

MCM Commission

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**NH Department of Health
and Human Services**



November 6, 2014

White Mountain Community College

Agenda

- Monthly Enrollment Update
 - MCM Step 1
 - NH HPP
- Key Program Indicator Report Update
- Step 2 Update
 - Phases and Timeline
 - Concepts
 - Next Steps
- Waiver Updates
 - Premium Assistance Waiver
 - Transformation Waiver
- Q&A from Commission and Public

Setting the Context

Care Management Program

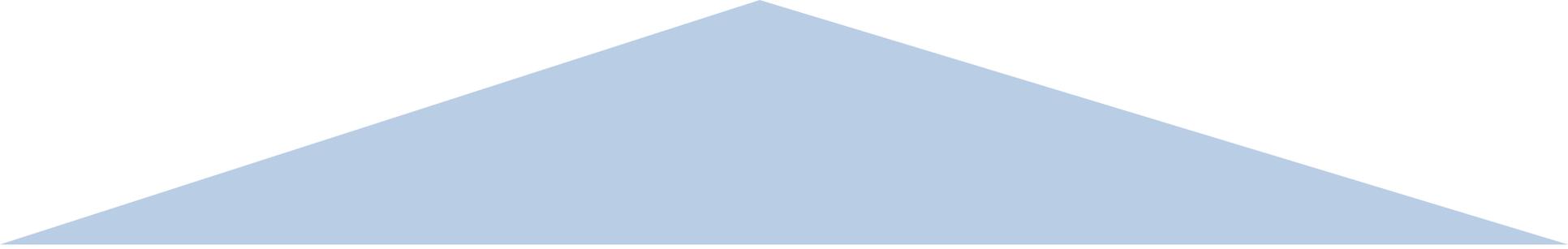
December 1, 2013 – October 31, 2014

@ 11 Months



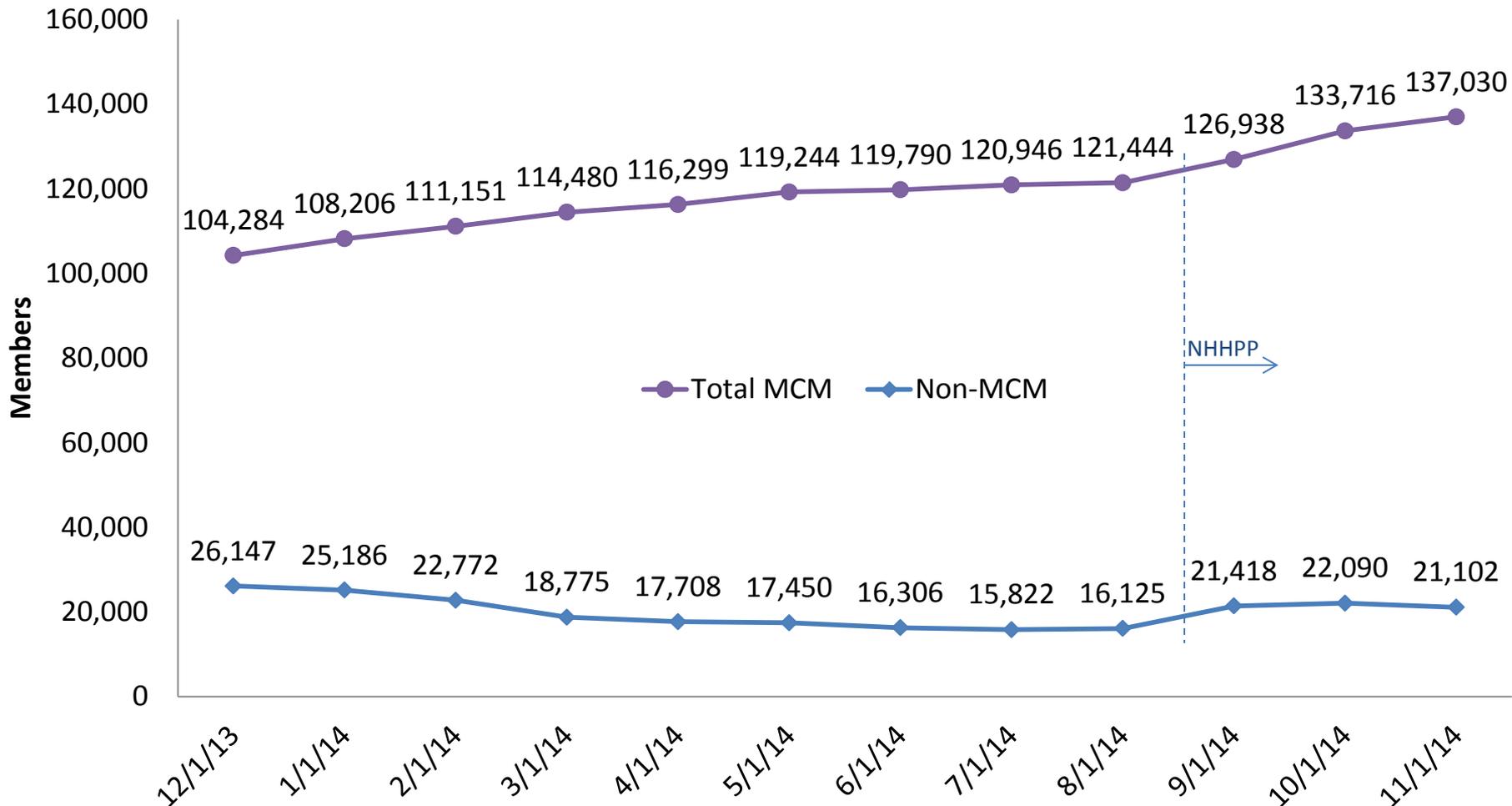
Guiding Principles of NH MCM

- Whole person management and care coordination
 - Foundation for Medicaid transformation
- Increase quality of care – right care, at the right time, in the right place to improve beneficiary health and quality of life
- Payment reform opportunities
- Budget predictability
- Purchasing for results and delivery system integration



