NH Medicaid Care Management Program

Public Forum

Manchester, NH

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Disclaimer

Please note that the comments and priorities that follow reflect the opinions of participating workgroups and not necessarily those of the Department of Health and Human Services.

Photos of charts reflect workgroup work process and product. Items crossed out typically reflect brainstormed suggestions that were combined with others.

Note: In this Forum the first exercise was skipped and the definition of Quality of Life was used from the first two forums. We have documented them as Exercises 1 and 2, while the flip charts may be labeled Exercises 2 and 3.
Program Users Perspective - Exercise 1

What's needed to increase # with high quality of life/health?

- Progression and stability as acceptable outcomes
- Eligibility based on recipient not caregiver income
- Doctors free from outside pressure
- Patient/Family Control
- Appeal rights on denial
- Community Cultural Change of Attitude
- Access to range of info making it geographically convenient and accessible
- Consistent standards implemented across all agencies and users
- Integrated whole family approach
- Wellness versus treatment
- Quality customer service follow up with enough personnel
- Quality and individual control meaning individual and provider or doctor make decisions. Not a one size fits all approach. In particular do not want services to be stopped simply because program user is not showing improvement.
- Communication to user in an easy to understand way. With someone they can talk to who knows them.
- Need to decide as a society on a common value...an agreed baseline in health and service access should be established as a right to every citizen.
- Person centered system that gives consumers choices and variety of health care providers (an increased pool of providers that are adequately reimbursed)
- A proactive case managed system that integrates services across the health and services program including prevention, education, and services all in one stop environment
- Different models of delivery (rural versus city) based on needs of a diverse population (including transport, mental health, substance abuse)
Provider Perspective – Exercise 1
What's needed to increase # with high quality of life/health

- Accessibility
- Preventative Care
- Accountability
- Fair and stable reimbursement including payment reform for innovation
- Comprehensive array of services to make appropriate referrals
- Better accountability at DHHS including an organization chart so providers know who to go to and can eliminate administrative barriers
- Guaranteed access
- Sufficient state and federal funding
- Face to face appeals based on medical necessity with focus on care improvement rather than denials.
- More education and follow up
- Funding and regulatory flexibility
- Integrated system of care using evidence based guidelines
- Access to quality providers – including transportation, home based care
- Care coordination utilizing a HUMAN response system to manage interagency coordination and referrals.
Program User Perspective – Exercise 2

In a care management program, what must happen in order to create knowledgeable and informed recipients?

• Access to benefits specialist, case manager who is an advocate.
• Easy and timely to get in, no fear of immigration and other reprisal
• Communication: clear, concise, in client language, and web based
• Case managers who are knowledgeable, proactive, and flexible to client needs
• Patient control of decisions and services
• Local Control and family involvement to encourage communication and involvement
• Better informed providers and a constant give and take so that they can communicate what they need. Bottom up rather than top down approach.
• Dissemination of info: understandable, easy to interpret, multiple media and outreach programs, local community access, informed providers (not just Medicaid users), peer support groups, survey to determine consumer limitations (i.e. no access to internet or English)
• User Accountability – they need to be open and willing to take in information (advocates needed for those with issues that limit accountability)
• Informative newsletters (electronic or paper) that are mailed out so they can have info readily accessible
• Accessible informational seminars and forums with transportation availability.
• More support groups with access to legislators
• Single point of access to care through medical home or PCP
• Succinct, understandable 4th grade level information
• Need to help users navigate the system (ideally through Medical Home)
Provider Perspective – Exercise 2

In a care management program, what must happen in order to create satisfied providers instead of dissatisfied (or Resistant) providers?

- Eligibility process is a nightmare and no access until found eligible. Can take 6 months to a year.
- Adequate reimbursement for everyone.
- Case Manager oversight provided by DHHS – someone watching them.
- Providers need fair and equitable reimbursement
- Clear guidelines for providers and less red tape
- Access to a comprehensive set of services so that they can make appropriate referrals
- Sufficient state and federal funding
- Fair and adequate funding
- Face to face appeals based on care improvement
- Adequate compensation
- Client care coordination with a team approach
- Consumer input and responsibility – look at what they need and want
- Communication between state and providers (specifically regarding Medicare rules and regulations)
- Community capacity to provide services
Program User Perspective - Exercise 1

What's needed to increase # with high quality of life/health?

1. Person Centered care that gives consumers choices and variety of health services, which in return increases their access to providers that are adequately reimbursed in Care Management Systems.

2. Pro active case management that integration of services across HHS programs, which include substance abuse, education on healthy lifestyle in a supportive environment.

