MARGARET WOOD HASSAN
Governor

STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

REPORT TO GOVERNOR HASSAN:

Recommendations
In Medicaid Care Management

Lesson Learned From
Acute Care

Transitions to
Managed Long Term Supports and Services

August 31, 2016

The Governor's Commission To Review and Advise on the Implementation of New Hampshire's Medicaid Care Management Program

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Table One:

Membership
The Governor's Commission on Medicaid Care Management:

Mary Vallier-Kaplan, Chair; former Vice President of the New Hampshire Endowment for Health

Donald Shumway, Vice Chair; former President and CEO of Crotched Mountain Foundation and Commissioner of the Department of Health and Human Services

Roberta Berner, Executive Director Grafton County Citizens Council, Inc. (Appointed October 2013)

Thomas Bunnell, policy consultant for NH Voices for Health

Susan Fox, Associate Director UNH Institute on Disability (Resigned May 2016)

Wendy Gladstone, MD, pediatrician at Dartmouth-Hitchcock Medical Center's Child Advocacy and Protection Program

Yvonne Goldsberry, Ph.D, MPH, President of the Endowment for Health and former Vice President of Population Health and Clinical Integration at Cheshire Medical Center/Dartmouth-Hitchcock-Keene

Catherine McDowell, founder of Coos Family Health (Resigned September 2013)

Douglas McNutt, Associate State Director for Advocacy, AARP NH

Gustavo Moral, President of Independent Services Network

Kenneth Norton, Executive Director of NAMI New Hampshire

Josephine Porter, MPH, Director of the NH Institute for Health Policy and Practice.

Lori Shibinette RN, MBA, NHA, CEO Merrimack County Nursing Home (Appointed May 2016)

Commissioner Nicholas Toumpas of the Department of Health and Human Services (ex-officio member of the Commission). (Resigned January 2016)

Commissioner Jeffrey Meyers of the Department of Health and Human Services (ex-officio member of the Commission). (Appointed February 2016)

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Staff members of the Governor's office provide ongoing consultation and assistance to the Commission. **Kathleen Sgambati's** support is particularly appreciated.

The Staff of the Department of Health and Human Services provide exemplary support, assuring transparent public access to information, individual quality of care and effective implementation of major policy change. Other State agencies including the Department of Insurance and the Office of Attorney General lend valued support.

All agendas, minutes, and materials of the Commission dating from 5/1/13 to present are posted on Governor Hassan's web page:
http://governor.nh.gov/commissions-task-forces/medicaid-care/index.htm

Work of the Commission

> *"The managed care model or models' selected vendors providing the Medicaid services shall establish medical homes and all Medicaid recipients shall receive their care through a medical home. In contracting for a managed care model and the various rate cells, the department shall ensure no reduction in the quality of care of services provided to enrollees in the managed care model and shall exercise all due diligence to maintain or increase the current level of quality of care provided."*
> *Chapter 125, Laws of 2011*

The Commission's work is carried out in accordance with the Executive Order 2013 – 05 (see Appendix), reflecting the following goals:

- assuring that the public is engaged in the understanding of the best practices of managed care and that New Hampshire Medicaid enrollees attain health outcomes needed by the citizens and communities of the State of New Hampshire;
- conducting ongoing review of the implementation of Medicaid Care Management in accordance with Chapter 125, Laws of 2011;
- recommending to the Governor changes that would assure implementation is in the public interest of assuring access for eligible populations, quality and appropriateness of care, and efficiency of care.

Pursuant to the Governor's Executive Order, beginning on May 1, 2013, the Commission on Medicaid Care Management has now held its 41st Commission meeting. In locations around the State from Littleton and Berlin to Portsmouth, Nashua, Keene, and points in between, public attendance at monthly meetings of an average of 50 individuals has allowed Commissioners to receive hundreds of hours of testimony on individual experience in the transition to managed care in New Hampshire. Commission members received hundreds of calls, letters, and emails with questions and comments. Every effort has been made to acknowledge each contact, publicly represent the issues in the formal meetings, and follow-up with referral to the Department of Health and Human Services and managed care organizations. Many outreach meetings with families, non-profit providers, key leaders and subject experts have occurred.

The Commission has requested and receives tremendous cooperation from New Hampshire providers of Medicaid funded and regulated care. Collaborative engagement and systematic problem solving has been demonstrated by all parties.

Commission meetings are organized around populations and problem-oriented inquiries and frequently call on local and national experts for their review. These individuals include:

Table 2:

Individuals Who Give Generously Of Their Expertise:

Date	Individual(s)	Organization	Topics
9/5/13	Carl Cooley, MD Don Caruso, MD	Crotched Mountain Foundation, Center for Medical Home Improvement President, Chief Executive Officer, Chief Medical Officer, Cheshire Medical Center, Dartmouth Hitchcock Keene	Medical Homes
10/3/13	William Gunn, PhD Steve Arnault, MA	Dartmouth, Department of Community And Family Medicine Center for Life Management, Derry NH	Behavioral Health Integration in Medical/Health Homes
12/5/13	Sanders Burstein, MD Sandra Pelletier	Medical Director, Dartmouth Hitchcock Nashua President/CEO Gateways Community Services Nashua/CareConnect	Care Connect Health Home for Adults with Developmental Disabilities
1/9/14	Steven Rowe Genevieve M. Kenney, PhD	President, Endowment for Health Co-Director and Senior Fellow, Health Policy Center, Urban Institute	Evaluation of New Hampshire's Medicaid Care Management by the Urban Institute
3/6/14	Roland Lamy	Helms & Company, Community Mental Health Center representative	Challenges and Opportunities in Behavioral Health
5/1/14	Steve Norton	Executive Director, NH Center for Public Policy Studies	Aging, Managed Care and the Long Term Care System
2/12/15	Cindy Robertson, Esq. Becky Whitley, Esq.	Disability Rights Center	Contract Considerations and Recommendations for NH Medicaid
	Sarah Aiken Cathy Spinney	Community Support Network, Inc.	Recommendations for NH Medicaid
11/12/15	Dennis Powers Connie Young	CEO, Community Crossroads Director, Rockingham County ServiceLink	Co-locating Area Agency and Service Link Resource Centers
1/14/16	Camille Dobson	Deputy Director, National Association of States United for Aging and Disabilities	LTSS Care Plans, Authorizations and Consumer Protections
2/11/16	Paul Saucier, MA	Truven Analytics	Care Coordination Models in Managed LTSS
4/14/16	Peter Kelleher Carol Furlow	CEO, Harbor Homes VP, Harbor Homes	Integration of Behavioral and Physical Health Services
5/12/16	Michael Bailit, MBA	Bailit Health Purchasing LLC	Effective State Purchasing in Medicaid Managed Care
6/9/16	Lisa Perales, ARNP, MBA Erin Hall	Crotched Mountain Foundation Brain Injury Association of New Hampshire	Choices for Independence Independent Case Management
8/11/16	John Meerschaert FSA, MAAA Principal, Consulting Actuary	Milliman	Financial Reporting and Evaluation

The Commission Has Found That New Hampshire Is Affirmatively Initiating Urgent Health Care Reform Under Medicaid Care Management

The "acute care" phase of implementation of Medicaid Care Management; Step One, has been complex and fast paced. In many instances the national effort to establish Medicaid Care Management has lacked national precedent and experience as well as Federal guidance in Medicaid policy so as to assure clear best practice. Timetables in NH have been appropriately balanced in reflection of the need for expeditious change and also for prudent recognition of vital health care demands in this very costly and complex transition. The Commission has found that New Hampshire is affirmatively initiating urgent health care reform under Medicaid Care Management.

1.) Individual Outcomes and Quality of Care:

Evaluations of NH's Medicaid Care Management transition are being conducted by both internal and external parties.

Internally, a strong commitment by DHHS to health outcome tracking has led to the creation of a very valuable, publicly available database of enrollee data and analysis: https://medicaidquality.nh.gov/

Externally there are two evaluations of note. First is the CMS mandated external evaluation from the Health Services Advisory Group. Their report can be found at: https://medicaidquality.nh.gov/sites/default/files/2016%20Q1%20MCM%20Quality%20Update%20EQRO.pdf

Also, the New Hampshire Endowment for Health has contracted with the Urban Institute to conduct a series of reviews. Their work can be found at: http://www.endowmentforhealth.org/index.php?mact=Resources,cntnt01,detail,0&cntnt01articleid=76&cntnt01returnid=64

These three evaluations provide significant protection to the objective understanding of the performance of our Medicaid program. In particular, over the coming years the DHHS investment in publicly available, detailed data on health outcomes will prove highly valuable in steering public policy.

> *DHHS' investment in highly transparent quality of care information has produced two results.*
>
> *First, the outcomes from the first phases of care management were publicly tracked and ultimately observed to be positive. There was little evidence of loss in access, quality, or results in the transition to Medicaid Care Management. This could have been a very disruptive change but the measured outcomes showed increased access and quality. While it will take time, years in many cases, to show health status improvements, we will be able to observe the*

progress as we go forward. The value for Medicaid enrollees and their families will be significant over time.

Second, many partners, in NH and beyond, have access to the tools of health data and analysis. These measurement systems have built the pathway for continuous learning and program improvement. In the area of the citizen's largest tax resource commitment, this is essential. It also strengthens our workforce development in that quality measurement and health data are increasingly a key ingredient of clinical and administrative education and practice.

2.) NH Health Protection Program

The provision of Medicaid support to 100,000 of our citizens, and the expansion of Medicaid to 50,000 more, is one of New Hampshire's most important public commitments to our families and communities. To accomplish so successfully the combination of transformations that managed care and caseload expansion represent has been a premier operational feat of the Department of Health and Human Services. The value in family and community stability and the economic impact of efficient access to care is fundamental to our State's future.

