

To: Members of the SB 553 Working Group
From: Michelle Winchester, Medical Care Advisory Committee
Date: August 17, 2016

The attached document was created last September by a Subcommittee of the Medical Care Advisory Committee (MCAC). I updated the document to the extent that I could.

This was a preliminary response to a review of the SFY 2016 NH-MCO contract. The intent of the document was to support initial discussions between the MCAC and the DHHS relative to implementation of managed long-term services and supports (MLTSS). You will see that the document contains many questions, as well as some initial recommendations and concerns.

Discussions began in August of 2015 and were suspended indefinitely not long after that. Any recommendations here were preliminary only and not voted on by the full MCAC.

**NEW HAMPSHIRE-MCO CONTRACT SFY 2016:
MLTSS PROVISIONS: PRELIMINARY ISSUES & QUESTIONS IDENTIFIED**

Medical Care Advisory Committee
Michelle Winchester
August 23, 2016

ENROLLMENT

Contract Provision: Exhibit A, Section 15.

15.2.2. For CFI **participants enrolled prior to December 1, 2015**, the MCO shall:

- 15.2.2.1. Assign a care coordinator by January 1, 2016, and inform the member of the name and contact information of the care coordinator within five (5) business days;
- 15.2.2.2. Conduct a face to face visit by March 30, 2016; and
- 15.2.2.3. Develop a care plan an individualized and comprehensive person-centered plan to meet the member's assessed needs by March 30, 2016.

15.2.3. For CFI **participants enrolled** in the MCO **between December 1, 2015 and December 31, 2015**, the MCO shall:

- 15.2.3.1. Assign a care coordinator no later than January 15, 2016, and inform the member of the name and contact information of the care coordinator within five (5) business days;
- 15.2.3.2. Conduct a face to face visit no later than February 15, 2016; and
- 15.2.3.3. Develop an individualized and comprehensive person-centered plan to meet the member's assessed needs by February 29, 2016.

15.2.4. For CFI **participants enrolled on or after January 1, 2016**, the MCO shall:

- 15.2.4.1. Assign a care coordinator within ten (10) business days of enrollment, and inform the member of the name and contact information of the care coordinator within five (5) business days of the assignment;
- 15.2.4.2. Conduct a face to face visit within twenty (20) business days of enrollment;
- 15.2.4.3. Develop an individualized and comprehensive person-centered plan to meet the member's assessed needs within thirty (30) business days of enrollment.

15.2.5. For CFI participants **enrolled prior to January 1, 2016**, the existing care plan will remain in effect until expiration, until the member's needs change, or until a new plan has been developed and is signed by the member.

15.2.6. For CFI **participants who transition to the MCO from another MCO**, the existing care plan will remain in effect for up to 90 days following member transition to the new MCO.

15.2.7. If the **member is in a nursing facility or a residential care facility**, the care coordinator shall contact the facility to inform the facility of the Member's face-to-face visit date.

MCAC Response

While we recognize there will be a change in implementation dates, we offer the following analysis based on original contract dates.

Participant enrolled prior to December 1, 2015

Safety issues identified for the participant enrolled prior to December 1, 2015 are:

- As of January 1, 2016, the fee-for-service case manager is no longer in place and the MCO has 5 business days to provide new contact information to the member, which in 2016 gives the MCO until January 8th. It appears there is a potential gap of 8 winter days in which the member would have no case manager to call for assistance should care plan services not be rendered as planned or should other safety issues occur, such as the member running out of heating fuel or experiencing a power outage due to a storm.
- Case management rules require monthly contact, with a face-to-face visit every 60 days. (Despite these requirements, for many contact is recommended at least weekly.) Is the intent here that the MCO is

ENROLLMENT**Contract Provision: Exhibit A, Section 15.**

allowed to deviate from minimum contact requirements in the initial enrollment period?

- It would seem effective, from a time and efficiency perspective, to allow the MCO to adopt or amend the existing care plan, as necessary, rather than require a new care plan for every member. Is there an assumption that the care plan developed under the fee-for-service (FFS) system is faulty? If a recipient transfers from one MCO to the other, the care plan developed by the first MCO must remain in place for 90 days. (See contract § 15.2.6.) It is not clear why the same protection is not in place for the transition from FFS to MCO.

In comparison, for the participant enrolled in December of 2015, there is a much longer wait of potentially 22 winter days for case manager contact information, although these participants may receive a face-to-face visit a month and a half before their prior enrolled counterparts and a care plan a month sooner.

Notification of CFI participant of face-to-face visit

It is not clear why a case manager would notify the assisted living or nursing facility rather than the member/ member representative of a face-to-face visit – perhaps even both. As written, it would appear that the convenience of the MCO and provider is given priority over the Medicaid participant.

