help develop a back-up plan for assumed risks and for emergencies.
- That individuals exercising budget authority have the opportunity, but not the obligation, to budget for and save funds for emergency needs and living with the intention of supporting independence and avoiding unnecessary institutionalization.
- That individuals' self-directed budgets and plans may be developed to include other services and supports as obtained, such as housing, and allow funds to be used in combination with those resources realized from other programs.

7. <u>Coordination of Medicare Services for Dually Eligible Enrollees and Private Insurance:</u>

The contract shall require:

- The MCOs to conduct adequate coordination with services provided through Medicaid on a fee-for-service basis, for services not covered by Medicaid and Medicare-funded services and Private Insurance.

8. <u>HCBS Benefit Packages/ Required Services:</u>

The contract shall require:

- MCOs be financially responsible for the full range of LTSS to ensure there is no directing individuals toward institutions rather than accessing support services while living in community-based settings.
- That MCO benefit packages include comprehensive HCBS including coverage for expenses related to care transitions and changes in beneficiary functional levels, such as moving expenses, community transitional services, housing counseling and home modifications needed for aging in place or after developing secondary conditions.
- The inclusion of baseline standards across all MCOs for enhanced and alternative services so individuals can understand the choices available to them, and the extent of services and treatments that are governed by MCO appeal rights.
- The MCOs to provide/offer/encourage alternative supports or services when appropriate to support the individual's long-term care goals and needs, including but not limited to: access to homeopathic/holistic/alternative providers/treatments/services.
- That HCBS not be subject to arbitrary limits such as wait lists, enrollment caps, and/or or geographic limitations.

- The MCOs to identify and support community-based "transition-out" programs to move enrollees when appropriate to community-based settings from nursing facilities and other institutions, and develop such programs where they don't exist or exist only at a rudimentary level. Peer support shall be an integral component of such programs.
- That community-based LTSS be delivered in settings that are aligned with federal requirements for home and community based characteristics and in ways that offer the greatest opportunities for active community and workforce participation.
- The MCOs to offer services in the most integrated setting possible, consistent with the State's obligations under the Americans with Disabilities Act (ADA) and the Olmstead v. L.C.
- The MCOs to develop new program models in locations or types where services are less available.
- The specification of reimbursement methods for reimbursing family, friends, and/or caregivers for transportation in a timely manner and without undue documentation requirements.
- That reimbursement strategies from the MCOs shall take into account other funding resources, following the guidance in the Memorandum of Understanding (MOU) with New Hampshire Vocational Rehabilitation.
- That the MCOs work with the Bureau of Developmental Services (BDS) as a resource for employment practices and services.
- That the MCOs have contract incentives with their providers regarding employment services.
- A comprehensive and adequate Crisis Avoidance/Crisis Response plan - Crises often do not occur during typical business hours. All organizations under contract shall have the decision-making authority and ability to respond to crisis, without repercussion when an individual's health and safety is in jeopardy, as determined by the Provider Agency. Any plan must include:
  - Hotline staffed by a local decision maker; 24/7.
  - Support for families in ANY crisis and facilitate immediate access to their support coordinator/team leader, etc. Crises include things like family/caregiver job or income loss, divorce, any major life crisis that can alter the families' daily life routine.
- That the MCOs make timely decisions, 24 hours or less.
- That the MCOs may not penalize local providers for making crisis decisions that occur outside of customary business hours.
- That MCOs maintain the current array of START services including assessments, crisis prevention and intervention planning, and Resource Centers (therapeutic respite).

9. <u>Cultural Competence:</u>

The contract shall require:

- Explicit language about what cultural competence encompasses with significant evaluation criteria.
- Compliance with National Standards on Culturally and Linguistically Appropriate Services (CLAS).
- That all services to be culturally and linguistically appropriate, including but not limited to: sign language, assistive listening and/or talking devices.

- That communication, family customs, preferences and relationships be respected and factored into Service Agreements.
- Certified interpreters are available.

The following two sections, Sections 10 and 11, are primarily related to the delivery of services in the nursing home environment. The NH DD/ABD QC does not have expertise in this area, but did do research. Since some individuals served by the NH Developmental Services System do live in these settings, we wanted to include the information we identified as important during the contract development.

10. <u>Nursing Facility Diversion and Transition:</u>

- The contract shall include nursing facilities and assisted living facilities as part of MLTSS for there to be incentives for the MCOs to move and keep enrollees in the community.
- In order to lessen the likelihood or duration of nursing facility stay, specific diversion and transition programs are critical. The contract shall contain incentives and explicit program requirements that promote safe and appropriate transitions from nursing facilities to community-based services.
- The contract shall require the MCO to create a "Nursing Facility Diversion Plan" which shall be approved by the State and CMS and requires the MCO to monitor hospitalizations and short-stay nursing facility admissions for at-risk enrollees.
- The contract shall require the MCOs to create a "Nursing Facility to Community Transition Plan" for those in nursing facilities who are capable of transitioning to the community and wish to do so.
- The contract shall require MCOs to identify nursing facility residents who can benefit from transition; work with state entities that can provide necessary services and funding; and monitor hospitalizations, re-hospitalizations, and nursing facility admissions to identify issues and improve enrollee outcomes.
- The MCOs shall have identified "transition coordinators" who assist people to move into community based settings.
- The contract shall permit applying a more lenient income standard for a nursing facility resident enrolling in the MLTSS program in order to move into community (i.e. Income standard would be Housing and Urban Development (HUD) fair market rent minus 30% of the Medicaid income level for single person household). The contract shall require the State to work with nursing facility staff, health plans and beneficiaries' family members in order to identify good candidates to utilize more lenient income standard.
- The contract shall require the results of programs to be publicly available.
- If costs of community services exceed cost of nursing facility and the enrollee chooses to enter or remain in the community with a less-than-recommended level of HCBS, the contract shall allow the enrollee to do so and require the MCO to complete a risk assessment detailing the risk, outlining safeguards, and establishing a back-up plan. This provision, however, would not alleviate the State of its obligations under the ADA.