Benefit expansion introduced by the Health Protection Program brought substance use treatment to groups at high risk for severely negative health status due to misuse and addiction. The incorporation of treatment into the larger Medicaid program is showing considerable progress and all involved deserve recognition for this health commitment.

This can also be seen as preparation to help NH adapt quickly to a world of health care change. Getting Medicaid Care Management right will prove extremely helpful as Medicare, community health delivery systems, and population health drive change forward. Bi-partisan commitment has achieved this positive position and it will require the same from here.

3.) Person Centered Care

The Department's commitment to rapid response to enrollee difficulties reflects an ethic of caring that is critical to successful fulfillment of its legislated mission. The State takes seriously each enrollee's experience in its care management. As problems have arisen, they have been acknowledged openly, aggressively studied, and creatively improved. In this, the State has shown its dedication to the needed population health practice that the future Medicaid program's sharply constrained resource availability will demand.

The leadership of the Department used this highly engaged problem solving to establish a "learning organization" culture of highly motivated staff working in

delegated, team based engagement with the public. This has served to build public confidence and to assure high performance results.

4.) CMS Compliance and Opportunities

Federal and State efforts in this partnership are sizable both financially and in administrative oversight. The public rightly demands evidence of good government in the critical arena of health care. In particular, two agendas should be noted:

First, CMS has updated its Medicaid Managed Care regulations, strengthening requirements in state contracting with Managed Care Organizations. Particularly important is CMS' requirement that all states incorporate a Medical Loss Ratio (MLR) into the contract. The new rules require each Managed Care Organization to demonstrate a financial performance of a MLR of 85% or greater. This means that all health plans must spend at least 85% of their Medicaid revenue on enrollee medical care and other activities that improve quality. The remaining 15% can be spent on MCO administrative tasks. This protects both our enrollees and our taxpayers. Nationally, many Managed Care Organizations already meet this standard.

Second, the Department of Health and Human Services is working closely with our communities of behavioral health stakeholders to assure addictive disorder prevention and treatment – one of our most demanding public health crises. DHHS has launched a farsighted integration of physical and behavioral health care with social supports. With this "Delivery System Reform Incentive Program" (DSRIP) DHHS and CMS are supporting local population health strategies with a major investment of Federal financial participation, payment reform, and community population health commitment.

5.) Economic and Resource Sustainability

New Hampshire has shown bi-partisan commitment to a forward looking policy of assuring best management of this area of the State's largest economic investment. Many states are struggling to maintain financial stability, public support, and quality in their Medicaid program and this will only become more challenging over time. Our elected leadership has put aside divisiveness and made a very notable commitment to the wellbeing of our communities.

With Medicaid Care Management, New Hampshire is building efficient operations thereby protecting its care giving resources. The State is also assuring equitable distribution of needed care thereby assuring fair, sustainable meeting of all enrollees highest priority needs during the upcoming decades of escalating demographic demand.

Still, it is very early in this effort. Major commitments to a constantly challenging health care context will test New Hampshire's politics, our administrative capacity, and our health care community. This must be faced with a shared civic intention and a consistent strategy of highly visible leadership, partnership, and information driven decision-making.

In Summary:

As demonstrated by the testimony received by the Commission, multiple evaluator sources, and the ongoing maturation of the Medicaid Care Management program, the performance of Medicaid Care Management in New Hampshire is being shown to be positive and is continuously improving.

In particular the Commission wishes to express its high regard for the work of the Department of Health and Human Services in this endeavor. The Department engaged with this process in a very affirmative manner, using public testimony and in depth quality management/results analysis to track progress in each step of implementation, forming a rapid response team to dig deeply into the concerns of individuals and organizations, and bringing problem solving reports back to the public on a continuous basis.

Second, often at great cost, the providers of care to NH's Medicaid enrollees invested in complex management systems and technology changes enabling their successful transition and uninterrupted care. Providers demonstrated great skill and commitment to the well-being of NH Medicaid enrollees and great value to New Hampshire tax payors.

Finally, the Managed Care Organizations, while reducing from three providers to two, have maintained a very high commitment to the success of the transition. Each has brought value and experience to the vital, many-sided concerns of New Hampshire's long-term stability of its population health agenda. The MCOs have provided visible leadership and responsive change strategies for the health of our citizens.

COMMISSION CONSIDERATIONS

The implementation of NH's Medicaid Care Management effort was in two parts. In December of 2013, Step One put into place the Managed Care Organizations, enrolled a portion of Medicaid enrollees, and began the provision of managed, acute care. One year ago, at the beginning of calendar year 2015, DHHS began preparations for Step Two, the enrollment of all Medicaid eligible individuals and the extension of care management from acute care to both acute and long-term supports and services (LTSS).

In May of 2015, in order for the Commission to review efforts under Step Two and to thereby establish its next report, the Commission organized four work groups. The role of the work groups was to examine the critical performance areas as suggested by national CMS findings in order to assure NH's readiness for managed LTSS in the implementation challenges of Step Two. Multiple public conversations ensued, involving NH Medicaid enrollees/families, providers and MCOs, third party evaluators, national experts, and the Department of Health and Human Services. The work group's process of establishing questions, setting priorities, reviewing and discussing available information, and then establishing draft recommendations, led to the Commission's Next Report.

Fundamental Readiness:
Many Commissioners provided comment on the importance of ongoing development of two areas; data and communication.

- Building on the success of Step One quality measurement and public analysis, Step Two data planning and implementation is viewed as fundamentally important. The value of data development was described not only as the creation of the data system to assure quality of the Step Two implementation, but also regarding the ongoing analysis of the impact of Step One and the Medicaid program as a whole, including access to health care for all populations, workforce experience, enrollee health status, and the finances and financial management of the Medicaid program.
- Communication was also seen as being critical for a successful implementation of Step Two, especially meaningful communication with critical partners, such as the County government, as well as enrollees.

The important issues of Data and Communication are reflected in the recommendations, including those recommendations that call for public engaged planning structures and processes, transparent financial and operational monitoring, and LTSS quality systems.

The Governor's Commission
To Review and Advise on the Implementation of
New Hampshire's Medicaid Care Management Program

Lesson Learned From
Medicaid Care Management - Acute Care

Transitions to
Managed Long Term Supports and Services

Assuring the Integrity of the Planning for Each Step in Medicaid Care Management

Management of the Medicaid Program is a critical function of the State of New Hampshire carried out on behalf of its most vulnerable citizens. And it is an expensive and complex element of our state-wide community infrastructure. It is essential that the continuing transition to Medicaid Care Management maintains key values and follows established principles to guide and to assure the integrity of this fundamental fabric of New Hampshire's family support. The Commission has previously recommended, and wishes to restate the following values and principles. The whole text can be seen in Appendix Three: Vision Principles, and Guidance:

Principles for a Medicaid Managed Long-term Services and Supports Program: Promoting Health, Wellness, Independence, and Self-Sufficiency

1. Development and implementation of a quality MLTSS program requires a thoughtful and deliberative planning and design process, building on the strengths of the current LTSS program.

2. Implementation and operation of the MLTSS program must be consistent with the Americans With Disabilities Act and the Supreme Court Olmstead v. L.C. decision, such that MLTSS is delivered in the community in the most integrated fashion and setting possible and in a way that offers the greatest opportunities for active community, educational, and workforce participation, all to the extent desired by and appropriate to the individual participant.

3. Payment structures for MLTSS support the goals and essential elements of the program, including encouraging, rather than dis-incentivizing, home and community-based care and promoting employment services.

4. The MLTSS participant must be assured the opportunity for informed choice and assistance through conflict-free education, enrollment/disenrollment assistance, and advocacy.

5. The MLTSS program must consider the unique needs of the whole person through person-centered policies and procedures, promotion of self-determination, and opportunities for self-direction.

6. Ensuring one entity is responsible for a comprehensive and integrated package of acute care services and LTSS (institutional and non-institutional) increases Medicaid program efficiency, avoids cost shifting and service disincentives, and enhances health outcomes and quality of life.

7. A provider network is adequate if it is strongly representative of the State LTSS infrastructure and it ensures the participant a choice of and timely access to providers and necessary services as well as continuity of care during transition periods.

8. Participant health and welfare in MLTSS is better assured with strong and clearly defined participant protections and supports.

9. There must be no reduction in the quality of care provided to participants in the MLTSS model, as compared to the fee-for-service model and the State must exercise all due diligence to maintain or increase the current level of quality.

10. Effective State oversight of MLTSS is vital to ensuring program vision, goals, and managed care contract elements.

RECOMMENDATIONS

The Governor's Commission on Medicaid Care Management makes the following recommendations to the Governor. The recommendations are offered in addition to the recommendations previously submitted as listed in Appendix 4: "Previous Recommendations of the Commission"

These recommendations are offered in consideration of several health systems goals deemed essential including:

- Assuring implementation of Chapter 125 of the Laws of 2011 and the stated requirements under Medicaid Managed Care of value, quality, and efficiency of care, which are responsive to the needs and concerns of beneficiaries and their caregivers.
- Assuring accountability, transparency, and communication through data collection and operations that serve to optimize efficient functioning of the NH Medicaid Program for and with all stakeholders.
- Assuring the integrity of a capable provider network.
- Assuring that recipients of the yet to be implemented Long Term Services and Supports (LTSS) "Step Two" receive appropriate care.
- Assuring Medical Homes and health outcomes reflective of best-practice health care for all Medicaid enrollees.

