# NH Medicaid
# Care Management Program
# *Public Forum*

Keene, NH

September 13, 2011

75 participants

Please note that the comments and priorities that follow reflect the opinions of participating workgroups and not necessarily those of the Department of Health and Human Services.

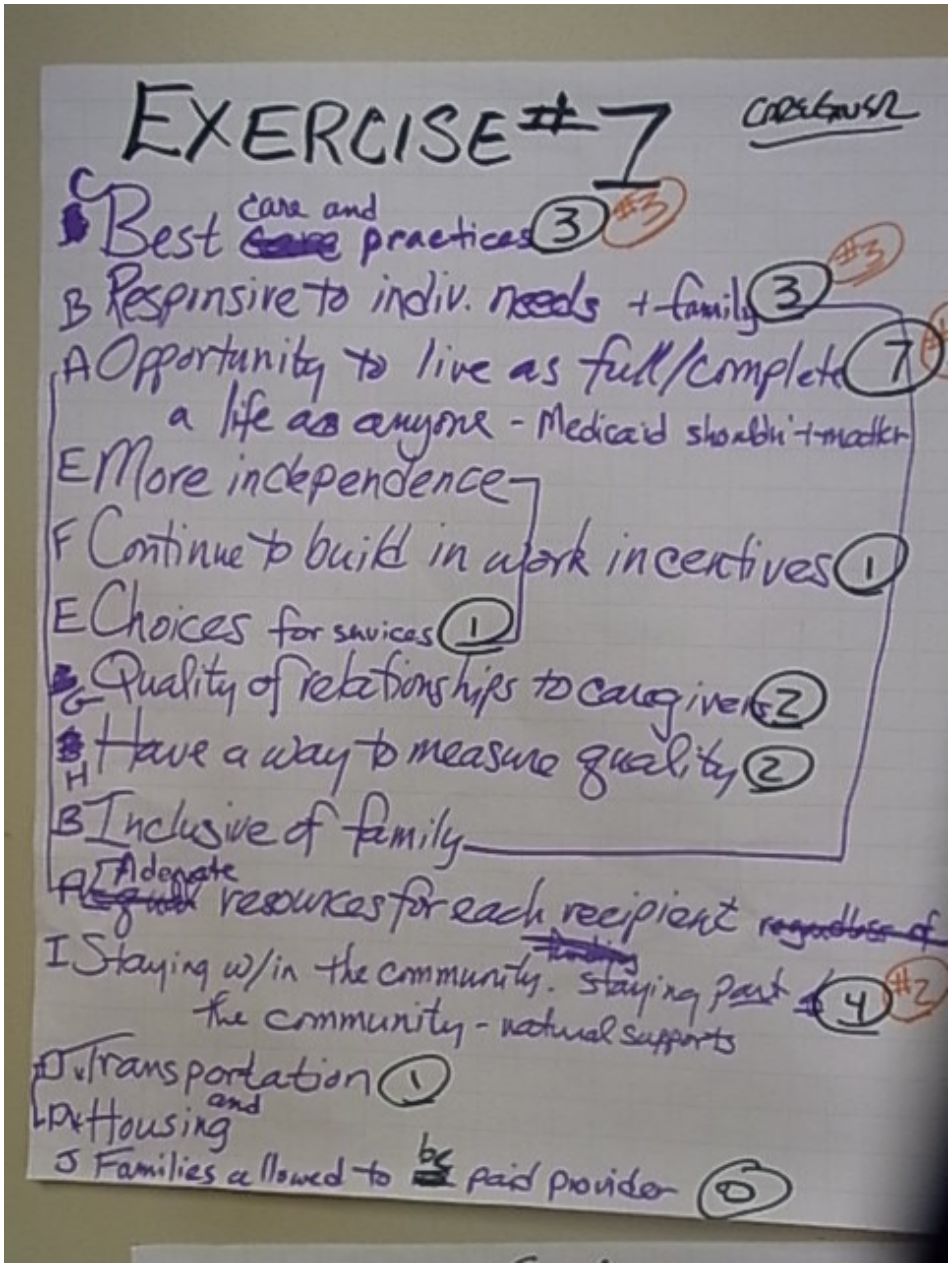
Photos of charts reflect workgroup work process and product. Items crossed out typically reflect brainstormed suggestions that were combined with others.

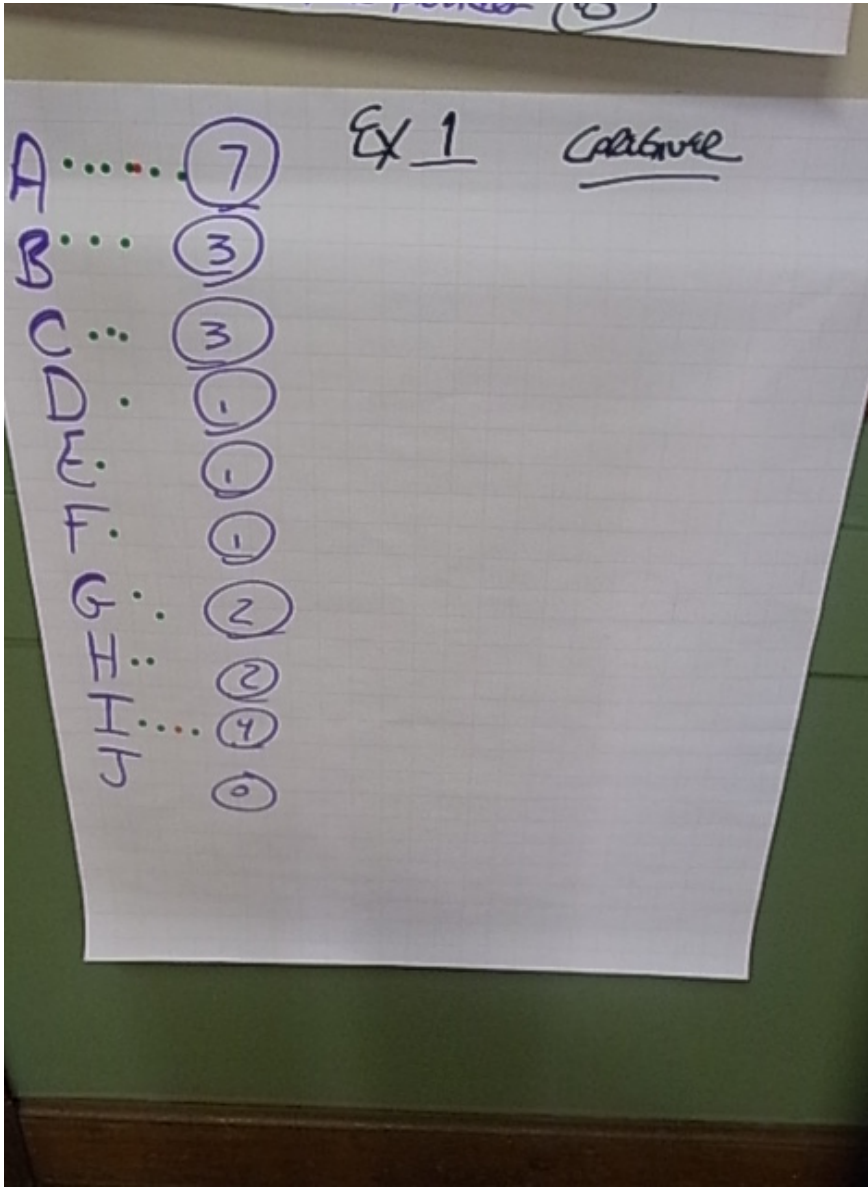
# *Recipient AND Provider Perspective – Exercise 1*

