



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

Step Two Update:

**Mandatory Enrollment and Integration of Choices for
Independence Waiver and Nursing Facility Services**

November 26, 2014

Why is New Hampshire moving its Medicaid Program into a Managed Care Model?

- An aging population and increased demand for Medicaid services will significantly impact the Medicaid program in New Hampshire
- New Hampshire's population is aging, with the largest impact set to occur after 2020
- Specifically, Medicaid expenditures for care for people over age 65 are projected to increase by approximately 50% by 2030
- In New Hampshire, approximately 25% of the Medicaid population drives 70% of the spending
- As a result, a change to the system is needed in order to sustain the current level of services

Source: "Aging, Managed Care and the Long Term Care System" Presentation by New Hampshire Center for Public Policy Studies to New Hampshire's Commission on Medicaid Care Management, May 1, 2014. Available at http://www.nhpolicy.org/UploadedFiles/Resources/050114_Managed_Care_Commission.pps

Source: "2013 Actuarial Report on the Financial Outlook for Medicaid" by Centers for Medicare & Medicaid Services (CMS). Available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/medicaidReport2013.pdf>



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

A Whole Person Approach

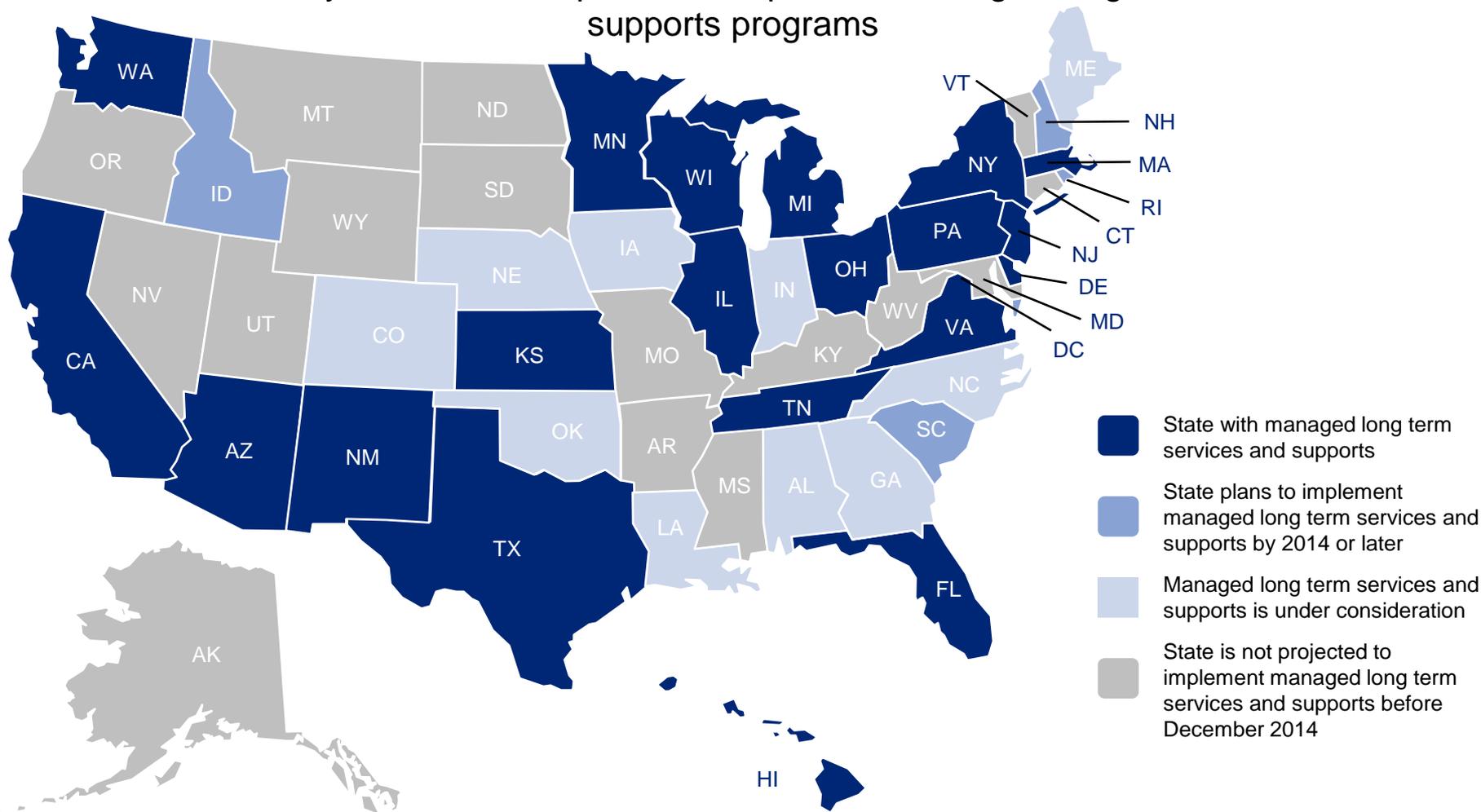
- Integrate all facets of an individual's care, including medical care, behavioral health care, and long term services and supports
- Prevent the need for more intensive medical and/or long term services and supports whenever possible
- Improve transitions of care
- Develop the most efficient and effective 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