- The contract shall require that if an enrollee is receiving HCBS and expects to receive HCBS after an intervening nursing facility stay, the enrollee's maintenance needs allowance shall be the community maintenance needs allowance (or more depending on the amount) rather than the allowance for nursing facility residents. The allowance shall be of sufficient amount to allow sufficient resources for the member to maintain his or her community residence back to the community.
- The contract shall require, as necessary, that the State and MCOs offer a benefit that would allow individuals to retain their house, apartment or other community-based setting during a hospitalization or nursing facility stay, in situations where expenses (or other factors) associated with the hospitalization or nursing facility stay otherwise would not allow individuals to maintain the house, apartment, or other setting.
- The contract shall require an MCO to ensure that its participating providers, particularly hospitals and nursing facilities, present enrollees with the full range of appropriate and available options, including HCBS, once the individual's condition has sufficiently stabilized and prior to discharge.
- The contract shall require that an individual's preferences be honored, pursuant to applicable Individual Service Agreement procedures. The contract shall also require that these preferences be documented.
- The contract shall require that prior to an individual's discharge from a hospital or nursing facility, the MCO shall ensure that an individual's service needs have been appropriately assessed and that a transition plan has been prepared. Accordingly, an MCO shall require that its participating hospitals and nursing facilities ensure that an individual's services needs have been appropriately assessed prior to discharge and that a transition plan has been prepared. The development of transition plans shall follow Individual Service Agreement requirements, particularly those relating to an individual's participation and appeal rights.
- The contract shall require that MCOs ensure that appropriate LTSS are available immediately upon discharge.
- The contract shall require MCOs to pay retainer payments or employ similar mechanisms to ensure that LTSS providers are available to re-start services when an individual returns from a hospitalization or nursing facility stay. This obligation shall apply equally when the LTSS provider is an assisted living facility, EFC home, staff residence, or similar setting; in that case, the State obligation applies both to service costs and to room and board expenses.
- The contract shall require that when an individual is living in a participating assisted living facility or similar setting, and then is hospitalized or admitted to a nursing facility, the assisted living facility or similar setting shall honor the individual's rights under the admission agreement and/or relevant State legal protections to retain possession of the living unit in the assisted living facility. As necessary, the assisted living facility or similar settings shall offer a room hold and be paid by the MCO. The contract shall require the MCOs to require that participating providers adopt and follow such policies, and alter any existing contractual requirements that state a contrary policy.
- The contract shall require that MCO benefit packages include coverage for expenses related to care transitions such as moving expenses and home modifications.

- The contract shall require MCOs find and support community-based "transition-out" programs to move individuals when appropriate to community-based settings from nursing facilities and other institutions, and develop such programs where they do not exist or exist only at a rudimentary level. Peer support shall be an integral component of such programs.

11. Rebalancing Data:

The contract shall require:

- DHHS to gather data related to the State's rebalancing efforts. Such data shall be made broadly available on an MCO-specific basis. Data points shall include:
- Number of beneficiaries receiving HCBS and nursing facility services prior to implementation of MLTSS.
- Number of enrollees receiving HCBS and nursing facility services during each 12 month period.
- HCBS and nursing facility expenditures for MLTSS as percentages of total LTSS expenditures during a 12 month period.
- Average HCBS and nursing facility expenditures per enrollee during a 12 month period.
- Average length of stay in HCBS settings and nursing facilities during a 12 month period.
- Percent of new MLTSS enrollees admitted to nursing facilities during a 12 month period.
- Number of enrollees transitioning from nursing facilities to the community, or from the community to nursing facilities, during a 12 month period.

12. Qualified Providers:

The contract shall require:

- MCOs to have an adequate provider network of all relevant LTSS providers in order to provide individuals with appropriate, person-centered, quality LTSS, including access to out-of-state providers.
- Clear standards for LTSS network adequacy.
- Where capacity is under or over-developed, MCOs shall develop transitional plans with specific targeted timelines to strengthen or adjust network capacity as needed beyond the stated minimum standards.
- At a minimum, the contract shall require the following to ensure network adequacy (for all services):
    - MCO shall contract with sufficient number of long-term care providers to provide all covered services and ensure that each covered service is provided promptly and is reasonably accessible.
    - Individuals shall have true choice, which is a choice of any and all available and appropriately experienced providers or provider organizations for every category of service identified in the plan benefit package.

- Time and travel distance standards of no greater than 30 minutes and 30 miles (with exceptions for very rural areas, and possibly for highly specialized expertise or ancillary capacities such as language).
- Travel time calculations shall take into account transportation available in the community for individuals who are unable to drive.

- **Transition to MLTSS**

  Prior to implementation, the contract shall require:

  - MCOs to offer monthly education and training for LTSS providers regarding claims submission and payment processes, for at least first 12 months of program. Providers shall be compensated for participating in same.
  - MCOs conduct practice billing sessions with LTSS providers, prior to implementation, during which MCOs provide detailed information to providers about proper billing practices, edit checks, prior authorizations, and audit procedures. Practice billing sessions shall be structured by provider type (such as, but not limited to: nursing homes, adult day care centers, personal care service vendors, etc.) so that LTSS providers can receive training on billing practices specific to the services they provide.
  - MCOs to use uniform billing forms and practices for LTSS, to the extent possible.

- **Access & Choice**

  The contract shall require:

  - For LTSS benefits involving intimate personal care or regular home visits, MCO shall purchase services from consumer's choice of any qualified provider who will accept and meet subcontractor provisions.
  - Reward quality of life gains above cost savings.
  - MCOs to contract with community-based organizations, such as independent living centers, recovery learning communities, aging services access points, deaf and hard of hearing independent living services programs, various therapeutic providers (such as but not limited to facilitated communication, hippo-therapy, pet therapy, music therapy, service animal providers), and similar organizations that serve particular subgroups of the demonstration population.
  - MCOs to provide individuals with an opportunity to meet with various LTSS providers to determine which provider would best suit their needs.
  - Participants the right to change providers immediately and at any time of year or if they are not satisfied with the services delivered.
  - MCOs provide true access to non-network providers when required services cannot be provided under applicable timeliness standards or when enrollee chooses/prefers/requires an out-of-network provider.

- Providers shall meet relevant Medicare and Medicaid federal and state professional qualification standards, but such standards cannot supplant or interfere with the individual's right to hire, train and supervise personal assistance providers of his/her choice.
- Shall prohibit MCOs from requiring a provider to sign a non-compete agreement.

13. <u>Quality Measurements, Data and Evaluation:</u>

The contract shall require:

- Following CMS' Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs, May 20, 2013.
    - The NH DD/ABD QC will approve and monitor quality indicators and measures related to those systems.
    - That individuals who use HCBS have a central role in the ongoing development of quality measures for HCBS, including the determination of appropriate worker qualifications, training, and individual outcome measures.

