MARGARET WOOD HASSAN
Governor

STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

DRAFT

FINAL REPORT TO GOVERNOR HASSAN
August 15, 2016

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

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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

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 Bernier, Executive Director Grafton County Senior Services (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)

Staff members from the Governor's office provide ongoing consultation and assistance to the Commission. Particular acknowledgement of **Kathleen Sgambati's** support is indicated.

Staff of the Department of Health and Human Services provided exemplary support, assuring transparent public access to information, individual quality of care and effective implementation of major policy change in vital public purpose.

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 was 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 improving access to eligible populations, quality and appropriateness of care and cost effectiveness.

Pursuant to the Governor's Executive Order, beginning on May 1, 2013, the Commission on Medicaid Care Management held 41 Commission meetings, 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 was 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 requested and received tremendous cooperation from New Hampshire providers of Medicaid funded and regulated care. Collaborative engagement and systematic problem solving was demonstrated by all parties.

Commission meetings were organized around populations and problem oriented inquiries and frequently called on local and national experts for their review. These individuals included:

Individuals who gave generously of their time and expertise:

Date	Individual	Organization
9/5/13	Carl Cooley MD Don Caruso, MD,	Center for Medical Home Improvement Dartmouth Hitchcock Keene
10/3/13	William Gunn, PhD Steve Arnault, MA	Behavior Health presentation
12/5/13	Sanders Burstein, MD, , Sandra Pelletier	Medical Director, Dartmouth Hitchcock Nashua/CareConnect President/CEO Gateways Community Services.
1/9/14	Steven Rowe Genevieve M. Kenney	President, Endowment for Health Co-Director and Senior Fellow, Health Policy Center, Urban Institute
3/6/14	Roland Lamy	Helms and Co., CMHC Representative
5/1/14	Steve Norton	NH Center for Public Policy
2/12/15	Cindy Robertson Becky Whitley Sarah Aiken Cathy Spinney	Disability Rights Center Disability Rights Center Community Support Network Quality Council
11/12/15	Dennis Powers Connie Young	CEO, Community Crossroads Director, Rockingham County ServiceLink
1/14/16	Camille Dobson	Deputy Director, NASUAD
4/14/16	Peter Kelleher	CEO, Harbor Homes
5/12/16	Michael Bailit	Bailit Health Purchasing LLC
6/9/16	Erin Hall, Lisa Perales	CFI Care Management Provider Network, BIANH and CMF

Implementation of Medicaid Care Management was complex and fast paced. In many instances the national effort to establish Medicaid Care Management has lacked sufficient study, national precedent, or Federal clarity from the Center for Medicare/Medicaid Services (CMS) in Medicaid policy to establish clear best practice. Timetables in NH were slowed in reflection of the need for prudence in this major event.

OF NOTE

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 is 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 of public commitments to our families' and community's strength. 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 in 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.

4.) CMS Compliance and Opportunities

Federal and State involvement of this partnership is sizable both financially and in its complexity. The public rightly demands evidence of good government in the critical arena of health care. The Department has responded both to the opportunity that is available in this time of change, and the risks in controls and compliance that arise in new territory.

In particular, two agendas should be noted:

First, CMS has now increased expectations of strengthening of state contracting in managed care. Particularly important is the recognition of the incorporation of a Medical Loss Ratio into the contract, with CMS' recommendation of a ratio

of 85%. The CMS rule 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 salaries, marketing, profits and other administrative tasks. This protects both our enrollees and our taxpayers. Nationally, many Managed Care Organizations already meet this standard, however, as noted by the New Hampshire Health Policy Institute in its publication reviewing NH's contracting for managed care, this was not incorporated.

Second, the Delivery System Reform Incentive Program (DSRIP): "Building Capacity for Transformation" 1115 Waiver Planning is a farsighted process of highly relevant health investment in our communities through integrated physical and behavioral health care with social supports. The impact of behavioral health needs including the need for addictive disorder prevention and treatment, is our most demanding public health crisis. The Department is succeeding in strong community building strategies with a major investment of Federal financial participation. Envisioned payment reform will be a key tool for our future health care administrative structure.

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 only become more compressed over time. With Medicaid Care Management, the State is showing promise to have the tools for careful harboring of its resources, equitable distribution of needed care, and thoughtful preparations for building demographic driven demand. Still, it is very early in this effort. Major commitments to a constantly evolving context will challenge our politics, our administrative capacity, and our health care community. This must be faced with a civic intention and a consistent strategy of investment in highly visible leadership, progression, and information.