A New Approach for NH's Medicaid Program



Because of the increase in demand for Medicaid services, many other states are moving their long term services and supports into managed care

24 states currently have or are expected to implement managed long term services and supports programs



Source: "MLTSS— a 360° view" presentation, National Association of States United for Aging and Disabilities 2014 HCBS Conference by Camille Dobson, Deputy Executive Director. Available at <http://nasuad.org/sites/nasuad/files/MLTSS%20Intensive%20-%20Dobson.pdf>

November 26, 2014



Overview of New Hampshire's Medicaid Care Management Program

- Mandated by New Hampshire 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



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

- Nursing Facility Stays **and** All Four of New Hampshire's Home and Community Based Care Waivers **and** Services provided through the Division for Children, Youth & Families:
 - Nursing Facility Stays
 - Choices for Independence Waiver (CFI)
 - Developmental Disabilities Waiver (DD)
 - Acquired Brain Disorders Waiver (ABD)
 - In Home Supports for Children with Developmental Disabilities Waiver (IHS)
 - Services provided to children and families associated with the Division for Children, Youth & Families



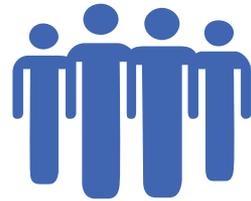
Planning for Change

- New Hampshire's development and implementation of managed long term services and supports aligns with federal principles for integrating services into managed care
 - Adequate Planning
 - Stakeholder Engagement
 - Enhanced Provision of Home and Community Based Services
 - Alignment of Payment Structures and Goals
 - Support for Beneficiaries
 - Person-centered Processes
 - Comprehensive, Integrated Service Package
 - Qualified Providers
 - Participant Protections
 - Quality

Source: "Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs" by Centers for Medicare & Medicaid Services (CMS). Available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf>



Stakeholder Engagement



Stakeholder Engagement Process Overview

- From July to October 2014, the Department of Health and Human Services hosted a series of stakeholder input sessions focused on Step 2 of the Medicaid Care Management Program. More than 850 key stakeholders were engaged
- During these sessions, the Department sought feedback from stakeholders using three key questions:
 - What works for you now in terms of how your Medicaid services are provided and what should be continued?
 - What are the “lessons learned” during Step1 implementation that we should consider for Step 2 planning and implementation?
 - What do you think should be included in a Step 2 Quality Strategy? What are the most important things that should be measured to make sure that the program is working well?



Themes from Stakeholder Forums Regarding Mandatory Enrollment in the Medicaid Care Management Program

- Will I be able to see the full provider list for each plan before choosing a plan?
- Where can I find this information?
- Does the list of providers include if they are accepting new patients?
- How will the program work with my primary insurance?
- Will the plans allow me to access specialized medical services in Boston?
- When enrolling with a provider, what information should I be prepared to share?
- Will existing prior authorizations be honored particularly for medications, durable medical equipment and specialized medical care?
- Will I receive information and support from my plan to help me understand their process along with who to call if I encounter any issues or concerns?
- What if I enroll with one health plan for my medical care but find I want to switch to the other for my long term services and supports?
- The need for more time for planning and implementation
- Will the health plans understand the complex medical needs of individuals with disabilities?



Themes from Stakeholder Forums for the Choices for Independence Waiver and Nursing Facility Services

- The Department of Health and Human Services held **12** input sessions specific to the Choices for Independence Waiver and Nursing Facility services which were attended by over **325** stakeholders
- Common themes heard from stakeholders include:
 - How eligibility for services will be determined
 - The prior authorization process that will be followed, including timeliness and frequency
 - Emphasis on the need for a process that considers individuals' complex long term care needs and must be different from the prior authorization process for acute medical care
 - The need for the Department to educate the health plans about long term services and supports and its programs
 - How health plans will be instructed with respect to contracting, network adequacy, etc.
 - The need to train providers and prepare them for the contracting process and new environment
 - The rates that will be paid by the health plans to service providers
 - The need for more time for planning and implementation