## For someone receiving Medicaid, what defines having the highest quality life/health?

**Top issues identified**

- Opportunity to live as fully as people not on Medicaid
- Resources for every recipient
- Choice of Providers and Services
- Availability of Comprehensive Array of Services
- Meaningful choice directed by recipient
- All encompassing health and wellness
- Independence and relationships built on trust
- Continuity and constancy of care…right care right time
- Self Determination
- Quality
- Affordability
- Integration of Services at all Levels – Breaking Down of Silos at Federal, State, and Provider, and Individual Level


EXERCISE #7
C Best care and practices 3
B Responsive to indiv. needs + family 3
A Opportunity to live as full/complete a life as anyone - Medicaid should + matter 7
E More independence
F Continue to build in work incentives 1
E Choices for services 1
G Quality of relationships to caregivers 2
H Have a way to measure quality 2
B Inclusive of family
Adequate resources for each recipient
I Staying w/in the community. Staying part of the community - natural supports 4
J Transportation 1
L Housing and
J Families allowed to be paid provider 0


Ex 1
A 7
B 3
C 3
D 1
E 1
F 1
G 2
H 2
I 4
J 0

EXERCISE # 1 Flavor A

1. Choice of Providers & Services
2. Individualized Services
3. Comprehensive Array of Services
4. ~~Choice of Services~~
5. Ongoing Care Mgmt Support
6. Family Centered Care:
7. ~~Needs met according to Hem's perception~~
8. Inclusion, participation - mutual relationships
9. ~~Access/availability for a full array~~
10. Full Range of available services
11. ~~Integrated Care~~

Exercise # 1 Flavor A

12. Advocates for patients:
13. Timely coordination, care
14. Affordability:
15. Network Strength to attract providers
16. Parity
17. Transportation to Services
18. Accessible Information
19. Integrated - No Silos at all levels
20. Innovative Systems
21. ~~Timely Care~~
22. ~~Integration of Policies/Procedures~~
23. Fostering Independency

Ex # 1 Flavor B

#1 Meaningful choice directed by the recipient (10)

#3 Independence + relationships built on trust (4)

Community involvement; feel like you are contributing (1)

#2 Health + wellness (allencompassing) + Quality of Care (supported by) (9)

# EXERCISE #1 Table B

What Defines highest Quality of Life:

Freedom to choose how to live one's life as who they truly are

Choice of Care providers

Confident trust

Quality of Care

Physical well being (acts/health)

Relationships

Continuity of Care

Maximize independence

Supports that are flexible enough/funded enough to meet changing needs

Community Access

Central care co-ord for all needs (inc. mental health)

Access to all required Meds

personal choice as opposed to Government directive

Affordability

Ability to handle outliers

Informed choices

Meaningful choice + control

↳ integration of services to meet your needs

# Combined - Exes 1

Table C

~~Access to appropriate services~~

Right of self determination (10) #2

Funding follows the individual (8) #4

Continuity of care (11) #1

Fluid access to provider #6

Consistent case mangement (1) #5

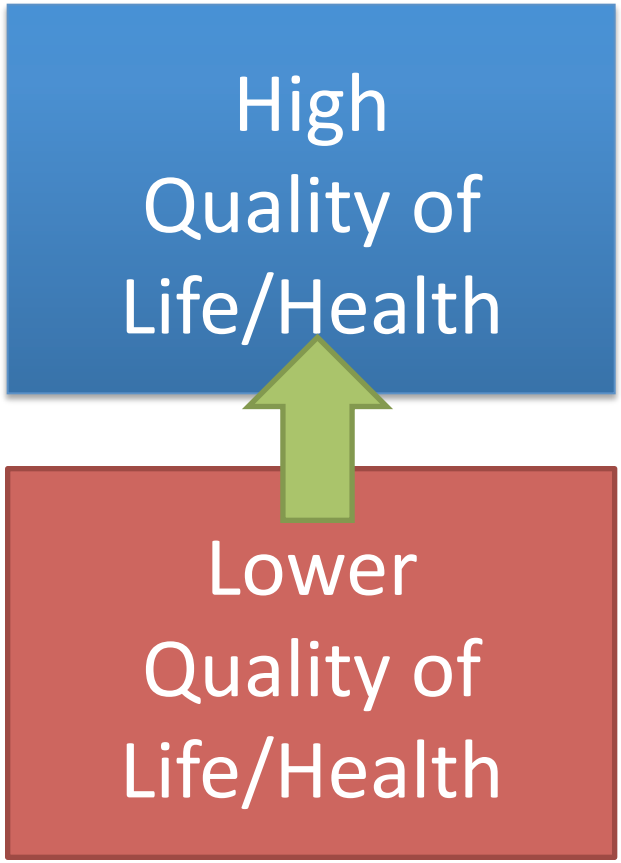
Quality (7) #3

# *Recipient Perspective - Exercise 2*

## What's needed to increase # with high quality of life/health?

**Top issues identified**

- Using best practices.
- Adequate and respectful compensation for providers
- Choices