SERVICES

Contract Provision: Exhibit A, Sections 2, 20, & 21.

"**Equal Access**" means Steps 1 and 2, and NHHPP members having the same access to providers and services for those services common to both populations.

The term "equal access" is used in the following Section 20 provisions:

20. Access

20.1.1. The MCO's network shall have providers in sufficient numbers, and with sufficient capacity and expertise for all covered services to meet the geographic standards in Section 20.2, the timely provision of services requirements in Section 20.4, **Equal Access**, and reasonable choice by members to meet their needs. . .

20.1.5. The MCO shall submit documentation quarterly to DHHS to demonstrate **Equal Access** to services for Step 1, 2 and NHHPP populations.

20.2.1. The MCO shall meet the following geographic access standards for all members, in addition to maintaining in its network a sufficient number of providers to provide all services and **Equal Access** to its members. (See time/distance network adequacy table.)

20.4.2. The MCO shall require that all network providers offer hours of operation that provide **Equal Access** and are no less than the hours of operation offered to commercial, and FFS patients. [42 CFR 438.206(c)(1)(ii)].

The term is also used in the following contract provisions:

9. Payment Reform Plan

9.2.1. The Payment Reform Plan shall contain: . . .

9.2.1.2. a process to ensure **Equal Access** to services;

21. Network Management

21.1.1. The MCO shall be responsible for developing and maintaining a statewide provider network that adequately meets all covered medical, behavioral health, psychosocial and LTSS needs of the covered population in a manner that provides for coordination and collaboration among multiple providers and disciplines and **Equal Access** to services. . . .

21.1.4. The MCO shall not employ or contract with providers who fail to provide **Equal Access** to services.

MCAC Response

- To the MCAC, the Federal law definition of "equal access" seems more appropriate to this contract. Under Federal Medicaid law, a State plan must ensure . . . "**care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.**" Federal law ensures "equal access" to services, not just amongst Medicaid populations, but access comparable to the general population in the Medicaid recipient's geographic area. How is the use of the contract definition more appropriate or different here?
- By the contract definition, how would "equal access" be defined for services not common to both populations?

| Contract Provision: Exhibit A, Section 20. | |
|---|--|
| Nursing Facilities | One (1) within sixty (60) minutes or forty-five (45) miles |
| CFI Adult Medical Day | Transport distance to licensed Adult Day Care providers shall not exceed sixty (60) minutes or forty-five (45) miles |
| Other CFI services | The MCO will submit their CFI network for DHHS approval. DHHS' expectation is the MCO will where possible have at least two (2) providers for each CFI covered service that cover each county. For CFI covered service provided in a member's place of residence, the provider does not need to be located in the county of the member's residence but must be willing and able to serve residents of that county. |

MCAC Response

Sufficiency of network adequacy standards

MCAC members believe that the State could not serve its current Medicaid CFI population on the minimal network for “other CFI services” described in Section 20 of the contract. The only way these standards will work is if MCO care coordinators structure care plans based on the available network of providers, rather than on the participant’s needs.

While this standard gives the recipient choice of two providers, the gross assumption here is that two agencies will have enough personnel to support all of the care needs of the recipients in a county. In fact, care plans now require support from multiple agencies. Agency capacity to provide care is impacted by a number of factors, including, for example, agency design and focus, agency and personnel location, Medicare certification, the level of skilled care provided, and workforce availability.

Establishing network adequacy standards based on geography calls for far more detailed and region-specific requirements in the LTSS arena, as the service infrastructure and needs in Coos County are not at all the same as those for Hillsborough County. These standards should also be tied to ongoing performance requirements to track and maintain a sufficient network.

The MCAC recommends the Department consider the Arizona approach, which includes a specific regional analysis. It also requires monitoring of service gaps in in-home care services, including home health care, personal care, homemaking, and respite services. (A “gap” is the difference between services scheduled and services actually delivered.) Gaps are tracked and MCOs must ensure that service gap hours represent no more than .05% of needed services in a given month. Arizona requires gap reports quarterly, accompanied by a short- and long-term correction plan when the limit is exceeded. (See Arizona AHCCCS Contractor Operations Manual, Sections 413 & 436, <http://www.azahcccs.gov/shared/ACOM/Chapter400.aspx>.)

Monitoring the LTSS Infrastructure

The MCAC also recommends the DHHS consider a quarterly report requirement on the providers who leave or will not join the network because of insufficient reimbursement rates, a report also required in Arizona.

