

# Implementation Plan for Medicaid Care Management: Nursing Facility/Choices for Independence Services

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March 2018



NAVIGANT

# Why are we moving to managed long-term services and supports (MLTSS)?

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## **Long-term services and supports (LTSS) are the largest single percentage of service costs in New Hampshire.**

- Costs are concentrated among the elderly and disabled, and long-term services are largest single percentage (45%) of service costs in Medicaid.
- State's population 65 and older is expected to more than double between 2010 to 2040.
- In June of 2016, SB553 legislation instructed the Department of Health and Human Services (DHHS) to develop an implementation plan for the remaining unimplemented phases of the Medicaid Care Management (MCM) program.



# New Hampshire plans to deliver Nursing Facility/Choices for Independence (NF/CFI) through managed care

## MLTSS is a proven national model and will offer New Hampshire Medicaid members and providers:

- More options for members to live and receive services in the community;
- Improvement in quality of life, member experience, and health outcomes;
- Increased access to services; and
- Expanded opportunities for providers in underserved areas.



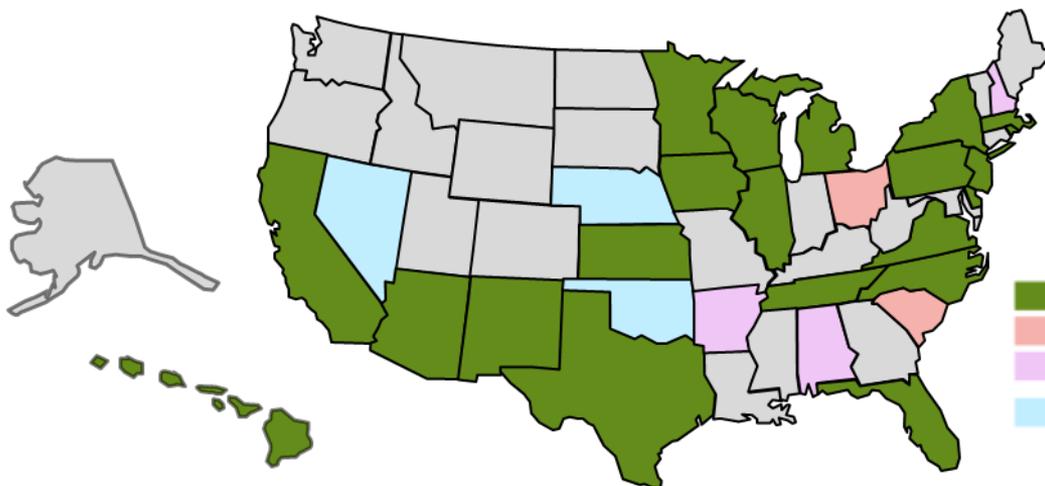
**23 States**  
with MLTSS Programs  
in 2018 (compared to  
8 in 2004)



**800,000+**  
MLTSS Enrollment



**36%**  
of Medicaid Spending



■ Current MLTSS Program  
■ Dual Demonstration Program Only  
■ MLTSS in Active Development  
■ MLTSS Under Consideration

Source: National Association of States United for Aging and Disabilities, Kaiser Family Foundation, NCI Analysis



# MLTSS Services

**DHHS plans to implement an integrated MLTSS program that will deliver both acute and LTSS services.**

Members will receive all current Medicaid services through MLTSS, including nursing facility (NF) services and those available through the Choices for Independence (CFI) waiver.

