NH Medicaid Managed Care Commission
Summary of Workgroup - Effective Operations and Payment Systems

Priority Issues:

1. **Streamline Prior Authorizations**
2. **Alternative Payment Models**
3. **DHHS Staffing Capacity and**
4. **LTSS Authorizations**

Streamline Prior Authorizations

The Effective Operations and Payment Systems Workgroup (the Workgroup) identified streamlining prior authorizations as a priority issue because there were a variety of concerns identified during Step I implementation for acute care prior authorizations. We noted that streamlined prior authorizations can increase efficiency for clinicians and improve timeliness and access to necessary health services and prescription medications. The Workgroup viewed this issue as important to successful implementation of overall Medicaid Managed Care and Step II.

In an effort to better understand concerns raised by both providers and consumers, the workgroup reviewed Commission meeting minutes to uncover Step I implementation issues. We requested and received a full briefing from NH DHHS staff to understand strategies being implemented to streamline prior authorizations.

The Workgroup determined that most prior authorization issues emerged regarding pharmacy claims or non-emergent medical transportation. Other problems with prior authorizations stemmed from a variety of isolated cases with specific providers. Most of these problems were resolved with assistance from NH DHHS staff working closely with each of the Managed Care Organizations (MCO).

The Workgroup took a closer look at pharmacy prior authorizations and non-emergent medical transportation by requesting a more detailed data review (see December 10, 2015 Commission Meeting Minutes and NH DHHS overview slides). The overwhelming majority of pharmacy claims did not require authorizations and very few claims are denied or appealed. Very few non-emergent medical transportation requests are denied. The transportation grievances indicated problems with one of the MCO's transportation vendors and a new vendor was put in place.

To identify best practices for prior authorizations under managed long term services and supports (LTSS), the Workgroup requested and received two telephone conferences and a briefing at a Commission meeting from Camille Dobson of the National Association of States United for Aging and Disabilities (see January 14, 2016 Commission minutes and overview slides). This information identified a distinction between MCO authorization processes for acute care medical services versus LTSS services. The acute care utilization review process had very different purposes and procedures from the LTSS needs assessment and service/care planning process. The Workgroup formulated a recommendation focused on this distinction (see recommendation XXX.)

Alternative Payment Models

Recommendation: The Department is committed to implementing alternative payment models as part of the recently approved Building the Capacity for Transformation waiver. Before moving forward with Step II, the Department should identify opportunities for building on the work of the waiver to identify 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 LTSS services that are not provided in an acute care medical setting. As part of planning for value-based purchasing within the Managed Care contracts, the Department should define "value" in a clear and measurable way, and should establish performance improvement objectives directly tied to payment reform. This should be included as part of the Department's plan for implementing LTSS under managed care contracts.

References:

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

DHHS Staffing Capacity for MLTSS

Recommendation: The Department requires the right staffing capacity, in the right place, at the right time for effective MLTSS implementation and oversight. Because appropriate staffing is vital to Medicaid managed care effectiveness in an LTSS context, the Commission recommends that DHHS propose and develop a core functions staffing model as part of its forthcoming operations planning process for MLTSS. DHHS should submit a staffing plan that assures strong leadership capacity in Contract Management, Fiscal Control, Actuarial Planning and Analysis, Population Health, Community Engagement, and Consumer Protection so as to protect the efficiency and effectiveness of NH taxpayers' largest investment in State support.

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.
- Michael Bailit: *Medicaid Managed Care: Lessons Learned About Effective State Purchasing*, Presentation to NH Medicaid Care Management Commission, May 12, 2016.

LTSS Authorizations

Recommendation: DHHS should clearly identify and define a distinction between acute care utilization review processes and LTSS service / care planning processes, as these two components of the health system have different purposes and intended outcomes. DHHS should include these definitions and distinctions in the Department's plan for implementing LTSS under Medicaid managed care. 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). The Commission recommends that DHHS follow best practice guidelines that include:

o Authorizations that are a full year in length for habilitative services, including habilitative physical therapy, occupational therapy, and speech therapy.

o Authorizations that are of shorter duration (less than one year) for LTSS short-term services (examples may include assistive technology or environmental modification).

o All authorizations should be supported in the member's care plan.

References:

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