QUESTION #2

CAREGIVER

A Get out of the way of the team - let the team make the decisions · (2)

B Opportunities for growth ·· (2)

C Local control ·· (2)

D Increase relationship building · (1)

E Have choices ··· (3) #3

C Case management services w/in NH

F Non-institutional environment · (1)

G Best care/practices ····· (5) #1

H Make application process easier · (2)
Less paperwork / less management / more direct care

I Encourage innovation/out of the box ·· (2)

J In accord w/ recipient's values

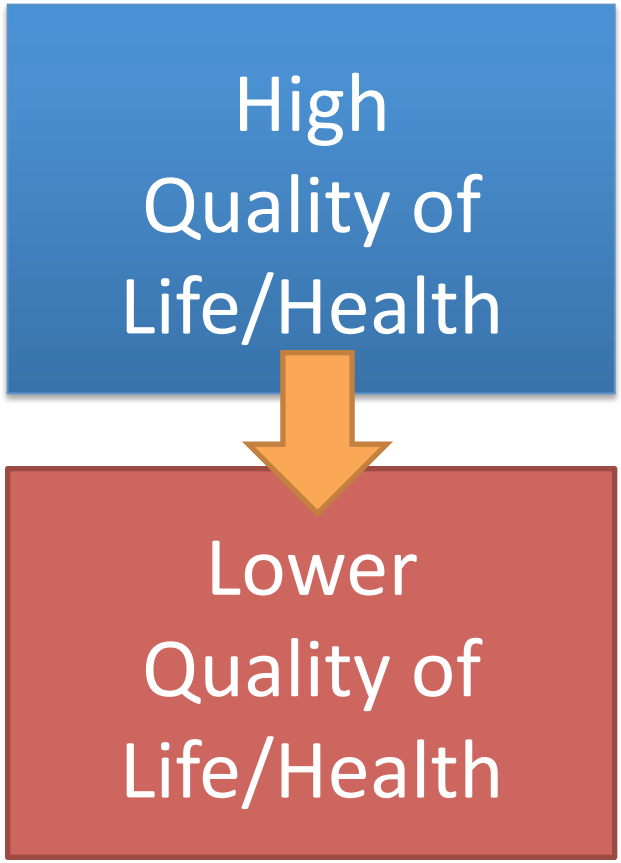
K Adequate, respectful compensation for providers ···· (4) #2