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 the public testimony 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.

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 complex and many-sided concerns of New Hampshire's interest in a long term stability of such a dynamic public agenda.

COMMISSION CONSIDERATIONS

In May of 2015, in order for the Commission to establish its final report, the Commission organized four work groups. The role of the work groups was to examine the critical questions/issues that must be addressed in order to assure NH's readiness for MCM and in particular the implementation challenges of Step 2. 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 Final 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 1 quality measurement and public analysis, Step 2 data planning and implementation was 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 2 implementation, but also regarding the ongoing analysis of the impact of Step 1 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 2, especially meaningful communication with critical providers, 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

Recommendations

"RECOMMENDATIONS FOR THE UPCOMING 90 DAYS":

Long Term Supports Planning:

Recommendation 3:

Consistent with recently enacted SB 553, DHHS should establish a formal advisory body and internal leadership for the transition and ongoing provision of Medicaid and related community supports for seniors and adults with LTSS needs. DHHS is recommended to formalize the planning for the development, implementation, and ongoing operation of the MLTSS program in senior/adult services with a broad representation of stakeholders including participants, community organizations, providers, and advocacy representatives. Planning should be based on a formal capacity assessment of the current system of services for older adults, with recommendations to address network adequacy and assurance of CMS compliance in meeting the needs for home and community based care for a growing population of older adults. Structure and continuity should be assured by establishing this committee as a standing committee of the MCAC.

Recommendation 7:

A DHHS/stakeholder plan and legislative request should be expeditiously developed which will update the long-term and community care financial structure. Planning should recognize the value of potential acute care savings under strong LTSS population health agendas, and foster the value based payments and global budgeting needed for Phase 2 of Medicaid Care Management. Nursing facility payment systems, including County payment, Acuity Based reimbursement, MPIP, Proshare, and other State and Federal opportunities should be specifically redefined. Potential formula change and waiver opportunities should maintain the stability of support through an ongoing change process while reflecting senior concerns for the development of community care.

Budget Preparations for FY 17/18:

Recommendation 4: DHHS should make an ongoing commitment to the community support needs of seniors in the establishment of internal and community leadership roles. A long-term commitment to the strengthening of Service Links should be emphasized in assuring best social determinants of senior health through access to care, supports coordination, and wellness support.

A DHHS formal review should be provided for the purpose of assuring rate adequacy and network access for LTSS as they convert from fee for service CFI waiver to capitated, risk based contracts. As necessary, DHHS should establish specifications of rate adjustment for senior care, under the upcoming revised CFI waiver. This rate adjustment should reverse the multi year problem of senior LTSS program loss and establish clear benchmarks for network adequacy. Goals should be clearly defined under Managed Care Organization contracting and reflect the fiscal and quality of care necessary to support individuals in their communities. Budgeting considerations should reflect this in upcoming budget development.

Recommendation 6:

DHHS should be appropriately budgeted to assure contractual services needed for financial analysis and actuarial support. This, the NH taxpayer's largest civic investment should maintain an investment in financial best practices including value based contract management and also fraud and abuse controls.

Legislative flexibility should be maintained to assure best available financing in conjunction with quality and operational Medicaid goals. Support should be given to all enhanced matching opportunities and to assure greatest Federal maintenance of effort as CMS regulatory requirement evolve and NH needs grow.

Financial Planning:

As it does with quality of care, DHHS should assure a transparent financial data availability and analytic process and produce a comprehensive Medicaid Care Management financial report on a quarterly and an annual basis. Financial evaluation, including Legislative Budget Assistant (LBA) external audit should monitor MLTSS financing related events, results, controls and financial outcomes including at the encounter level, to assure fiscal transparency, stability, and accountability.

Part One: Recommendations in support of Meeting Enrollee's Needs Through Public Engagement And Community Based Supports And Services:

Introduction:

Recommendation 1:
Request that there be a statutorily created Commission to receive a DHHS plan for the Future of Medicaid in NH. The plan should recommend:

- Finance options to build value based purchasing reflecting the State's interest in NH's Medicaid fiscal stability and quality of care.
- State assumption of current Federal, CMS authority for NH citizens who are "Dually Eligible", i.e. Medicaid and Medicare eligible.
- Multi year budget goals with caseload and cost assumptions.