14. <u>Client Rights, Appeals & Grievances:</u>

The contract shall include:

- By reference, all State Medicaid agency guidelines, policies and manuals.
- List all client rights, similar to those listed in NH Code of Administrative Rule He-M 310.
- Detail all rights and requirements associated with the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program.
- Give enrollees the right to advocate for a particular service or level of service without retaliation from the MCOs.
- Individuals have the right to appeal the following:
    - denial or limited authorization of requested service including type or level of service;
    - reduction of previously authorized service;
    - suspension of previously authorized service;
    - termination of previously authorized service;
    - denial in whole or in part of payment for service;
    - failure to provide services in timely manner;
    - failure of MCO to comply with timeframes for dispositions of grievances and appeals;
    - denial of rural consumer's request to obtain services outside MCOs network;
    - development or amendment of consumer-centered plan that is unacceptable to consumer (for example because it requires consumer to live in place that is unacceptable to consumer, does not provide sufficient care, treatment or support, or requires consumer to accept care, treatment or support items that are unnecessarily restrictive or unwanted);
    - denial of a requested budget adjustment;
    - placement on a wait list;
    - use of enrollment cap;

  - denial of request for referral; and
  - any MCO act or omission which impairs quality, timeliness, or availability of benefits.
- MCOs include fair hearing rights attach to all written decisions.
- Clearly outline due process requirements in federal law.
- Prohibit MCOs from limiting the period of aid paid pending to a current authorization period. Contract shall specify that MCOs shall continue benefits for duration of the appeal process (until the resolution of the appeal).
- MCOs shall give written notice to beneficiaries of any provider termination at least 60 days before effective date.
- The decision-makers in the appeals process are qualified and trained to evaluate the necessity of LTSS, taking into account the non-medical goals and benefits of these services.
- MCOs to collect and share publicly, data on the DD/ABD/CFI populations specifically regarding:
  1. the number of appeals, grievances, and fair hearings requested, including the category of appeal and outcome;
  2. the rate of denials (including partial denials) of requested services;
  3. the timeframe from the request of service to authorization; and
  4. the number of appeals that result in the reversal of an MCO action/decision.
- The contract shall require DHHS to collect and share publicly, data on:
  1. the number of requests for fair hearing related to an MCO action/decision; and
  2. the number of MCO actions/decisions reversed at a State fair hearing.
- The contract shall require MCOs to submit data for State review for any notice of action that reduces services, etc. by a certain percentage (i.e. 25%).
- Individuals to request a fair hearing at any time without being forced to exhaust the MCO appeal process.
- Individuals' clear right to appeal any care plan provisions.
- MCOs to submit to the State quarterly reports that analyze trends, identify issues and providers that are the subject of appeals and grievances, and demonstrate how appropriate corrective actions will be identified and implemented.

15. <u>Advocacy Support for Enrollees:</u>

The contract shall require:

- Each enrollee to have access at no cost to an independent advocate or advocacy system that is not involved in providing waiver services or overseeing the waiver.
- While enrolled in a plan, consumers to have access to independent, conflict-free assistance with any disputes with the State or plan.
- An enrollee has the ability to un-enroll from a managed care plan at any time when termination of a provider from that MLTSS network would result in disruption in their residence or employment.
- MCOs shall not interfere with and/or prohibit enrollee's access to representation/consultation by and with independent advocacy entities.

16. Meaningful Systemic Stakeholder Involvement:

The Contact shall require:

- MCO to have a standing consumer advisory committee that includes seniors, younger persons with disabilities, and family members of individuals enrolled in plans. A range of disabilities shall be represented and users of a range of LTSS shall be included. The advisory committee shall advise the MCO on all policies and practices affecting the experience of care, have access to information regarding the MCOs policies and practices as well as grievance and quality measure information, and make recommendations for changes in policy or practice to be presented to the MCOs governing board.
- MCO to convene meetings with its members at least quarterly to document fully all grievances raised by individuals at the meetings, to keep comprehensive minutes of all member meetings that are made available to all individuals, and to provide written responses to all articulated grievances prior to the convening of the next member meeting. The MCOs shall notify all members at least 15 days prior to each meeting regarding the date and location of the meeting, and offer to assist with transportation to the meeting if the member cannot travel independently. Telephone access or other provisions shall be made for participation by people who cannot travel.
- The meetings be held in locations that are physically accessible. Accommodations such as sign language interpreters shall be available for individuals requesting them.

17. Civil Rights:

The contract shall require:

- For LTSS, as for all covered services, providers are required by law to ensure access to equally effective services regardless of the individual's disability, age, sexual orientation or gender identity, and linguistic, cultural or racial background.
- Pro-active planning to ensure that the MCOs, as well as their provider network and subcontractors, can meet requests from individuals for reasonable accommodations and policy or procedural modifications that are needed for quality health care.
- MCOs be prepared to provide American Sign Language interpretation or other effective communication aids to both the individual and the personal assistance worker when necessary.
- MCOs to conduct a staff review of their provider networks, using available facility site review tools, to ensure that the provider network is physically accessible, and providers make reasonable modifications of policies, practices, and procedures (programmatic accessibility) to meet the array of disability-related needs of all beneficiaries, such as height-adjustable examination tables, assistance with filling forms or undressing, or extended appointment times or diagnostic equipment and other accommodations.
- Providers be advised of their accessibility obligations under the ADA and other applicable federal and state statutes and rules.

- Enrollees and MCO employees be able to easily and readily find information about the accessibility of individual providers and provider sites in order to be able to choose physically and programmatically accessible providers.
- The plans survey, identify, and commit to preserving providers that deliver unique or specialized LTSS for people with disabilities or high-needs senior populations, including those that have uncommon linguistic or cultural abilities (such as, but not limited to: Spanish, sign language).
- MCOs to be part of the State's Olmstead plan, participate in any Olmstead committee, and have their own plan for delivering services consistent with the ADA and the integration mandate.
- MCOs to develop language access plans to address the needs of Limited English Proficient (LEP) individuals in every aspect of the organization's interaction, from enrollment to initial assessment to grievance and appeal procedures. The communication needs of LEP individuals and people with visual, hearing, or other communication impairments shall be especially accounted for when giving notices related to, assessing for, or providing home and community-based services.
- MCOs to incorporate DHHS Office of Minority Health cultural competency standards (CLAS) into all levels of the organization and services delivery system.
- MCOs gather data about, and take into account, the needs and preferences of lesbian, gay, bisexual and transgender beneficiaries.
- All health care services and supports to be furnished in ADA-compliant settings.
- All modes of public transportation used to convey enrollees to and from any sites where Medicaid services are being provided meet the ADA transportation accessibility standards.
- Services not only be accessible, but also culturally and linguistically appropriate.
- All communication, family customs, preferences and relationships be respected and factored into Individual Service Agreements.

18. <u>Financing:</u>

The contact shall require:

- The rates MCOs pay local, in-state network providers are high enough to create and maintain adequate and sustainable networks and prevent local providers from failing, thereby opening the door to large "big box" national providers.
- Capitation rates include both institutional and non-institutional services to properly incentivize community-based alternatives to nursing home care. MCOs shall be at equal risk for institutional and home and community-based placement of people with LTSS needs.
- Financial incentives shall focus largely on maintaining and fostering independence among people in community settings and moving people in institutional settings to the community to the extent possible and desired by the individual.
- Any quality incentive payments to providers or plans shall be fully transparent and based on meeting or exceeding quality targets that include consumer-centric measures.

- Rates shall be sufficient to enable providers and members/families to attract and retain highly qualified staff in all positions. See Appendix C for the NH DD/ABD QC's Proposal for Compensation of Direct Support Professionals.

