



**New Hampshire Department of Health and Human Services
Medicaid Care Management Program**

**Step Two Update: Final Draft of Design Considerations for
Mandatory Enrollment and Integration of Choices for
Independence [CFI] Waiver Services**

February 25, 2015

Overview of New Hampshire's Medicaid Care Management Program



- Mandated by Senate Bill 147 and signed into law in June 2011
- The Department of Health and Human Services contracts with two health plans to provide services to program enrollees: (1) New Hampshire Healthy Families, and (2) Well Sense Health Plan
- **Step 1** of the program began on December 1, 2013
 - Most but not all Medicaid recipients were required to enroll with a health plan for their **medical services**, which include services such as doctors visits, pharmacy services, hospital care, therapies, etc.
- **In Step 2** of the program
 - Most Medicaid recipients who were not required to enroll with a health plan for their medical services in 2013 will now be required to enroll with a health plan for their medical services [referred to as **mandatory enrollment**].
 - Long term services and supports will be integrated into the Medicaid Care Management program



Guiding Principles: New Hampshire Medicaid Care Management Program



Whole Person Approach with emphasis on the individual and family and integration of medical, behavioral and long term services and supports and the social determinants of health.

Services and supports are driven by person centered planning processes and principles. Care is coordinated across medical, behavioral health, psychosocial and long term supports and services domains.

Improved Quality with emphasis on improved experience of care and improved health of NH's population.

Home and Community Based Care as a primary source of managed long term services and supports.

Improved Cost Effectiveness through reducing and better managing the costs of health care to ensure sustainability of the Medicaid program to meet future needs of NH citizens.



How will New Hampshire citizens benefit from the Care Coordination Provided by the Medicaid Care Management Program?

A Whole Person Approach for NH's Medicaid Program

- Provide **Care Coordination** for all facets of an individual's supports, including medical, behavioral health care, psychosocial and long term services and supports
- Prevent the need for more intensive supports and services whenever possible
- Improve transitions of care
- Develop the most efficient and effective health and long term services and supports possible
- Ensure sustainability of the Medicaid program to meet future needs of New Hampshire citizens
- Impact positively the social determinants of health



What is Care Coordination?

The deliberate organization of activities between two or more participants, with the individual at the center, involved in an individual's services and supports to facilitate the appropriate delivery of medical, behavioral, psychosocial and long term services and supports.

Organizing care involves the marshaling of personnel and other resources needed to carry out all required services and supports, and requires the exchange of information among participants responsible for different aspects of care.



What are the Long Term Services and Supports that are included in Step 2?

- Choices for Independence Waiver (CFI) Services
- Nursing Facility Services
- Developmental Disabilities Waiver (DD) Services
- Acquired Brain Disorders Waiver (ABD) Services
- In Home Supports for Children with Developmental Disabilities Waiver (IHS) Services
- Services provided to children and families associated with the Division for Children, Youth & Families



Stakeholder Input Regarding Guiding Principles

DHHS greatly appreciates the input and suggestions of the many stakeholder groups that have submitted Guiding Principles, Guidelines and Recommendations for the integration of Long Term Services and Supports into the NH Care Management Program, including:

- Governor's Commission on Medicaid Care Management
- Granite State Home Health Association
- NH Health Care Association
- NH Association of Counties
- Nursing Home Affiliate
- Developmental Services Quality Council
- Brain Injury Association of NH
- Interested Stakeholders: AARP, Disabilities Rights Center-NH, NH Legal Assistance, Heritage Case Management, NH Council on Developmental Disabilities, NH Academy of Family Physicians, EngAging, NH, LifeCoping, Harbor Homes, Inc., Granite State Independent Living, New Futures, NH Family Voices, Tri-County CAP



Guidelines, Principles and Recommendations

DHHS has aligned its work in Step 2 planning and implementation in keeping with all applicable state/federal statutes and regulations as well as:

Medicaid Managed Care for People with Disabilities, National Council on Disability:
<http://www.ncd.gov/publications/2013/20130315/>