Stakeholder Engagement Process Overview

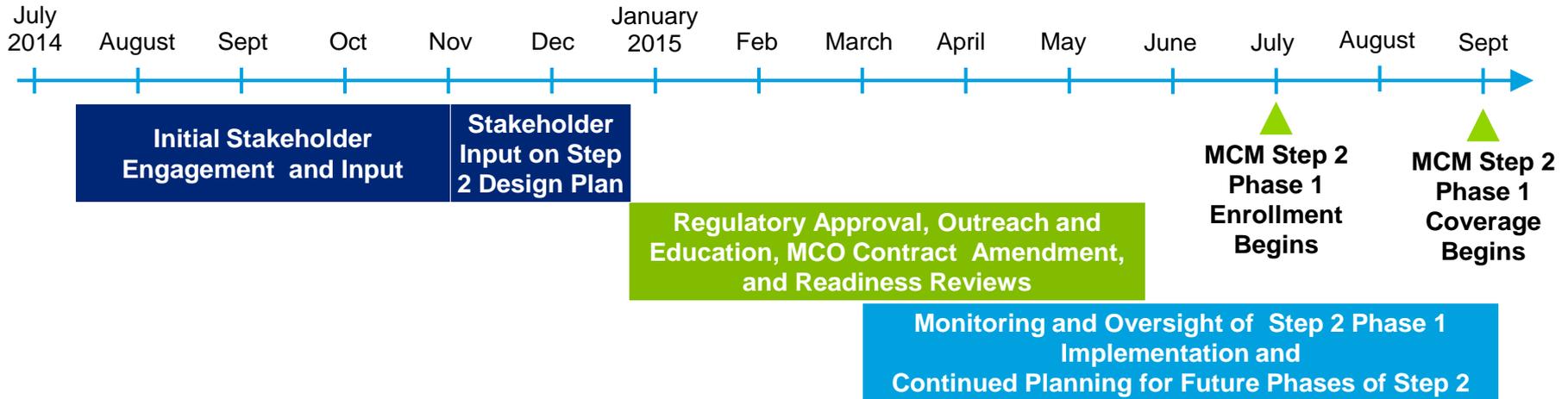
Follow Up:

As a result of stakeholder input, the Department of Health and Human Services adjusted the timeline for Step 2 Mandatory Enrollment and integration of Choices for Independence Waiver and Nursing Facility services to allow more time for input and planning

- A summary of comments and questions received from the stakeholder engagement process is available online on the Step 2 Medicaid Care Management website
- The Step 2 Medicaid Care Management website is <http://www.dhhs.nh.gov/ombp/caremgt/step2.htm>



Medicaid Care Management Step 2 Timeline Updated November 2014



- **Stakeholder Input Process: July to December 2014**

- Initial Stakeholder Engagement and Input completed in October 2014
- Additional forums will be held to elicit stakeholder feedback on the Step 2 Design Considerations in November and December of 2014

- **Step 2 Phase 1:**

- On **July 1, 2015**, require all populations to enroll with a health plan for their medical services, Choices for Independence Waiver services and Nursing Facility stays
- On **September 1, 2015**, coverage with the health plan begins for their medical services, Choices for Independence Waiver services and Nursing Facility stays



Stakeholder Engagement Process Overview

Next Steps:

- DHHS has developed a Concept Paper for Mandatory Enrollment and integration of Choices for Independence Waiver and Nursing Facility services into the Medicaid Care Management Program, which is available online on the Step 2 Medicaid Care Management website
- DHHS is hosting stakeholder input sessions for feedback on the concepts and plan starting in November 2014. A schedule of forums can be found online on the Step 2 Medicaid Care Management website
- During these sessions, the Department will seek feedback from the public on key concepts and the proposed phased plan for:
 - Mandatory Enrollment into the Medicaid Care Management Program
 - Integration of Choices for Independence Waiver and Nursing Facility services into the Medicaid Care Management Program



Key Design Considerations for Mandatory Enrollment



Step 2 Mandatory Enrollment

- The following populations will be required to enroll with a health plan for their medical care **effective July 1, 2015** and coverage begins September 1, 2015
 - Foster Care Population
 - Medicare Dual Eligible Population
 - Home Care for Children with Severe Disabilities
 - Children with special health care needs enrolled in Special Medical Services / Partners in Health
 - Children with Supplemental Security Income
 - Native Americans, Native Alaskans



**Key Design Considerations for Integration of
Choices for Independence Waiver
and Nursing Facility Services into
the Medicaid Care Management Program**



Fundamental Principles of Medicaid Care Management Step 2 Planning and Implementation

A Whole Person Approach

Build on the **strengths and successes** of the current long term services and supports system in New Hampshire

Values Based

- Person Centered
- Strong Emphasis on Participant Management and Direction
- Strong Emphasis on Family Support

Provide a **continuum of services and supports** designed to improve health, improve the experience of care and continue to manage costs

Develop **quality measures** based on these principles and recommendations received through stakeholder input including the State Innovation Model process



How will the Long Term Services and Supports I am receiving now change?

