



New Hampshire
Department of Health and Human Services

*Medicaid Care Management Program
Step 2 Design Concept*

Redesign of New Hampshire's Long Term Services and
Supports Delivery System:
A Concept Paper for Stakeholder Review and Input

November 26, 2014



Introduction

In June 2011, the New Hampshire State Legislature enacted a law – Senate Bill 147¹ – requiring the Department of Health and Human Services (the Department) to employ a care management model for administering the New Hampshire Medicaid program. As a result, the Department is undergoing a transition from its fee-for-service model to a care management model, referred to as Medicaid Care Management². The Medicaid Care Management program enrolls Medicaid recipients into a contracted managed care organization, or health plan, who manages their care and pays their providers. The Department currently contracts with two health plans to provide services to Medicaid Care Management program enrollees: (1) New Hampshire Healthy Families³ and (2) Well Sense Health Plan⁴. The care management program is being implemented in multiple steps. Step 1 of the program began on December 1, 2013 and included the enrollment of most of the Medicaid population into care management, while others were allowed to remain in the fee-for-service program. The Medicaid recipients included in Step 1 were required to enroll with a health plan for their medical care, which include services such as doctors’ visits, pharmacy services, hospital care, therapies, etc.

In Step 2, most of the Medicaid population that remained in fee-for-service will be required to enroll in the Medicaid Care Management program and will receive their medical care and services through a health plan. This is referred to as mandatory enrollment. Step 2 will also move New Hampshire’s four home and community based waiver services and other long term services and supports into care management, including Nursing Facility stays and services provided to children and families, in two phases. This concept paper outlines the components of these phases, the impacted populations and services, and other design elements the Department is considering as it plans for Step 2 implementation.

Medicaid Care Management Program Goals

A key goal of the care management program is to implement a “whole person approach” to providing Medicaid services. A whole person approach to service delivery means that individuals and populations are viewed as the sum of five interwoven characteristics: physical, emotional, intellectual, social, and spiritual. By taking this



¹ New Hampshire Senate Bill 147, available at <http://www.governor.nh.gov/media/news/2013/documents/mm-05-01-sb147.pdf>

² New Hampshire Medicaid Care Management Program, available at <http://www.dhhs.nh.gov/ombp/caremgmt/>

³ New Hampshire Healthy Families, available at <http://www.nhhealthyfamilies.com/>

⁴ Well Sense Health Plan, available at <http://wellsense.org/>



approach, the Department can redesign the New Hampshire health care system in a way that provides a continuum of services and supports designed to improve the health of the population, improve the experience of care, and continue to manage costs.

The Department has developed a set of six distinct goals for Step 2 of the Medicaid Care Management program:

1. Improve coordination of medical care, behavioral health care, and long term services and supports
2. Prevent the need for more intensive medical and/or long term services and supports whenever possible
3. Improve transitions of care
4. Develop the most efficient and effective health and long term services and supports possible
5. Ensure sustainability of the Medicaid Program to meet future needs of New Hampshire citizens
6. Impact positively the social determinants of health

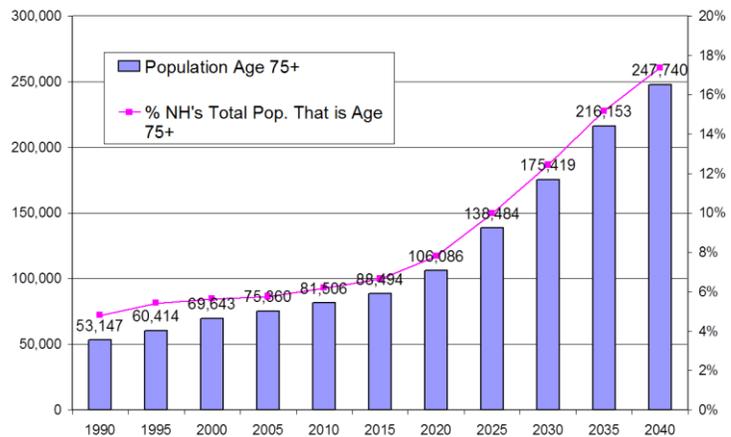
The Department believes that achieving these goals is imperative to the sustainability of the Medicaid program in light of future demands on the system with New Hampshire’s aging population, increased service demands, and rising Medicaid costs.