19. Values:

The contract shall reflect the following NH values:

- Dignity of Risk
- Freedom of Choice (of providers, direct support staff, coordinators and services)
- Self Determination
- Empowerment- individuals and families
- Person and Family-Centered Planning and Care
- Community-Based Services
- Transparency
- High Quality and Oversight
- Employment
- Collaboration between all parties- families, state, agencies, MCOs; no top-down dictates
- Social Role Valorization
- People First of NH language and the overt presumption of competence as a fundamental principle

20. Caregiver Support and Quality of Life:

The contract shall require:

- Each Area Agency to have a Family Support Council, with direct funds from DHHS. There shall be no reduction of Family Support Councils or Family Support funding.
- Support is available for families to navigate the Individual Education Plan (IEP) process, including subsidies for paid professional counselors and mediators.
- MCOs shall not have access to the IEP without appropriate parental consent to see what services are utilized in school. In-school services are for the learning and education of the child and that information shall not be used to determine needs outside of school.
- Strengthen respite for families. This includes funding and trained, available, on-call resources. Hourly rates shall be increased to attract/retain qualified providers.
- Include payment for Family-to-Family/Peer Support – A statewide List Serve shall be maintained for individual/family communication.
- Include the option for payment to family caregivers for their direct support of any individual over age 18, with rigorous safeguards to prevent conflict of interest and/or quality of services for any member.
- MCO establish a dedicated fund to provide resources for zero interest loans to individuals/families to access assistance for home and vehicle modifications, uncovered or

under-covered durable medical equipment, and/or any other non-covered goods or services that enhance an individual's quality of life, including but not limited to travel expenses, conference fees, camperships, learning opportunities, workshops/classes/training.

- When family members are required to provide direct support (i.e.: when staff are unavailable), they shall be reimbursed for their time at a rate agreed upon during the Individual Service Agreement meeting (but not less than the highest hourly rate of hired staff).

APPENDIX

A. Recommendations for Quality Outcome/Performance Measures and Mechanism for Managed Care Organizations or Other Models

B. White Paper Recommendations Committee and Direct Support Workforce Committee of the Developmental Services Quality Council

C. Proposed Actions Relative to White Paper Recommendations on Salary and Benefits for Employees of the Developmental Services Delivery System

D. Considerations for Employment Services in Care Management

E. Report of Employment Subcommittee of the Quality Council on Statewide and Regional Quality Indicators for Employment (7/12/11)

Appendix A

RECOMMENDATIONS FOR QUALITY OUTCOME/PERFORMANCE MEASURES AND MECHANISM FOR MANAGED CARE ORGANIZATIONS (MCOS) OR OTHER MODELS BY DEVELOPMENTAL SERVICES QUALITY COUNCIL

I. BACKGROUND

A. Among the core duties of the NH Developmental Services Quality Council (Quality Council) created by RSA 171-A:33 in 2009 is to develop and recommend to the Department of Health and Human Services/Bureau of Developmental Services (DHHS/BDS):

- Standards of quality and performance expected of Area Agencies (AA's) and provider agencies
- Methods to determine whether standards are being met through data and information collection and other quality assurance and oversight mechanisms
- Content, frequency and recipients of quality assurance reports
- Expectations and procedures for improvements when identified

B. The Quality Council has developed and recommended performance and quality standards, most notably in the Employment area, and a mechanism(s) to ensure that they are met. See Appendix A. BDS has adopted some of the recommendations and may adopt additional ones in the future. These recommendations were not necessarily made in the context of the MCOs but based on the current AA system. However, these standards are clearly applicable and transferrable to the accountability measures for MCOs.

II. The overarching purpose of the long term care service delivery system is to ensure that services delivered to individuals are provided efficiently and effectively and lead to quality of life outcomes. Under federal and state law, this is a core responsibility of those who oversee and supervise long term care service delivery systems (DHHS, MCOs) as well as those who provide services (vendors, providers).

III. As recognized by Center for Medicare and Medicaid Services (CMS), to meet this overarching purpose, service delivery systems for long term care under a managed care model, must have a "Comprehensive Managed Care Quality Strategy"[1] which contains two overarching components:

A. Outcome and performance metrics (quantifiable standards and measures) to measure the efficiency and effectiveness of service delivery). Such metrics are called for by federally-

[1] Centers for Medicare and Medicaid Services, "*Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs*, " version 1.0 (May 20, 2013), p. 15.

funded Medicaid reform efforts in NH, including Real Choice Incentive Grant, Managed Care Initiative, Money Follows the Person and the Balancing Incentive Fund.

B. A Quality Assurance method(s) or mechanism(s) that:

1. Determines whether the measures are being met and improvement strategies when they are not, or progress is needed.

2. Consolidates accountability and quality assurance indicators and mechanisms across all long term care systems (as opposed to a more silo approach); as called for by CMS a Comprehensive Managed Care Quality Strategy

"include[s] a system for continuous quality improvement (CQI) that builds upon previous and current development efforts and resources, reduces duplication, and fosters standardization of core elements across Medicaid authorities including quality measures that are focused on outcomes and critical processes; an appropriate, representative, statistical sampling methodology where applicable; and mechanisms for the tracking and aggregation of data, remediation and system improvement efforts."[2]

3. Is independent from the service delivery system, is professionally operated and has the capacity to carry out the quality assurance/CQI duties, including those listed in B(2) above. As CMS has stated: The State Medicaid Authority (NH DHHS) is responsible for assuring the quality and operation of Managed Long Term Services and Supports (MLTSS) and "may not delegate this responsibility."[3]

IV. PROPOSAL ADDRESSING ABOVE NEED AND PURPOSES

A. A Quality Assurance entity be established with an independent governing board made up of stakeholders representing each consumer group, as well as experts in quality assurance from the private sector (profit and non-profit) and academic communities with no direct interest in the service delivery systems. Three models are offered for consideration: Administrative Attachment to DHHS, a Division within DHHS, or a separate Quality Assurance Public Authority. In whatever form it takes, it is recommended that it have an independent governing board.

B. The Division's/Authority's overarching purposes and responsibilities would be to:

1. Establish quality of life and long term care outcome and performance measures for incorporation into the regulatory and contract structures with MCOs or other entities.

2. Develop and implement methods to determine whether or not measures have been met, including data reporting and verification, onsite professional or other type of monitoring reviews and program audits, announced and unannounced.

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[2] Id.
[3] Id. at 16.

3. Develop and provide for corrective measures, rewards, consequences and sanctions if measures are or are not met.

In accordance with CMS Guidance,[4] and to ensure the above purposes are carried out, the Division at a minimum would perform the following specific activities:

a. Evaluate contractually required quality assurance reports and financial reports.
b. Evaluate impact or effectiveness of incentive programs.
c. Conduct quality-focused audits, including onsite reviews, announced and unannounced.
d. Provide quality-related technical assistance.
e. Validate that corrective actions by MCO (or other management entity) have been implemented.
f. Analyze quality findings and develop reports to assess quality trends and to identify areas of improvement.
g. Develop, implement and evaluate performance improvement projects for MLTSS.
h. Solicit and analyze participant feedback.
i. Investigate and follow-up on critical incidents and sentinel events.