Recommendation 2:
Convene an ongoing Executive Branch, multi-stakeholder "Senior Supports Cabinet" in reflection of demographic growth and necessary policy and operations for older adults. Goals should include the tracking of predicted demographic change of our aging population and coordinated community awareness and strengthening of supports. This Cabinet should be reflective of the efforts of the Governor's executive order which creates a taskforce to study workforce issues, any related legislative committee work and state agency and provider experience. New approaches to recruitment, retention, training needs and barrier removal should be included in a HHS strategic development plan that undergoes stakeholder review and contribution. State, MCO, network enrolled providers, and community workforce representatives should be included.

Recommendation 3:
Consistent with recently enacted SB 553, (Underway…) DHHS should establish a formal advisory body and internal leadership for the transition and ongoing provision of Medicaid and related community supports for seniors and adults with LTSS needs. DHHS is recommended to formalize the planning for the development, implementation, and ongoing operation of the MLTSS program in senior/adult services with a broad representation of stakeholders including participants, community organizations, providers, and advocacy representatives. Planning should be based on a formal capacity assessment of the current system of services for older adults, with recommendations to address network adequacy and assurance of CMS compliance in meeting the needs for home and community based care for a growing population of older adults. Structure and continuity should be assured by establishing this committee as a standing committee of the MCAC.

Recommendation 4:
DHHS should make an ongoing commitment to the community support needs of seniors in the establishment of internal and community leadership roles. A long-term commitment to the strengthening of Service Links should be emphasized in

assuring best social determinants of senior health through access to care, supports coordination, and wellness support.

Achieving Stability of the Medicaid Program Finances Despite Significant Challenge:
Meeting Demographic growth, Assuring Financial Efficiency and Maintaining Financial Control While Utilizing Value Based Opportunities – Recognition of current Acute and LTSS weakness, network risk, population demands. Value based care and payment reform in the upcoming managed care system, building opportunities for innovation.

Recommendation 5:
As it does with quality of care, DHHS should assure a transparent financial data availability and analytic process and produce a comprehensive Medicaid Care Management financial report on a quarterly and an annual basis. Financial evaluation, including Legislative Budget Assistant (LBA) external audit should monitor MLTSS financing related events, results, controls and financial outcomes including at the encounter level, to assure fiscal transparency, stability, and accountability.

Recommendation 6:
DHHS should be appropriately budgeted to assure contractual services needed for financial analysis and actuarial support. This, the NH taxpayer's largest civic investment should maintain an investment in financial best practices including value based contract management and also fraud and abuse controls.

Legislative flexibility should be maintained to assure best available financing in conjunction with quality and operational Medicaid goals. Support should be given to all enhanced matching opportunities and to assure greatest Federal maintenance of effort as CMS regulatory requirement evolve and NH needs grow. Such authorization may, for example, include:

- MMIS systems matching for the development of person directed individual budgets and reporting controls.
- Eligibility and claims processing investments.
- Electronic Health Records and the Coordination of Care including interoperable technology to long-term care, behavioral health providers, substance abuse treatment centers, and other providers
- "Health Homes" serving Medicaid beneficiaries with chronic conditions including the six core health home services provided by a designated provider or health team:
- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Support for patients, their families, and their authorized representatives;
- Referral to community and social support services, when needed; and

- The use of health information technology to link services, as feasible and appropriate.
- Short term IMD admissions coverage under Medicaid Care Management
- Early, pre-release enrollment in managed care of Department of Corrections inmates
- Fee for Service system weakness and actuarial implications

Recommendation 7:
A DHHS/stakeholder plan and legislative request should be expeditiously developed which will update the long-term and community care financial structure. Planning should recognize the value of potential acute care savings under strong LTSS population health agendas, and foster the value based payments and global budgeting needed for Phase 2 of Medicaid Care Management. Nursing facility payment systems, including County payment, Acuity Based reimbursement, MQIP, Proshare, and other State and Federal opportunities should be specifically redefined. Potential formula change and waiver opportunities should maintain the stability of support through an ongoing change process while reflecting senior concerns for the development of community care.