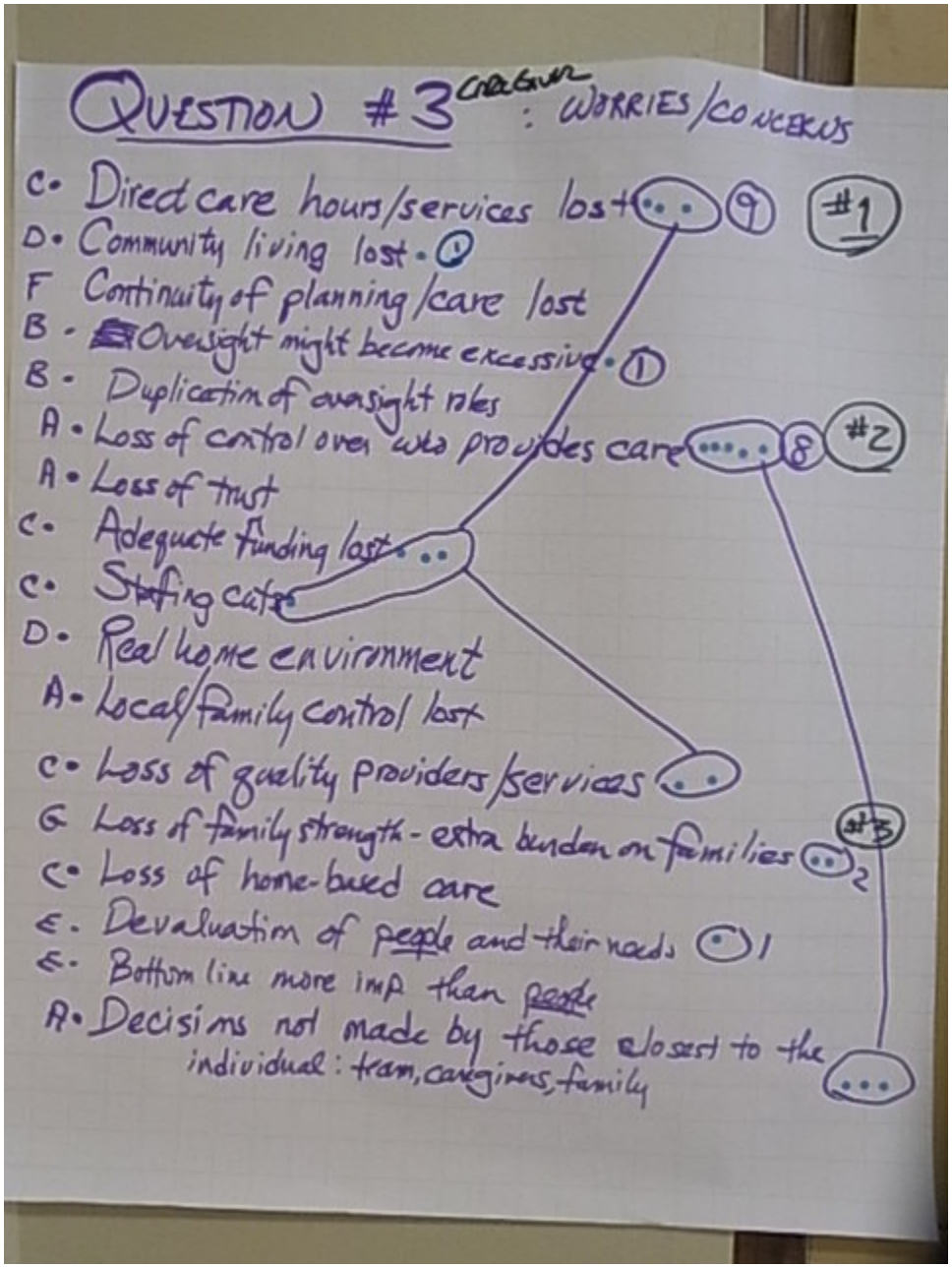
# *Recipient Perspective – Exercise 3*

## Supports you are concerned care management might remove

**Top issues identified**

- Adequate funding and staffing
- Loss of control over who controls the care
- Decisions will not be made by individuals close to caregivers
- Extra burden based on families



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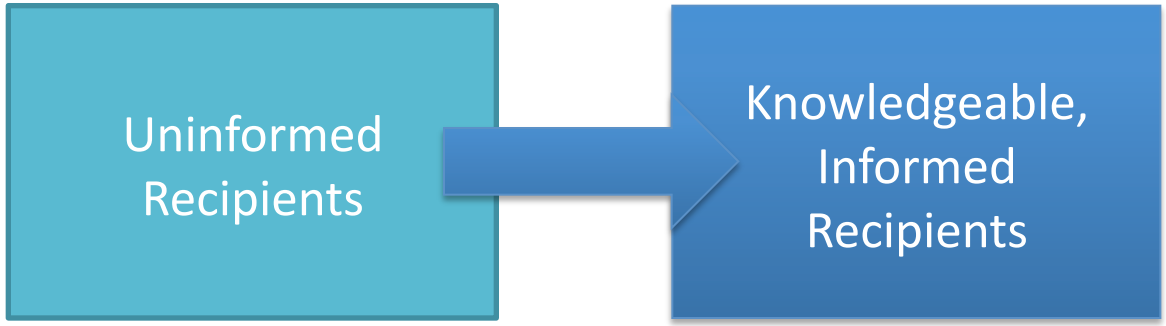
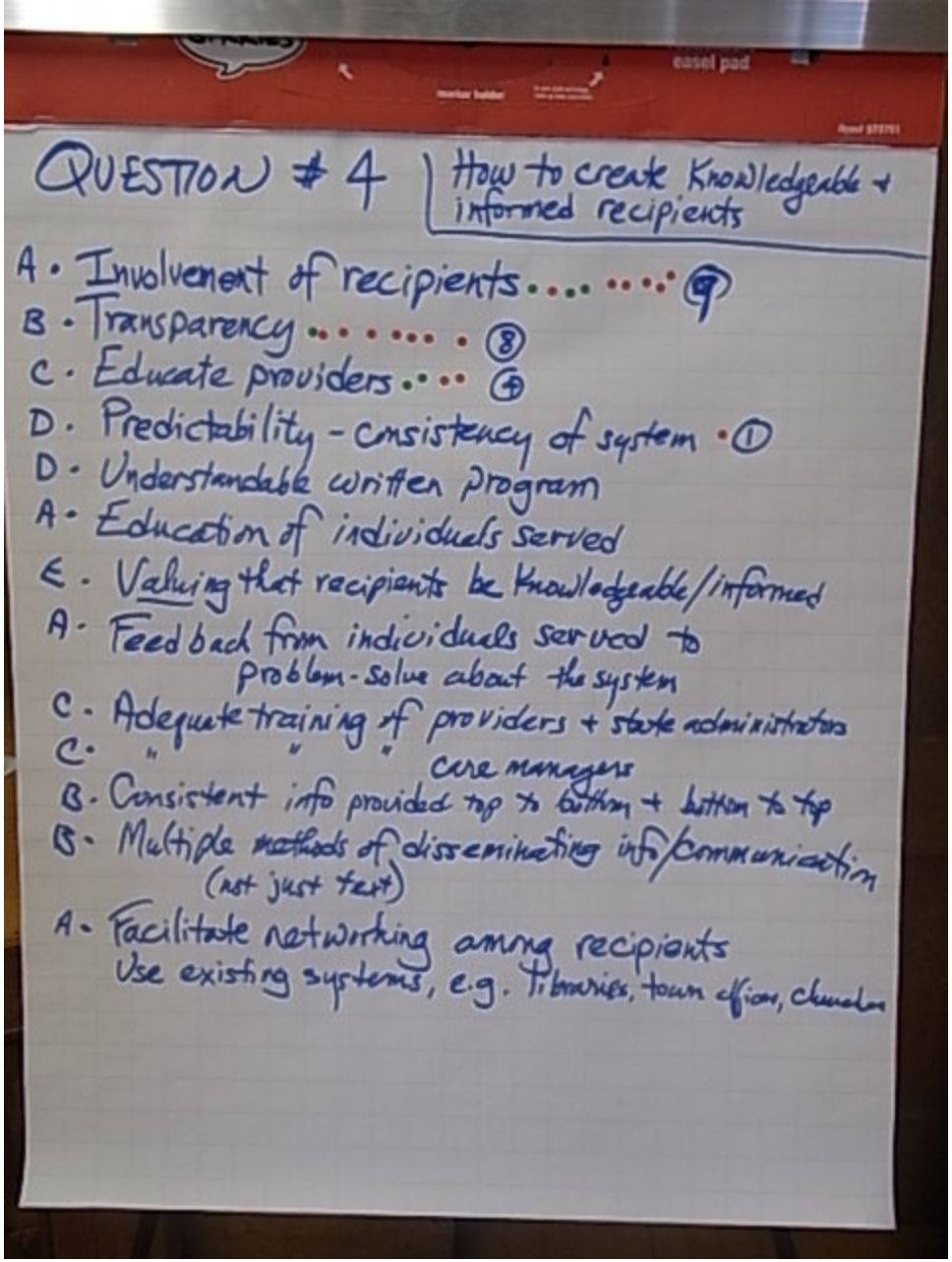
# *Recipient Perspective – Exercise 4*