- Current Choices for Independence Waiver and Nursing Facility recipients will continue to have access to the services that are currently covered by the Choices for Independence Waiver and Nursing Facilities
- Some of the processes that are in place for authorizing and approving services will change
- The Department realizes that this is a big change and that a gradual approach is necessary
- Integration of long term services and supports into the Medicaid Care Management Program is going to be phased in over two years as described in the next slides
- The Department will review progress and may revise the phased timetable if needed



Who will determine eligibility for the Choices for Independence Waiver and Nursing Facility services?

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



The Department will continue to determine eligibility for Choices for Independence Waiver and Nursing Facility services

Note: Eligibility for the Choices for Independence Waiver and Nursing Facility services are one and the same



**Key Design Considerations for
Choices for Independence
Waiver Services**



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

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

Current

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

Year 1

- Current service authorizations are honored by health plans until their expiration date, unless the individual's needs change
- The health plans authorize the services that individuals receive on the Choices for Independence Waiver
- The Department approves any reduction to service plans 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

Year 2

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



Who will help me manage my Choices for Independence Waiver services?

The **health plans** shall *coordinate* medical and Choices for Independence Waiver care and services in a conflict free manner under the direction of **the Department**

Current

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

Year 1

- The health plans coordinate the integration of medical care and long term services and supports using a whole person approach
- The health plans may offer contracts to current Choices for Independence case management agencies

Year 2

- The health plans coordinate the integration of medical care and long term services and supports using a whole person approach



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?

All Choices for Independence Waiver service providers currently enrolled and meeting criteria will be offered a contract in **Year 1 of Step 2**

Current

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

Year 1

- The health plans offer contracts to all currently enrolled Choices for Independence Waiver service providers who meet applicable requirements from the National Committee for Quality Assurance as approved by the Department
- Reimbursement rates are equal to the Department's current fee schedule

Year 2

- 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 I be allowed 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

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

Year 1

- 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

Year 2

- 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
- The Department will provide oversight and technical assistance as needed regarding consumer direction for budget management

Year 3

- Consumer direction for budget management is fully integrated into the menu of service options within the Choices for Independence Waiver



Key Design Considerations for Nursing Facility Stays



How will my Nursing Facility stays be authorized, and by whom?

The **health plans** shall *authorize* Nursing Facility stays based upon criteria approved by **the Department**

Current

- The Department authorizes Nursing Facility stays

Year 1

- Current service authorizations of Nursing Facility stays are honored by health plans, unless the individual's needs changes
- The health plans authorize coverage of Nursing Facility stays for new members and evaluate the clinical needs of individuals receiving Nursing Facility services under an authorization issued by the Department
- The Department approves any reduction in services recommended by 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

Year 2

- The health plans authorize coverage of Nursing Facility stays



Who will help me manage my Nursing Facility care and services?

The **health plans** shall *coordinate* medical and Nursing Facility care and services under the direction of **the Department**

Current

Year 1

Year 2

- The health plans are responsible for coordinating medical services only for those individuals who are enrolled with a health plan
- Some Nursing Facilities provide care management for residents
- The health plans coordinate members' care, integrating medical care and long term services and supports using a consistent whole person approach



How will existing Nursing Facility service providers operate as part of the health plan's provider network? How will payment rates be determined?

All Nursing Facility service providers currently enrolled and meeting criteria will be offered a contract and payment rates will continue to be calculated by the Department in **Year 1 of Step 2**

Current

- The Department enrolls approved Nursing Facility providers
- The Department sets reimbursement rates for Nursing Facility stays
- The Department utilizes an acuity-based rate setting model, which includes per diem and supplemental payments

Year 1

- Health plans offer contracts to all Nursing Facilities who are currently licensed, Medicaid enrolled, and meet applicable requirements from the National Committee for Quality Assurance as approved by the Department
- Health plans will make payments to nursing facilities as calculated by the Department under an acuity-based payment model

Year 2

- The health plans manage their networks to meet their access and quality requirements
- Reimbursement rates will be negotiated between providers and health plans



Additional Key Design Considerations



How will the New Hampshire Department of Health and Human Services monitor and report on Quality Measures?