The Commission encourages a full consideration of these recommendations as DHHS works to implement Step Two of the Medicaid managed care plan. The Commission also urges consideration of these recommendations as DHHS completes tasks associated with developing the comprehensive plan for services to be incorporated into managed care, as required by Senate Bill 553(http://www.dhhs.nh.gov/sb553/documents/sb-553-final.pdf).

Recommendations are cross-referenced with the Senate Bill 553 plan elements in Table 1 below.

PLANNING NOW TO ASSURE QUALITY OF CARE AND CONSUMER PROTECTION IN THE FUTURE

For Seniors:

Recommendation 1: **Creation of a Senior Supports Cabinet**

The State should, by executive order or legislative action, convene an ongoing, multi-agency "Senior Supports Cabinet" in reflection of our older adult demographic growth and needed State agency efforts. Goals should include the tracking of predicted demographic change of our aging population, State policy updating, and coordinated community awareness and strengthening of local supports. This Cabinet should incorporate the related recommendations of the

Governor's Commission on Health Care and Community Support Workforce.

Recommendation 2: **Committing to Community Supports for Seniors**

DHHS should make an ongoing and long term commitment to the community support needs of seniors by establishing internal and community leadership roles. DHHS should develop comprehensive and coordinated oversight and administration of all of its aging services regardless of funding source through an internal staffing plan an assurance of strong leadership for acute and LTSS senior care. This commitment should support access to care, services and supports coordination, and wellness promotion opportunities by promoting and sustaining ServiceLinks.

For the Medicaid Program:

Recommendation 3: **Creation of a Strategic Plan for the Future of the Medicaid program in NH**

DHHS should create a strategic plan for the future of Medicaid in NH. The plan should provide strategic policy and finance options to build value-based purchasing reflecting the State's interest in NH's Medicaid fiscal stability and quality of care. Considerations should reflect State assumption of current Federal, CMS authority for NH citizens who are "Dually Eligible", i.e. Medicaid and Medicare eligible. The plan should inform multi-year budget projections including caseload and cost trends. Approaches to workforce recruitment, retention, and training, reflecting the Commission on Health Care and Community Support Workforce, should be included in the strategic plan. State, MCO, and network enrolled provider roles should be recognized.

Recommendations 4: **Establishment of a Consumer Protection Committee**

DHHS should assure the wellbeing of New Hampshire's most vulnerable citizens by establishing a standing "DHHS Committee on Consumer Protection in the Oversight of MLTSS".

For Seniors and the Medicaid Program:

Recommendation 5: **Planning for LTSS Financing, Addressing Concerns of Seniors**

DHHS should revise the long-term supports and services financial structure by expeditiously developing a DHHS/Stakeholder plan for

risk based financing. The plan should specifically define nursing facility payment systems, including County payment, Acuity Based reimbursement, MQIP, Proshare, IMD and other State and Federal opportunities. Payment formula changes and waiver opportunities should be crafted to maintain support through the change process. The plan should reflect the concerns of senior citizens in the development of community based care.

ESTABLISHING DATA COLLECTION SYSTEMS AND SUFFICIENT STAFFING TO OPTIMIZE MEDICAID FUNCTIONING:

Transparent Monitoring of Medicaid Finances:

Recommendation 6: **Medicaid Care Management Financial Reporting and Evaluation**

DHHS should assure the availability and transparency of financial analysis and data by producing comprehensive Medicaid Care Management financial reports. DHHS should assure fiscal transparency, stability and accountability by monitoring MTLSS financing related events, results, controls and financial outcomes, including at the encounter level. Financial evaluations should use internal and external audits. This will require that the DHHS budget be adequate to cover contractual and actuarial services necessary for financial analysis and financial best practices including value-based contract management and fraud and abuse controls.

Medicaid Efficiency and Effectiveness

Recommendation 7: **Providing Sufficient DHHS Staffing to Assure Medicaid Efficiency and Effectiveness**

DHHS should develop a core functions staffing model and an implementation plan that together protect the efficiency and effectiveness of the Medicaid Care Management Program and assure strong leadership capacity in contract development, monitoring and enforcement; provider network adequacy and access to services; quality and care coordination assurance and improvement; member education and consumer protection; and rate setting adequacy and financial oversight.

ASSURING THAT LTSS RECIPIENTS RECEIVE APPROPRIATE CARE:

By addressing payment systems and access barriers:

Recommendation 8: **Assurance of Rate Adequacy and Network Access for LTSS**

DHHS should conduct a formal capacity assessment of the current system of services for older adults specifically including a review of rate adequacy and network access barriers for LTSS before the conversion from waivered services to capitated, risk based contracts is implemented. The assessment should include recommendations to address network adequacy and assurance of CMS and other Federal compliance needs for home and community based care with immediate priority on the "Choices for Independence "(CFI) waiver.
DHHS should use upcoming waiver revisions to establish rate adjustments for senior care. The rate adjustments should be sufficient to reverse the multiyear financial and program losses in LTSS programs. This review should be repeated for all subsequent waivers.
DHHS should clearly define Managed Care contracting goals to reflect the quality and financial requirements necessary to care for and support individuals in their communities.

By following best practices to provide care:

Recommendation 9: **Contract Language to Assure Access to Health Resources and Services Administration Medical Homes**

DHHS should monitor Medicaid enrollees' access to patient-centered integrated delivery models, such as patient-centered medical homes and health homes, by measuring and following quality and outcome indicators. This should include indicators specifically focused on two vulnerable populations of the dually eligible and those with complex care needs.

Recommendation 10: **DHHS Identification of Alternative Payment Models to Help Promote Medical/Health Homes**

DHHS should proactively build on the work of the Capacity for Transformation waiver by identifying alternative payment arrangements that can support and facilitate the development of patient-centered integrated delivery models (Patient-Centered Medical Homes and Health Homes) as well as supporting and enhancing the LTSS services that are not provided in a medical setting. Payment arrangements should assure that savings accrued by meeting population health outcomes under integrated delivery models are redistributed throughout the LTSS delivery system. DHHS should define "value" in a clear and measurable way and establish performance improvement objectives directly tied to payment reform within the Managed Care contracts. This should be included as part of the Department's plan for implementing managed LTSS.

Recommendation 11: **Assurance of Best Practice in Care Coordination for Step Two**

DHHS should sustain the commitment to quality standards by adopting and implementing best practice quality strategies for LTSS as they are developed at the national level, such as through provider and MCO accreditation by NCQA, and by including requirements for such in contractual language for Managed Care Organizations and network providers .

Recommendation 12: **Contract Requirement for Person-Centered Care with Enrollee and Advocate Input**

DHHS should establish Step Two, person-centered treatment and service planning by defining and specifying it as a requirement in contracts with Managed Care Organizations. This should reflect CMS requirements for person-centered care and be based on extended review with enrollees and their representatives.

Recommendation 13: **Clearly Define the Difference Between Acute Care Utilization Review and LTSS Service Planning**

DHHS should follow best practice guidelines to clearly identify and define a distinction between the purpose and intended outcomes of acute care utilization review, and LTSS service /care planning, authorization, and review. DHHS should include these definitions in the MLTSS implementation plan.

By supporting existing relationships with care providers:

Recommendation 14: **Avoidance of Interruption of Existing Provider Relationships for Enrollees with Complex Needs**

DHHS should develop and enforce a policy that complex care enrollees who are receiving services, or need services, from out-of-network or out-of-state providers are able to access these providers, or receive adequate notice and explanation from Managed Care Organizations for changing providers, during any appeals and grievances.

Recommendation 15: **Protecting Service Continuity During Transition to Integrated LTSS**

DHHS should develop service authorization requirements that assure continuity of services during the first 12 months of implementation of managed LTSS. Due to the nature of LTSS prior authorization continuation applies to both the function and its provider and location. This should require that Managed Care Organizations honor existing

service and medical authorizations until the expiration date or needs change; that any reductions to services must be approved by the Department; and that service authorizations for specific providers must continue to recognize that provider whether or not the provider is participating in the managed care provider network.

By including high-quality behavioral health care:

Recommendation 16: **MCM Contracts to Assure Quality of Care in Behavioral Health for Medicaid Enrollees**

In contracts with Managed Care Organizations, DHHS should provide sufficient detail in program requirements to assure that the program elements are implemented as identified in CMS policy or regulatory requirements, or State compliance requirements such as the community mental health agreement. DHHS should also specify program requirements necessary to meet population health priorities of the State, such as the reduction of substance misuse and the provision of treatment of substance use disorders. A formal, stakeholder involved process should be convened by DHHS to address these issues prior to the next MCO contract cycle.

By following national and state quality and compliance guidelines:

Recommendation 17: **MCM Contracts to Assure Quality of Care in Long Term Supports and Services for Medicaid Enrollees**

DHHS should incorporate LTSS program and quality requirements into contracts with Managed Care Organizations of sufficient detail to assure that the program elements are implemented as identified in CMS policy or other Federal requirements, or State compliance requirements. DHHS should maintain its policy of not proceeding with the next steps in Medicaid Managed Care until it is prepared. Such preparation should include the assurance of quality of care measurement during and after the conversion to Medicaid Care Management. At this time, no national system of quality measurement under LTSS exists, unlike the well-developed national quality systems related to the Step One related conversion.

BUILDING AND MAINTAINING A STRONG PROVIDER NETWORK:

Recommendation 18: **DHHS Engagement of Medicaid Enrollees/Advocates in Defining Step Two "Network Adequacy"**

DHHS should carefully review and consider the unique needs of populations who are dually eligible and/or have complex health care needs when defining network adequacy. DHHS should engage Medicaid enrollees, their families, advocates and providers in defining

"network adequacy" for services particular to Step Two and for populations who are dually eligible and/or have complex health care needs.