## What must happen to create knowledgable and informed recipients?

### Top issues identified

- Involvement of the recipients including feedback to problem solve about system
- Facilitated networking among recipients
- Transparency
- Consistency of Information
- Multiple methods of disseminating information
- Education of providers including State Administrators



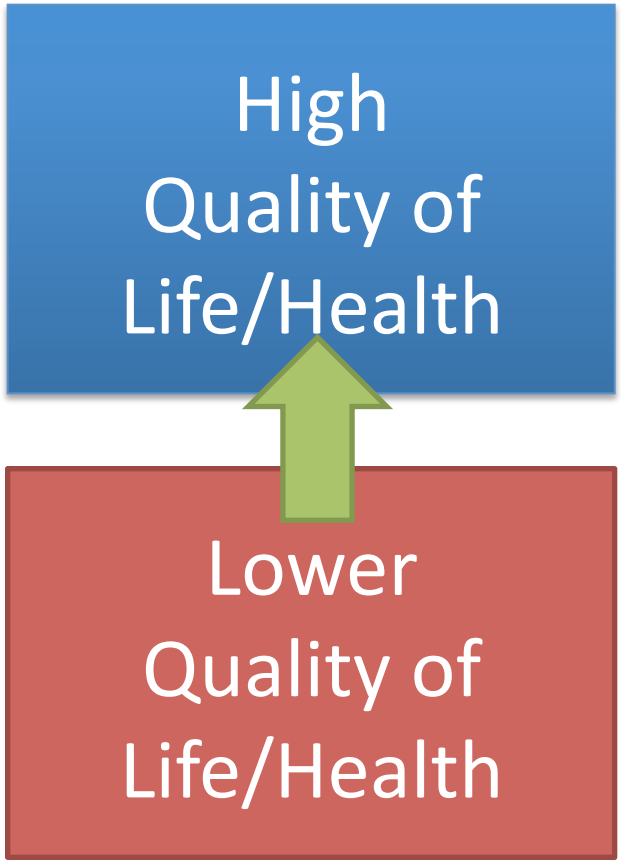

easel pad
QUESTION # 4
How to create Knowledgeable + informed recipients
A. Involvement of recipients ..... 9
B. Transparency ..... 8
C. Educate providers ..... 4
D. Predictability - consistency of system . 1
D. Understandable written program
A. Education of individuals served
E. Valuing that recipients be Knowledgeable/informed
A. Feedback from individuals served to problem-solve about the system
C. Adequate training of providers + state administrators
C. " " " care managers
B. Consistent info provided top to bottom + bottom to top
B. Multiple methods of disseminating info/communication (not just text)
A. Facilitate networking among recipients
Use existing systems, e.g. libraries, town offices, churches

# *Provider Perspective – Exercise 2*

## What's needed to increase # with high quality of life/health

### Top issues identified

- Integrate primary care with mental health, substance abuse, developmental services, nursing, etc
- Including a full array of substance abuse disorder services as part of benefits package
- Centralized, shared, current database of and for providers that is easy to access and shared.
- Eliminating redundancy within provider system to facilitate clear consistent communication
- Utilize technology to improve coordination
- Empower consumers through health literacy standards
- Care coordinator needs to work for the consumer, not for the system
- Choice and flexibility
- Adequate Funding
- Access to Information
- Cover cost of care delivery and administration
- Increased flexibility of programing and funding
- Reduction of barriers to services – a broker who looks at the broader care needs whose decisions are NOT based on finances