- The Department is developing Quality Measures based on recommendations from stakeholders, current Home and Community Based Care Waivers performance measures and national best practices
- The Department will develop a process for monitoring and reporting on Quality Measures similar to the process that exists for Step 1 of the Medicaid Care Management program



What about the design concepts for future phases of Step 2?

- The design concepts for transitioning Developmental Disabilities, Acquired Brain Disorders, and In Home Supports Waiver services into the Medicaid Care Management Program are not reflected in this document and will be presented at a subsequent meeting
 - The Department is expecting more formal input from the NH Bureau of Developmental Services Quality Council on the concept development very soon
- Design concepts for services provided to children and families associated with the Division for Children, Youth & Families are also in development
 - These services will transition along with the Developmental Disabilities, Acquired Brain Disorders and In Home Supports Waiver at a date to be determined



Where can I submit questions and comments about the key concepts and the proposed phased plan for Step 2?

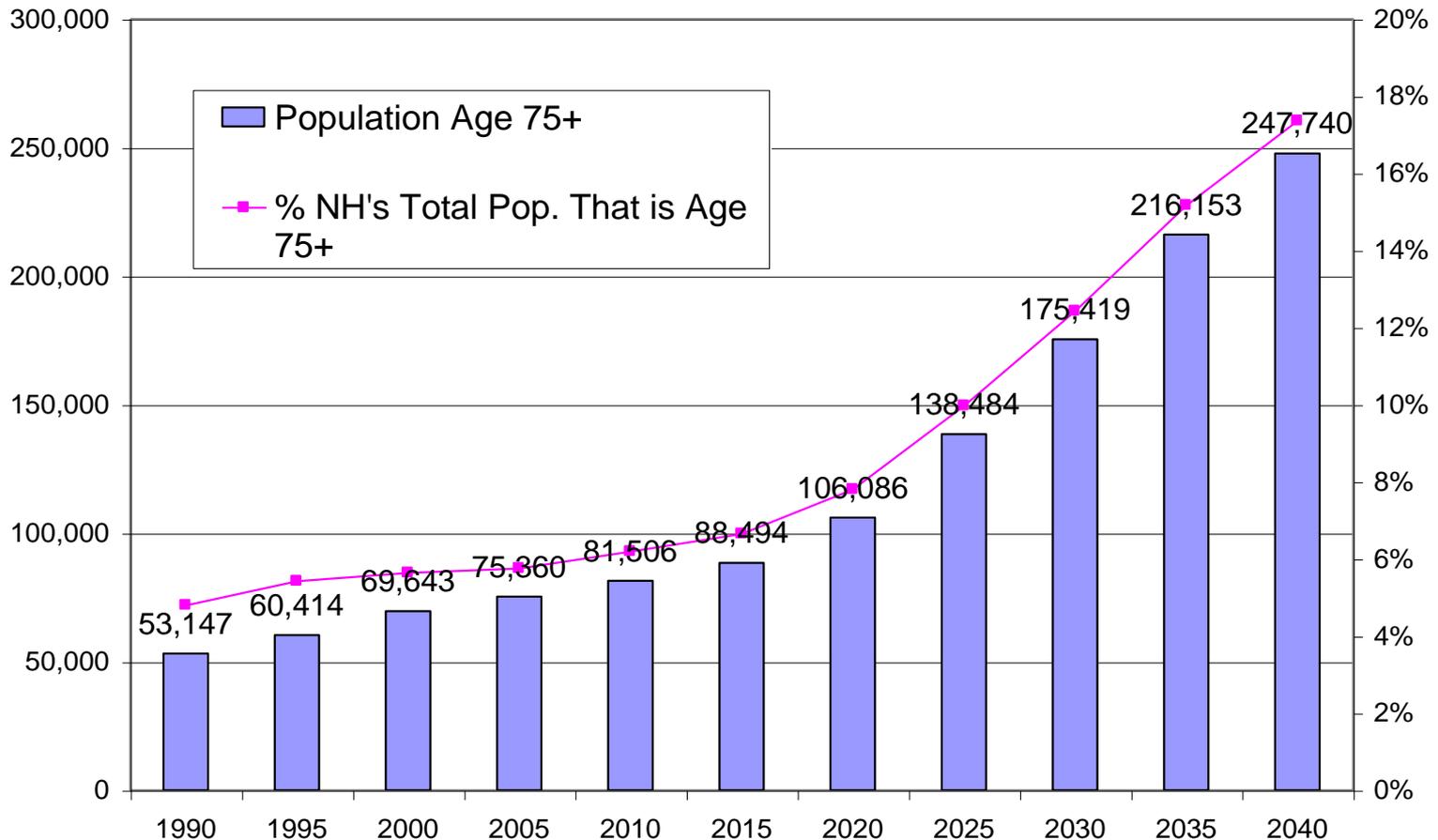
- Attend a public forum. A schedule of forums can be found online on the Step 2 Medicaid Care Management website at:
<http://www.dhhs.nh.gov/ombp/caremgmt/step2.htm>
- Questions regarding Step 2 planning for the Choices for Independence Waiver and Nursing Facility services may be directed to the Bureau of Elderly & Adult Services at: beasmcmstep2@dhhs.state.nh.us
- Questions regarding Step 2 planning for the Developmental Disabilities, Acquired Brain Disorders, and In Home Supports Waiver services may be directed to the NH Developmental Services Quality Council at:
bdsqualitycouncil@dhhs.state.nh.us