Recommendation 19: **Ongoing DHHS Network Adequacy Evaluation Through Solicitation of and Response to Provider and Enrollee Concerns**

DHHS should systematically and directly engage with Medicaid providers and with Medicaid enrollees utilizing quality improvement methodologies to measure, analyze and publish concerns about existing or emerging difficulties in providing or receiving care. To assure the continued availability of essential providers, DHHS should monitor network adequacy with multiple measures, including but not limited to: monitoring the associated workforce supply, turnover, and vacancy levels.

ESTABLISHING STRONG RELATIONSHIPS WITH MEDICAID ENROLLEES AND EFFECTIVELY ADDRESSING CONCERNS:

Recommendation 20: **Assuring Effective Communications Between DHHS and LTSS Recipients**

DHHS should provide clear, accessible, customer-focused education and outreach through direct mail and other known methods of effective communication to all Medicaid enrollees about program choices, benefits, and enrollee rights in advance of Step Two implementation. This should be vetted by consumers and include accessible, widely distributed, understandable information on the changes in services offered and/or service providers, information on how to access services, program contact information, problem/complaint resolution options and enrollee's rights to make health care decisions. Explanation of their rights should include information on specific grievance and appeal rights, the Ombudsman Program, department contacts, and the State fair hearing process.

Recommendation 21: **Requirements for Enrollee Complaint Resolution**

DHHS should meet compliance standards of CMS final rules by assuring that all elements of the complaint and appeals process are coordinated with, or part of, a beneficiary support system that serves Medicaid enrollees before and after transition into a Medicaid managed care plan.

Recommendation 22: **Preventing and Addressing Abuse, Neglect, Exploitation and Complaints**

DHHS should assure that systems are in place to prevent, detect, report, investigate and remediate abuse, neglect and exploitation, and that those systems will adequately monitor and track complaints.
DHHS should provide training and education for MCO staff and providers about abuse, neglect and exploitation and all prevention, detection, reporting, investigation and remediation procedures and requirements.
DHHS should provide initial and ongoing training and education to Medicaid enrollees about abuse, neglect, exploitation, and reporting inclusive of complaints.

Recommendation 23: **Establishment of an LTSS Ombudsman**

At least four months prior to further implementation of Step Two, DHHS should establish a Statewide Long Term Services and Supports Ombudsman Program.

This independent Ombudsman Program should provide enrollees direct assistance in navigating their coverage and in understanding, and exercising their rights. It should provide consumer education and information and serve as an access point for unresolved complaints and concerns. The program should be empowered to assure timely resolution of enrollee problems as well as transparent reporting on issues identified. The Program should include a robust data collection system that documents the volume and type of consumer contacts/complaints to State and health plan officials along with the State's Medicaid Care Advisory Committee (MCAC). Reports should be provided at least quarterly to the State, to the managed care companies, and to the MCAC and should be posted on the respective distribution party's web page.

Recommendation 24: **Establishment of a System to Respond to Complaints and Critical Incidents**

DHHS should ensure efficient beneficiary issue resolution and overall systemic improvement by implementing a transparent, coordinated complaint and critical incident management system with pathways for reporting, inclusive of robust data collection. DHHS should monitor funding, MCO compliance, fee for service compliance and Ombudsman data and provide for continuous process improvement, maintaining overall responsibility for the identification, reporting, and investigation systems.

Critical Issues Needing Additional Attention

The Commission workgroups identified several issues that will require additional attention before implementing Medicaid Care Management Step Two. We encourage DHHS to continue working to resolve these items as they could trigger ongoing quality concerns.

Defining Network Adequacy

The Commission's Workgroup on Assuring Access to an Adequate Network of Providers has been particularly concerned about the availability of appropriate services for Medicaid enrollees and the ability of service providers to weather the various administrative changes as they occur. For example, it is important that under managed care, the appropriate specialized care for a child on Medicaid would continue to be available and not replaced by the general care available in a community setting, where the skills required for success are often very different. As another example, a provider of rehabilitative services in a small office with limited resources would likely find it challenging to adapt to new reporting and billing systems under managed care and it would be essential that those necessary administrative adjustments not interfere with the provider's primary role of continuing to provide services to Medicaid enrollees.

The network of providers under Medicaid managed care includes not only individual medical and behavioral health professionals but also systems of care that may be based in hospitals, outpatient facilities and/or community-based settings. The network is the source of primary and specialty care, medications, durable medical equipment, rehabilitative services, developmental support, community-based services, and all other care and supplies necessary for Medicaid enrollees to achieve optimal physical, emotional, and social health. The network's adequacy depends on these providers being located within a reasonable distance of Medicaid recipients and both able and willing to supply appropriate services in a timely fashion regardless of an enrollee's diagnosis, cultural background, access to transportation or any other characteristic that might be a potential barrier to accessing care. When the network is "adequate" for the vast majority of Medicaid enrollees it may be inadequate for a minority with special circumstances such as those needing care outside of the provider network. These enrollees will need individualized attention to assure that their health care needs are met.

Ultimately, achieving ***network adequacy*** means that all enrollee's health needs are satisfactorily addressed and that they are able to live, learn, work, and find recreation in the setting that they choose, working with providers acceptable to them and/or their families (see WHO definition of Health). While network adequacy is well defined for Medicaid services that transition to managed care under Step One (which includes primary care, specialty care and behavioral health), there is no similar generally accepted definition for services transitioning under Step Two (long term care, community-based services, developmental services, and services for the elderly). Populations that are especially vulnerable to the transitions under Step

Two include those Medicaid enrollees who are either dually eligible for both Medicaid and Medicare and/or those children and youth with complex health care needs. Continuity of care is an essential feature of health service delivery. Movement between equally "adequate" providers may make financial sense but could imperil an enrollee's health.

Assuring patient centered care (Step One) and/or person centered care (Step Two) for Enrollees with Complex Care Needs

The Commission's workgroup on Assuring Access to an Adequate Network of Providers has been concerned about developing and maintaining continuity of services for enrollees with complex care needs, both the dually eligible and those with complex health issues, under a patient centered care[1] plan (Step One) and/or a person centered care[2] plan (Step Two). The authorizing statute, RSA 126-A:5, XIX, requires no diminution in the quality of care for enrollees. As people with complex needs are enrolled in MLTSS, it will be important to maintain contract provisions requiring person centered care through integrated delivery systems (medical homes/health homes) and that these delivery systems are supported to meet NCQA quality standards. The MCO contracts should specifically require the systematic availability of person-directed supports in the settings of, and with staff support reflecting, the person centered plan. MCO enrollee assessment, oversight, and equitable distribution of resources should reflect person centered care planning. MCO contracts should assure independent care management for enrollees with complex care needs, and ongoing MCO oversight and consumer protection reporting. The New Hampshire Department of Health and Human Services will need to continuously monitor access to services described above and specifically follow indicators for enrollees with complex care needs by measuring outcomes including:

- completion of health maintenance activities (i.e. preventive services)
- continuity of prescribed medications, equipment and treatments
- receipt of those services that are indicated for the achievement and maintenance of optimal physical, emotional and social health
- enrollee satisfaction with services provided by their home-based caregivers

Defining and Fully Supporting Service Authorizations within MLTSS

The Commission's Workgroup on Assuring Effective Operations and Payment remains concerned about service authorizations within MLTSS. As noted in recommendation number 13, the Workgroup asks DHHS to clearly identify and define a distinction between acute care utilization review processes and LTSS service / care planning processes, as these two components of the care system have different purposes and intended outcomes. The LTSS plan should provide for service and support authorizations for extended time periods, as appropriate, for long-term maintenance or improvement of skills and functions for daily living (habilitative services and supports).

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[1] See NCQA Definitions for Patient Centered Medical Homes.
[2] See CMS Definitions for Person Centered Care in LTSS.

The Workgroup suggests that DHHS follow emerging guidance (see Dobson, January 14, 2016) in this area that includes:

- Authorizations that are a full year in length for habilitative services, including habilitative physical therapy, occupational therapy, and speech therapy.
- Authorizations that are of shorter duration (less than one year) for LTSS short-term services (examples may include assistive technology or environmental modification).
- All LTSS in the member's care plan should be authorized.

Implementing and Supporting Consumer Protections

The Commission's workgroup on Establishing Upfront Consumer Protections has been concerned about having mechanisms for providing support, education, and a central contact for complaints or concerns for enrollees, in place during and after the transition from a fee for service system to managed care. In May 2016, the U.S. Department of Health and Human Services (HHS) issued a final rule on managed care in Medicaid and the Children's Health Insurance Program (CHIP) that requires:

- an access point for complaints and concerns about enrollment, access to covered services and other related matters;
- education on enrollee grievance and appeal rights, the State fair hearing process, and enrollee rights and responsibilities, and additional resources;
- assistance in navigating the grievance and appeal process and appealing adverse benefit determinations made by a plan to a State fair hearing; and
- review and oversight of LTSS program data to assist the state Medicaid Agency on identification and resolution of systemic issues.

CMS guidance also requires that states establish and maintain a structure for stakeholder engagement in program planning and oversight and that enrollees with LTSS needs are involved in person centered treatment and service planning.