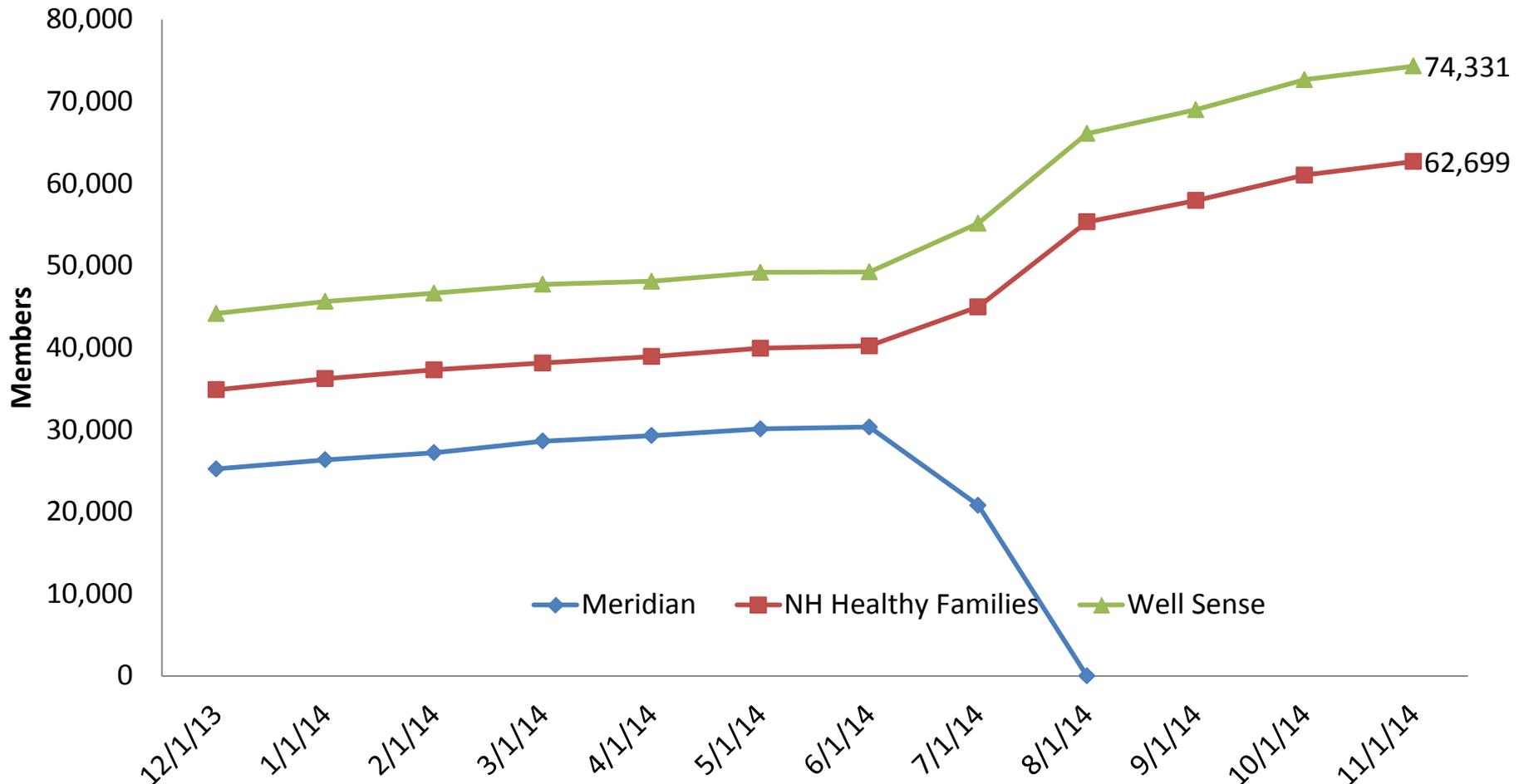
MCM Monthly Enrollment Update

NH Medicaid Care Management Enrollment, 12/1 – 11/1



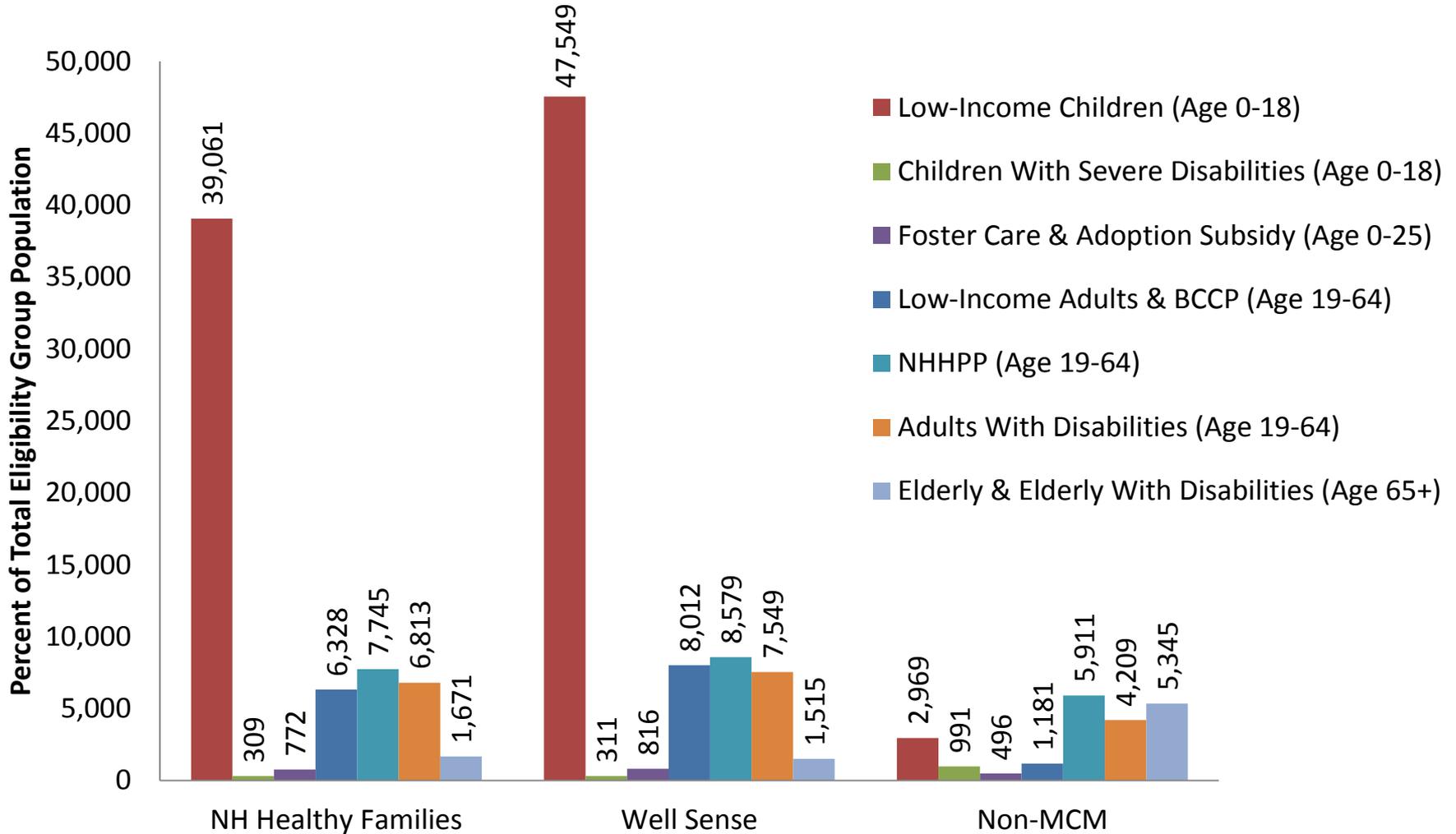
Note: Non-MCM Includes retroactive enrollment and excludes members who only have Medicare savings plans (e.g., QMB)

NH Medicaid Care Management Enrollment by Plan, 12/1 – 11/1



Note: Non-MCM Includes retroactive enrollment and excludes members who only have Medicare savings plans (e.g., QMB)

NH Medicaid Care Management by Eligibility Group, 11/1/14

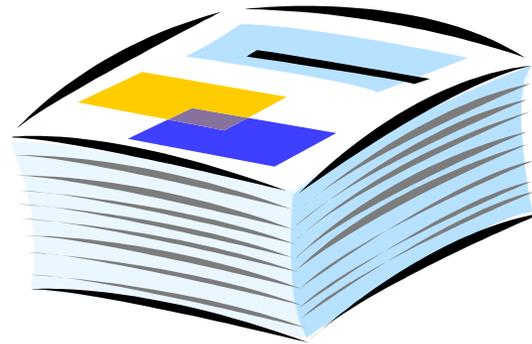


NH HPP Update

As of 11/4/2014

- Recipients
 - 22,208 enrolled
 - Over 9,000 are new to DHHS
 - Over 7,100 are new to NH HPP but have been clients in the past
- Benefit Plans
 - 20,442 are in the ABP (Alternative Benefit Plan)
 - 1,454 of Medically Frail are in the ABP
 - 312 of Medically Frail in standard Medicaid
- Care Management / HIPP
 - 56 Enrolled in HIPP
 - 705 are Potential HIPP
 - 8,807 are enrolled in WSHP
 - 7,901 are enrolled in NHHF
 - 4,739 are in Fee For Service/not yet enrolled in a plan

Key Performance Indicator Report



MCM Key Indicators

Metrics in the Key Indicators Report include:

- Access & Use of Care
- Customer Experience of Care
- Provider Service Experience
- Utilization Management
- Grievance & Appeals
- Preventative Care
- Chronic Medical Care
- Behavioral Health Care
- Substance Use Disorder Care
- General

Notable Results Summary 1

Figure 1-4: 25.6% of August transportation requests were not approved or not delivered. The most common reason transportation was not delivered, was that the ride was delivered in the following month, and not represented in the month it was requested. The Department is reviewing this measure with changes anticipated in early 2015. Rides that are not delivered will be categorized in part to include:

- Ride cancelled by member;
- Ride cancelled by the provider;
- The member failed to show up for transportation, or
- The provider of transportation failed to show up.

Figure 3-1 and 3-3: Clean provider claims are being paid, accurately and within MCM contract standards for timeliness.

Figure 3-4: The trend in answering provider calls within 30 seconds is downward indicating that a rising number of calls are being answered in more than 30 seconds. The Department will monitor this trend.

Notable Results Summary 2

Figure 4-4: An increase in the service authorizations, both approvals and denials, reflects the close of the initial 90 day transition into the MCM program. The health plans have begun to review services according to DHHS approved utilization management policies. An increase in denials may represent more appropriate utilization management.

- In Quarter 2, the health plans received 37,448 requests for **NEMT**. The percentage of denied requests for NEMT has decreased from Quarter 1 to Quarter 2. Initial denials for NEMT were in part due to a lack of adherence to prior authorization procedures. A reduction in denials may represent an increasing understanding in how to access services from the MCOs.
- While the number of **therapies** reviewed increased from Quarter 1 to Quarter 2, the percentage of denied requests for therapies has remained essentially the same from Quarter 1 to Quarter 2.
- The percentage of denied requests for **inpatient surgery** and **drugs** has increased. The Department will continue to monitor these trends.

The Technical Report is a regulatory requirement, produced by the EQRO, and will be delivered to NH the beginning of November. A presentation to the MCM Commission is planned for December 2014.

Follow-up from October MCM Meeting

1. Requested of DHHS to report out on the findings, if available, and/or agenda items of focus groups held in October with respect to the KPI report.

DHHS Response: The final report is anticipated in December. The Department anticipates public reporting in January 2015.

2. DHHS to clarify if reference to “doctor” in description of measure on page 34 of the KPI actually means “provider” as presented to MCMC

DHHS Response: The November report has been revised to state Mental Health Practitioner, the term used in the national follow-up appointment measure.

3. DHHS to review KPI finding that a low or falling number of follow-up appointments within 7 days indicates a successful discharge.

DHHS Response: The November report has been revised.

4. DHHS to review language within KPI and future presentations to focus more on care transitions instead of discharge planning

DHHS Response: The Department understands the importance and magnitude of care transitions. For a deeper focus on this topic, the Department recommends that the MCM Commission invite the MCOs to present their individual programs related to care transitions.

Follow-up from October MCM Meeting (cont.)

5. DHHS to prepare an update on the overall quality management system being created for a future presentation to the MCMC.

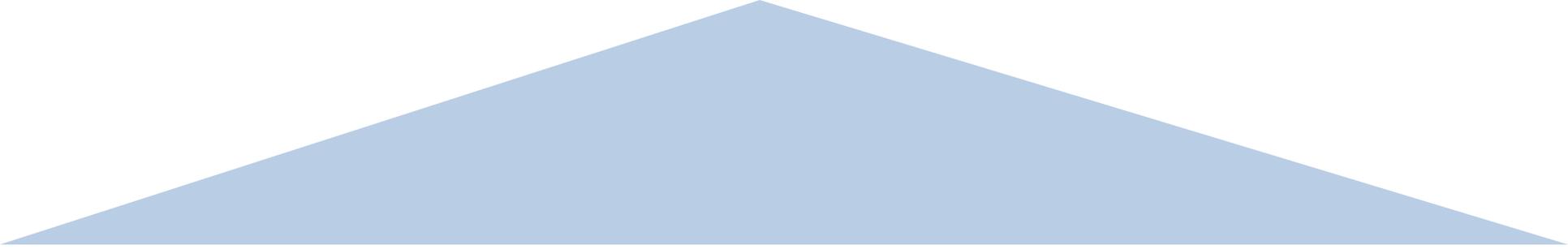
DHHS Response: DHHS will work with the MCOs to present their Quality Strategies. DHHS will present an updated Quality Management strategy. There are two drivers to the update. An integral part of Step 2 will be updated measures, but no change in our approach. Secondly, the Department is in the midst of a ReDesign with one key theme is the expansion of our Quality Strategy to be Department wide.