Governor's Commission on Medicaid Care Management: Guiding Principles:
<http://www.governor.nh.gov/commissions-task-forces/medicaid-care/documents/mm-2014-mltss-principles.pdf>

National Senior Citizens Law Center: Advocate's Library of Managed Long Term Services and Supports Contract Provisions: <http://www.nsclc.org/index.php/ltss-contracts-index-appeals-notices/>

Summary - Essential Elements of Managed Long Term Services and Supports Programs, Centers for Medicare & Medicaid Services:
<http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSS-Summary-Elements.pdf>



Stakeholder Input

DHHS also greatly appreciates the input and suggestions of the many stakeholders that attended stakeholder forums held across the state between July 2014 through January 2015. Over 1000 stakeholders were engaged. Some examples of how the Department has responded to Stakeholder input in its Final Draft Design Considerations include:

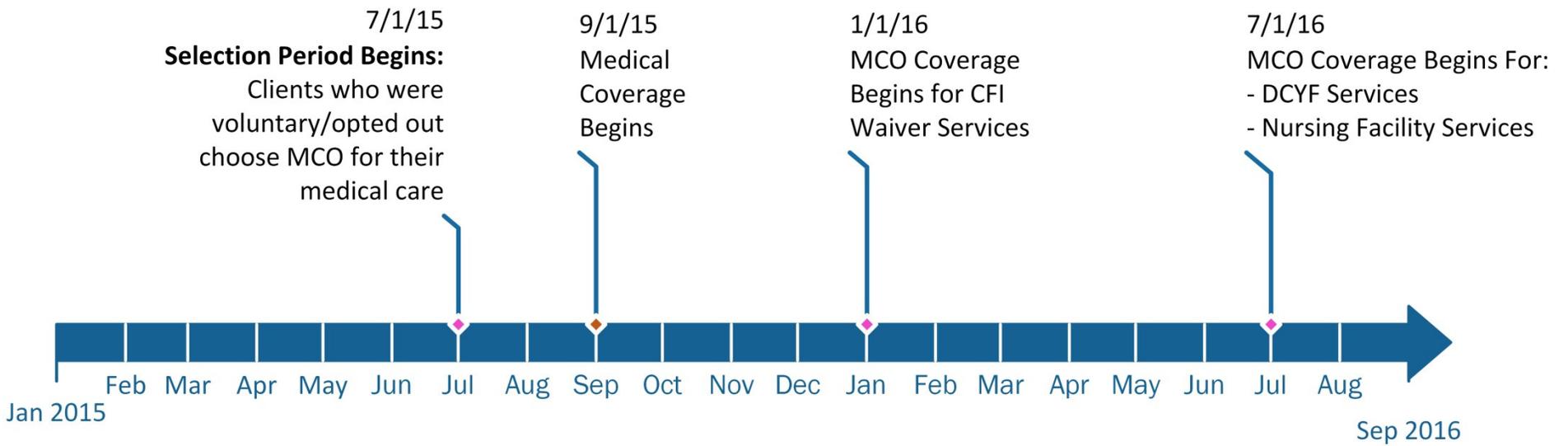
- Providing more time for implementation of Step 2
- The importance of retaining clinical and financial eligibility determination within the Department
- Rate stability in Year 1 of Step 2
- Integration of Conflict Free Case Management Principles
- Safeguards regarding transfers and discharges from long term care settings
- Contract requirements regarding Quality Measures
- DHHS approval of potential reductions in services in Year 1 of Step 2



The Step 2 Timeline: Updated

- Starting on July 1, 2015, all Medicaid recipients who were considered voluntary in the Care Management Program [including those who opted out] will be required to select a Managed Care Organization [MCO] for their **medical care**.
 - **Individuals with Medicaid and Medicare coverage [Dual Eligible Population]**
 - **Home Care for Children with Severe Disabilities [HC-CSD] more commonly known as Katie Beckett**
 - **Children with special health care needs enrolled in Special Medical Services/Partners in Health**
 - **Children with Supplemental Security Income**
 - **Foster Care Population**
 - **Native Americans, Native Alaskans**
- On September 1, 2015 coverage for medical care under the MCO begins for all of the above populations.
- On January 1, 2016, Choices for Independence Waiver Services will be integrated into the Care Management Program.