Recommendation 8:
A DHHS formal review should be provided for the purpose of assuring rate adequacy and network access for LTSS as they convert from fee for service CFI waiver to capitated, risk based contracts. As necessary, DHHS should establish specifications of rate adjustment for senior care, under the upcoming revised CFI waiver. This rate adjustment should reverse the multi year problem of senior LTSS program loss and establish clear benchmarks for network adequacy. Goals should be clearly defined under Managed Care Organization contracting and reflect the fiscal and quality of care necessary to support individuals in their communities. Budgeting considerations should reflect this in upcoming budget development.

Stability of Medicaid Workforce in Care-Giving, Clinical, and Administrative Personnel and Strengthening Leadership and Capacity of DHHS to Administer the Medicaid Care Management System:
Medicaid is the State's largest dedication of revenue and its most rapidly changing management system. As with any such large, complex, changing business, the Medicaid program, overall, requires a dedication to effective and efficient operations, planning, and control.

Recommendation 9:
TO BE DEVELOPED BY THE WORKGROUP ON EFFECTIVE AND EFFICIENT PURCHASING The DHHS should be requested to 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 this the NH taxpayers largest investment in State support.

Recommendation 10:
(Held open for recommendation)

Recommendation 11:
The DHHS should, in its staffing plan, assure strong leadership in senior care, both acute and LTSS within the Department of Health and Human Services with a comprehensive and coordinated oversight and administration of all aging services regardless of funding source.

Recommendation 12:
Alternative Payment Models: 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.

Recommendation 13:
Step 2 sustained commitment to standards of care, reflecting national experience of best practices should be established. The Commission recommends contractual requirement of network as well as plan NCQA and new CMS guidelines as care management standards.

Managed Care Organization Role and Assurance of Accountability
DHHS/MCO Contract and Reporting Improvements:

Recommendation 14:
DHHS and MCO contracts should better reflect RSA 126-A:5, XIX and the evolving CMS regulatory requirements of the State of New Hampshire and the Federal Medicaid Program and include minimum care requirements:

- The authorizing statute, RSA 126-A:5, XIX, required that no diminution in quality of care for enrollees occur. In support of this requirement, and the pending inclusion of enrollees with complex Managed Long Term Support Service (MLTSS) needs, the initial Managed Care Organization (MCO) contract provision requiring medical homes for enrollees should be maintained, be better defined by requiring NCQA or similar quality status, and enforced.

- Furthermore, given the high population health risks of behavioral health (both mental health needs and substance use treatment needs) such care in pain management, opioid control, dual diagnosis support, and similar treatment is urgently called for in the evolving care management system. The incorporation of integrated primary and behavioral health services in well-developed Health Homes and Integrated Delivery Networks needs to be an addition expectation of the contracts.

- An MCO quarterly report on the above, including the utilization data of substance use prevention and treatment and the evolving use of opiods under managed pharmacy coverage must be transmitted by DHHS to the Governor.

- The rebalancing between acute and LTSS and within LTSS needs to become contractually recognized, including the contract establishment of capitated rate structures that recognize savings in acute care in order to rebuild capacity in LTSS. In addition, in rewriting the current CFI waiver, restrictions in individual expenditures for community care, must be eliminated. Furthermore, a report on Olmstead compliance should be required of each MCO on an annual basis.

- DHHS contracts should reflect person centered planning and individual budgeting. Contracts should specifically require systematic availability of person directed supports in the settings of, and with staff support reflecting, the person centered plan. Person Centered Plan related MCO enrollee assessment, oversight, and equitable distribution of resources should be contractually defined and monitored.

- Contract specifications for each MCO should include complex care enrollee assurance of independent care management with MCO oversight and consumer protection reporting.

Part Two: Assure Access To An Adequate Network Of Providers

INTRODUCTION: For the past several years, the Governor's Commission on Medicaid Care Management has been monitoring the transition of New Hampshire's Medicaid program from a fee-for-service to a managed care format. The Commission's Network Adequacy Workgroup has been particularly concerned with two aspects of that transition: the availability of appropriate services for Medicaid recipients and the ability of service providers to weather the various administrative changes as they occur. As an 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 recipients. The Network Adequacy Workgroup encourages adoption of policies and actions that, if fully implemented, would provide a consistently high standard of care to all Medicaid Managed Care enrollees. The attainment of that standard is challenging because there are interfering factors at play in New Hampshire beyond the control of the Medicaid Program. These factors include:

- the health care workforce is not fully staffed
- it is not evenly distributed throughout the state
- it includes some providers that decline to participate in Medicaid at all
- not all providers currently have the ability to make substantive changes to their practice as outlined in the recommendations below.