Impetus for Change

Step 2 of the Medicaid Care Management program primarily focuses on individuals who are in need of long term services and supports in the form of home and community based waiver services or staying at a Nursing Facility. The Department believes that this population would benefit from receiving their medical services and

long term services and supports in a managed care setting, as their complex health needs are served by multiple delivery systems and are generally not well coordinated, often resulting in suboptimal health outcomes for individuals and a compromised quality of care.

In addition, New Hampshire’s overall population is aging. According to the New Hampshire





Center for Public Policy Studies, the largest impact of aging will occur after 2020⁵, with Medicaid expenditures for people over age 65 projected to increase by approximately 50% by 2030.

The Medicaid program is the second largest health program in the United States as measured by expenditures, second only to Medicare, and the largest as measured by enrollment nationally. Medicaid represents one-sixth of the health economy. In 2012, its outlays of \$432 billion accounted for a sizeable portion of Federal and State budgets. Medicaid also serves as a safety net for the Nation's most vulnerable populations, covering nearly 58 million recipients in 2012.

Over the next ten years, expenditures are projected to increase at an average annual rate of 7.1% and to reach \$853.6 billion nationally by 2022. In addition, average enrollment is projected to increase at an average annual rate of 3.3% over the next ten years and to reach 80.9 million nationally in 2022. In New Hampshire, 25% of the Medicaid population drives 70% of the spending⁶. A change to the system is needed in order to sustain the current level of services, which is the catalyst for Step 2 of the care management program.

Because of this increase in demand for Medicaid services, many other states are moving their long term services and supports into managed care. Currently, approximately 70% of all Medicaid recipients nationwide are enrolled in some form of managed care. By 2014, 24 States will have included some or all of their long term services and supports services into a managed care program⁷.

⁵ "Aging, Managed Care and the Long Term Care System" Presentation by New Hampshire Center for Public Policy Studies to New Hampshire's Commission on Medicaid Care Management, May 1, 2014. Available at http://www.nhpolicy.org/UploadedFiles/Resources/050114_Managed_Care_Commission.pps

⁶ "2013 Actuarial Report on the Financial Outlook for Medicaid" by Centers for Medicare & Medicaid Services (CMS). Available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/medicaidReport2013.pdf>

⁷ "MLTSS – a 360° view" presentation, National Association of States United for Aging and Disabilities 2014 HCBS Conference by Camille Dobson, Deputy Executive Director. Available at <http://nasuad.org/sites/nasuad/files/MTLSS%20Intensive%20-%20Dobson.pdf>



Step 2, Phase I – Mandatory Enrollment, Choices for Independence Waiver, and Nursing Facility Services

In Step 2, current Choices for Independence waiver and Nursing Facility recipients will continue to have access to the services that are currently covered by the Choices for Independence waiver as well as services currently provided in Nursing Facilities. Some of the processes that are in place for authorizing and approving services will change, however many will remain the same. For example, the Department will maintain responsibility for determining eligibility for both the Choices for Independence waiver and Nursing Facilities. The Department realizes that implementing Step 2 is a significant system change and that a gradual approach is necessary, therefore the integration of Choices for Independence waiver and Nursing Facility services into the care management program will be phased in over two years, as described in the sections below.

Mandatory Enrollment

The first phase of Step 2 will include the mandatory enrollment of most of the recipients who were given the option to participate in Step 1 of the program. These recipient groups that will be required to enroll with a health plan beginning July 1, 2015 for their medical services, Choices for Independence waiver services and Nursing Facility stays during Phase I of Step 2, and coverage will begin September 1, 2015.

- Foster Care Population
- Medicare Dual Eligible Population
- Home Care for Children with Severe Disabilities, also referred to as Katie Beckett
- Children with special health care needs enrolled in Special Medical Services / Partners in Health
- Children with Supplemental Security Income
- Native Americans and Native Alaskans

Although most recipient groups will transition into care management during Step 2, a very small number of people will be exempt and therefore remain in the traditional fee-for-service Medicaid program. These exempt recipient groups include:

- Members with Veterans Affairs Benefits
- Individuals receiving the Family Planning Only Benefit
- Initial part month and retroactive eligibility segments (excluding auto eligible newborns)
- Spend-down population
- Qualified Medicare Beneficiary and Specified Low-Income Medicare Beneficiary only (no Medicaid) population
- Health Insurance Premium Payment Program

In addition to these recipient groups, several types of services will remain excluded from care



management and therefore be delivered in fee-for-service Medicaid. This includes services provided by intermediate care facilities for individuals with intellectual disabilities, services provided by the Medicaid to Schools program, and Medicaid dental benefit services.