EXERCISE 2 Row. D

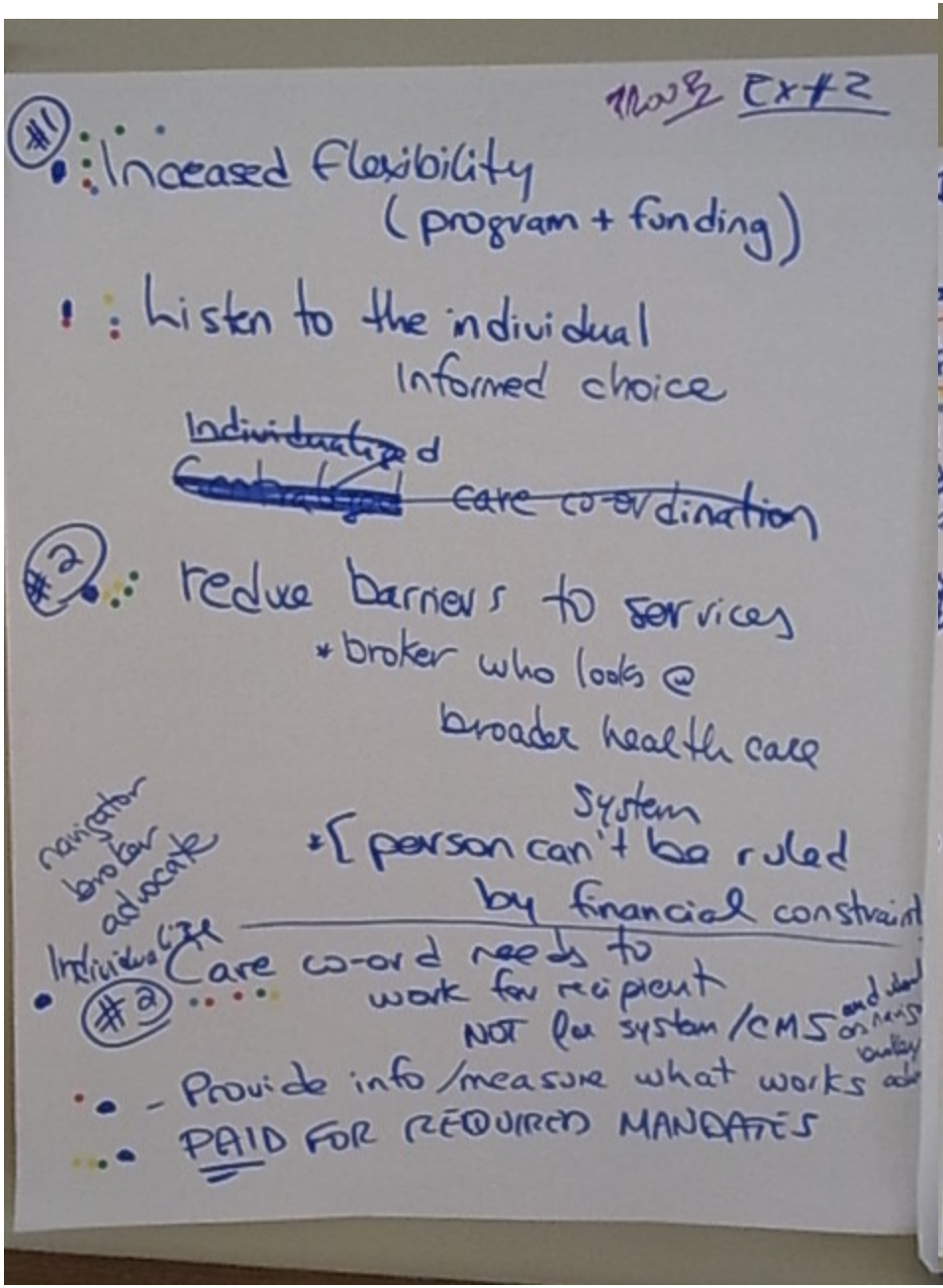
1. Include a full array of Substance Use Disorder services as part of benefits package
2. Improve access (communication/coordination)
3. Integrate primary care with mental health, substance use, developmental services, nursing etc
4. Ensure a comprehensive benefit pkge that encompasses prevention thru Recovery
5. Centralized (nonrepetitive) intake/elligibility
6. Using E Based assessment tools
7. System that is client choice-based
8. Centralized, shared current database of and for providers (easy to access/share)
9. Measurement of outcomes and Quality and cost effectiveness

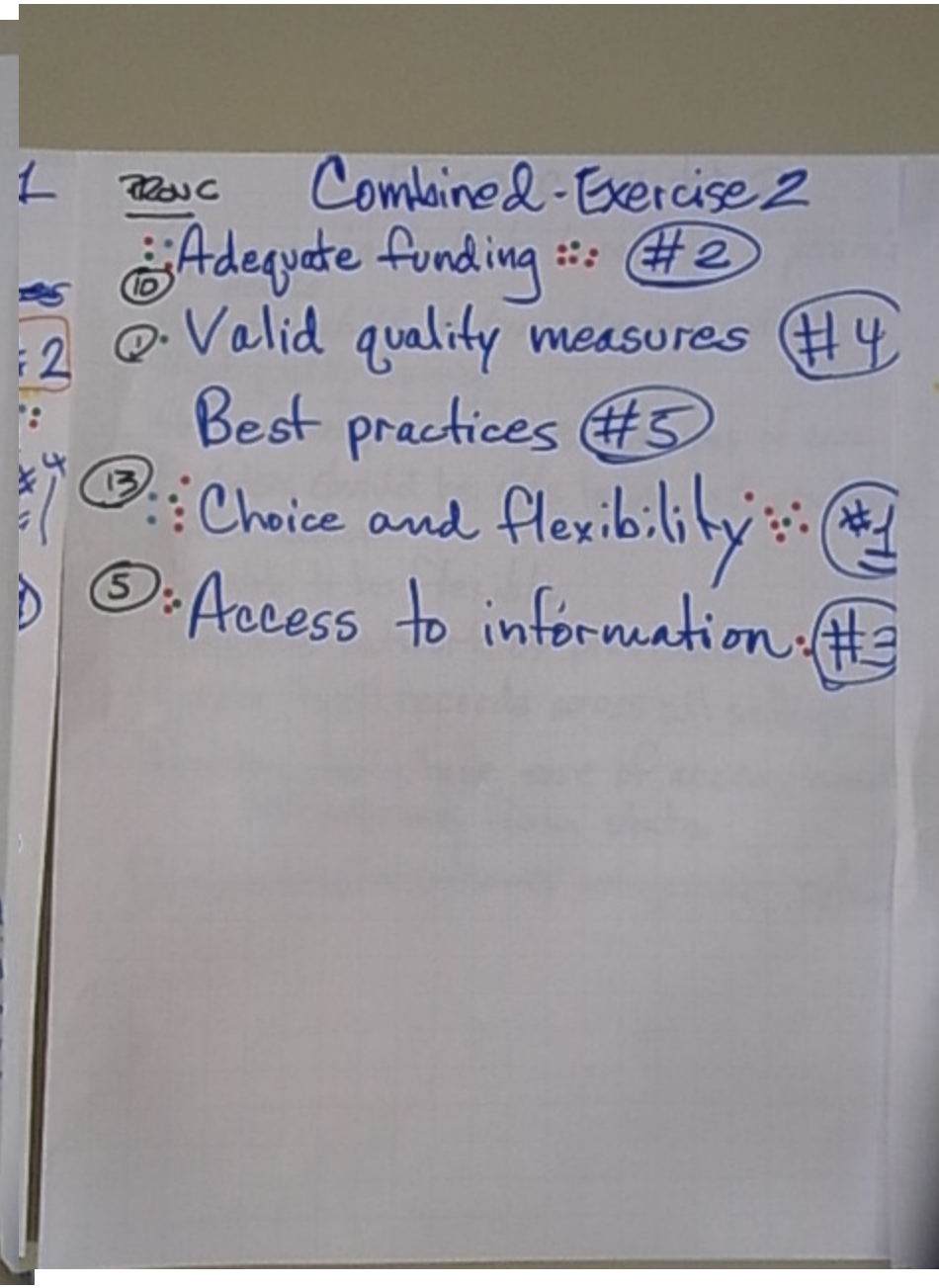
Exercise #2 Row A

1. Control Careplan
2. ~~Share information~~
3. Communication at State Level to ↓ Red Tape
4. System for making referrals in place
5. ~~Provider integration~~ Increased electronic integration for application process
6. Empower consumer through health literacy standards
7. Eliminate redundency in system to facilitate clear consistent communication.
8. ~~Direct access to decision makers~~
9. System must come close to covering costs of care delivery/administration