Appendix

New Hampshire's Population is Aging

The Largest Impact of Aging will occur after 2020



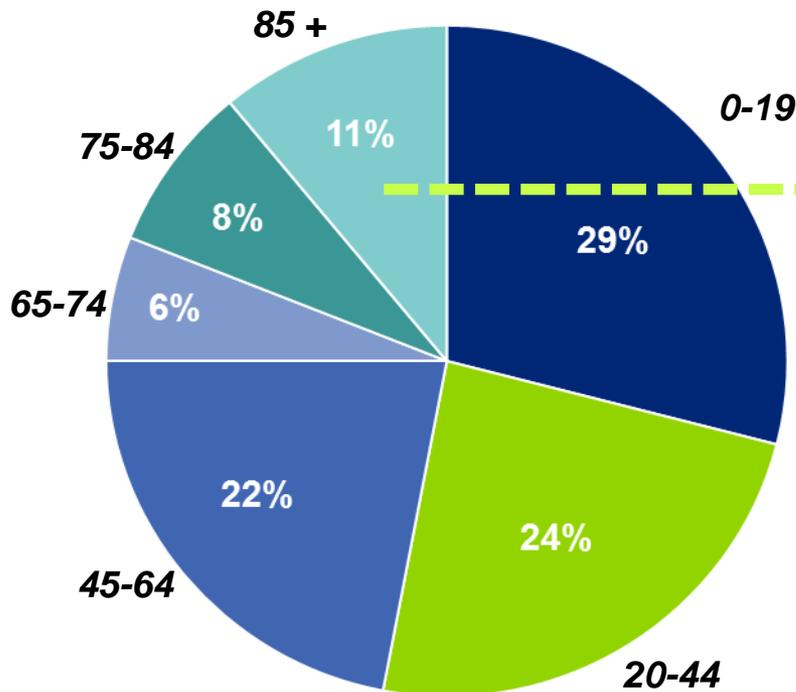
Source: "Aging, Managed Care and the Long Term Care System" Presentation by New Hampshire Center for Public Policy Studies to New Hampshire's Commission on Medicaid Care Management, May 1, 2014. Available at http://www.nhpolicy.org/UploadedFiles/Resources/050114_Managed_Care_Commission.pps



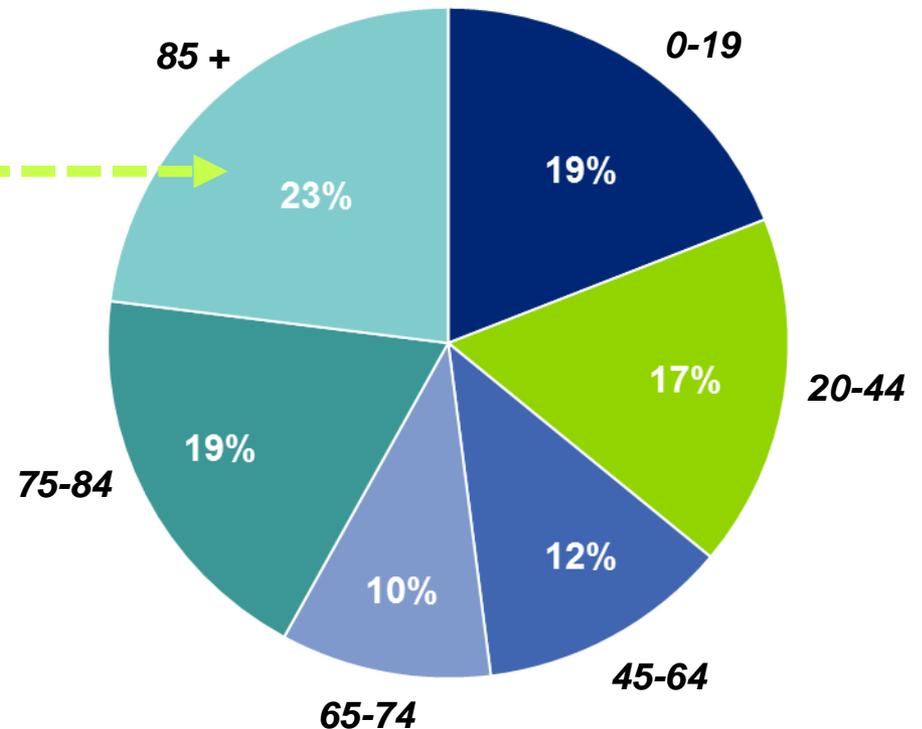
Shifts in Medicaid Spending are Driven by Age and Shifts in Demand for Services