Choices for Independence Waiver Services

The first phase of Step 2 will also transition services provided by the Choices for Independence waiver into the Medicaid Care Management program. Beginning on July 1, 2015, members will enroll with a health plan for their medical services, Choices for Independence waiver services and Nursing Facility stays. On September 1, 2015, coverage with the health plan begins for medical services, Choices for Independence waiver services and Nursing Facility stays. Services provided under the Choices for Independence waiver are currently available to seniors and adults with physical disabilities who are financially eligible for Medicaid and medically qualify for the level of care provided in nursing facilities⁸. The Choices for Independence waiver provides a wide range of service choices that enable these eligible adults to stay in their own homes and communities.

Currently, the Department authorizes the services the individuals receive on the Choices for Independence waiver. As these waiver services transition into care management, the health plans will authorize Choices for Independence services based upon criteria approved by the Department. In the first year of Step 2, service authorizations issued before September 1, 2015 will be honored by the health plans until their expiration date or until the individual's needs changes. The Department will approve any reduction to service plans recommended by a health plan during the first year, and the administrative rules and laws pertaining to transfers and discharges, such as RSA 151:26, will continue to apply. In the second year of Step 2, the health plans will continue to authorize the services that individuals receive on the Choices for Independence waiver using the Department's approved criteria.

As it relates to care management for Choices for Independence waiver services, the health plans will coordinate medical and Choices for Independence waiver care and services in a conflict-free manner under the direction of the Department. Currently, in Step 1, the health plans are responsible only for coordinating behavioral health and medical services for their enrollees. The Department is currently responsible for coordinating Choices for Independence waiver services, which occurs through case management agencies presently. Beginning in the first year of Step 2, the health plans will coordinate behavioral health, medical and Choices for Independence waiver services using a whole person approach. In doing so, the health plans may offer contracts to current Choices for Independence case management agencies operating in the state.

⁸ NH DHHS Choices for Independence waiver program, available at <http://www.dhhs.state.nh.us/dcbcs/beas/homecare.htm>



In the current system, the Department enrolls approved Choices for Independence waiver service providers and sets reimbursement rates for Choices for Independence waiver services. In the first year of Step 2, the health plans will offer contracts to all currently enrolled Choices for Independence waiver service providers who meet applicable health plan credentialing requirements as approved by the Department. Reimbursement rates paid in the first year will be equal to the Department's current fee schedule. In the second year of Step 2, the health plans will contract with Choices for Independence waiver service providers based on network needs defined in their contract with the Department and provider performance. Reimbursement rates will be negotiated between providers and health plans.

A new concept for the Choices for Independence population that the Department plans to explore in its implementation of Step 2 is the use of consumer-directed budgets. Consumer-directed budgets are not currently an offered service within the Choices for Independence waiver. In the first year of Step 2, the Department will develop a consumer-directed and managed long term services and supports model for the Choices for Independence waiver and seek stakeholder input on the model.

In the second year of Step 2, the Department will seek approval from Centers for Medicaid and Medicare Services to implement a consumer directed pilot program within the Choices for Independence waiver program. After the second year of the program, if the pilot is successful, consumer directed budgets will be fully integrated into the menu of service options within the Choices for Independence waiver program.

Each of the design elements for the Choices for Independence waiver program will be refined as the Department further plans for Step 2 implementation, and the Department will carefully consider all input gathered from stakeholders in developing this plan.

Nursing Facility Stays

The first phase of Step 2 will also transition services provided by Nursing Facilities into the Medicaid Care Management program. Beginning on July 1, 2015, members will enroll with a health plan for their medical services, Choices for Independence waiver services and Nursing Facility stays. On September 1, 2015, coverage with the health plan begins for medical services, Choices for Independence waiver services and Nursing Facility stays. For individuals unable to stay in their own homes and communities under the Choices for Independence waiver program, the Nursing Home Care program provides services for eligible individuals who are ill, frail and need 24-hour nursing care and supervision. These services typically include residency, meals, skilled



nursing and rehabilitative care, medical services, and protective supervision⁹.