Dates To Be Determined:
MCO Coverage for remaining waiver services:

- Development Disabilities
- Acquired Brain Disorder
- In Home Supports



Who will determine eligibility for the Choices for Independence Waiver services?

The Department of Health and Human Services will maintain responsibility for determining eligibility and for redetermination of eligibility for Choices for Independence Waiver services



The Department will continue to determine eligibility and perform redeterminations for Choices for Independence Waiver services



How will my Choices for Independence Waiver services be authorized, and by whom?

The health plans will authorize Choices for Independence Waiver services based upon criteria approved by the Department

Current Approach in Fee for Service Program

- The Department authorizes the services that individuals receive on the Choices for Independence Waiver

Step 2 Year 1 of Care Management

- Current service authorizations are honored by health plans until their expiration date, unless the individual's needs change
- The health plans utilize the criteria approved by the Department to authorize coverage of Choice for Independence Waiver services for new enrollees.
- The Department reviews, and if appropriate, authorizes reductions to services recommended by a health plan during the first year
- The administrative rules and laws pertaining to transfers and discharges, such as RSA 151:26, will continue to apply

On-Going

- The health plans authorize the services that individuals receive on the Choices for Independence Waiver



Who will help me manage and coordinate my Choices for Independence Waiver services with my other supports and services?

The health plans provide care coordination in a conflict free manner based upon criteria approved by the Department

Current Approach in Fee for Service Program

- The health plans are responsible for coordinating medical and behavioral health services for people who are enrolled with a health plan
- The Department is responsible for coordinating care for long term services and supports

Step 2 Year 1 of Care Management

- The health plans coordinate the integration of medical, behavioral health, psychosocial and long term supports and services using a whole person approach, in accordance with NH DHHS conflict free case management principles
- The health plans may offer contracts to all willing Choices for Independence case management agencies

On-Going

- The health plans coordinate the integration of medical, behavioral health, psychosocial and long term services and supports using a whole person approach, in accordance with NH DHHS conflict free case management principles



How will existing Choices for Independence Waiver service providers operate as part of the health plan's provider network?

How will payment rates be determined?

The health plans may offer contracts to all willing Choices for Independence service providers

Current Approach in Fee for Service Program

- The Department enrolls approved Choices for Independence Waiver service providers
- The Department sets reimbursement rates for Choices for Independence Waiver services

Step 2 Year 1 of Care Management

- The health plans may offer contracts to all willing Choices for Independence Waiver service providers.
- Reimbursement rates are equal to the Department's current fee schedule

On-Going

- The health plans contract with Choices for Independence service providers based on network needs and provider performance
- Reimbursement rates will be negotiated between providers and health plans



Will there be an option to manage my own budget for Choices for Independence Waiver services?

Consumer-direction of budgets will be introduced as an option within the Choices for Independence Waiver

Current Approach in Fee for Service Program

- Consumer direction for budget management is not currently a service offered within the Choices for Independence Waiver

Step 2 Year 1 of Care Management

- The Department will develop a consumer directed and managed long term services and supports option for the Choices for Independence Waiver
- Stakeholder input will be sought
- The Department will request approval for this new service from the Centers for Medicare & Medicaid Services

Ongoing

- The health plans will implement a consumer directed and managed long term services and supports option within the Choices for Independence Waiver after approval from the Centers for Medicare & Medicaid Services



For More Information on Step 2 Planning and Implementation

For more information about Step 2 of the Medicaid Care Management Program, please go to:

<http://www.dhhs.state.nh.us/ombp/caremgmt/step2.htm>

As dates for the Stakeholder Input Sessions are finalized, you will find details at: <http://www.dhhs.state.nh.us/ombp/caremgmt/step2.htm>

To provide information or input, please use this dedicated email address:
beasmcmstep2@dhhs.state.nh.us