An increasing aging population will strain the Medicaid program

2009 Medicaid Spending by Age



2030 Aged Spending (Based on 2010 data)



Source: "Aging, Managed Care and the Long Term Care System" Presentation by New Hampshire Center for Public Policy Studies to New Hampshire's Commission on Medicaid Care Management, May 1, 2014. Available at http://www.nhpolicy.org/UploadedFiles/Resources/050114_Managed_Care_Commission.pps



Medicaid Sustainability

The Medicaid program is the second largest health program as measured by expenditures (second only to Medicare) and the largest as measured by enrollment nationally

\$432B

Medicaid represents one-sixth of the health economy. In 2012, its outlays of **\$432 billion** accounted for a sizeable portion of Federal and State budgets



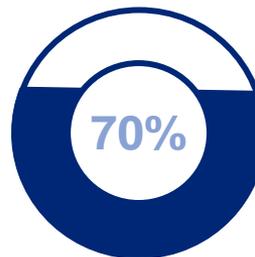
58M

Medicaid serves as a safety net for the Nation's most vulnerable populations, covering nearly **58 million** beneficiaries in 2012



Over the next 10 years, expenditures are projected to increase at an average annual rate of **7.1** percent and to reach \$853.6 billion nationally by 2022

Average enrollment is projected to increase at an average annual rate of **3.3** percent over the next 10 years and to reach 80.9 million nationally in 2022



In New Hampshire, 25% of the Medicaid population drives **70%** of the spending

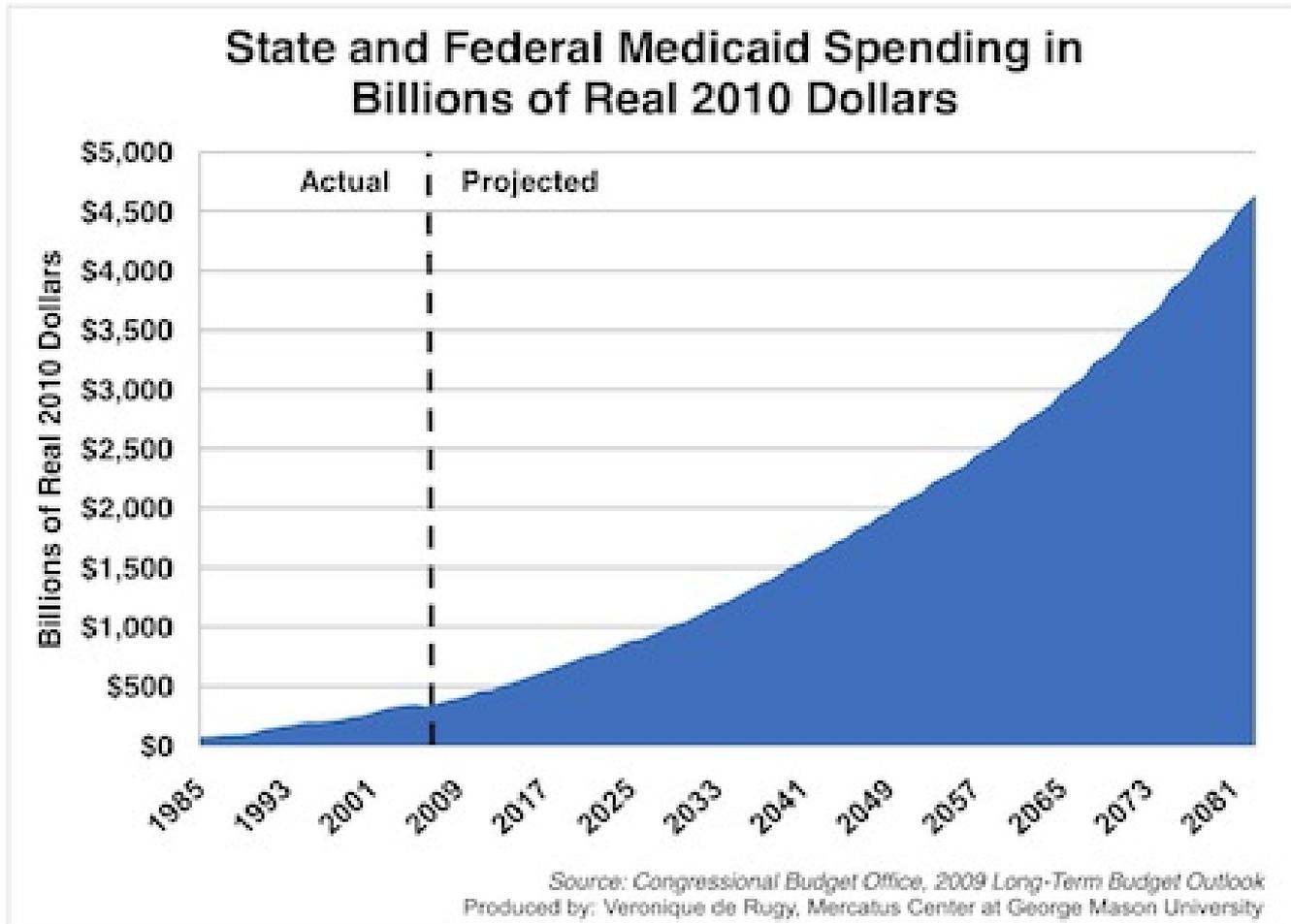
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Projected State and Federal Spending on Medicaid