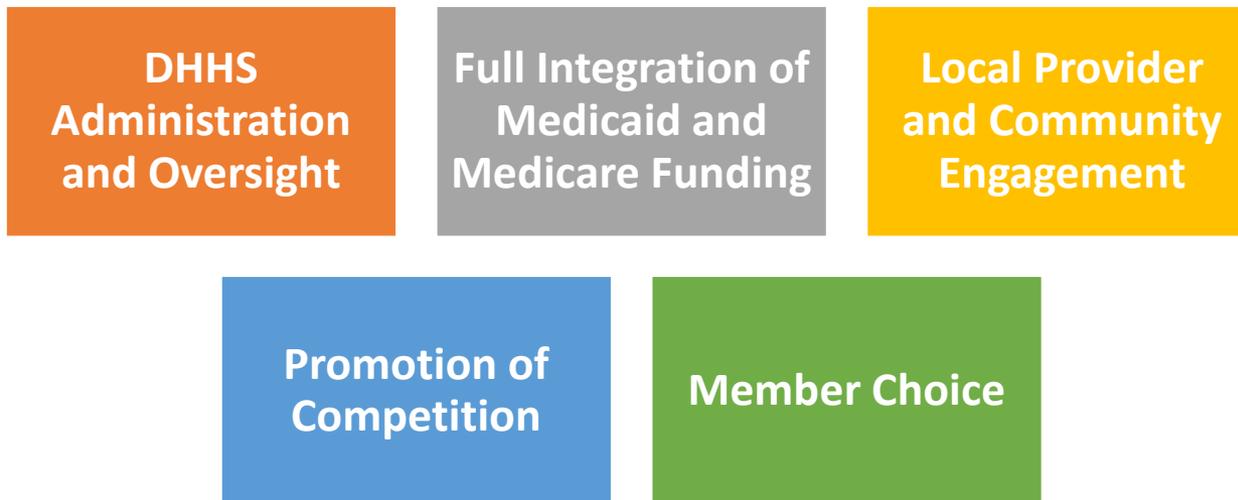
Program or Provider Type	Key Features	
<b>Choice for Independence</b>	<ul style="list-style-type: none"> <li>• Targeted case management provided by 7 case management agencies</li> <li>• <b>Services include:</b> <ul style="list-style-type: none"> <li>○ Adult medical day services</li> <li>○ Home health aide</li> <li>○ Homemaker</li> <li>○ Personal care</li> <li>○ Respite</li> <li>○ Supported employment</li> <li>○ Financial management</li> <li>○ Adult family care</li> <li>○ Adult in-home services</li> <li>○ Community transition services</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>○ Environmental accessibility services</li> <li>○ Home-delivered meals</li> <li>○ Non-medical transportation</li> <li>○ Participant directed and managed services</li> <li>○ Personal emergency response system</li> <li>○ Residential care facility services</li> <li>○ Skilled nursing</li> <li>○ Specialized medical equipment</li> <li>○ Supportive housing services</li> </ul>
<b>Nursing Facility</b>	<ul style="list-style-type: none"> <li>• 60 private nursing facilities (NFs)</li> <li>• 10 counties operate 11 public NFs</li> </ul>	



# DHHS will also launch Program for All-Inclusive Care for the Elderly (PACE)

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- **What are PACE programs?** They are local/regional collaboratives which receive approval to provide LTSS care, under a capitated Medicare/Medicaid payment, and entirely separate from the MCM program.
- **What is the goal of the PACE model?** They are designed to keep members out of nursing homes. PACE was one of the first programs to blend Medicare and Medicaid funds to provide services to frail, community based individuals with comprehensive medical and social support services.
- **What are key features and benefits?**



# PACE Implementation

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**DHHS will work with interested LTSS providers who have a long and successful history in meeting the needs of the most frail and vulnerable adults needing LTSS to develop PACE Programs.**



The State’s choice counseling program will provide prospective members with access to clear explanations of the benefits of the PACE, allowing them to select between a local PACE center or one of the managed care organizations (MCOs).

# PACE Payments

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**Each PACE Center will receive two fixed, capitated, per-member per-month (PMPM) payments for the provision of care from Medicare and Medicaid.**

- **DHHS** will develop the PMPM based on existing claims data for all NF and CFI members who would meet the PACE enrollment criteria and who reside in the specified enrollment areas. The rate will be calculated based on a 12 month average expenditure\*.
- **Medicare** will develop the PMPM using a blend of two formulas:
  - The county rate book multiplied by a uniform PACE frailty adjuster, and
  - A risk adjusted payment methodology.

**PACE would provide and/or pay for necessary services covered in the prescribed capitation rate.**

\*DHHS will work with interested providers in negotiating the capitation rate methodology.



