



NH Health Care Association



December 15, 2014

Commissioner Nicholas Toumpas
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

Re: Medicaid Managed Care Step 2

Dear Commissioner Toumpas:

Several months ago, our Associations sent you statements of the principles which we think should govern the long term care aspects of Step 2 of Medicaid Managed Care. We also forwarded to you a list of questions concerning managed care. We are still awaiting answers to these questions.

We know that you will agree that we have an obligation to the residents of our long term care facilities, to their families, to the taxpayers, and to those who might someday need long term care, to ensure that managed care is not implemented unless and until these questions (and any others that might arise) are satisfactorily answered.

We appreciate the opportunities you have established for stakeholders to have input here, and as you know we have been engaged in significant efforts to work with DHHS and the MCOs over the past year. But the fact of the matter is that, at this point, with Step 2 enrollment slated to begin only a little more than 6 months from now, we cannot continue to proceed as we have been doing. The stakes are simply too high for us to try to navigate through this enterprise under a cloud of uncertainty.

Thus, we are writing this to let you know that, if we do not have adequate responses to review by January 2, 2015, we will be forced to reconsider the approach our Associations have taken to the implementation of Step 2.

Thank you.

Very truly yours,

A handwritten signature in blue ink that reads "John Poirier". The signature is written in a cursive style.

John Poirier, President
N.H. Health Care Association

A handwritten signature in blue ink that reads "Ted Purdy". The signature is written in a cursive style.

Ted Purdy, President of Nursing Home Affiliates
N.H. Association of Counties



New Hampshire Health Care Association

Commissioner Nicholas J. Toumpas
NH DHHS, Brown Building
129 Pleasant Street
Concord, NH 03301

September 12, 2014

Dear Commissioner ~~Toumpas~~ *Nicks*,

The New Hampshire Health Care Association has developed the attached documents which we hope will be of assistance to all concerned as DHHS proceeds with the implementation of Step 2 of Medicaid Managed Care.

We appreciate the efforts DHHS and others have made to this point with many, many meetings and gathering input. As DHHS has been very busy implementing many aspects of MCM, we know focus had to on other phases of implementation.

The first document is a list of principles that we believe must be adopted, at a minimum, to govern the substance and the implementation of the managed care program.

The second document is a list of more specific questions relative to implementation of the long term care aspects of Medicaid Managed Care. We believe these are key questions that to date no one from DHHS or the MCOs have been able to effectively answer.

We would greatly appreciate the opportunity to meet with you and a few members of your senior staff along with a few members of the provider community to explore these critical issues.

We look forward to working with you on these matters that have the potential to dramatically impact the lives of thousands of long term care recipients in our state.

Very truly yours,

A handwritten signature in black ink, appearing to read 'John E. Poirier', is written over a large, stylized flourish that extends downwards and to the left.

John E. Poirier
President and CEO

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New Hampshire Health Care Association

Proposed Principles to Govern Long Term Care Managed Care

1. Quality of care is paramount. The transition to MMC should not directly or inadvertently impair the quality of care or quality of life experienced by long term care recipients and nursing home residents.
2. The NH DHHS should continue to be the rate setter for facility based care.
3. Any "rebalancing" of the care delivery system planned as part of MMC should not be funded at the further expense of nursing homes.
4. NH DHHS should continue to be responsible for determining clinical eligibility for nursing home care to assure uniform application of standards.
5. Any willing provider should be allowed to contract for MMC services. Access to services is already an issue in rural areas.
6. Previously approved capital costs that have been included in reimbursement rates should continue to be recognized and compensated in any revised reimbursement formula, and the reimbursement system should recognize the need for further capital improvements to aging facilities.
7. The reimbursement formulas applied to any class of LTC services should be neutral to type or form of ownership. No form of ownership should be advantaged or disadvantaged by state policy.
8. The NH DHHS should implement a pilot system of MMC for approximately six months to assure a smooth transition and minimize unexpected outcomes on this special population. There are very few existing working models of MMC in place for long term care nursing home residents.
9. All current Medicaid nursing home residents should be assured that they will not be discharged to another level of care unless they voluntarily, personally make such a request. Further, no resident residing in a nursing home should be denied eligibility for nursing home level of care until they have been safely discharged from the nursing home.
10. The administrative processes of all MMC plans should be consistent for all major functions such as prior authorizations, claims processing and appeals or eligibility related matters.
11. Grievance and appeals processes for both individual long term care recipients and long term care providers should be established that include accessible, knowledgeable, high level liaisons. In the case of recipients the liaison should function as a "managed care ombudsman".



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Medicaid Managed Care for Long Term Care Global Questions 9/ 8 / 2014

1. What are the goals and objectives of implementing managed care for the nursing home and mid-level care residential populations?

In particular:

- a. What specific quantified financial savings opportunities identified by NH DHHS are expected to be achieved by implementing managed care for nursing home residents?
- b. What specific or quantified quality improvement or care coordination opportunities identified by NH DHHS are expected to be achieved by implementing managed care for nursing home residents?
- c. In light of the very low Medicaid reimbursement rates for Residential Care services and resulting very low acceptance of Residential Care residents by the provider community, does NH DHHS see an opportunity to adjust mid-level care rates so that additional facilities will accept Medicaid recipients and provide a viable placement opportunity for lower acuity individuals who need 24 hour access to supportive care?
- d. What specific quantified financial savings or improvements in quality of care coordination are expected to be achieved by implementing managed care for mid-level "Residential Care or Supported Residential Care" residents?