Nonetheless, our commitment as a state to the health of our most vulnerable citizens obliges us to strive for excellence, addressing systemic as well as operational issues.

DEFINING NETWORK ADEQUACY: 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 recipients 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 a recipient's diagnosis, cultural background, access to transportation or any other characteristic that might be a potential barrier to accessing care. Ultimately, achieving ***network adequacy*** means that all patients' 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.[i] While network adequacy is

well defined for Medicaid services that transition to managed care under Step 1 (which includes primary care, specialty care and behavioral health), there is no similar generally accepted definition for services transitioning under Step 2 (long term care, community-based services, developmental services, and services for the elderly). Populations that are especially vulnerable to the transitions under Step 2 include those Medicaid recipients who are either dually eligible for both Medicaid and Medicare and/or those children and youth with complex health care needs.

Recommendation 15:
The New Hampshire Department of Health and Human Services (DHHS) will engage Medicaid recipients, their families, advocates, and providers in defining "network adequacy" for services particular to Step 2 and for those populations who are dually eligible and/or have complex health care needs.

Recognizing that the dually eligible and those with complex health care needs (particularly pediatric populations) require additional time and resources to address their health needs and understanding the value of addressing the needs of these populations in the patient-centered medical home model, it is particularly important for these populations to obtain their primary medical care in a site that follows that model of care.

Recommendation 16:
Through explicit and detailed contractual language, New Hampshire Medicaid will ensure that all individuals, particularly those in these two high risk and high cost populations, have access to a patient-centered medical home that is incentivized to successfully provide those services described as integral to the medical home model by the Health Resources and Services Administration.[ii] Incentives will require the consideration and implementation of novel methods of reimbursement including:

- risk adjusted per member per month administrative payments to practices
- risk sharing arrangements
- performance payments.

Recommendation 17:
The New Hampshire Department of Health and Human Services will continue to monitor the ability of Medicaid recipients to access the services described above and specifically follow these indicators for the two vulnerable populations of the dually eligible and those with complex health care needs. This monitoring will include measurement of the following outcomes:

- 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

- satisfaction of patients, their home-based care givers and the providers who serve them.

Continuity of care is an essential feature of health service delivery. Movement between equally "adequate" providers may make financial sense but can imperil a patient's health.

Recommendation 18:
Patients who have been receiving services from out-of-state or out-of-network providers will be able to continue with them or get adequate warning and explanation for why the managed care organizations feel that such relationships should be interrupted. Any change in provider(s) should be to an equivalent new provider with the patient's and family's input. There should be a policy that care will continue from established providers during any appeals and grievances.

APPROACH: Assuring that Medicaid recipients in New Hampshire have access to an adequate network of health providers and services is achieved in two ways: proactively, by predicting potential problems and addressing them before services are affected; and reactively, by soliciting and listening to emerging issues that are already impacting providers and Medicaid recipients. Issues to be addressed proactively include assuring that there is an adequate network of providers in terms of sufficient numbers, state-wide distribution, and capacity to manage the administrative changes that occur with the transition from fee-for-service to managed care. Providers who are unfamiliar with the challenges of new rules for prior authorizations for services and supplies, different procedures for coding and billing and the changes in how payments are managed might have difficulty sustaining the provision of adequate services. As an example: the Network Adequacy Workgroup became aware that some providers of pediatric physical, speech, and occupational therapy might have to close their practices (as some of their colleagues had been forced to do) because of changes in payments under managed care that led to accounting and budgetary difficulties. As another example: a number of families alerted the Governor's Commission on Medicaid Care Management to a severe shortage of home pediatric nursing services and offered suggestions to enable their children to receive all the hours of specialized home-based care already approved by Medicaid.

Recommendation 19:
The Department of Health and Human Services should seek and welcome concerns from providers and recipients about existing or emerging difficulties in providing or receiving care.

Recommendation 20:
The Department of Health and Human Services should monitor the number of providers who participate in Medicaid and/or Medicaid Care Management.

Recommendation 21:

The Governor's Office should continue its efforts to address workforce shortages that impact the care received by Medicaid recipients.

QUALITY: In the future, states will be required to publicize the quality ratings of their Medicaid managed care plans, following a measurement established at the federal level entitled QRS for "Quality Rating Strategy"[iii]**.** This measure is currently under development and will be released for public comment sometime in 2018 with an expected implementation date of 2021. Now is the time for New Hampshire to assure that those aspects of care quality that are particularly important to its Medicaid population are incorporated into the final QRS document.