6. DHHS to review current contract standards for quality to determine where/how benchmarks are set, e.g. whether they reflect national standards, best practices, or if they can be set to future improvement standards

DHHS Response: The Department uses a combination of national standards as well as best practice benchmarks. The DHHS is working to incorporate comparators into the KPI report in early 2015.

7. DHHS to continue to review if benchmarks for certain measures can be set by current NH fee-for-service (FFS) metrics, as opposed to national industry standards

DHHS Response: See response to #6.



Step 2 Update

Concepts
Timeline

Key Changes

- Phase I and Phase II, Mandatory Enrollment and the integration of Choices for Independence Waiver and Nursing Facility services into Medicaid Care Management, have been combined.

- Step 2 will still be phased in.

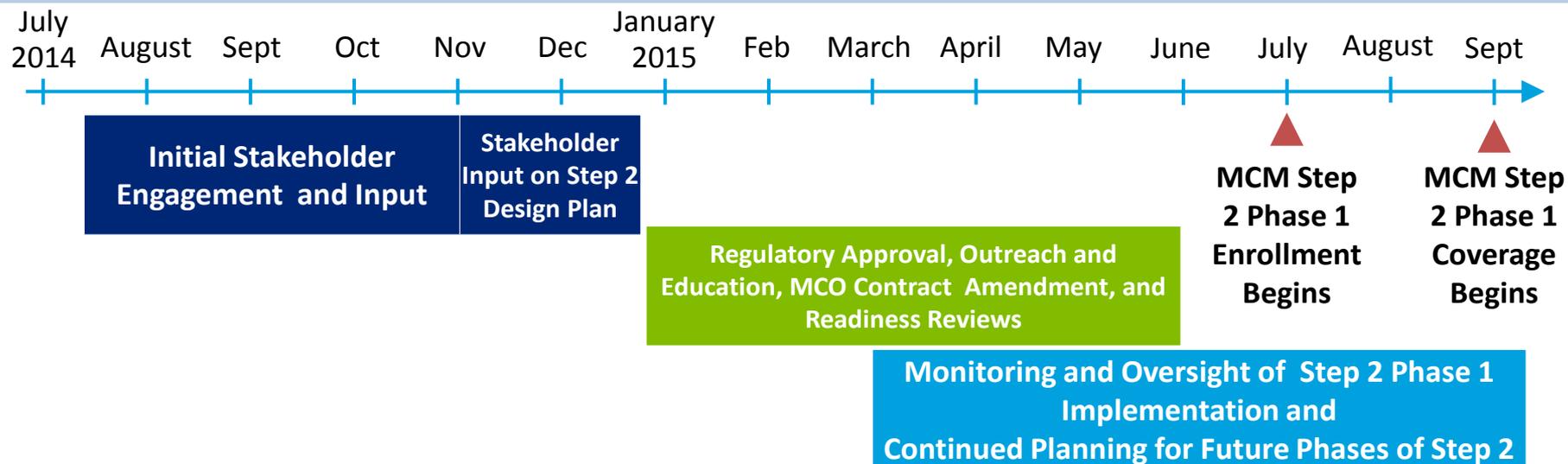


- Design considerations of managed long term services and supports, including provider contracting and payment, will evolve over time.