Currently, the Department authorizes Nursing Facility stays. In the first year of Step 2, authorizations for Nursing Facility stays issued before September 1, 2015 will be honored by the health plans until the individual's needs changes. The health plans will authorize coverage of Nursing Facility stays for new members based upon criteria approved by the Department, and will evaluate the clinical needs of individuals receiving Nursing Facility services under an authorization issued by the Department before September 1, 2015. Any reduction in Nursing Facility services recommended by health plan during the first year will be approved by the Department. The administrative rules and laws pertaining to transfers and discharges, such as RSA 151:26, will continue to apply. In the second year of Step 2, the health plans will continue to authorize the Nursing Facility stays using the Department's approved criteria.

With respect to care management for Nursing Facility stays, the health plans will coordinate medical and long term services and supports under the direction of the Department. Currently, in Step 1, the health plans are responsible for coordinating behavioral health and medical services only for those individuals who are enrolled with a health plan. Beginning in the first year of Step 2, the health plans will coordinate members' care, including integrating medical care, behavioral health care, and long term services and supports using a whole person approach.

Currently, the Department enrolls approved Nursing Facility providers and sets reimbursement rates for Nursing Facility stays. To do so, the Department utilizes an acuity-based rate setting model, which includes per diem and supplemental payments. In the first year of Step 2, the health plans will offer contracts to all Nursing Facilities who are currently licensed, Medicaid enrolled, and meet applicable health plan credentialing requirements that are approved by the Department. Health plans will make payments to nursing facilities as calculated by the Department under an acuity-based payment model. In the second year of Step 2, the health plans will manage their Nursing Facility provider networks to meet their access and quality requirements, and reimbursement rates will be negotiated between providers and health plans.

As with the Choices for Independence waiver program, each of the design elements for Nursing Facility stays will be refined as the Department further plans for Step 2 implementation, and the Department will carefully consider all input gathered from stakeholders in developing this plan.

Quality Measures

The Department is developing Quality Measures based on recommendations from stakeholders,

⁹ NH DHHS Nursing Home Care Program, available at <http://www.dhhs.state.nh.us/dcbcs/beas/nursinghome.htm>



current Home and Community Based Care Waivers performance measures and national best practices. The Department will develop a process for monitoring and reporting on Quality Measures similar to the process that exists for Step 1 of the Medicaid Care Management program.

Step 2, Phase II – Developmental Disabilities, Acquired Brain Disorders, In Home Supports Waivers

The second phase of Step 2 will transition services provided under the Developmental Disabilities waiver, the Acquired Brain Disorders waiver, and the In Home Supports for Children with Developmental Disabilities waiver, as well as services provided by the Division for Children, Youth & Families into a managed care setting at a date yet to be determined. This document does not reflect the approach for transitioning these services into Step 2 as the design concepts for doing so are still in development. In addition, the Department is expecting formal input from the Bureau of Development Services Quality Council on the concept development in January of 2015 and will review that input as it furthers its program design.

Changes in Federal Regulations/Expectations

In May 2013, the Centers for Medicare & Medicaid Services released guidance and support to states related to the development, expansion, reconfiguration, and implementation of Medicaid managed long term services and supports programs¹⁰. The Centers for Medicare & Medicaid Services expects the following ten elements to be incorporated into managed long term services and supports programs.

1. Adequate Planning
2. Stakeholder Engagement
3. Enhanced Provision of Home and Community Based Services
4. Alignment of Payment Structures and Goals
5. Support for Beneficiaries
6. Person-centered Processes
7. Comprehensive, Integrated Service Package
8. Qualified Providers
9. Participant Protections
10. Quality

The Department is addressing each of these ten elements as it plans for the implementation of Step 2 of the Medicaid Care Management program. Prior to seeking approval from the Centers for Medicare & Medicaid Services for Step 2, the Department will follow a thorough stakeholder process to ensure robust engagement and feedback.

¹⁰ “Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs” by Centers for Medicare & Medicaid Services (CMS). Available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf>



Compliance with Centers for Medicare & Medicaid Services' Final Rule for HCBS Settings

In addition to the changes resulting from Step 2, the Department must also comply with the new Final Rule for HCBS Settings. In January 2014, the Centers for Medicare & Medicaid Services published a Final Rule regarding Medicaid home and community based services waivers, focused on enhancing the quality of services and protecting participants¹¹. The regulations define new requirements under which states must provide home and community-based services and long term services and supports. The Department will amend the four 1915(c) home and community-based services waivers described in this document, and therefore comply with the contents of this Final Rule.

The Final Rule describes requirements for how services can be provided in certain home and community-based settings, defines person-centered planning requirements across all waivers, defines requirements for conflict-free case management, and provides states with options to combine coverage for multiple populations into one waiver, to streamline how waivers are administered, and design waivers around functional needs.