C. The Division/Authority would be appropriately staffed to carry out both its initial charge and its ongoing operational responsibilities described in B above.

D. Resources for Staffing and Other Needs. Potential sources include:

1. For start-up and the first several years of operation, grant funding or front-loaded federal 1115 funds be tapped, along with state general funds or Medicaid funds as needed.

2. Where several Bureaus and Divisions within DHHS have personnel dedicated to these activities, most or all of the positions should be moved to this new Division/Authority.

3. State general funds.

Note: Effective quality assurance can result in savings in the long run either due to improved services directed toward consumer independence or reduction in service duplication. Thus a strong case can be made for increased funding from this perspective for this important infrastructure area from state, federal or other funding sources.

4. The Division/Authority would have the authority to contract out components of the evaluation and measurement processes.

E. While this proposed Division/Authority and its independent governing board will have the authority to determine the Quality Assurance metrics with the DHHS Commissioner, there should be a mechanism for the various DHHS advisory councils to have input i.e. Office of Consumer and Family Affairs, Medical Care Advisory Committee (MCAC), New Hampshire State Behavioral Health Advisory Council, Developmental Services Quality Council, Advisory Committee for the New Hampshire Office of the Long Term Care Ombudsman, and the State Committee on Aging.

F. Incorporate the above into the DHHS statutory and regulatory structure and contracts with MCOs.

[4] Id.

White Paper Recommendations Committee and Direct Support Workforce Committee of the Developmental Services Quality Council

Approved by Developmental Services Quality Council (Quality Council) on May 13, 2013

I. Preface and Purpose - This recommended plan would be phased in and ultimately encompass professional development for Direct Support Professionals (DSPs), and DSP Supervisors across all long term care systems i.e. state licensed or funded systems serving people with developmental disabilities and acquired brain injuries, serious mental illness, physical disabilities, elderly in need of direct support/personal care attendance. The initial steps begin with the developmental services system. The plan also encompasses service coordinators in the developmental services system.[5]

The purpose of this plan is to put a permanent professional development infrastructure in place to ensure that DSP's, DSP Supervisors and Service Coordinators/Case Managers have the values, knowledge and skills[6] necessary to provide person centered support to meet the needs of individuals they support.

Timeframes in the Section II are not hard and fast and are meant to be rough estimates. They have also been inserted to provide a framework for the sequencing of the various actions and phases.

II. Overarching and Guiding Principles should guide this imitative and may ultimately be a pre-condition to achieving optimal success.

A. The culture in the "workplace" and at all levels of the organization must be reinforcing of the values, knowledge and skills learned in the pre-service, in-service training and continuing education.
B. Management and human resources systems at the vendor and provider level must (1) provide for supervision, mentoring, and coaching and personnel evaluations system which reinforce the values, knowledge and skills needed for certification and to properly support individual consumers.
C. No position or staff filling a position can or should be an expert in everything. For example, a DSP should advocate for the person he or she supports and sometimes be the person's voice, but we should not expect the DSP to be a substitute for a trained advocate or a lawyer when that is needed, nor be a substitute for a guardian when one is needed. Similarly the DSP may have a role in advocating that the person he or she serves to have rewarding employment, but that does not necessarily make the DSP a job coach or job developer. Someone with more specialization may be needed.
D. Compensation to DSP's, their Supervisors, and Service Coordinators/Case Managers must be sufficient to attract and retain personnel not only interested in this type of work, but to go through this certification training and to pay for at least some of it. The Quality

[5] The Quality Council did not explore whether the plan should cover service coordinators/case managers in the other systems. It is recommended that DHHS and stakeholders from the other systems determine this issue.
[6] See Attachment A for graphic depiction of "values, knowledge, and skills" for DSPs.

Council has previously made recommendations to the Department of Health and Human Services (DHHS) in this area as have other bodies.

III. Overview/Goals

A. Continue, Expand and Refine the 2013 DSP Certificate Course at NHTI in Concord so that 30 to 45 DSPs and DSP Supervisors satisfactorily complete the course **over the next 12 months.** If feasible, involve one other college *(for DSP's in developmental services system).*

B. Conduct an independent evaluation of 2013 NHTI courses and the expanded courses proposed above to determine their effectiveness and to obtain recommendations for improvements and how it might be integrated into a permanent, statewide system of professional development, including pre and in-service components; **12 to 24 months** *(for developmental services system and other systems).*

C. Conduct the same evaluation of the CSNI's Essential Learning Initiative; **12 to 24 months** (*for developmental services system and other systems*).

D. Establish by statute an independent board (described below) with necessary expertise to develop a curriculum, course and practicum requirements for DSP's and DSP Supervisors to be launched statewide; **18 to 30 months** *(for developmental services system initially).*

E. Independent board do the same for Service Coordinators/Case Managers; **24 to 36 months** *(for developmental services system initially*).

Note: For a variety of reasons positions such as Service Coordinators where a Bachelor's Degree is already required, supplemental pre-service or in-service training would still be required as well as continuing education unless the prior degree incorporated the certification requirements.

F. Consider rolling out E *for other systems;* **30 to 48 months.**

G. Create Partnership with Community College System to accomplish above and many of the other objectives and activities described below; **6 to 12 months.**

H. Explore with school systems and the Department of Education course work, credits and certification possibilities for high school students wanting to pursue these careers; **36 to 54 months.**

IV. An Independent Certification and Workforce Development Board (Board) be established that is administratively attached to DHHS.

A. Composed of consumers (individual and family members) and representatives from consumer and advocacy organizations, DHHS, DHHS regional surrogates (e.g. AA's Community Mental Health Centers (CMHC's), Service Link) vendors, DSP's, supervisors, and service coordinators/case managers, community college representatives and possibly other segments of private and public higher education.

B. Adequately staffed with persons with subject matter expertise in value based professional development. Personnel could be employed or contracted or a combination. It could also

vary during start-up in which greater reliance may be placed on consultants vs. ongoing operations.

C. Responsibilities of Board:
   1. II B through F and H, above.
   2. Develop approved curriculum/courses/hours and other certification components based on the following principles and standards:
      a. A strong and coherent value base principally from Social Role Valorization, person-centered planning, etc.
      b. At the pre-service and in-service level, content which contains and imparts sufficient values, knowledge and skills so DSPs can properly support individuals and otherwise perform all tasks.
      c. Subject to the results of the evaluation in II B and C above and based on a review of studies, other literature and experience, the pedagogy, including instructional methodology should be based on the following presumptions:
         (1) Direct instruction should be primarily live e.g. lecture, discussion and interactive, through traditional classroom and virtual interactive classroom.
         (2) Include a variety of online approaches, e.g. video conferencing/virtual classrooms and self-directed or self-paced learning.