Revised Step 2 Timeline

- Earlier Timeline
 - Phase 1 Mandatory Populations by January 1, 2015
 - Phase 2 Choices For Independence (CFI) and Nursing Facility Services (NF) by April 1, 2015
 - Phase 3 Developmental Disabilities, Acquired Brain Disorder and In Home Support waivers will be implemented at a date to be determined.
- New Timeline
 - Phase 1 and Phase 2 combined
 - Enrollment begins July 1, 2015
 - Services begin September 1, 2015

Timeline



- **Stakeholder Input Process: July to December 2014**

- Initial Stakeholder Engagement and Input completed in October 2014
- Additional forums will be held to elicit stakeholder feedback on the Step 2 Design Considerations in November and December of 2014

- **Step 2 Phase 1:**

- On **July 1, 2015**, require all populations to enroll with a health plan for their medical services, Choices for Independence Waiver and Nursing Facility services
- On **September 1, 2015**, coverage with the health plan begins for medical services, Choices for Independence Waiver and Nursing Facility services

MCM Commission Step 2 Principles

- The Department has reviewed the vision, principles, and guidance recommended by the MCM Commission for implementing a Managed Long Term Services and Supports Program (MLTSS): Promoting Health, Wellness, Independence, and Self-Sufficiency.
- In response, the Department conducted a crosswalk of its actions taken and/or planned for Step 2 to each of the MCM Commission's recommended principles and principle implementation guidance.
- This crosswalk will evolve over time and be shared publically as the Department plans for and implements Step 2.

MCM Commission Step 2 Principles

Crosswalk Example

Principle #1

Development and implementation of a quality MLTSS program requires a thoughtful and deliberative planning and design process, building on the strengths of the current LTSS program.

DHHS Actions Taken/Planned Crosswalk

1. *Initiated a stakeholder input process for Step 2 MLTSS in November 2011 as part of the Round One State Innovation Model (SIM) Model Design Grant. Extensive Stakeholder Input and publication of the State Health Care Innovation Plan occurred in December 2012.*
2. *Medical Care Advisory Committee (MCAC), representing a wide range of cross disability stakeholders, has been engaged.*
3. *The Governor's Commission on MCM, a formal advisory body, was created in April 2013.*
4. *The BDS Quality Council, representing a wide range of stakeholders, has been engaged.*
5. *In July 2014-November 2014, over 580 participants were engaged in stakeholder meetings hosted across the state at various time of the day/evening/week and offered through a variety of modalities including video conferencing, phone conferencing, webex, and in-person meetings.*
6. *Stakeholder input has been used to reset and extend the Step 2 MCM program implementation timeline.*
7. *In November 2015, a summary of Stakeholder Input from July-November will be posted on the DHHS MCM Step 2 Website.*
8. *In November 2015, the Draft Design Concepts for integration of Choices for Independence Waiver and Nursing Facility Services will be presented to the MCM Commission.*
9. *A second round of statewide stakeholder meetings is scheduled to begin in December 2014 to elicit input regarding Step 2 Design Concepts for Choices for Independence Waiver and Nursing Facility Services.*

Key Questions

Key questions addressed in the Draft Design Considerations include:

1. Who will determine eligibility for the Choices for Independence Waiver and Nursing Facility services?
2. How will Choices for Independence Waiver and Nursing Facility services be authorized, and by whom?
3. Who will manage the care for people receiving either Nursing Facility and Choices for Independence Waiver services?
4. How will existing service providers operate as part of the health plan's provider network? How will payment rates be determined?
5. Will I be allowed to manage my own budget for Choices for Independence Waiver services?

Introducing the Draft Design Considerations

- Current Choices for Independence Waiver and Nursing Facility recipients will continue to have access to the same menu of supports and services that are available to them now.
- Some of the processes that are in place for authorizing and approving services will change.
- The Department realizes that this is a big change and that a gradual approach is necessary.
- Integration of long term services and supports into Medicaid Care Management is going to be phased in over three years.