# Program description of Medicaid Care Management – Nursing Facility/Choices for Independence

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**The following slides describe following key program areas.**

- Continuity of Care
- Transportation
- Network Adequacy
- Provider Contracting
- Case Management
- Transition Planning
- Utilization Management/Prior Authorization
- MLTSS Ombudsman
- Quality
- Rates and Payment
- Implementation Timeline



# Continuity of Care

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**MCOs will designate appropriate personnel to support members as they seamlessly transition into MLTSS or disenroll from one MCO and enroll into another.**

- MCOs must:
  - Ensure a smooth transition for members by not discontinuing a member's service plan **for calendar 180 days after** the member transition unless mutually agreed to by the member or responsible party;
  - Honor existing authorizations for all covered services for a **minimum of 180 calendar days**, with enrolled Medicaid providers; and
  - Complete a full care plan assessment for all current Choices for Independence (CFI) waiver members and those in **NFs within the first six months** of the program.
- CFI case managers will remain in place to manage CFI waiver services between July 1, 2019 and December 31, 2019.
- Between December 31, 2019 and June 30, 2020, each MCO will be **required to offer a contract** to any willing and qualified CFI case management agency.



# Transportation

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## **MCOs will be required to maintain current transportation options for CFI waiver services during the first year.**

- During the second year of implementation, DHHS will require MCOs to implement at least one alternative transportation service for CFI recipients which:
  - Empowers members with Person-Centered On-Demand Options;
  - Expands opportunities for community engagement; and
  - Leverages technology to meet members needs.
- There will be **no change** to the provision of Medicaid non-emergency transportation services as specified in the State plan.



# Network Adequacy

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## **The Medicaid Care Management – Nursing Facility/Choices for Independence (MCM – NF/CFI) program will:**

- Build upon existing infrastructure of medical care coordination, expanding access to providers and improving quality outcomes for the covered populations; and
- Consider the MCO's ability to provide all services identified in the member's care plan in effect in the year preceding the commencement of MLTSS

## **Network adequacy standards will:**

- Support a member's choice of provider;
- Ensure the health and welfare of the member; and
- Support the community integration preferences of the member.

## **If unable to provide necessary services in-network, MCOs will:**

- Cover services on an out-of-network basis for as long as the MCO's provider network is unable to provide services covered under the MCM – NF/CFI program.



# Provider Contracting

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## **Prior to procurement selection, MCOs will:**

- Submit non-binding letters of intent (LOI) from providers demonstrating willing to work with the MCO and the ability to deliver a provider network capable of providing CFI waiver and NF services.

## **After procurement, DHHS will:**

- Require MCOs to demonstrate full network adequacy through submission of fully executed provider contracts;
- Provide a LTSS provider contract template for MCOs to use; and
- Require the MCO to pay current rates, as established by the State, for the first year.

Each MCO will offer a contract to each willing and qualified CFI case management agency.

Each MCO must demonstrate readiness to meet the consumers needs and have adequate networks in place.



# Case Management/Care Coordination

*Case Management/Care Coordination (CM) will be provided as a core service under MLTSS. **Currently, case management is often fragmented where HCBS or state plan services are coordinated under the waiver and acute care under the MCO contract.** Under MLTSS, each MCO will develop a comprehensive Person Centered Support Plan (PCSP), customized to meeting the unique medical and long term care needs of each individual member.*



The MLTSS case manager is expected to:

- Assess a member's comprehensive needs (LTSS, medical, behavioral, etc.);
- Identify the medical and LTSS services the member needs;
- Ensure timely access to services that are delivered in a person centered manner; and
- Facilitate access to other social supports and assistance to help the member remain safely at home and to delay or prevent the need for more expensive institutional services.

# Care Coordination

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## **As part of care coordination for members, MCOs must:**

- Coordinate care among health care and LTSS providers;
- Monitor members with ongoing medical or behavioral health conditions;
- Improve access to preventive services in order to minimize over-reliance upon emergency department services; and
- Implement appropriate discharge planning activities to facilitate a safe and rapid return to home.