             Note: Self-directed or self-paced learning, such as Essential Learning or College of Direct Support, especially done without complimentary live support would primarily be used to convey an overview of the system and its values or conveying "knowledge" in discrete areas that can be taught and absorbed with little or no traditional reinforcement, such as "paper compliance" areas.
         (3) A significant portion of the training, particularly as the learner transitions into in-service would consist of practical applications i.e. practicum's, internships etc. Two tracks or approaches may be necessary in this area:
             (a) For those who have been hired by an AA or family, after the pre-service component, the practicum component may generally involve the person they are supporting.
             (b) For those who are seeking certification and are not yet employed, the practicum component would entail an internship.
      d. The in-service or continuing education component may involve the learning partner, the individual being supported, not just in the real environment but in the "classroom" if the learning partner is willing.
      e. Two other mandatory parts of training would include:
         (1) Needed orientation or training to policies and procedures of the AA. This would be done by the AA and must be consistent with the standardized pre-service and in-service training the staff is receiving.
         (2) Training based on the individualized needs of the person being or to be supported, whether specifically spelled out in a service agreement/plan of care, or some other document e.g. on a person's positive behavior support plan, in

addressing significant medical or safety issues, person's unique communication style, the do's and don'ts on lifts or transfers, likes and dislikes, etc. Some of this may occur as part of the practicum.

3. Development of Certification Regulations addressing and incorporating III(C)(2) above.
4. In addition to the III(C)(2) above, issues concerning transferability of certification and specialization should be addressed in certification standards/regulations to include:
   a. Certification would enable a person to obtain a corresponding job in any system. By way of example, if a certified DSP's initial job was supporting a person with development disabilities, the DSP could still use the certification if he or she switched jobs to support a person with mental illness.
   b. In cases in which a person moves to a different system or moves to another person within the same system, provision should be made for the necessary training of the staff person on the unique needs of the new person. In some cases that may require formalized or systematic training in others more informal or a combination of both. This should be provided for in regulation or standards to assure it happens.
   c. Whether certification and the individualized person centered training is alone sufficient when a staff person moves to another system, for example a service coordinator who received certification and then worked in the elderly system for a number of years, may likely need additional or refresher training if moving over to developmental services system.
   d. The need for additional or specialized certification and hence additional or specialized pre-service or in-service, e.g. persons with forensic or significant medical needs or with a dual diagnosis or other significant behavioral health needs.
5. Develop and implement methods to ensure:
   a. In conjunction with the Community College system or other sites, that consistent quality training is delivered.
   b. In conjunction with DHHS, that there is an ongoing or periodic evaluation process to ensure that the training is leading to intended outcomes.
6. Develop and implement in conjunction with DHHS and the Community College system (and seek legislative approval as necessary) methods to obtaining certification affordable and desirable. Ideas discussed at the Quality Council Subcommittee level were:
   a. Funds from applicable Bureaus and Divisions of DHHS funds (or surrogates, such as AA's or CMHC's) that are line itemed for or otherwise earmarked for training be made available to pay for some or most of the administration and tuition costs of certification. (Bureau of Developmental Services (BDS) already has about $75,000 per year earmarked for training.)
   b. Loan forgiveness or reimbursement programs, for example employer pays off 25% of loan after one year employment, 50% after two years, 75% after three years, etc.
   c. More traditional loan or scholarships mechanisms.
   d. Use of federal money during first one to three years, e.g. Balancing Incentive Program (BIP).

e. Raise entire pay scale of these positions so that people are attracted to the positions and would be willing to pay for some or all of the cost of the certification training similar to LNA's.

V. DHHS in consultation or in conjunction with the Board and DHHS funded or licensed agencies, (e.g. AA's, CMHC's other vendors) should take steps appropriate to their role to ensure and promote high quality coaching, mentoring, and sharing of DSPs, DSP Supervisors, and Service Coordinators/Case Managers which reinforce the values, knowledge and skills acquired as part of certification and to properly support individual consumers.

VI. DHHS in consultation with the Board and Quality Council (or the Legislature and Governor), should determine whether certification is an absolute condition of employment or whether it enables the worker to earn more money at a higher pay grade. There was discussion on this but no formal recommendation. One thought was that it could start out as the latter (i.e. higher pay grade) then phase into certification being a condition of employment.

VII. DHHS in consultation with the Board and Quality Council, (or the Legislature and Governor), should determine how certification would respect and dovetail with the choice individuals or guardians have for selecting a support person under the consumer directed service mechanisms.

VIII. DHHS/BDS should take a lead in initiating this initiative and/or encourage others to submit proposals or take lead.

A. While the initial phases emphasize the development services system, the goal is to develop a quality workforce/certification system across disabilities, thus there will be a need for intradepartmental involvement under the leadership of the Division of Community Based Care Services. Other similar groups working on similar initiatives should be contacted to gauge and recruit interest and support e.g. the Coalition for the Direct Care Workforce coordinated by the Institute on Disability.
B. Initial discussion with the Community College system will be needed at the chancellor and college level.
C. Representatives from groups which could potentially be on the Board should be contacted to gauge and recruit interest and support
D. BIP funding should be looked at and tapped through an appropriate proposal to underwrite components that meet the BIP criteria.

Appendix C

Proposed Actions Relative to White Paper Recommendations on Salary and Benefits for Employees of the Developmental Services Delivery System

The relevant White Paper recommendations can be found Under Section G of the chart of recommendations, pp. 9-10. Where most of these actions were taken from the SB 138 Workforce Development Committee Report, it is recommended subcommittee members review that report when considering the proposals below that can be accessed at http://drcnh.org/SB138Report11-28-07.pdf

I. The New Hampshire (NH) Department of Health and Human Services (DHHS) should propose and support, and the NH Legislature and Governor should:

   A. Enact into law a salary schedule for Direct Support Professionals (DSP's) and DSP Supervisors that provides and maintains parity on a permanent basis with the NH Hospital Mental Health Workers and their Supervisors, to include:

      1. For DSP's, parity with Mental Health Worker I classification.
      2. For DSP Supervisors, parity with comparable positions at NH Hospital.
      3. Salary increments or differentials for completion of advanced training and education which results in increased competence.

   B. DHHS should propose and the Legislature and Governor appropriate sufficient funding to support and maintain the salary schedule for DSPs and DSP Supervisors, and if necessary phase in the funding and salary schedule so that parity is achieved in three years.

   C. DHHS, the Legislature and Governor should consider broadening the above recommendations to DSPs who provide support to persons with mental illness, physical disabilities, seniors and others in need of long term services in the community.

II. DHHS should, with input from the Developmental Services Quality Council, develop and seek to enact into law and fund a salary schedule for service coordinators and nurses which will adequately compensate them and enable the service delivery system to recruit and retain qualified staff in these areas.