The new rule requires the development of a transition plan which describes how the state will comply with the new rule by March 17, 2015 or earlier if it amends its waiver(s). The transition plan and changes made to the Department's four home and community-based services waivers as described in this document will require public comment and hearing(s), separate from this concept paper and the 1915(b) described indicated above.

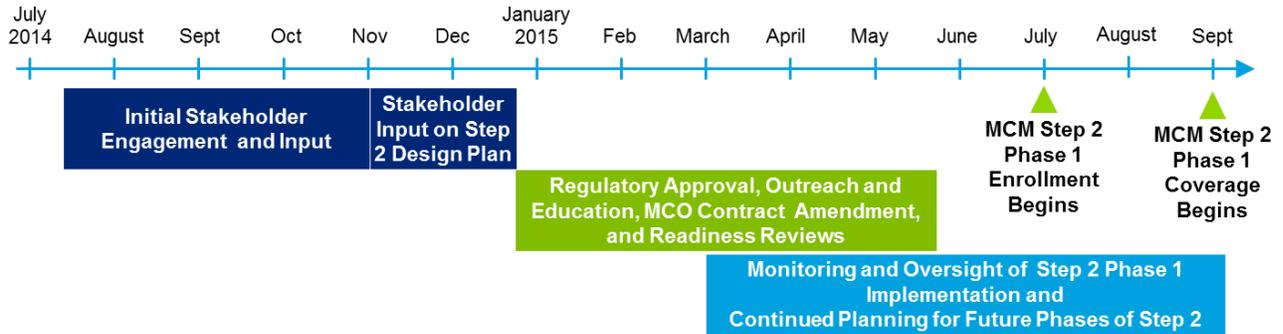
More information on the Final Rule can be found at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/home-and-community-based-services.html>.

¹¹“Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers” Final Rule from the Centers for Medicare & Medicaid Services (CMS) on January 16, 2014. Available at <https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider>.



Step 2 Timeline

On July 1, 2015, the Department will require all populations to enroll with a health plan for their medical services, Choices for Independence waiver services, and Nursing Facility stays. Health plan coverage for these services will begin on September 1, 2015.



Next Steps for Step 2 Implementation

The Department is hosting stakeholder input sessions for feedback on the concepts included in this document beginning in November 2014. A schedule of forums can be found online on the Step 2 Medicaid Care Management website¹². During these sessions, the Department will seek feedback from the public on key concepts and the proposed phased plan for Phase I of Step 2, which includes mandatory enrollment into the care management program, and the integration of Choices for Independence waiver services and Nursing Facility stays.

¹² NH DHHS Step 2 Medicaid Care Management website is available at <http://www.dhhs.nh.gov/ombp/caremgt/step2.htm>



Appendix

Stakeholder Engagement Process

From July to October 2014, the Department of Health and Human Services (the Department) hosted a series of stakeholder input sessions to solicit comments and questions about the next step for the Medicaid Care Management Program. As a result, over 850 stakeholders were engaged in 28 sessions throughout the state. During these sessions, the Department sought feedback from stakeholders using three key questions:

- What works for you now in terms of how your Medicaid services are provided and what should be continued?
- What are the “lessons learned” during Step 1 implementation that we should consider for Step 2 planning and implementation?
- What do you think should be included in a Step 2 Quality Strategy? What are the most important things that should be measured to make sure that the Medicaid Care Management Program is working well?

The Department received verbal, written and emailed responses, suggestions and comments that are being considered in the development and implementation of Step 2 of the Medicaid Care Management Program. A full breakdown of the stakeholder sessions is below, and themes from stakeholders are described on the following pages.

Stakeholder Forums for Choices for Independence Waiver and Nursing Facility Services

- Department of Health and Human Services Legislative Subcommittee for Child & Family Services Workgroup: July 9, 2014
- Joint Meeting with Adult Day Program Providers, New Hampshire Association of Residential Care Homes, Residential Care Providers, and Office of Long Term Care Ombudsman: July 17, 2014
- Joint Meeting with Transportation and Senior Nutrition Providers: July 21, 2014
- ServiceLink Resource Center Managers: July 23, 2014
- Joint Meeting with Long Term Care Eligibility Steering Committee, Nursing Facility & County Administrators, and New Hampshire Health Care Association: July 25, 2014
- Joint Meeting with Case Management Agencies, Home Care Providers, Statewide Independent Living Council, Endowment for Health: July 31, 2014
- State Committee on Aging: August 4, 2014
- Elder Rights Coalition: August 6, 2014
- TLC Medical Day Care for Adults: August 26, 2014