The Commission workgroup urges the Department to continue to move forward with implementing the new CMS rules and developing consumer protections processes including:

- All elements of the complaint and appeal process should be coordinated with, or be a part of a beneficiary support system that serves enrollees before and after enrollment into a Medicaid managed care plan.
- Members of a health plan should first access their plan's Customer Services Unit and should be provided with prompt, courteous service. If the problem is not resolved to the member's satisfaction, he or she have a right to contact the Department's Administrative Appeals Unit for issue resolution and, if necessary, file an appeal with the DHHS. In urgent situations, enrollees may request an expedited appeal that must be heard within three days.
- In all cases, whether the interaction occurs with the managed care plan, DHHS Rapid Response Team, or with the DHHS Administrative Appeals Unit, the member has a right to expect prompt, professional treatment that meets the needs of a diverse population.
- Quality benefits management dictates that a member's concerns are resolved at the lowest level of the complaint process possible and that assistance is given in a

timely and courteous manner. Information must be clear, accessible, and meet the cultural and intellectual needs of the member.

- Decisions made by a managed care plan or the Department of Health and Human Services must be made consistent with a patient centered care plan (Step One) and/or a person centered care plan (Step Two). A resolution must consider and respond to the unique needs of the individual.

Fully Supporting Behavioral Health Service Needs

The Commission's Workgroup on Assuring Effective Operations and Payment remains concerned about integrating behavioral health services (both mental health and substance use disorders) into the evolving care management system. These services include those for pain management, opioid control, dual diagnosis support, and similar treatment. Of particular concern is the potential that the prior authorization process may result in disruptive denials for psychiatric medications. During the Commission's review DHHS provided detailed data concerning this issue. While there is currently no evidence of a systemic problem with medication denials, there continue to be isolated problems with individual enrollees and providers. The Commission workgroup encourages DHHS to continue to actively monitor prior authorization denials information and to work closely with providers and enrollees to resolve problems as they may occur. DHHS should also work closely with behavioral health providers and MCOs to co-develop medication review processes and criteria to assure that enrollees with acute or chronic behavioral health conditions receive medication authorizations that are appropriate to the enrollee's treatment needs and patient centered care plans.

Appendix One:
Authorizing Statute

CHAPTER 125

SB 147-FN – FINAL VERSION

03/16/11 0790s

03/23/11 1019s

27Mar2011… 1564h

27Mar2011… 1610h

05/18/11 1827eba

2011 SESSION

11-0215

01/10

SENATE BILL ***147-FN***

AN ACT relative to Medicaid managed care.

SPONSORS: Sen. Bradley, Dist 3; Sen. De Blois, Dist 18; Sen. Forrester, Dist 2; Sen. Forsythe, Dist 4; Sen. Gallus, Dist 1; Sen. Groen, Dist 6; Sen. Lambert, Dist 13; Sen. Luther, Dist 12; Sen. Morse, Dist 22; Sen. Odell, Dist 8; Sen. Sanborn, Dist 7; Sen. White, Dist 9; Sen. Barnes, Jr., Dist 17; Sen. Boutin, Dist 16; Sen. Carson, Dist 14

COMMITTEE: Health and Human Services

AMENDED ANALYSIS

This bill requires the commissioner of the department of health and human services to issue a 5-year request for proposals to enter into contracts with vendors of a managed care model to provide for managed care services to the Medicaid population. The commissioner, in consultation with the fiscal committee of the general court, is granted rulemaking authority for the purposes of this bill.

- - - -

Matter removed from current law appears [~~in brackets and struckthrough.~~]

Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

03/16/11 0790s

03/23/11 1019s

27Mar2011… 1564h

27Mar2011… 1610h

05/18/11 1827eba

11-0215

01/10

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Eleven

AN ACT relative to Medicaid managed care.

Be it Enacted by the Senate and House of Representatives in General Court convened:

125:1 New Paragraph; Medicaid Managed Care. Amend RSA 126-A:5 by inserting after paragraph XVIII the following new paragraph:

XIX.(a) The commissioner shall employ a managed care model for administering the Medicaid program and its enrollees to provide for managed care services for all Medicaid populations throughout New Hampshire consistent with the provisions of 42 U.S.C. 1396u-2. Models for managed care may include, but not be limited to, a traditional capitated managed care organization contract, an administrative services organization, an accountable care organization, or a primary care case management model, or a combination thereof, offering the best value, quality assurance, and efficiency, maximizing the potential for savings, and presenting the most innovative approach compared to other externally administered models. The department shall present the opportunities of the various models or combination of models with a recommendation for the best managed care model for New Hampshire, no later than July 15, 2011, to the fiscal committee of the general court which shall consult with the oversight committee on health and human services. Services to be managed within the model shall include all mandatory Medicaid covered services and may include, but shall not be limited to, care coordination,

utilization management, disease management, pharmacy benefit management, provider network management, quality management, and customer services. The model shall not include mandatory dental services. The commissioner shall issue a 5-year request for proposals to enter into contracts with the vendors that demonstrate the greatest ability to satisfy the state's need for value, quality, efficiency, innovation, and savings. The request for proposals shall be released no later than October 15, 2011. The vendors of the managed care model or combination of models demonstrating the greatest ability to satisfy the state's need for value, quality, efficiency, innovation, and savings shall be selected no later than January 15, 2012 with final contracts submitted to the governor and council no later than March 15, 2012 unless this date is extended by the fiscal committee. After the bidding process, the commissioner shall establish a capitated rate based on the bids by the appropriate model for the contract that is full risk to the vendors. The capitated rate shall be broken down into rate cells for each population including, but not limited to, the persons eligible for temporary assistance to needy families (TANF), aid for the permanently and totally disabled (APTD), breast and cervical cancer program (BCCP), home care for children with severe disabilities (HC-CSD), and those residing in nursing facilities. The capitated rate shall be approved by the fiscal committee of the general court. The managed care model or models' selected vendors providing the Medicaid services shall establish medical homes and all Medicaid recipients shall receive their care through a medical home. In contracting for a managed care model and the various rate cells, the department shall ensure no reduction in the quality of care of services provided to enrollees in the managed care model and shall exercise all due diligence to maintain or increase the current level of quality of care provided. The target date for implementation of the contract is July 1, 2012. The commissioner may, in consultation with the fiscal committee, adopt rules, if necessary, to implement the provisions of this paragraph. The department shall seek, with the approval of the fiscal committee, all necessary and appropriate waivers to implement the provisions of this paragraph.

(b) The department shall ensure that all eligible Medicaid members are enrolled in the managed care model under contract with the department no later than 12 months after the contract is awarded to the vendor or vendors of the managed care model.

(c) For the purposes of this paragraph:

(1) An "accountable care organization" means an entity or group which accepts responsibility for the cost and quality of care delivered to Medicaid patients cared for by its clinicians.

(2) "An administrative services organization" means an entity that contracts as an insurance company with a self-funded plan but where the insurance company performs administrative services only and the self-funded entity assumes all risk.

(3) A “managed care organization” means an entity that is authorized by law to provide covered health services on a capitated risk basis and arranges for the provision of medical assistance services and supplies and coordinates the care of Medicaid recipients residing in all areas of the state, including the elderly, those meeting federal supplemental security income and state standards for disability, and those who are also currently enrolled in Medicare.

(4) “A primary care case management” means a system under which a primary care case management contracts with the state to furnish case management services, which include the location, coordination, and monitoring of primary health care services, to Medicaid recipients.

125:2 Effective Date. This act shall take effect upon its passage.

Approved: June 2, 2011

Effective Date: June 2, 2011

Appendix Two:
Executive Order

MARGARET WOOD HASSAN
Governor

STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

BY HER EXCELLENCY
MARGARET WOOD HASSAN, GOVERNOR
EXECUTIVE ORDER 2013-05

an order establishing the Governor's commission to review and advise on the implementation of New Hampshire's Medicaid care management program

WHEREAS, effective June 2, 2011, New Hampshire passed Senate Bill 147 directing the Department of Health and Human Services to employ a statewide managed care model to administer the Medicaid program and to provide for managed care services for all Medicaid populations;

WHEREAS, Senate Bill 147 authorized multiple options of models of care for all Medicaid recipients and the Department of Health and Human Services requested proposals from managed care companies that would include new payment methods;

WHEREAS, the managed care program is intended to improve the value, quality and efficiency of services provided through Medicaid, maximize savings, and stimulate innovation for New Hampshire;

WHEREAS, Senate Bill 147 requires that no reduction occur in the quality of care to all Medicaid enrollees and that all due diligence be exercised to maintain or increase the current level of quality of care provided;

WHEREAS, the care management program shall be implemented in three phases through contracts entered into between the Department of Health and Human Services and certain Managed Care Organizations who are responsible for the provision of all health care services to the low-income, disabled, and elderly enrollees in the New Hampshire Medicaid Program on a risk basis;

WHEREAS, the health of New Hampshire's residents and of the care management program depend upon the accountability of the managed care organizations, transparent and full communication and the care management model's responsiveness to the need and concerns of beneficiaries and their care givers; and

WHEREAS, in order to ensure that the implementation of each step of the phase-in of Senate Bill 147 meets the purposes of the Medicaid program and the needs of New Hampshire Medicaid beneficiaries, the Governor would benefit from the periodic review and recommendations of a commission comprised of individuals with experience in various areas of care who are qualified to review the program's implementation, the status and integrity of the planning for each step, and the program's responsiveness to quality of care concerns including those raised by New Hampshire citizens.

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TDD Access: Relay NH 1-800-735-2964

NOW, THEREFORE; I, MARGARET WOOD HASSAN, GOVERNOR of the State of New Hampshire, by the authority vested in me pursuant to Part II, Article 41 of the New Hampshire Constitution, do hereby establish the Governor's Commission on Medicaid Care Management, effective April 10, 2013, which shall be comprised of eleven (11) members of the public appointed by the Governor representing a broad diversity of interests in an effective, efficient, and high-quality Medicaid care management system for the State of New Hampshire, including members with expertise in managed care and payment reform models of care, Medicaid public policy, elderly affairs, children's health, public health, mental health, developmental disabilities and adult health care services.