Recommendation 22:
New Hampshire should actively engage in developing state-specific concerns to be addressed in the federal Quality Rating Strategy.
Assuring an adequate network of care providers for Medicaid recipients in New Hampshire under managed care will require a comprehensive and proactive approach in which emerging trends that could affect service delivery are actively addressed. The seven recommendations described above will be important components of such an approach and will help to assure the optimal health and functioning of our state's medically vulnerable populations.

Part Three: Establish Upfront Consumer Protections

Introduction:
The Governor tasked the Commission to ensure that consumer protections were in place during and after the transition from a fee for service system to a managed care model. A subcommittee focused on member education and communications, as well as the development of a problem resolution system that is responsive to individual circumstances and central to quality improvement efforts.

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 mirrored and further enhanced the work of the Commission in consumer protections. For consumers requiring long term services and supports (LTSS), the rule also establishes mechanisms for providing support, education, and a central contact for complaints or concerns for beneficiaries, including assistance with enrollment, disenrollment, and the appeals process. The rule requires:

- An access point for complaints and concerns about enrollment, access to covered services, and other related matters;
- Education on enrollees' grievance and appeals 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. Based on this regulatory guidance, as well as lessons learned from other early adopter states for MLTSS, technical assistance from National Association of States United for Aging and Disabilities (NASUAD), and the guiding principles accepted by the Governor, the Commission recommends the following:

<u>Recommendation 23</u>:
Person Centered Care
Require person centered treatment and service planning in contracts with the State's health plans and in the administration of State-managed fee-for-service programs. Members and their representatives should be included in plan development, reviews and modifications.

<u>Recommendation 24</u>:
Stakeholder Engagement

Include stakeholder engagement in oversight for MLTSS programs. Structure and continuity in stakeholder engagement should be assured by establishing a standing Consumer Protections committee as part of a standing committee or a newly created advisory structure which oversees DHHS planning and operations of the State's Medicaid Care Management Program.

Recommendation 25:
Effective Communications
Provide for education and outreach, through direct mail, email and other known methods of effective communication, to all members about program choices, benefits and member rights in advance of the Step 2 implementation of Managed Long Term Services and Support. The Department should provide for accessible, widely distributed, understandable information on the changes in services offered and/or service providers, information on how to access services, program contact information, and problem/complaint resolution options and their right to make health care decisions. Explanation of their rights should include information on the specific grievance and appeal rights, the Ombudsman Program, department contacts, and the state fair hearing process. The State should provide clear, accessible, customer focused materials, vetted by consumers and advocates, to explain the grievance system and how to navigate the managed care plans.

Recommendation 26:
Member Complaint Resolution
All elements of the complaint and appeals process should be coordinated with, or be a part of a beneficiary support system that serves members before and after enrollment into a Medicaid managed care plan, as required in the CMS final rules.

Members of a health plan should first access their plan's client services and should be provided with prompt, courteous service. If the problem is not resolved to the client's satisfaction, they have a right to contact the Department's client services operation for issue resolution and, if necessary, file an appeal with the Department of Health and Human Services. In urgent situations, clients may request an expedited appeal which must be heard within three days.

In all cases, whether the interaction occurs with the managed care plan, DHHS client services, or during the grievance or appeal process, the member has a right to expect prompt, professional treatment that meets the needs of a diverse population.

Recommendation 27:
The Department must have systems in place to prevent, detect, report, investigate, and remediate abuse, neglect, and exploitation as well as systems monitor and track complaints. MCO staff and providers must be provided with training and education to understand abuse, neglect, exploitation and all prevention, detection, reporting, investigation and remediation procedures and requirements. Individuals receiving services and their families must be provided with initial and ongoing training and

education programs on abuse, neglect, exploitation, and reporting inclusive of complaints.

Recommendation #28:
Quality benefits management dictates that a member 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 or intellectual needs of the member.

The Ombudsman position discussed below can provide support at any point in the process.

Recommendation #29:
Decisions made by a managed care plan, a hearings officer or the Department of Health and Human Services, must be made in line with a person centered care plan. A resolution must consider and respond to the unique needs of the individual.