3. Different models of delivery (not limited to primary) that is based on client needs that addresses diverse population including mental health and substance abuse.
Q1: Summarized

1. Access to range of information easy
2. Consistent standards implemented across systems
3. Integrated, holistic, family/team approach
4. Quality customer service/follow up
5. Wellness vs. treatment/independent choices
6. Consumer-centered providers

PROGRAM USERS

Q1
- Range of family approach
- Access to information
- Education
- Local/geographical access
- Enable independence for consumer
- Less red tape
- Uniform standards
- Compassion
- Knowledgeable decision makers
- Shared information across programs
- Replicate VA integrated care system
- Having enough pump personnel
- More wellness plans
- More wellness plans (as opposed to treatment plans)
- Quality customer service
- Holistic treatment
- Follow regs consistently
- Follow up
USERS B Q1

1. Doctors free from outside pressure
2. Patient/family control
3. Community cultural change of attitude
4. DHHs needs to adopt #3
5. Appeal rights when denied services

PROGRAM USERS B Q 7

1. Completely Insurer
2. Agency has high standard of care
3. Money
4. Lessons learned from history
5. Opportunities to get proper care
6. Access to more information about child family members who use the system
7. Understanding spend-downs and deadlines
8. Better communication between providers and caregivers
9. Free choice of providers
10. No denial of necessary care
Different Model for different communities

PROGRAM USERS C

Q1

1. Person-centered
2. Consumer choice of specialist (not geographically)
3. Welcoming to diverse population
4. Varieties of choice for healthcare providers

Q2

1. Prevention
2. Integration of services across programs
3. More providers accepting Medicaid
4. Education of consumers/eligibility

Q3

1. One Stop Shopping
2. Adequate reimbursement of providers
3. Health care for substance abuse
4. Transplantation
5. Pro-active Case Management
Q1: PROGRAM USERS’ D

PROGRESSION/STABILITY AS
ACCEPTABLE OUTCOMES

ELIGIBILITY BASED ON
RECIPIENT INCOME

CONSUMER CONTROL OVER
TREATMENT PROVIDERS

STRONG OVERSIGHT
COORDINATED CARE BY TEAM

10. STRONG OVERSIGHT
11. PREVENTION = STABILITY
12. PROGRESSION
13. RECIPIENT-BASED
   RE: INCOME
14. CARE MGMT ↑ IN
    MEDICAL HOME
15. INDIVIDUALIZED
    PLANNING
16. OUTREACH
17. INTEGRATION
18. INDEPENDENT/
    CARE
19. COST EFFECTIC
20. ACCESSIBILITY
21. COORDINATED CARE
    ON TEAM
22. CRAP ON MED CARE
23. CONSUMER CONTROL
Provider Perspective – Exercise 1
What's needed to increase # with high quality of life/health

1. Sufficient state/EA funding
2. Fair equitable payment
3. Face to face appointments (medical necessity) with focus on care improvement rather than downsizing based on defined CT. controlled outcomes
providers

providers access to family

information

providers access to care

in rural areas = too costly (care mis)

case management = a staple

improved access to transportation

to follow up care (all care)

more education and follow up

so consumers don't lose benefits (and pay twice)

providers local access

- continued eligibility

- help people pick "best" plan

- informed services by

- whose family to model

- focus on preventive/preventive

- modes of care

mechanism to appeal

- care decisions (medical necessity)

- stay away from tax

- based system that dictates

equity

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10. ACCESIBILITY  
- Accessibility
- Education
- Co-pay

PREVENTATIVE CARE
- Outreach/Communication
- Education
- Inform all possible options
- Pursuit of care

ACCOUNTABILITY
- Consumer directed
- Transparent performance measures
- Boxer in resident clinical integrity
- Response from the state
- State regulations
- Decrease fragmentation
- Consistency
- Compensation
- Independent choice

W.B. PROVIDERS B
Q  1. accessibility
- x education
- cost effective
- Consumer directed
- Transportation
- Independence in choice
- Engagement in all levels of care
- Accountability
- Regulation
- Quicker referrals for necessary service
- Better follow-up
- Better communication or resources
- Integriti outreach
- Consistency
- Pursuit of fogy fulriment of resident
- Respect doing
- Products for accountability
- Timelines of decisions
- Evaluation of meeting needs
- Appropriate level of care
- Address all possible options
- Preventative care
- Transparent performance measure
Question 1: PROVIDERS

- FAIR & STABLE Reimbursement
  - Including Payment Reform
  - Inclusion of Indigent & New I.D.
  - Interstate Funding

- Better Organizational Chart
  - Who is accountable
  - Eliminate Admin Responsibilities

- Access to Necessary Services
Q1 PROVIDER

1. Integrated care based on using evidence-based guidelines

2. Access to care using quality providers
   - Transportation
   - Home-based/chronic DIS
   - Information/communication

3. Care coordination utilizing a human response system to manage emergency/communication resources.

PROVIDERS Q1 PROD

A. Systematic approach, evidence-based guidelines
B. Access to quality transportation
C. Home-based SCS for chronic care
D. Shift resources quickly if needed
E. Well-trained providers

1. Human response system to
   A. Care coordination
   B. Access to providers
   C. Access to info from multiple sources

2. Interagency communication
   A. Clear goals and expectations
   B. Clear referral process
PARTICIPANT

RESPONSIBILITY

DATA: Population

C U
Program User Perspective – Exercise 2

In a care management program, what must happen in order to create knowledgeable and informed recipients?