Exercise #2

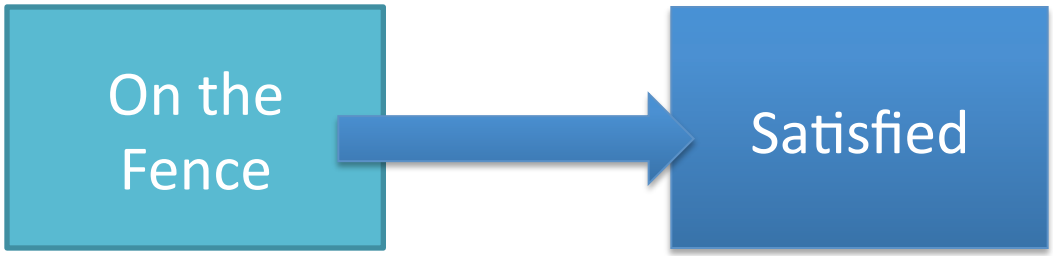
10. Utilize Technology to improve coordination.


Ex #2
#1 Inceased Flexibility
(program + funding)
Listen to the individual
Informed choice
Individualized
care co-ordination
#2 reduce barriers to services
* broker who looks @
broader health care
system
* [ person can't be ruled
by financial constraint
navigator
broker
advocate
Individualize
#2 Care co-ord needs to
work for recipient
NOT for system / CMS
- Provide info / measure what works
PAID FOR REQUIRED MANDATES


Combined - Exercise 2
Adequate funding #2
Valid quality measures #4
Best practices #5
Choice and flexibility #1
Access to information #3

# *Provider Perspective – Exercise 3*

## What's needed to satisfy providers




**Top issues identified**

- Adequate reimbursement *3
- Behavioral health integrated into primary care
- Streamline and simplify licensure and regulatory requirements
- Have the system be patient centered – screening for services not needed, too much admin oversight, appropriate service allocation
  Real time access to authorizations
- Positive and rewarding regulatory framework with low paperwork and respect for quality
- No more unfunded mandates
- Capacity for caregivers to use professional judgment rather than having to
- Availability of resources needed to serve patients
- Reduced bureaucracy

Exercise # 3 Row D

#1 1. Adequate reimbursement for prevention & treatment svcs.

#2 2. Getting behavioral health integrated into primary care

3. Increase capacity to meet patient/client needs and to Decrease wait times

~~5. Adequate funding for prevention svcs.~~

6. Get away from "all or nothing" funding mentality

7. Ability to educate, recruit, and retain qualified staff.

#3 8. Streamline & Simplify licensure reqs & requirements

9. Reduce administrative burden

10. EMR's have to "talk to each other" – State should lead

11. Quality Training

12. Standardized tools across systems

Row A

Exercise # 3

1. Good Customer Service

#2 2. Adequate Reimbursement

3. Clarity of ~~Expectations from funder~~

4. Participation in Creation of Systems

5. Simple Review Process

6. Manageable number of patients per provider

~~7. Access to answers (decision makers)~~

~~8. Adequate resources to complete the careplan (# of visits, disciplines)~~

9. Real time access to authorizations

#3 (avoid last minute non-coverage of necessary services)

~~10. Timely Redetermination~~

11. Good faith practice – continuity coverage

Row B

Ex. #3

12. Patient centered care needs

#1 · screening for SUC's not needed
· too much administrative oversight
· appropriate service allocation

13. Long Term "Block" grant of services guaranteed for longer time frames

14. Simplified Regulations to produce Clarity

15. Dedicated Staff @ State Level + access to decision makers

#3

- Positive/rewarding regulatory system c̄ ↓ paperwork that supports + values quality as much as the rules
- Sufficient reimbursement for required mandates and quality based programming
- Capacity to use prof. judgment vs. justifying each clinical decision
- Independent appeals process
- Better informed expectations to public
- user friendly HMO

#3

Providers need meaningful choice + control

- Payment for required mandates to be able to provide quality care
- Independent appeals process
- Easier access to $ 5 justifying each clinical decision
- less paperwork
- Capacity to use Prof. judgement vs Reg. oversight
- more public education - better informed public/recipients
  [ Better informed expectations to public/recipients ]
- Funding to support quality based HMO that is less adversarial - more issues accountable

#3

- Positive/rewarding regulatory system
- non-rule loving regulators that supports Quality of care

PROVC

# Combined – 3

Consistent access in and out of network #6

- Reduced bureaucracy #3
- Transparency #4
- Accountability #5
- Adequate funding #1
- Availability of resources needed #2

# *Provider Perspective – Exercise 4*

## What might create resistant providers

**Top issues identified**

- **Reduced reimbursement**
- Reduced access to medically necessary services
- Reduced client safety
- Reduction in funds – costs become more important than quality…unmet individual needs…NCO profit margins
- Uncertainty regarding long term success and vendors…Undoing of a cost effective system that works
- Decline in positive outcomes and client satisfaction
- Limited scope of services provided and length of availability diminished
- Expectations that providers deliver with inadequate resources
- Bonuses and incentives paid to gatekeepers for denials of care
- Arbitrary decisions about who gets care