2. What process will DHHS and the MCOs utilize to gain an understanding of the needs of LTC residents before designing and implementing any systems?

- a. To date there has been little effective coordination of a joint effort between the state and the MCOs to work together with providers. Can NH DHHS identify a timeline with processes and milestones for developing a managed care system for LTC recipients?



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3. What if any system testing is anticipated prior to implementing a LTC managed care system?

- a. Will NH DHHS explore the possibility of conducting a pilot demonstration for approximately 6 months to assure a smooth transition?

4. Will participation of licensed nursing home providers in the Medicaid program be limited in any way?

- a. Will any willing provider be able to contract with the managed care organizations?
- b. If limitations on provider participation are anticipated, what entity will determine or approve the criteria for inclusion or exclusion of providers?

5. If reimbursement of providers is not uniform among the participating MCOs, will providers be able to contract selectively with one or some but not all MCOs?

- a. If a provider chooses not to contract with any MCO, what provisions will exist to transfer residents to other facilities, given OBRA limitations on discharging nursing facility residents?
- b. If a provider chooses not to contract with some MCOs, what provisions will exist to transfer residents to other MCOs' plans?

6. Will the current methodology of reimbursement continue or might it change in some manner?

- a. What entity will determine the methodology of reimbursement for services?
- b. Will it be a goal of MMC to reduce the current state and county expenditure for residents of nursing homes, mid-level care or home care and support services?
 - i. Given that N.H. has historically under-funded nursing home care and has among the largest gaps between cost of care and reimbursement, what is the scope of any anticipated reductions in overall costs?
- c. If it is anticipated that reimbursement might change, what methodology will be used?



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- d. If it is anticipated that reimbursement might change will any of the following be factors in determining reimbursement?
 - i. Acuity of residents?
 - 1. If acuity is a factor what criteria will be used? Current RUG 34 Grouper or some other case mix based system?
 - ii. Stability of the reimbursement rate over provider budget cycles?
 - iii. Individual providers cost of providing care such as direct nursing care costs currently in rate setting methodology?
 - iv. Geographical labor costs?
 - v. Existing capital investment costs?
 - vi. Future capital investment costs?
 - 1. What if any capital costs will be recognized?
- e. Does the state recognize a societal value in upgrading the accommodations available to the expanding senior population?

7. What if any changes might be made to the scope of “covered” or “routine” services to be included in a per diem rate?

8. Will either “financial” or clinical” eligibility criteria for LTC Medicaid change in any way?

- a. If it is anticipated that clinical or financial eligibility might change, what entity will determine the methodology of eligibility determination for services and what entity will administer the eligibility determination process? What assessment tool will be used?

9. What systems will be put in place to monitor the care received by residents of nursing homes, given this population’s limited ability to self-report disruptions in service that may be triggered by systemic changes? What if any consideration has been given to the totality of this population’s dependence on the care provided by nursing homes and affiliated ancillary service providers?

- a. What are the potential care coordination and care delivery problems that DHHS has identified as being the most likely to arise as a result of any anticipated changes resulting from implementation of managed care, and what potential ways of monitoring these problems have been identified?



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- 10. Will all care management and coordination initiatives directed at nursing home and mid-level care residents be provided only by the managed care contractors or could some be provided by nursing homes and mid-level providers who best know the residents and already provide significant care management and coordination?**
- a. Have NH DHHS or the MCOs considered any opportunities to designate or qualify providers who might be appropriate to provide care management and coordination?

September 2, 2014

Dear Governor's Commission on Medicaid Care Management,

The Nursing Home Affiliate (The 11 County Nursing Homes) is very concerned about the timing of the potential implementation of Medicaid Managed Care – Step 2.

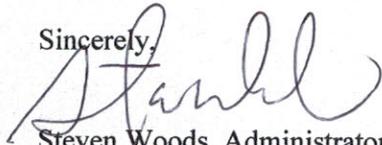
With a very short window, less than nine (9) months, between now and April 1, 2015 the nursing homes in New Hampshire still do not know the answers to the following critical questions:

- Who will calculate our per diem rates moving forward?
- What will the rates be based on – acuity or otherwise?
- What will happen with MQIP or the bed tax under the new system and who will calculate it if it remains in place?
- What will be the status of pro-share match under the new system and who will calculate it if it remains in place?
- What will the contracts with nursing homes and the MCO's cover? Drugs, therapies, doctors etc.
- Will the current atypical rates continue for those facilities with atypical patients?
- Who will be responsible for pre-authorization of admission to nursing homes clinically and financially?
- Will contracts between the MCO's and the nursing homes be available for review prior to the open enrollment period and, if not, how would those eligible be able to decide which plan best meets their needs?
- When will the list of health care providers in each MCO's network be available for review?
- How will physicians be reimbursed particularly those who are employed by the facility?
- How will the MCO's handle/reimburse patient drugs/medication and will each MCO have different formularies?

Obviously the above does not come close to answering all of our questions concerning this transition; however, we feel it would be prudent, based on the many unanswered critical questions, for the state to delay the current effective date of 4/1/15 for at least one year and to reset the new effective date utilizing January 1 or July 1.

We urge the Commission to consider this request and thank you in advance for your consideration. Please feel free to contact me should you have any questions.

Sincerely,



Steven Woods, Administrator (Nursing Home Affiliate President)

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