III. DHHS should propose and support, and the Legislature and Governor should:

   A. Enact into law annual rate, salary and stipend increases for all other staff and providers at the Area Agencies (AA's) and subcontract vendor agencies in the service delivery system. The increases should:

      1. Be indexed to the Consumer Price Index, All Items, as published by the US Department of Labor, Bureau of Labor Statistics, and

2. Recognize and incorporate salary increase differentials for the completion of advanced training and education which result in increased competence.

B. DHHS should propose and support, and the Legislature and Governor should appropriate sufficient funding to support and maintain the annual and other salary increases in III (A).

IV. DHHS should propose and the Legislature and Governor should appropriate funding:

A. To reimburse one hundred percent (100%) of the cost of coverage for a single person health care plan (not to exceed the cost of the average of the three largest NH plans for a 45 year-old female) for Enhanced Family Care (EFC) providers. Such plans shall be purchased individually by the EFC provider and reimbursement will be offered based on documentation of valid health insurance coverage.

B. Alternatively offer or provide health insurance benefits afforded to classified state employees.

C. Enact this arrangement into law on a permanent basis.

V. DHHS should propose and the Legislature and Governor should enact a law and appropriate sufficient funds to offer or provide health insurance to all employees of the AA's and subcontracted vendors of the service delivery system equivalent to health insurance benefits afforded classified state employees.

VI. DHHS should propose and the Legislature and Governor should enact a law and appropriate sufficient funds for mileage reimbursement at the Privately Owned Vehicle Reimbursement Rate.

Appendix D

Consideration for Employment Services In Care Management

Respectfully Submitted by
The Developmental Services Employment Leadership Committee
October 8, 2014

Opportunities for Improved Outcomes

1. Opportunities for Quality Improvement Areas: We have identified these areas as desired elements of the system and opportunities for partnerships.

Funding:

- Funding that supports person-centered goals, preferences and interest.
- Funding models that allow for the individual to become as independent on the job as possible such as utilizing natural supports, job accommodations, job creation, job carving, assistive technology and incorporating strategies for fading paid supports.
- Support for employment services to those who have participated in employment training during their high school years.

Outcomes:

- Explore models that provide incentives for desired outcomes such as increased number of hours worked, employment setting, increased wages, offer of benefits; use of natural supports and staff fading from the job site.
- Consistent and easy access to work incentives counseling services (information about how income affects public benefits).
- Measurement of Progress on different elements involved in achieving and maintaining employment; Discovery (development of employment interests and aptitude profile), Plan Development (setting specific goals, objectives, timelines, and responsibilities), Job Development; on and off the Job Training/Coaching.
- Increasing level of independence on the job; Retention of the job, etc.
- Development of an authorization of funding for different elements of job procurement as outlined above.

Case Management:

- On-going training for Case Managers to help facilitate employment outcomes for each individual.
- Provide opportunities for individuals with disabilities and their families to exercise informed choice by learning about options for employment, the impact of earned income

on public benefits, and the opportunity to hear about employment success stories from their peers.

Staff and Provider Credentialing:

- Clear expectations for meeting nationally recognized competencies for providing employment services as outlined in He-M 518.
- Appropriate reimbursement for services that are provided by credentialed/certified employment specialists (vs. staff that are non-certified).
- Department of Health and Human Services (DHHS) should continue to publish quarterly employment reports broken down by statewide, regional and provider level data.

2. Managed Care Organization (MCO) reimbursement strategies must take into account other funding resources following the guidance outlined in the Memorandum of Understanding (MOU) with New Hampshire Vocational Rehabilitation.

3. DHHS/Bureau of Developmental Services (BDS) should serve as a resource to MCOs and their providers with respect to all issues related to the provision of services for employment.

4. DHHS should have the following contractual and network expectations regarding employment services:
    - Increase the number of providers with certified employment specialists.
    - Provide outcome data on a quarterly basis.
    - Provide consistent access to training for case managers, direct support staff, job developers and employment specialists.
    - Provide user friendly and consistent access to information about employment services, options, and outcomes.
    - Increase the number of certified employment staff.
    - Number of participants participating in sector training programs (such as Project SEARCH) and resulting employment outcomes.
    - Number of sector training sites.
    - Implement satisfaction surveys that reflect access to information and outcomes.
    - Include contract expectations for hiring individuals with disabilities and for exploration of a sector-training program within the MCO.

INFORMED CHOICE

MCOs shall ensure that consumers and families are informed about the benefits of competitive employment and the services available to them for finding and keeping paid employment by providing access to Work Incentive Benefits Planners beginning at age 14. MCOs shall ensure that consumers and their families receive timely, complete and periodically updated information about the impact of earned income on public benefits, and are assisted to take advantage of the work incentive provisions of these programs in order to maximize their earned income without jeopardizing needed benefits.

1. MCOs shall ensure the availability of a wide range of service options for assisting consumers to obtain and succeed in competitive employment, including but not limited to job creation and job carving approaches to job development, supported employment, and self-employment.

2. MCOs shall ensure that staff providing employment services receive adequate in-service training to be thoroughly familiar with state-of-the-art methods of job development and job support for individuals with disabilities. Staff shall be trained and certified through recognized and qualified training resources such as the New Hampshire (NH) Association of Community Rehabilitation Educators (ACRE) Training; Relias.

MCO Partnerships with the Business Community

In order to ensure that all individuals served by the care management organization MCO have access to employment opportunities equal to those available to NH citizens without disabilities, the following efforts should be undertaken to grow partnerships with the NH business community and increase the hiring of job candidates with disabilities for existing and customized positions.

1. The MCO will support the structure of regional workforce coalitions, to allow for all providers of employment services to have a unified presentation to employers. Employers in each region will have a central resource for all employment needs, questions and concerns. These efforts include supporting marketing and outreach efforts in collaboration with NH Vocational Rehabilitation, NH Workforce Investment Act (WIA) programs, NH Temporary Assistance for Needy Families (TANF) programs, other NH employment programs and their subcontractors.

2. The MCO will work with relevant state partners such as NH Vocational Rehabilitation, the Department of Labor, the Department of Resources and Economic Development, NH Employment Security and NH Community Colleges to continue growing employment outreach efforts relating to the following:

    - The MCO will support collaborative efforts to educate employers on the business benefits of hiring people with disabilities and the untapped labor pool available in NH. As part of these efforts the MCO will engage with local Chambers of Commerce, local Society of Human Resource Managers (SHRM) chapters, and other relevant associations.
    - The MCO will support the growth and evolution of statewide marketing initiatives that create awareness about the value of employing people with disabilities. This will include highlighting employment success stories and recognizing NH businesses with the best diverse and inclusive hiring practices through the Employment Leadership Awards.
    - The MCO will have inclusive hiring practices and encourage other local and state government entities and their subcontractors to have inclusive hiring practices as well.
    - The MCO will engage with NH businesses and corporations to address and reform company-wide policies that limit employment opportunities for individuals with disabilities.