Stakeholder Forums for Choices for Independence Waiver and Nursing Facility Services

- New Hampshire Benefits Planners Group: September 9, 2014
- Nashua Senior Center: September 10, 2014
- Hillsborough Nursing Facility: October 1, 2014

Stakeholder Forums for Developmental Disabilities, Acquired Brain Disorders and In Home Supports Waiver Services

- State Family Support Council: August 4, 2014
- New Hampshire Brain Injury Association: August 13, 2014
- Eastern New Hampshire (Exeter) Hosted by Area Agencies: Afternoon, August 18, 2014
- Eastern New Hampshire (Exeter) Hosted by Area Agencies: Evening, August 18, 2014
- New Hampshire Bureau of Developmental Services Quality Council: August 20, 2014
- Developmental Disabilities waiver Specific: August 27, 2014
- Acquired Brain Disorders waiver Specific: August 28, 2014
- In Home Supports waiver Specific: August 29, 2014
- Southern New Hampshire (Bedford) Hosted by Area Agencies: Morning, September 9, 2014
- Southern New Hampshire (Bedford) Hosted by Area Agencies: Evening, September 9, 2014
- Western New Hampshire (Peterborough) Hosted by Area Agencies: Afternoon, September 15, 2014
- Western New Hampshire (Keene) Hosted by Area Agencies: Evening, September 15, 2014
- Northern New Hampshire (Albany) Hosted by Area Agencies: Morning, September 16, 2014
- Northern New Hampshire (Gorham) Hosted by Area Agencies: Afternoon, September 16, 2014
- Northern New Hampshire (Whitefield) Hosted by Area Agencies: Evening, September 16, 2014
- People First of New Hampshire: September 20, 2014

Themes from Stakeholders Regarding Mandatory Enrollment in the Medicaid Care Management Program

During each of the 28 sessions, the Department accepted comments and questions about the mandatory enrollment of the following population groups into the Medicaid Care Management program.



- Medicare Dual Eligible Population
- Home Care for Children with Severe Disabilities, e.g. Katie Beckett
- Children with special health care needs (enrolled in Special Medical Services / Partners in Health)
- Children with Supplemental Security Income
- Foster Care Population

Common questions and comments received with respect to mandatory enrollment in the Medicaid Care Management program include:

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

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

The Department held 12 input sessions specific to Choices for Independence waiver and nursing facility services, which were attended by over 325 stakeholders. Common themes heard from stakeholders include questions about:

- The rates that will be paid by the health plans to service providers
- How health plans will be instructed with respect to contracting, network adequacy, etc.
- The prior authorization process to be followed, including timeliness and frequency; Emphasis on the need for a process that considers individuals' complex long term care needs and must be different from the prior authorization process for acute medical care



- How eligibility for services will be determined
- The need for the Department to educate the health plans about its programs for long term services and supports
- The need to train providers and prepare them for the contracting process and new environment
- The need for more time for planning and implementation
- Assuring continuum of care for individuals, especially when transitioning between settings

Themes from Stakeholder Forums for Developmental Disabilities, Acquired Brain Disorders and In Home Supports Waiver Services

The Department held 16 input sessions specific to the Developmental Disabilities, Acquired Brain Disorders and In Home Supports waiver services, which were attended by over 525 stakeholders. Common themes heard from stakeholders include questions about:

- Functional therapy, e.g. physical therapy, occupational therapy and speech-language pathology, approvals for individuals with complex and/or long term needs
- Pharmacy prior authorizations for people with complex mental health needs
- Overall concerns regarding managed care for individuals with long term needs
- Compliance with the intentions of RSA 171-A (Services for individuals with Developmental Disabilities)
- Knowledge/experience of the health plans with long term services and supports
- Role of area agencies and relationships with knowledgeable, responsive and local staff
- Self-direction and flexibility in the system for long term services and supports
- The need for more time for planning and implementation

This summary of comments and questions received from the stakeholder engagement process is available online on the Step 2 Medicaid Care Management website¹³.

¹³ NH DHHS Step 2 Medicaid Care Management website is available at <http://www.dhhs.nh.gov/ombp/caremgt/step2.htm>