Recommendation #30:
Ombudsman
Establish a Statewide Long Term Services and Supports Ombudsman Program, defining the technology and reporting requirements, and staffing and resources, needed to support individuals in the concurrent fee for service (FFS) and Medicaid Care Management (MCM) programs.

At least four months in advance of the State's Step 2 Medicaid Care Management implementation for the Choices for Independence (CFI) Waiver and Nursing Facility (NF) services, the Department should establish and adequately fund an independent Ombudsman Program with extensive knowledge of long term services and supports.

The Ombudsman Program should provide participants receiving services through the concurrent fee-for-service and Medicaid Care Management programs with direct assistance in navigating their coverage and in understanding, and exercising, their rights. The focus of the program should be on timely resolution of a member's problems as well as reporting on trends identified. The Program shall implement 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. Reports should be provided at least quarterly to the State, to the managed care companies and to the MCAC. Additionally, it is recommended that this information be publicized on the respective distribution parties' web page

The Ombudsman Program must also provide for consumer education and information, as well as serve as the primary access point for unresolved complaints and concerns.

Recommendation 31:
Complaint and Critical Incident Management Systems
Implement a transparent, coordinated complaint and critical incident management system with pathways for reporting, inclusive of robust data collection, to ensure efficient beneficiary issue resolution and overall systemic improvement. The role definitions and reporting practices must be explicit in the managed care contract and program descriptions. The Department must monitor findings, MCO compliance, FFS compliance, Ombudsman data, and provide for continuous process improvement; maintaining overall responsibility for the identification, reporting, and investigation systems.

The Department's ability to capture complaint and critical incident data across all resources, inclusive of the Ombudsman, that is responsive and useful, is fundamental to providing effective consumer safeguards. The Department must have a system to identify, report, and investigate complaints and critical incidents that occur within the delivery of LTSS as well as track complaints to make systemic improvements. The Department must modify existing, and if necessary establish, coordinated complaint and incident reporting systems, including those that are electronic in nature, to clarify newly defined roles, expectations, and responsibilities for the Department, providers, MCOs, and Ombudsman function.

Recommendation 32:
Transition Protections
Managed care entities shall provide continuity in services during the program's transition from the current system to integrated long term care services and supports. In the first twelve months of implementation, the Department should require the MCOs to honor a recipient's current service and medical authorizations until the expiration date or needs change; any reductions to services must be approved by the Department. If the service authorization specifies a provider, the MCO must continue to use that provider whether or not the provider is participating in the MCO network.

Part Four: Assure Effective Operations & Payment Systems

Introduction:

The workgroup will provide an overview of the efforts to review and resolve issues that were raised about the acute care prior authorization (PA) process. This will make a distinction between acute care prior authorizations and long term care service authorizations. The workgroup brought considerable data to the Commission about this issue and most of the early issues with denials and length of time processing PA's have been resolved. There are two PA areas that require additional attention and will be included as recommendations below: psychiatric medications and various therapies necessary for habilitation.

Recommendation 33:
The workgroup is crafting a recommendation related to adequate staffing of the Medicaid program office working on Medicaid Care Management. The recommendation will reference the AARP public Policy Institute document "Keeping watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports." The recommendation will ask the Department to consider the capacities outlined in this report as it develops the Step II implementation plan.

Recommendation 34:
The workgroup is crafting a recommendation that will ask for a distinction between the acute care prior authorization process and service planning needed for LTSS. The recommendation will reference information from the presentation by Camille Dobson from the National Association of States United for Aging and Disabilities. This recommendation will address therapy services and will draw a distinction between rehabilitative services and habilitative services.

Recommendation 35:
The workgroup is crafting a recommendation specifically focused on PA for psychiatric medications. Additional data has been requested from the Department and will be reviewed at the Commission's meeting in July, 2016.

Appendix One:

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.

- -

Explanation: Matter added to current law appears in ***bold italics.***

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:

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
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 Four:
References/Sources

In addition to materials distributed and posted on the Commission's web site, 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 (on deck for presentation in July)

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

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

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[i] See the World Health Organization's definition of health at http://who.int/about/definition/en/print.html

[ii] http://www.hrsa.gov/healthit/toolbox/Childrenstoolbox/BuildingMedicalHome/whyimportant.html

[iii] http://www.communitycatalyst.org/blog/a-super-condensed-advocates-guide-to-the-new-medicaid-managed-care-rules?source=email#.V18ToeTrvIU