Finally, the MCAC again requests a commitment from the DHHS to monitor the LTSS network overall – for the welfare of the Medicaid participant, as well as the general public. Medicaid is the primary payor of LTSS services here in New Hampshire, as it is across the nation. It is a program that has the power to shape LTSS for everyone in the State, as well as to destroy it.

Contract Provision: Exhibit A, Section 15.

15.4.3. The MCO shall submit for DHHS approval its criteria for authorizing long term services and supports, including frequency of reauthorizations, documentation requirements, and any associated tools.

MCAC Response

The MCAC is very concerned that the State appears to allow the MCO to independently establish criteria for authorizing long-term services and supports. It has the appearance of development and implementation of state policy outside of a public process. These are standards that should be established in administrative rule, through a public process, as is the process now in New Hampshire and as is done in many other states with Medicaid managed care.

Contract Provision: Exhibit A, Section 10.

10.11.2.3. The MCO shall reach out to members identified with long term care needs and their PCP to inform them of additional services and supports available to them through the MCO.

MCAC Response

The MCAC would be interested in understanding what additional services will be available through the two MCO plans and when/where this information will be provided to recipients and providers, particularly in written format.

Contract Provision: Exhibit A, Section 15.

15.6.1. The MCO shall not transition residents of an assisted living facility to another facility or to a different community based setting unless: . . .

15.6. 1.3. The **member** or member representative **provides written consent to transition to another facility based on** quality, member's or member representative's preference, or **other reasons raised by the MCO**, which shall not include the facility's rate of reimbursement; or

15.6.1.4. The **facility** where the member resides is **not a participating provider**.

15.6.2. In Year I of Step 2 Phase 3, if the MCO intends to transfer a member because the facility where the member currently resides is not a participating provider, the MCO shall submit a plan to transfer the member for DHHS approval. The MCO shall provide continuation of residential services at the provider until the expiration date of the prior authorization specifying the provider, the member's needs changes, or if the provider no longer participates in the Medicaid program, whichever comes first, regardless of whether the provider is participating in the MCO network.

MCAC Response

Given the recent change in the Federal Medicaid managed care rule, the health and safety concerns related to forced transitions are not listed here. However, the MCAC looks forward to a public discussion on this matter.

Contract Provision: Exhibit A, Section 15.

15.1.2. The MCO shall support individual choice and preference of services and service providers within the MCO network through **person-centered planning**, and shall provide a detailed description to DHHS of how this shall be carried out.

15.1.3. The MCO shall ensure that CFI Waiver services are authorized and delivered, based on a **person-centered** approach, where the member and their family's personal goals and needs are considered central in the development of the individualized service plans.

MCAC Response

“Person-centered planning” is a critical element in LTSS quality and the contract does not define the term. Given that New Hampshire law alone has multiple definitions of the term, it is essential that the correct definition of the term be made clear, in order that the standard be made clear. Importantly, is a standard that goes to the core of the care plan process.

The term “person-centered planning” is used in more than a dozen places in the contract, including as an element in:

- The coordination of children’s behavioral health services, health homes, and long-term services and supports;
- Choices for Independence home and community-based long term services and supports, including a requirement for a person-centered care plan in accordance with State rule He-E 805; and
- MCO utilization management policies for Step 2 services.

A State long-term care statute defines the term as “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, VII-a. This is the State definition that is most comparable to the Federal definition. (Different and varied definitions are found in at least 9 DHHS rules, including the definition in He-E 805¹, a rule often referenced in the contract.)

Furthermore, while the RSA 151-E:2 definition may be adequate, the MCAC strongly recommends the contract include the Federal definition of the person-centered plan in 42 CFR § 441.301, to make clear the expectation for this process in the CFI program and in other LTSS, as well as to ensure uniform care plan development standards and to better ensure compliance with Federal law.

¹ He-E 805.02 provides: “Person-centered” means a process for planning and supporting the participant receiving services that builds upon the participant's capacity to engage in activities that promote community life and honors the participant's preferences, choices, and abilities, and which involves families, friends, and professionals as the participant desires or requires.

CARE COORDINATION VS. CASE/CARE MANAGEMENT

Contract Provision: Exhibit A, Sections 2 & 10.

"Conflict Free Care Coordination" separates clinical or non-financial eligibility determination from direct service provision. Care Coordinators and evaluators of the beneficiary's need for services are not related by blood or marriage to the individual, their paid caregivers or to anyone financially responsible for the individual; robust monitoring and oversight are in place to promote consumer-direction and beneficiaries are clearly informed about their right to appeal or submit a grievance decisions about plans of care, eligibility determination and service delivery. State level oversight is provided to measure the quality of care coordination services and to ensure meaningful stakeholder engagement. In circumstances when one entity is responsible for providing care coordination and service delivery, appropriate safeguards and firewalls exist to mitigate risk of potential conflict.