FURTHER, the Governor's Commission on Medicaid Care Management shall include the Commissioner of the Department of Health and Human Services, or designee, as an *ex officio* member;

FURTHER, if any one of the appointed members is unable to serve, the Governor shall replace such member;

FURTHER, the Governor's Commission on Medicaid Care Management shall be charged with the following responsibilities:

a. The Commission shall advise the Governor regarding the Medicaid care management program's implementation to ensure that the program:
    i. is implemented consistent with Senate Bill 147 and with contract terms entered into between the Department of Health and Human Services and managed care organizations;
    ii. in accordance with the best practices of managed care models and payment methods; and
    iii. is operated to achieve goals of improving access to eligible populations, quality and appropriateness of care and cost effectiveness of the Medicaid program.
b. The Commission shall seek input and expertise from the public, including enrollees, providers, managed care organizations, advocates and public policy specialists, as needed to assess the progress and performance of the Medicaid care management program;
c. The Commission shall have the opportunity to review the Medicaid care management program's performance data in the form of reports and/or summaries provided to or by the Department of Health and Human Services to assess the needs for future changes to the program and recommend such changes to the Governor; and
d. The Commission shall have the opportunity to review in advance proposed changes, work plans and designs for all phases of the Medicaid care management program and provide written input to the Governor regarding the same.

FURTHER, the Governor shall designate a chairperson and vice-chairperson from among the members;

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FURTHER, members shall serve at the pleasure of the Governor or until resignation in writing is submitted to the Governor by a member;

FURTHER, the commission shall:

a. Meet at least monthly at the call of the chair. Such meetings shall be open to the public.
b. Provide periodic updates, reports, and recommendations to the Governor on the implementation and integrity of the Medicaid care management program.
c. Schedule the first organizational meeting within 30 days of this Executive Order.

FURTHER, the Department of Health and Human Services shall provide administrative support to the commission as necessary; and

FURTHER, the Commissioners of the departments of Health and Human Services and Insurance shall serve as technical advisors to the Commission members.

NOW, THEREFORE; I, MARGARET WOOD HASSAN, GOVERNOR of the State of New Hampshire, by the authority vested in me pursuant to Part II, Article 41 of the New Hampshire Constitution, do hereby establish, effective April 10, 2013 the Governor's Commission on Medicaid Care Management.

Given at the Executive Chambers in Concord, this 10th day of April, in the year of Our Lord, two thousand and thirteen and of the independence of the United States of America, two hundred and thirty-seven

Margaret Wood H

GOVERNOR OF NEW HAMPSHIRE

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Appendix 3
Recommendation 4: Vision Principles, and Guidance

STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

MARGARET WOOD HASSAN
Governor

February 10, 2015

Ms. Mary Vallier-Kaplan, Chair
Commission on Medicaid Care Management
95 Steele Road
Peterborough, NH 03458

Dear Commissioners:

It was with great pleasure that I reviewed the care management principles that you have developed. They accurately reflect the values that I presented to the Commission last year and will lead to the quality and characteristics that I believe should be part of our program going forward. I heartily accept and endorse them as our guide to the development of all care management services.

The principles are only worth the effort that you have invested, however, if they are applied to all facets of our work on care management. I know that you and the Department are applying these principles as parts of the care management program are being developed. I am confident that you will continue to do so, and I ask HHS to develop all future contracts, program operations and program evaluations utilizing them. The MCO's need to apply them both in service design and customer service interactions, and the Commission and other groups need to continue to use them as a touchstone and a measure of the work we are involved in.

The shift to managed care can only be successful if all parties understand the goals and means to achieve quality care. As your principles state, care must be comprehensive, individualized, integrated, and community based. Your principles reaffirm the competency of families to manage care, reflect and support the needs of the individual, and reinforce that we expect the high quality that can only come from integrating all services, and all voices, in the care plan.

I congratulate the Commission on this important piece of work and thank all those involved, especially Sue Fox and Doug McNutt for their research and drafting efforts. The Commission has been an important partner in shaping, correcting and developing care management and I thank you for the enormous dedication that you have all shown.

With every good wish,

Maggie H

Margaret Wood Hassan
Governor

cc: Nick Toumpas, Commissioner, DHHS
Scott Westover, CEO, NH Healthy Families
Eric Hunter, COO, Well Sense Health Plan

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Governor Hassan's Commission on Medicaid Care Management

January 6, 2015

Governor Maggie Hassan
State House
107 North Main Street
Concord, NH 03301

Dear Governor Hassan,

As its fourth recommendation, the Governor's Commission on Medicaid Care Management urges the establishment of the following vision, principles and guidance be endorsed to inform and evaluate the transition from the current systems of providing Medicaid-funded Long Term Services and Supports (LTSS) to a more efficient, effective and cost effective Managed Medicaid Long Term Services and Supports (MLTSS) system and to ensure that the individuals who rely on these services experience a smooth transition to MLTSS and maintain a high quality of care, as well as a high quality of life.

These past months have witnessed unparalleled positive change in health care in New Hampshire. Medicaid expansion has led the way with the rapid and highly successful addition of more than 25,000 of our neighbors becoming insured in just a few months. What is more, they have for the first time in our State's history, also been insured for the treatment of substance use disorders. These are our working citizens of low income, and increasingly they will be our healthy citizens.

Reversing a troubling loss of care, New Hampshire has recommitted to our needed community mental health programs. An array of services will now be present in our cities and towns to assure that those with mental health needs have homes they can feel safe in, skilled clinicians coordinating their care, and crisis response capacity to step in when called on.

Our health exchange has begun with an expanding competitive market and lowering cost of care. This is an enormous relief for businesses, large and small, and a stabilizing factor in our larger economy. New investment in our Community College System and the University System of New Hampshire are producing a workforce with professional health care skills and a lower college debt level. This is how we will build a health care capacity for our future.

And, Medicaid Care Management has launched, bringing new tools in care coordination to the highest need populations in the State. As the Governor's Commission on Medicaid Care Management we have met in community halls and libraries throughout the State. We have heard testimony from many parents, clinicians, administrators, and policy makers. We have brought updated policy and announcements of change to the public at every opportunity, and streamed many of our meetings into the workplaces and homes around the State.

The Department of Health and Human Services deserves to be commended for the successes of this new management system. Commissioner Toumpas and the staff of the Department have continuously engaged with the Commission and the participating public. They have conscientiously planned and executed very difficult operational change and have done so with the best interests of Medicaid enrollees foremost. This change is not without ongoing challenges. Most importantly, at all times the Department has been open to learning and improving, especially notable given the constrained management capacity and tremendous work load involved.

In addition to the Commission's findings, two independent evaluations are underway. Over the coming years, these evaluations will provide valuable guidance on our implementation of Medicaid Care Management. Preliminarily, the impression from both the evaluations and the Commission findings note the successes in the first year as well as several "early" cautions. We will be mindful of those concerns as we continue our deliberations. Prior authorization of specialty services and pharmaceuticals, clinical efficiency in gaining access to care for patients, transportation, billing of low frequency services and other aspects of care management have been found to need improvement in several of the evaluatory steps. We hope to see improvements in coming months.

And now, the most challenging changes lie before us in "Step Two". New Hampshire enjoys a deep commitment to the well being of our neighbors in greatest need. This is true for the young and old, individuals with disabilities, and those who are experiencing severe, chronic health problems. We have a long history of local support and building solutions to allow our communities to come together, with State partnership. Our values reflect that commitment to self-determination, work ethic, and independent living. We have succeeded in leading the nation in guiding our care giving with our values of freedom and local control.

The next step in the legislated mandate of Medicaid Managed Care brings us to both mandatory participation in managed care and the inclusion of the Medicaid long term supports and services on behalf of our most vulnerable citizens. This is a new challenge, nationally, in the field of managed care, in a State still in its infancy in these techniques. Most importantly, "we do things our way" in our communities and families. These are our values, this is how we know how to live. As a result, we are challenged by the possibilities of care management and independent living-with-support, in a self-directed culture.

These concerns have been raised at each of our eighteen community meetings and in countless letters, emails, and calls. They are raised in a quest for retaining our independence and family structure while assuring the care for our elders, our veterans, and our children. They are understood to be questions of life and death.

To this end, the Commission has proposed, held hearings, amended, and voted unanimously in favor of a set of principles to guide most carefully this next transition. We are recommending that a "*vision, principles, and guidance be endorsed to inform and evaluate the transition from the current systems of providing Medicaid-funded Long Term Services and Supports (LTSS) to a more efficient, effective, and cost-effective Managed Medicaid Long Term Services and Supports*

(MLTSS) system to ensure that the individuals who rely on these services experience a smooth transition to MLTSS and maintain a high quality of services and supports, as well as a high quality of life."

We thank you for the honor of these considerations. Please feel free to contact me for further information. Thank you very much.
Sincerely,

Mary Vallier-Kaplan
Chair, Governor's Commission on Medicaid Care Management
mvallierkaplan@gmail.com
603-731-3542

Donald L. Shumway
Vice Chair, Governor's Commission on Medicaid Care Management
don.shumway@crotchedmountain.org
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RECOMMENDATION:

The Governor's Commission on Medicaid Care Management hereby recommends that the following vision, principles, and guidance be endorsed to inform and evaluate the transition from the current systems of providing Medicaid-funded Long Term Services and Supports (LTSS) to a more efficient, effective, and cost-effective Managed Medicaid Long Term Services and Supports (MLTSS) system to ensure that the individuals who rely on these services experience a smooth transition to MLTSS and maintain a high quality of services and supports, as well as a high quality of life.