# Transition Planning

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**Transition Planning enables members to seamlessly transition from a hospital or Nursing Facility to members preferred setting of choice.**

- The MCO transition planning program must:
  - Coordinate appropriate follow-up services from any inpatient or facility stay;
  - Update a member's PCSP when a member receiving LTSS services is hospitalized;
  - Perform necessary mental health and substance abuse services upon member discharge from a psychiatric inpatient facility or residential treatment center;
  - Complete appropriate screening and/or intake processes for members referred to treatment in a NF immediately to facilitate timely transition; and
  - For members already admitted, complete an assessment of the member's interest and ability to transition into a more integrated community setting.

**MCOs must have an established process to work with providers and hospitals to ensure members receive the appropriate follow-up care and care coordination.**



# Utilization Management

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**MCOs must develop, operate, and maintain a utilization management (UM) program with defined policies and procedures reviewed and approved by DHHS.**

- The UM program must have criteria that:
  - Are objective and based on medical, behavioral health, and/or LTSS evidence, to the extent possible;
  - Are applied based on individual needs (including social determinants);
  - Are applied based on an assessment of the local delivery system;
  - Involve appropriate practitioners in developing, adopting, and reviewing them; and
  - Are annually reviewed and up-dated as appropriate.
- Changes to the UM processes **must be** communicated to DHHS **at least 30 days** prior to implementation.
- MCOs must also have mechanisms in place that are **compliant with federal requirements** regarding inappropriate denials or reductions in care.



# Beneficiary Support System/Ombudsman

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## **MLTSS Ombudsman is an independent contracted entity that assists members by:**

- Serving as an access point for member complaints and concerns about their MCO,
- Advocating on behalf of the members to informally resolve problems with their providers or MCO,
- Explaining the member's:
  - MCO's grievances and appeals process.
  - Right to a second review by the State through a State Fair Hearing after an adverse decision by the MCO.
- Assisting members with filing an MCO appeal or State Fair Hearing request, and;
- Referring members to legal counsel, if necessary.

**Maximus and ServiceLink will provide independent choice counseling – by phone, web and in-person, to ensure informed member selection of MCO.**



# Quality



- Enhanced collaboration between MCOs and DHHS to maintain 1915(c) waiver assurances and improve performance measures and outcomes
- Continued transparency on program quality and performance using the NH Medicaid Quality website
- MCO Quality Management/Quality Improvement (QM/QI) program with specific expectations for LTSS

# Quality (Continued)

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## **MCM – NF/CFI program quality oversight will:**

- Integrate LTSS quality measures and oversight mechanisms;
- Expand medical care measures (i.e., HEDIS) to include CFI waiver participants; and
- Add new person-centered outcomes measures, including the National Core Indicators-AD consumer survey.

## **Quality measures will be tied to key factors for deferring NF placement, such as:**

- Maintaining mobility and health status;
- Integration of early warnings and incident management (IM) reporting and tracking for reduction of falls in home; and
- Person-centered care coordination.



# Rates and Payment

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**MCOs will receive a fixed, capitated, per-member per-month (PMPM) payment for each Medicaid member enrolled.**

**The capitated payment will be developed and based upon the following provider reimbursement requirements and assumptions:**

- NFs will no longer receive Medicaid Quality Incentive Payments (MQIP) or ProShare payments directly from the State, effective on December 31, 2019;
- However, the State plans to require that the MCOs make these payments to nursing facilities as a permissible “directed payment” under CMS guidelines, and;
- For at least the first year of MCM – NF/CFI Program implementation:
  - MCOs will utilize the approved fee-for-service (FFS) rate to pay providers for CFI waiver services.
  - Negotiated rates will be no less than the rates paid to providers in SFY 2018.
  - MCOs may negotiate a higher rate with individual providers to ensure coverage.

# Implementation Timeline

## Pre-Implementation

Planning Design

RFP, Contract, & Waiver Development

RFP Procurement and Award

PACE Application Process Initiation

Readiness

## Go-Live

MCOs "At Risk" for Acute Care Services

MCOs "At Risk" for CFI & Nursing Facilities  
Go-Live for PACE

Winter '18

Spring '18

Spring '18

Summer '18

July '18 - July '19

July '19

Dec. '19