"Conflict Free Care Management" (see Care Coordination)

"Care coordination" is the deliberate organization of patient care activities between two or more participants (including the individual) 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 marshalling 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. (42 CFR 438.208).

Effective care coordination includes the following:

- Actively assists patients to acquire self-care skills to improve functioning and health outcomes, and slow the progression of disease or disability;
- Employs evidence-based clinical practices;
- Coordinates care across health care settings and providers, including tracking referrals;
- Actively assists patients to take personal responsibility for their health care;
- Provides education regarding avoidance of inappropriate emergency room use;
- Emphasizes the importance of participating in health promotion activities; Provides ready access to behavioral health services that are, to the extent possible, integrated with primary care; and
- Uses appropriate community resources to support individual patients, families and caregivers in coordinating care.
- Adheres to conflict of interest guidelines set forth by the health plan and contractor (State of NH)
- Ensures the patient is aware of all appeal and grievance processes including how to request a different care coordinator.
- Facilitates ready and consistent access to long term supports and services that are, to the extent possible, integrated with all other aspects of the member's health care.

10.11.1.3. Ensure that each member with long term care needs receives conflict free care coordination that facilitates the integration of physical health, behavioral health, psychosocial needs, and LTSS through person-centered care planning to identify a member's needs and the appropriate services to meet those needs; arranging, coordinating, and providing services; facilitating and advocating to resolve issues that impede access to needed services; and monitoring and reassessment of services based on changes in a member's condition.

MCAC Response

- The MCAC recommends the "conflict free care coordination" definition recognize specifically the MCO conflict of interest.
- The MCAC recommends standards for "appropriate safeguards and firewalls" be identified in the contract for the MCO employee acting as a "conflict free care coordinator."
- The MCAC strongly recommends CFI care coordination be performed independent of the MCO and that the State retain the current physician/independent case manager arrangement.

Contract Provision: Exhibit A, Sections 6 & 15.

- 6.1.1.6. Coordinators for the following five (5) functional areas shall be responsible for overseeing care coordination activities for MCO members with complex medical, behavioral health, developmental disability and long term care needs. They shall also serve as liaisons to DHHS staff for their respective functional areas:
- 6.1.1.6.1. Special Needs Coordinator: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. The individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities with a particular focus on special needs populations.
 - 6.1.1.6.2. Behavioral Health Coordinator: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. The individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities within community mental health services.
 - 6.1.1.6.3. Developmental Disabilities Coordinator: The individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field. The individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to services provided for developmentally disabled individuals.
 - 6.1.1.6.4. Substance Use Disorder Coordinator: The individual will have a minimum of a Master's Degree in a SUD related field and have a minimum of eight (8) years of demonstrated experience both in the provision of direct care services at progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to substance use disorders.
 - 6.1.1.6.5. Long Term Services and Supports Coordinator: The individual will have a minimum of a Master's Degree in a Social Work, Psychology, Education, Public Health or a LTSS related field and have a minimum of eight (8) years of demonstrated experience both in the provision of direct care services at progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to long term care.
- 15.7. Choices for Independence (CFI) Waiver Program - Care Coordinators
- 15.7.1. Every member receiving CFI covered services shall have a Care Coordinator. Care Coordinators must be in contact with members at a minimum of every thirty (30) days. The Care Coordinator must have a face-to-face meeting with the member at least every sixty (60) days, or more often if needed.
 - 15.7.2. The designated Care Coordinator shall monitor the services provided to a member, as follows and in accordance with He-E 805.05 Required Case Management Services and RSA 151E:17:
 - 15.7.2.1. Ensure that services are adequate and appropriate for the member's needs, and are being provided as described in a comprehensive care plan;
 - 15.7.2.2. Ensure that the member is actively engaging in the services described in the comprehensive care plan;
 - 15.7.2.3. Ensure that the member is satisfied with services and that they are being provided in accordance with their comprehensive care plan;
 - 15.7.2.4. Identify any changes in the member's condition, discuss these changes with the member in order to determine whether changes to the comprehensive care plan are needed, and make changes to the comprehensive care plan as needed; and
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15.7.2.5. Document the member's Medicaid eligibility redetermination and Medicare Part D statuses to ensure that preparations for redeterminations and Part D enrollments are adequate and that deadlines are met.