RATIONALE:

The Governor's Commission has been tasked with making recommendations to the Governor about issues relating to Medicaid Care Management. The Commission recommends the following vision, principles and guidance as a framework to follow in developing the plan and contracts for implementing Step 2 of the Care Management program to include MLTSS. It is important to build on important work that has already been documented through various Real Choice Systems Change grants, the State Innovation Model Process (SIM), and the ongoing stakeholder engagement process.

In 2006, funded through a Centers for Medicare and Medicaid Services (CMS) Real Choice grant, a vision and mission for long term services and supports in NH was developed. The development of this vision and mission included a broad cross-section of stakeholders across all populations and ages. At the time, the NH Department of Health and Human Services affirmed this vision and mission. Subsequently, this vision and mission statement was adopted during the State Innovation Model stakeholder planning process and was included as part of the SIM plan submitted to CMS. The Commission recommends that this vision and mission be adopted to guide the implementation of MLTSS in New Hampshire.

> *The vision for Medicaid Managed Long Term Services and Supports is for all eligible New Hampshire citizens to have access to the full array of long-term supports and services. This allows them to exercise personal choice and control, and affords them dignity and respect throughout their lives. To the greatest extent possible, citizens should be able to make informed decisions about their aging, health, and care needs. There should be a high level of quality and accountability in everything offered and in everything provided.*
>
> *The purpose is to create a dynamic and enduring community-based system of long term services and supports, so all New Hampshire citizens may live and age with respect, dignity, choice, and control throughout their life.*

The following principles and guidance incorporate the principles presented by Governor Hassan to the Governor's Commission, the guidance on MLTSS from the Centers for Medicare and Medicaid Services (CMS),[1] stakeholder forum input, and Federal Medicaid policy and should guide the development and implementation of MLTSS and should be used as a guidepost for the development and implementation of contracts with the participating MCOs.

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[1] Principles adapted from "Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs", issued by the Centers for Medicare and Medicaid Services. (May 20, 2013).

Principles for a Medicaid Managed Long-Term Services and Supports Program: Promoting Health, Wellness, Independence, and Self-Sufficiency

1. Development and implementation of a quality MLTSS program requires a thoughtful and deliberative planning and design process, building on the strengths of the current LTSS program.
2. Implementation and operation of the MLTSS program must be consistent with the Americans with Disabilities Act and the Supreme Court *Olmstead v. L.C.*[2] decision, such that MLTSS is delivered in the community in the most integrated fashion and setting possible[3] and in a way that offers the greatest opportunities for active community, educational and workforce participation, all to the extent desired by and appropriate to the individual participant.
3. Payment structures for MLTSS support the goals and essential elements of the program, including encouraging, rather than dis-incentivizing, home and community-based care and promoting employment services.
4. The MLTSS participant must be assured the opportunity for informed choice and assistance through conflict-free education, enrollment/disenrollment assistance, and advocacy.
5. The MLTSS program must consider the unique needs of the whole person through person-centered policies and procedures, promotion of self-determination, and opportunities for self-direction.
6. Ensuring one entity is responsible for a comprehensive and integrated package of acute care services and LTSS (institutional and non-institutional) increases Medicaid program efficiency, avoids cost shifting and service disincentives, and enhances health outcomes and quality of life.
7. A provider network is adequate if it is strongly representative of the State LTSS infrastructure and it ensures the participant a choice of and timely access to providers and necessary services, as well as continuity of care during transition periods.
8. Participant health and welfare in MLTSS is better assured with strong and clearly defined participant protections and supports.
9. There must be no reduction in the quality of care provided to participants in the MLTSS model, as compared to the fee-for-service model, and the State must exercise all due diligence to maintain or increase the current level of quality.[4]
10. Effective State oversight of MLTSS is vital to ensuring program vision, goals, and managed care contract elements.

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[2] *Olmstead v. L.C.*, 527 U.S. 581 (1999).
[3] The "most integrated setting" is defined as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." 28 C.F.R. Pt. 35, App. A (2010).
[4] Senate Bill 147 (2011); RSA 126-A:5, XIX.

Principle Implementation Guidance

Adequate Planning

1. Ensure adequate time to: develop a clear vision and goals; obtain stakeholder input; educate program participants, providers, State personnel, and MCOs; identify State monitoring and oversight responsibilities; assess and ensure MCO, State, and provider readiness; and develop a transition plan to MLTSS with mechanisms to reduce risk to beneficiaries and for rapid identification and resolution of LTSS problems.
2. Engage a cross-disability representation of stakeholders, including a formal advisory body, in the development, implementation, and ongoing operation of the MLTSS program, which includes participant, community organization, provider, and advocacy representatives.

Community Integration

Undertake meaningful compliance with CMS home and community-based setting requirements and include services and incentives to enable and support employment, including volunteer work.

Payment Structures

1. Ensure payment structures that are adequate to provide participants access to and choice of needed LTSS providers, such that the MLTSS network is sufficient in provider number, type, and geographic location so as to afford the participant access to LTSS that is at least equivalent to that available to the general public in the participant's community.
2. Ensure routine State oversight and evaluation of payment structures to assess effect on goal achievement and impact on the LTSS infrastructure, as well as to hold MCOs accountable through performance-based incentives and penalties.
3. Ensure payment structures are cost-efficient in order to best meet the needs of all eligible persons needing services.
4. Ensure that providers have education and support to implement new billing and payment processes to minimize disruption in operations and service delivery.

Conflict-Free Participant Support

1. Require that participant education, assistance, and advocacy be provided by an entity that is not an MCO or a service provider and establish an independent advocate or ombudsman to assist participants. Provide each in a manner that is accessible, ongoing, culturally competent, and consumer-friendly.
2. Require conflict-free LTSS clinical eligibility determinations.

Person-Centered Processes

1. Provide training for and require the use of a standardized person-centered needs assessment[5] and the use of person-centered service planning and coordination, including the promotion of self-determination.
2. Require MCOs provide, but not require, opportunities and supports for self-direction of services.

Comprehensive, Integrated Service Package

1. Require MCOs provide and coordinate the full array of LTSS (including institutional and non-institutional) to ensure integration and delivery of all needed services identified in needs assessments and care plans.

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[5] The assessment instrument includes current health status and treatment needs; social, employment, and transportation needs and preferences; personal goals; participant and caregiver preferences for care; back-up plans for situations when caregivers are unavailable; and informal support networks.

2. Routinely assess the impact on goal attainment resulting from the exclusion of any services from MCO or State benefit packages.

Qualified Providers and Network Adequacy

1. Require MCOs develop and maintain an adequate network of LTSS providers who meet State qualification requirements. Require State approval of MCO provider qualification requirements that materially exceed those of the state Medicaid agency to determine potential impact on the LTSS provider infrastructure for participants and for the general population.
2. Require, to the extent possible, that all existing Medicaid LTSS providers be incorporated into the MCO provider network and identify any essential provider groups for whom the State should mandate incorporation as network providers.
3. Provide support to LTSS providers in areas where they lack MLTSS experience or capacity.
4. Establish transition plans to ensure continuity and coordination of care when out-of-network providers are involved in the transitioning participant's care, with a particular focus on transitions that may impact the participant's residence or employment.

Participant Protections

1. Establish and educate participants and MCOs about: participant rights and responsibilities; a critical incident management system; and a system to prevent, detect, report, investigate, and remediate abuse, neglect, and exploitation.
2. Educate participants and MCOs on grievance, appeal, and fair hearing protections, including continuation of authorized services pending appeals of service coverage. Require these processes be easily accessible, culturally competent, and consumer-friendly. Offer the services of an MLTSS ombudsman who can provide conflict-free assistance to participants.
3. Ensure that auto-assignment to a health plan includes consideration of LTSS providers utilized by the participant. Allow participant disenrollment from a health plan for cause when termination of a provider from the MLTSS network would result in a disruption in residence or employment.

Quality

1. Develop a MLTSS quality strategy and quality improvement system that is tailored to each MLTSS population and that is built upon and integrated with current programs. Include: an External Quality Review process to assess and validate critical MLTSS quality elements, with a focus on individual outcomes and critical processes; a quality of life indicators measure for participants; and a strategy for the transition from fee-for-service to MLTSS.
2. Develop and maintain a transparent data collection and reporting system that provides a strong feedback loop to assure that MLTSS are managed in an efficient and responsible manner that ensures the highest level of quality and meets the unique needs of MLTSS participants. Include an MCO MLTSS report card utilizing quality data.

State Oversight

1. Ensure State administrative and leadership capacity in the following areas in order to provide effective oversight of MLTSS in: contract monitoring and performance improvement; provider network adequacy and access to services; quality assurance and improvement; member education and consumer rights; and rate setting.[6]
2. Require MCO personnel involved with MLTSS have experience and expertise in LTSS and with the populations served, including personnel in leadership, management, utilization review, interdisciplinary care teams, care coordination, and provider relations.

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[6] AARP Public Policy Institute, Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports, July 2012.

RESOURCES

The following resources should be utilized by NH DHHS and the MCO's in their implementation of Medicaid MLTSS programs in NH:

1. Transitioning Long Term Services and Supports Providers Into Managed Care Programs, May 2013, Brian Burwell & Jessica Kasten, Prepared by Truven Health Analytics for CMS, available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/Transitioning-LTSS-.pdf
2. Summary - Essential Elements of Managed Long Term Services and Supports Programs, CMS, available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSS-Summary-Elements.pdf
3. Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs, May 20, 2013, available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf
4. Summary of CMS Guidance on Managed Long-Term Services and Supports, May 2013, NSCLC, available at: http://www.nsclc.org/wp-content/uploads/2013/05/MLTSS-Guidance-052313.pdf
5. AARP Public Policy Institute, Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports, July 2012 available at: http://www.aarp.org/health/medicare-insurance/info-07-2012/keeping-watch-building-state-capacity-to-oversee-medicaid-managed-long-term-services-and-supports-AARP-ppi-health.html

Appendix 4:
Previous Recommendations of the Commission
and
Recommendation Cross-Reference with Senate Bill 553

Recommendation #1: Medicaid Expansion, May 31, 2013

The Governor's Commission on Medicaid Care Management hereby recommends that Medicaid expansion be implemented in New Hampshire due to its necessity in ensuring the successful transition from a Medicaid fee for service system to a more efficient, more effective, and more cost-effective Medicaid care management system in the Granite State.