A change to the system is needed in order to sustain the current level of services



Who will be exempt from enrolling in Medicaid Care Management?

- Populations and services excluded from Medicaid Care Management to remain in the New Hampshire Medicaid Fee-For-Service Program are:
 - Members with Veterans Affairs benefits
 - Family Planning Only benefit
 - Initial part-month and retroactive eligibility segments (excluding auto eligible newborns)
 - Spend-down population
 - Qualified Medicare Beneficiary and Specified Low-Income Medicare Beneficiary only (no Medicaid) population
 - Health Insurance Premium Payment Program enrollees
 - Intermediate Care Facilities for Individuals with Intellectual Disabilities services
 - Medicaid to Schools services
 - Dental Benefit services



Glossary of Terms

- **Care coordination:** The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care. (42 CFR 438.208)
- **Centers for Medicare & Medicaid Services (CMS):** The federal agency within the U.S. Department of Health and Human Services with primary responsibility for the Medicaid and Medicare program
- **Conflict-free case management:** A process to develop an individual's plan of care that is created independently and without any conflict of interest from the availability of funding to provide services
- **Conflict of interest:** Conflict between the private interests and the official or professional responsibilities of a person, such as providing other direct services to the program participant, being the guardian of the participant, or having a familial or financial relationship with the participant (He-E 805.02)
- **Consumer-Direction**, also known as Participant Directed and Managed Services or Self-Directed Services: Family-managed services created to help individuals to reach certain outcomes
- **Health Plan**, also known as Managed care organization (MCO): An entity that has a comprehensive risk-based contract with the department to provide managed Medicaid health care services



Glossary of Terms

- **Long term services and supports**, also known as long term care services and supports: A broad array of supportive medical, personal, and social services needed when a person's ability to care for themselves is limited due to a chronic illness, disability, or frailty. Long term services and supports include all four of New Hampshire's Home and Community Based Care Waivers and Nursing Facility services
- **Managed care**: The integration of both the financing and delivery of health care within a system that seeks to manage the accessibility, cost and quality of that care
- **Medicaid**: A federal and state funded health care program that serves a wide range of needy individuals and families who meet certain eligibility requirements. The program works to ensure that eligible adults and children have access to needed health care services by enrolling and paying providers to deliver covered services to eligible recipients
- **Medicare Dual Eligible Population**: Individuals qualifying for both Medicare and Medicaid coverage
- **National Committee for Quality Assurance (NCQA)**: A non-profit organization dedicated to improving health care quality, and accredits and certifies a wide range of health care organizations
- **Person-centered planning**: A planning process to develop an individual support plan that is directed by the person, his or her representative or both, and which identifies his or her preferences, strengths, capacities, needs, and desired outcomes or goals (RSA 151-E: 2)
- **Whole person approach**: An approach to ensure that the person's physical, behavioral, developmental, and psychosocial needs are addressed