15.7.3. The MCO in its CFI care coordination role shall maintain access to a toll free number for all members served and respond to calls as follows:

15.7.3.1. Responses to calls received on Monday through Friday shall be made within twenty-four (24) hours; and

15.7.3.2. Responses to calls received on Saturdays, Sundays and holidays shall be made within forty-eight (48) hours.

15.7.4. Members may request to change their Care Coordinator at any point. The MCOs shall include in its description of Care Coordinator services how members may request a different Care Coordinator and the MCO review process for handling member requests to change Care Coordinators.

MCAC Response

- How does the DHHS envision care coordination occurring when member co-morbidities cross the coordinator arenas of expertise? Will there be multiple care coordinators?
- When is care coordination mandatory and when is it voluntary? How do members know this?

Contract Provision: Exhibit A, Section 10.

10.11.4. Staffing Ratios

10.11.4.1. The MCO shall submit for DHHS approval its Case Manager/member ratio for Step 2 services prior to the first readiness review for each phase of Step 2 and thereafter, annually.

10.11.4.2. The MCO shall ensure that each Choices for Independence Waiver participant has a care coordinator.

10.11.4.3. The CFI Care Coordinator's caseload shall not exceed 1:50 for members living in private homes or apartments and shall not exceed 1:100 for members living in residential care facilities.

10.11.4.4. The MCO must receive authorization from DHHS prior to implementing caseloads whose values exceed those specified above. The MCO may establish lower caseload sizes at its discretion without prior authorization from DHHS.

10.11.4.5. Care coordination shall be provided in compliance with He-E 805.

MCAC Response

- Current case managers report that a staffing ratio of 1:100 for recipients in small assisted living facilities is not sufficient and 1:50 is more appropriate for this population.
- What are the standard(s) for exceeding the maximum staffing ratios?

Contract Provision: Exhibit A, Section 10.

10.11.3 .Community Integration

10.11.3.1.As part of readiness for Step 2 Phases 2-4 the MCO shall implement a **community integration plan** that has been prior approved by the DHHS that allows eligible seniors and members with disabilities to postpone or avoid institutional placements. The proposed integration plan will be available for DHHS review during the readiness review process.

10.11.3.2.The MCO's policies and procedures for its community integration plan shall describe how the MCO will work with providers (including hospitals, community service providers, ancillary service providers, and nursing facilities regarding notices of admission and discharge planning) to ensure appropriate communication among providers and between providers and the MCO, training for key MCO and provider staff, early identification of members who may be candidates for community integration, and follow-up activities to help sustain community living. The description shall identify key activities and associated timeframes for completion.

10.11.3.3.This process shall not prohibit or delay a member's access to nursing facility services when nursing facility services are medically necessary and requested by the member.

10.11.3.4.At a minimum, the MCO's community integration process shall be tailored to meet the needs of each of the following groups:

10.11.3.4.1.Members who are waiting for admission to a nursing facility;

10.11.3.4.2.Members residing in their own homes who have an adverse change in circumstances and/or deterioration in health or functional status and who request nursing facility services;

10.11.3.4.3. Members residing in assisted living facilities who have an adverse change in circumstances and/or deterioration in health or functional status and who request nursing facility services;

10.11.3.4.4. Members who are admitted to an inpatient hospital or inpatient rehabilitation facility who are not residents of a nursing facility and who request that their discharge be to a community based setting and whose needs would be met in a community based setting; and

10.11.3.4.5.Members who are placed on a short-term basis in a nursing facility regardless of payor source.

10.11.3.5.If a member is already working with the statewide ServiceLink Resource Center (SLRC) network, the New Hampshire Aging and Disability Resource Center model or NH Community Passport Program (NHCP), the MCO shall partner with the SLRC network or NHCP to support the member's successful integration into the community. In addition, the MCO shall accept formal and informal referrals for transition from the treating physician, nursing facility, DHHS Long Term Care Unit, SLRC, NHCP, other providers, family, the State, and self-referrals; and identification, through the care coordination process, including, but not limited to: assessments, information gathered from nursing facility staff, or an affirmative response on Section Q of the Minimum Data Set.

10.11.3.6.The member shall be made aware of all available community care waiver options and Medicaid State Plan Services that pertain to their condition. The summary of the conversation shall be documented in the Risk Identification and Mitigation Planning (RIMP - BEAS 3202) or equivalent tool as approved by DHHS.

MCAC Response

- What are the components of a “community integration plan”?
- Are there standards for evaluating these plans? Will these standards go through a public process?
- How will recipients be made aware of this plan so that they may proactively reach out to the MCO for assistance?
- Par. 10.11.3.4 perhaps should also include recipients waiting or wanting to be discharged from nursing facilities, after more than on a short-term residence (“short-term” is not defined), and assisted living facilities.