We recommend the implementation of Medicaid expansion to ensure the successful transition from a Medicaid fee for service system to a more effective and more cost-effective system of Medicaid Care Management in and for our state. A failure to approve and implement Medicaid expansion imperils this pragmatic and compelling opportunity".

Recommendation #2: Management Reporting, November 7, 2013

Governor's Commission on Medicaid Care Management hereby recommends that the Governor request from the Department of Health And Human Services (DHHS) systematic public reporting of information that tracks implementation concerns, as consistent with DHHS data collection process and other reporting requirements associated with Medicaid Care Management.

Beginning with the initial implementation of Medicaid Care Management and through June 30, 2014, The Commission recommends that the Governor request that DHHS establish Public Information Reporting on a key set of issues which have been identified during Commission meetings as those that are priorities for successful public benefit of Medicaid Care Management. The Commission recommends that the reporting be completed on a timely basis, published as frequently as monthly when applicable.

Recommendation #3: Patient-Centered Medical Home, April 3, 2014

The Governor's Commission on Medicaid Care Management hereby recommends ongoing system transformation that embraces the Patient-Centered Medical Home (PCMH) practice model as a principal primary care service delivery model of the New Hampshire Medicaid Care Management Program.

Recommendation #4: Operating Principles, April 3, 2014:

The Governor's Commission on Medicaid Care Management hereby recommends that the following principles be implemented to guide the transition from the current systems of providing Medicaid funded Long Term Services and Supports (LTSS) to a more efficient, effective, and cost-effective Managed Medicaid Long Term Services and Supports (MLTSS) system to ensure that the individuals who rely on these services experience a smooth transition and maintain a high quality of services and supports.

These principles incorporate the principles presented by Governor Hassan to the Governor's Commission, the guidance on MLTSS from the Centers for Medicare and Medicaid Services (CMS), stakeholder forum input, and Federal Medicaid policy, should guide the development and implementation of Medicaid Managed Long Term Services and Supports (MLTSS) and be used as a guidepost for development of contracts with the MCO's.

Recommendation #5: Medicaid Expansion, May 15, 2016

The Governor's Commission on Medicaid Care Management hereby recommends that Medicaid expansion be continued in New Hampshire due to its positive impact on the health of our citizens, our health care system and our economy.

Table 3	
Recommendation Cross-Reference with Senate Bill 553	
SB 553 Plan Element	Recommendation Number
Eligibility and Enrollment	1,2,3,5,6,7,10,11,13,14,15,16,17,21,24
Covered Services	5,16,21
Transition Planning	14,15,16
Prior Authorization	
Transportation	
Pharmacy	14
Case Management	2,7,10,11,12,13,21
Network Adequacy	1,3,7,6,15,16,19,20,21
Credentialing	
Quality Metrics and Outcome Measurements	3,6,10,11,18,20
Patient Safety	
Utilization Management	8
Finance and Reimbursement	2,3,5,6,11
Rates and Payment	6,7,9
Grievance and Appeals	7,15,16,21,22,23,25
Office of Ombudsman	21,24
Providing value, Quality , Efficiency Innovation and Savings	1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20,21,22,23,24,25

Appendix 5:
Work Groups of the Commission:

1) MEET ENROLLEE'S NEEDS THROUGH PUBLIC ENGAGEMENT AND COMMUNITY BASED SUPPORTS AND SERVICES:	
Members	Priority Inquiries:
❖ Doug McNutt ❖ Sue Fox ❖ Roberta Bernier	▪ MCO staff are knowledgeable re: purpose & structure of community based services & LTSS and federal and state mandates and thes. ▪ …….e are reflected in policies & procedures ▪ DHHS staff are knowledgeable re: purpose & structure of community based services & LTSS and federal and state mandates and these are reflected in policies & procedures ▪ Each individual has access to care coordination which works with family & providers including the medical home reflecting their values and resulting in continuity of care ▪ Infrastructure & policies ensure individuals & providers have personal choice & control in determining their health care needs & LTSS ▪ Role of Bureau of Developmental Services is clearly defined during planning, implementation & evaluation

2) ASSURE EFFECTIVE OPERATIONS & PAYMENT SYSTEMS	
Members	Priority Inquiries:
❖ Yvonne Goldsberry ❖ Tom Bunnell	❖ Prior authorization is streamlined ❖ MCO procedures accommodate long term care realities ❖ Operational constructs allow for timely change if process not working ❖ Conflict of interest is clearly articulated and systems reflect such ❖ At onset, full standardization of paperwork, communication, billing, reporting materials ❖ Payment systems support goals & essential elements of program ❖ Incentivize home & community based care ❖ Contracts allow & support innovation (combine with 1st item on PA) ❖ Address rate setting & management in addition to prior authorization

3) ASSURE ACCESS TO AN ADEQUATE NETWORK OF PROVIDERS	
Members	Priority Inquiries:
❖ Wendy Gladstone MD ❖ Jo Porter MPH	❖ Includes LTSS and home and community base providers ❖ Includes Step 1 providers to provide medical home & specialty care to new Step 1 populations including the "dual eligible, Medicaid-Medicare enrollees" and "children with special medical needs" ❖ Are well trained in prior authorization, coding, billing and payment (operations?) ❖ Coordinates with existing provider network not related to LTSS including acute care resulting in an integrated system of care ❖ Includes in and out of state services ❖ Provides medical home and specialty services (merge with 2nd bullet) ❖ Address needs of "all" including the "difficult person"

4) ESTABLISH UPFRONT CONSUMER PROTECTIONS	
Members	Priority Inquiries:
❖ Gus Morale ❖ Ken Norton	▪ Access to client ombudsman for assistance ▪ Grievance & appeal process is efficient, timely, knowledgeable & respective for individuals & providers (needs to be an upfront problem resolution system that clients are aware of before this level) ▪ Consider maintaining existing services during initial implementation for a determined amount of time where appropriate ▪ Are in place & provide information that is accessible & understandable to all ▪ Program is adjustable over time as feedback is received ▪ Today's strong system of advocacy is sustained

Appendix Six:
Acronyms/References/Sources

Table 5: Acronyms:	
CFI	DHHS Medicaid Waiver; Choices for Independence
CMHC	Community Mental Health Center
CMS	Center for Medicare and Medicaid Services
CSNI	Community Support Network Inc.
DHHS	New Hampshire Department of Health and Human Services
DSRIP	Delivery System Reform Incentive Program
FFS	Fee For Service
IMD	Institutions for Mental Diseases
LTSS	Long Term Supports and Services
MCO	Managed Care Organization
MLR	Medical Loss Ratio
MLTSS	Managed Long-term Services and Supports Program
MMIS	Medicaid Management Information System
MQIP	Medicaid Quality Incentive Payments
NCQA	National Committee for Quality Assurance
NASUAD	National Association of States United for Aging and Disability
NF	Nursing Faciltiy
PA	Prior Authorization

In addition to the extensive materials distributed and posted on the Commission's website, http://governor.nh.gov/commissions-task-forces/medicaid-care/index.htm the following materials were used directly to develop recommendations.

Consumer Protections

Federal Sources:
Federal Register, Vol. 81, No. 88, Friday, May 6, 2016/Rules and Regulations, page 128
Department of Health and Human Services, Centers for Medicare & Medicaid Services, 42 CFR Parts 431, 433, 438, et al., Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. Federal Register, Vol. 81, No. 88, Friday, May 6, 2016/Rules and Regulations. Link is: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf

CMS Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports
CMS Final Rule

Other:
Camille Dobson/NASUAD Presentation
DHHS Presentation Consumer Protections and CFI Waiver Amendment
Commission on Medicaid Care Management, Statement of Principles

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Effective Operations

References:

AARP Public Policy Institute and Mathematica: *Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports*, Debra J. Lipson, et al., July 2012.

Camille Dobson: *LTSS Care Plans, Authorizations and Consumer Protections,* Presentation to NH Medicaid Care Management Commission, January 14, 2016.

Bailit Health and the National Association of Medicaid Directors: *The Role of State Medicaid Programs in Improving the Value of the Health Care system,* March 22, 2016.

Bailit, Michael: Presentation *"Medicaid Managed Care: Lessons Learned About Effective State Purchasing"*, New Hampshire Medicaid Care Management Commission Meeting, May12, 2016

National Governor's Association, Bailit, et. al.,"2015 Medicaid Health Care Purchasing Compendium." National Governor's Association Center for Best Practices, November 2015.

Norton, Steve (2014). "Aging, Managed Care and the Long Term Care System." Presentation to the Governor's Commission on Medicaid Care Management. May 1, 2014.

Norton, Steve (2012). "Aging and the Public Long-term-care System." Report published by the NH Center for Public Policy Studies. September 2012.

Norton, Steve (2015). "The Economics of Aging: Challenges and Opportunities." Powerpoint Presentation. http://www.nhpolicy.org/topics/health-care-in-nh

Olmstead v. L.C., 527 U.S. 581 (1999).

World Health Organization (1946), WHO Definition of Health.