Exercise #4

1. Inadequate reimbursement
2. Too much paperwork
3. Arbitrary decisions about who meets eligibility requirements (Complicated PA process) (2)
4. Inadequate benefit package
5. Expectation that providers deliver services w/o adequate resources, (1)
6. Cost of MCO admin further reduces available $ for svcs.
7. Bonuses & incentives pd. to gatekeepers for denial of care (1)

Ex. #4 Row A

1a. Add'l Admin costs to appeal denial decisions
1b. More people denied services will stress town gov't systems

Exercise #4

1. Mismanagement
2. No phone calls back when asking questions
3. Rules applied differently for certain providers
4. Care not patient centered
5. ~~Inadequate care plans~~ (#1)
6. Inadequate reimbursement (4)
7. Blaming Provider when things go wrong (2)
8. Lack of clarity in regulations - open for interpretation. (2)
9. Perception of care mgmt's profit motive - will this cost cut into patient's benefit (#2)
10. Limited Scope of Services provided and length available. (4)
11. Lack of ability to make care mgmt decisions

Post-it Easel Pad
Tableau à feuilles mobiles
Block de Hojas Reposicionables

#2 Decline in positive outcomes #4
and client satisfaction

#1 Insufficiency of funds;
reduction
- costs 1° vs quality of care
- capitated system ∅ meet ind. needs
- HMO profit margin takes away from avail funds
- narrowing of client eligibility 2nd limited funds

#3 Uncertainty regarding long term success + available vendors + savings
reduction

Onerous regulations designed to ↓ access & hostile communications towards providers

Undoing of a cost effective DD system that works

Hostile Communication towards the providers #4

if you are interested in quality ASK A CRAFTSMAN NOT a quality expert

Decline in outcome measures

onerous regulations who's 1° job is to limit access to services

Decline in positive outcome

small rural state's ability to attract/retain an HMO

Decline recipient sastifaction

Profit margin to HMO vendor will ↓ available resources

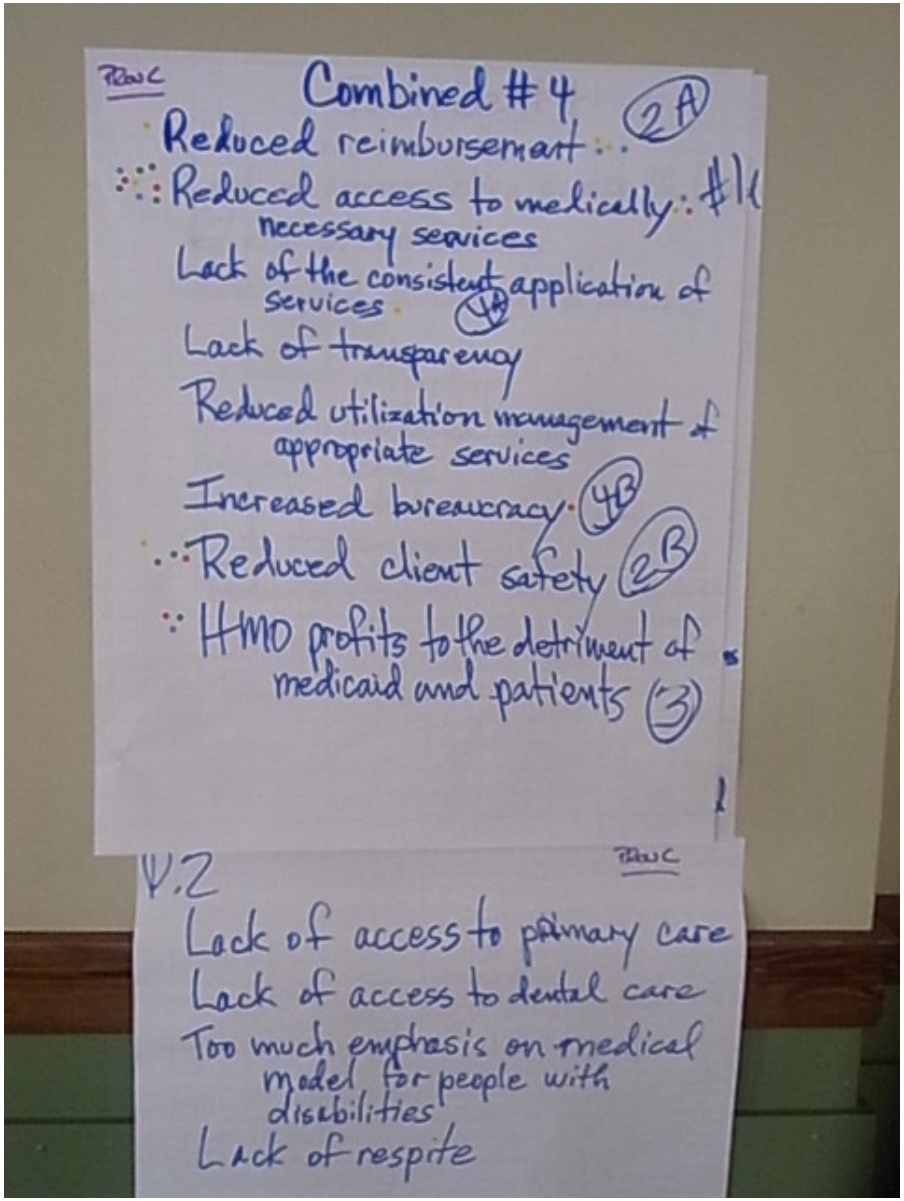
Costs will be 1° factor

Capitated system won't meet Ding needs or provide flexibility

Narrowing of client eligibility (2nd profit margin)

Replacement of a working system that's cost effective that can't be undone if it ∅ work

Uncertainty of savings (upfront costs)


Combined #4
Reduced reimbursement
Reduced access to medically necessary services
Lack of the consistent application of services
Lack of transparency
Reduced utilization management of appropriate services
Increased bureaucracy
Reduced client safety
HMO profits to the detriment of medicaid and patients
Lack of access to primary care
Lack of access to dental care
Too much emphasis on medical model for people with disabilities
Lack of respite