- The MCO supports awareness and education of the availability of tax credits for NH businesses that hire individuals with disabilities.
- The MCO will support collaborative efforts to reform government policies and practices to allow for better employment possibilities for individuals with disabilities.

3. Ensure that families have access to information that demonstrates their rights, responsibilities and roles in the transition to employment process by linking them with necessary resources and guides. This information will assist families in advocating for employment as an outcome and encourage them to be an active participant and facilitator in the employment and transition process. Included in this information are:

   Explanations of Rights and Responsibilities:

   - Knowledge of Individuals with Disabilities Education Act (IDEA) and how to advocate for services within the guidelines.
   - Process for exercising choice and control.
   - Purpose of Individualized Service Plans and Person Centered Planning.
   - List of preferred contracted employment vendors.

4. Access to benefit planners so that they understand the relationship between benefits and employment income.

The Developmental Services Employment Leadership Committee respectfully requests DHHS to incorporate these recommendations clearly and specifically into its contract expectations with each of the Managed Care Organizations to ensure employment remains a high priority for individuals with disabilities.

Appendix E

Report of Employment Subcommittee of the Quality Council on Statewide and Regional Quality Indicators for Employment (7/12/11)

Employment Subcommittee's Charge and Background

The law establishing the Developmental Services Quality Council, RSA 171: A:33 (also known as HB 483, 2009) requires the Quality Council to develop and recommend to the Department of Health and Human Services/Bureau of Developmental Services (DHHS/BDS):

- Standards of quality and performance expected of Area Agencies (AA's) and provider agencies.
- Methods to determine whether the standards are being met through data and information collection and other quality assurance and oversight mechanisms.
- Content, frequency and recipients of quality assurance reports.
- Expectations and procedures for improvements when identified as needed.

The Quality Council determined that it should tackle the employment domain first and assigned a subcommittee to make recommendations to the full committee. A preliminary report and presentation from the subcommittee was made at the April 12, 2011 meeting, and at the June14, 2011 meeting the Quality Council approved the indicators with some modifications.

Attached as an Appendix A are the approved standards and indicators. As of now, they are not intended to replace other standards or methods DHHS/BDS uses to review or evaluate AA performance. ***It is recommended that the Quality Council and/or BDS go through other licensing, certification and quality assurance standards and mechanisms to eliminate any duplication and unnecessary measures or mechanisms and add or align them with the standards/indicators recommended here.***

The Quality Council Guiding Principles, which are taken from legal or best practice standards, and which support the recommendations are attached as Appendix B.

Quality Indicators for Employment

As noted, Appendix A lists the indicators and the sources of data or methods to determine whether the indicators have been met. The indicators specified as "primary" are the ones in which performance of the AA's will be directly measured and upon which actions may be taken when they are not met.

Almost all of this data is being collected now. The difference is that they will be measured against benchmarks and targets.

Most of the data on the secondary indicators is also being collected. They will have several related purposes. Like the primary indicators, they will also inform on how well the AA's are doing in promoting employment and employment outcomes. They will also help explain why

one or more primary indicators are not being met and therefore suggest a corrective action or conversely explain why an AA is meeting or exceeding primary indicators.

Further Recommendations

1. Provide a 5-7 year timeframe for AA's to meet established targets for each primary indicator. BDS, with input from the Quality Council, shall determine the targets and use as a guiding principle the expectation and norms for persons without disabilities. See Appendix C for examples. Regional, economic or other salient factors should be taken into account. For example, if the employment rate in one region of the state is 80% and another it is 95%, the targets should be adjusted accordingly.

2. Annual or biannual benchmarks would be set leading to the 5 to 7 year target. For example if the goal is to achieve an average of 30 hours per week of employment by the final year, intermediate benchmarks for year one could be 15 hours, year two-17.5 hours, year three-20 hours, etc.

3. If the in-house capacity does not exist at DHHS/BDS or otherwise in state government to determine the employment economics aspects of the determinations, calculations and the metrics, a consultant(s) should be retained.

4. The benchmarks and targets would not be set until after collecting 12-18 months of baseline data for at least each primary indicator.

5. In addition to looking at the averages and expectations of the non-disabled population, the targets and benchmarks would be based on:
   (a) What is both realistic and challenging
   (b) The assumption that best practices and well trained and supervised staff will be used
   (c) The baseline data (i.e. what the starting point is)
   (d) Possibly allowances for certain types of disabilities
   (e) And as noted, regional differences

6. Consideration should be given to allowing for adjustments to the benchmarks or target in the implementation phase when there are compelling reasons such as a major shut down of an employer in a region. Alternatively rather than alter the benchmark, such significant events could be taken into account in determining the action that should (or should not) be taken if the benchmark or target is not met.

7. The above process and the benchmarks and targets should be incorporated in the DHHS—AA contracts or through some other means so that they have legal effect. The process/contract will also provide rewards, consequences or assistance depending on whether or not the benchmarks and targets are met. Specifically, it is recommended that

DHHS/BDS, with input from the Quality Council, consider the following menu of options:

(a) Rewards, including financial incentives, and/or recognition when benchmarks are met and especially when they are exceeded.
(b) Corrective Action Plans/Technical Assistance when they are not, based on a root cause analysis.
(c) Financial penalties, nonrenewal of contract, de-designation.
(d) Contracting out employment supports and services to other AA's or vendors.

Factors to weigh in determining the type and severity of the sanctions would be the scope and/or amount of the departure for benchmark or target, the reasons and the frequency (one year vs. three years in a row of failure to meet benchmarks).

8. Given the purpose and nature of this initiative, it will be important that definitions are clear, e.g. what is considered "employment," and that the data be accurate. There should be a valid verification system to ensure reliability of data and measurement.

9. There should also be targets and benchmarks statewide for each indicator so that the whole state is working toward the same goal and so that the DHHS Commissioner, BDS Director, Governor and Legislature, and all stakeholders can evaluate the performance of the service delivery system as a whole and DHHS/BDS.

10. More thought should be given as to how vendors should be integrated into this approach. Since vendor contracting is not uniformly dispersed across the state or clients, it would be difficult on a macro basis to pre-set benchmarks and goals for vendors. Preliminarily it seems sufficient to have the targets and benchmarks at the AA level. Each AA could then determine how and how many vendors they wish to contract with and then fashion the contracts consistent with AA's responsibility to meet their own benchmarks and targets. For example, for XYZ vendor the AA may want them to support 6 people in jobs making at least $9.00 per hour 20 hours per week; but for ABC vendor who serves a different or larger population, the AA may contract with them for 25 people in jobs for at least $7.50 per hour, 18 hours per week.

11. Finally, to be completed by the end of the baseline period, each AA should develop a strategic or action plan designed to achieve the benchmarks and targets. Similarly there should be a statewide plan both to define the state's role in implementation and to engage in those complimentary activities that are best done at the state level.