1. Equal Access [define]
2. Quality and Individual Control
3. Communication
4. Values/Resources/Money
5. Patient control of services/decisions
6. Local control/family involvement
7. Better informed providers
8. Consistent application of Rules/Laws/Services/Forms
9. Communication

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- Computer Access/List Serve
- Understandable language of the rules
- Frequent workshops
- Meeting of case managers
- Family involvement
- Local control/local boards
- Fewer brochures/more 1-1 talk
- Informing community organizations/Sharing informational community organizations
- More infb.wl Medicaid Health Home offices
- Knowledgeable of informed program providers
- Uniform forms/consistent paperwork/less paperwork
Access

1. Benefits Specialist
2. Case Manager / Advocate
3. Easy & Timely
4. No fear of reprisal / Immigration / Medical

Communication

1. Clear and simple rules
2. Client language
3. Web based options
4. Clear, written materials

Case Manager
proactive and flexible to individual needs

Question 2

1. Clear and simple rules for benefits and eligibility
   - Proactive Case Manager / Advocate
   - Flexibility to meet clients needs

2. Mandated delivery of services in clients language
   - Web based options for Medical Home

3. Clear communication materials focused on prevention

4. Easy access to case management
   - Access to information of the Managed Care provider / Benefits Specialist
   - No fear of reprisal / Immigration / Medical

5. Timely access to case manager
Q2 USERS D

INFORMATIVE NEWSLETTERS
(E-based + otherwise)

ACCESSIBLE INFORMATIONAL CLASSES OR SEMINARS/PUBLIC FORUMS

SUPPORT GROUPS INCLUDING SPECIALIZED SPEAKERS/LEGISLATORS

UTILIZE PEER SUPPORT

CENTRAL REPOSITORY FOR INFO/FAQ'S (CASE MRR?)

PROGRAM USERS' D FORMS

PROGRAM STABILITY AS

PROBD Q2

1. UTILIZE PEER SUPPORT

2. INFORMATIVE NEWSLETTERS

3. CENTRAL REPOSITORY FOR INFO

4. INFORMATIONAL CLASSES OR SEMINARS/PUBLIC FORUMS

SUPPORT GROUPS

INCREASE ACCESSIBILITY

SPECIALIZED SPEAKERS + LEGISLATORS

PUBLIC FORUMS
Provider Perspective – Exercise 2

In a care management program, what must happen in order to create satisfied providers instead of dissatisfied (or Resistant) providers?

Adequate compensation
Timelines of referral
Cross-over of system communication
Strong care management approach
Coordination of care
Centralization of where resource are available
Clinical integrity
IT upgrade
Medicare/Medicaid coordination
Consumer responsibility
Concurrent services
Transition
Increased community capacity

Adequate compensation
Community input/responsibility
Communication
State Medicare
Consumer input/responsibility
Client care coordination
Team approach & integrity
WHAT TO DO TO POSITIVELY IMPACT COHORT PROVIDERS (2)

(1) GUARANTEE ACCESS TO PROVIDERS
   (COMPREHENSIVE, COORDINATED, FAMILY
   CENTERED CARE INCLUDING: MENTAL
   HEALTH & SUBSTANCE ABUSE) IN URBAN AND RURAL AREAS

(2) MORE EDUCATION & FOLLOW UP REGARDING
    RIGHTS, BENEFIT PLANS & RESOURCES
    SO PATIENTS DON'T AVOID CARE & PICK THE RIGHT PLAN

(3) FUNDING & REGULATORY FLEXIBILITY

WHAT'S NEEDED TO SATISFY PROVIDERS IN A CARE MGMT PROGRAM:

(1) FAIR EQUITABLE PAYMENTS
    SET FEES BASED ON BILLED SERVICES
    EASY ACCESS TO INFORMATION ON BILLING MODELS
    FOCUS ON COST IMPROVEMENTS RATHER THAN ON DISEASE MANAGEMENT
    SUFFICIENT FEDERAL FUNDS

(2) INCENTIVIZE CONSUMER FEEDBACK
    DEFINE OUTCOMES & FOLLOW-UP FOLLOW THROUGH
    PROVIDER COMMUNICATION
What can DHHS allow us to do to improve educating users

1. Educate on a fourth grade level - multi languages
2. Secret info
3. Learn to educate the nation
4. Single point of access - primary care
Q2

Provider

1. Eligibility

2. Adequate Reimbursement

3. Oversight & Quality Assurance
   Provided by HHS
   for ALL Providers

Q2 - Provider D

- Easy Eligibility process
- Length of time to determine eligibility
- Availability of Managed Care Program & Requirements - Care mgmt coordination
- Reimbursement for pt education
  Proactive for mgmt
- Ability to track outcomes
  Ability to track pts

- HHS must provide clear oversight of vendor
  Broad list of attributable providers
  Reimbursement to support robust network of providers