Draft Design Considerations Year 1

Choices for Independence Waiver

1. Who will determine eligibility for Nursing Facility and Choices for Independence Waiver services?

The Department will continue to determine eligibility for Nursing Facility and Choices for Independence Waiver services.

Note: Eligibility for the Choices for Independence Waiver and Nursing Facility services are the same.

Draft Design Considerations

Year 1 (cont.)

2. How will Choices for Independence Waiver services be authorized, and by whom?

- *The health plans will authorize Choices for Independence Waiver services based upon criteria approved by the Department.*
- *Current service authorizations will be honored by health plans until their expiration date, unless the client's condition changes.*
- *The Department will approve any reduction to service plans recommended by a health plan during the first year.*
- *Administrative rules and laws pertaining to transfers and discharges, such as RSA 151:26, will continue to apply.*

3. Who will help the person receiving waiver services manage their care?

- *The health plans will coordinate the integration of medical care and Choices for Independence Waiver services in a conflict free manner under the direction of the Department, using a whole person approach.*
- *The health plans may offer contracts to current Choices for Independence case management agencies.*

Draft Design Considerations

Year 1 (cont.)

4. How will existing Choices for Independence waiver service providers operate as part of the health plan's provider network and how will payment rates be determined?

- *All Choices for Independence waiver service providers currently enrolled and meeting criteria will be offered a contract in Year 1 of Step 2.*
- *The reimbursement rates for Choices for Independence services will equal the Department's current fee schedule.*

5. Will I be allowed to manage my own budget for Choices for Independence waiver services?

- *The Department will develop a consumer directed and managed long term services and supports option with Stakeholder input.*
- *The Department will request approval for this new service from the Centers for Medicare and Medicaid Services .*

Draft Design Considerations Year 1 (cont.)

Nursing Facility Services

1. How will Nursing Facility services be authorized, and by whom?

- *The health plans will authorize coverage of Nursing Facility services based upon criteria approved by the Department.*
- *Current service authorizations will be honored by health plans, unless the client's condition changes.*
- *The Department will approve any reduction in services recommended by health plan during the first year.*
- *The administrative rules and laws pertaining to transfers and discharges, such as RSA 151:26, will continue to apply.*

Draft Design Considerations

Year 1 (cont.)

2. Who will coordinate care for people receiving Nursing Facility services?

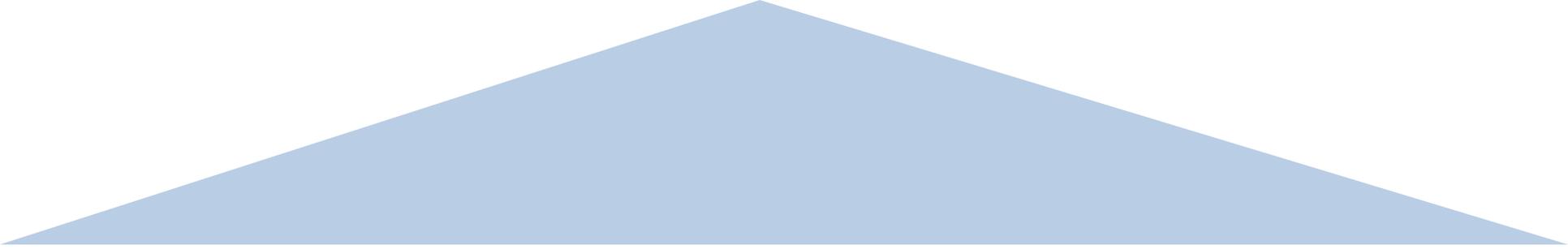
- *The health plans will coordinate the integration of medical care and Nursing Facility services using a whole person approach under the direction of the Department.*

3. How will existing Nursing Facility service providers operate as part of the health plan's provider network and how will payment rates be determined?

- *Health plans will offer contracts to all Nursing Facilities that are currently licensed, Medicaid enrolled, and meet applicable requirements from the National Committee for Quality Assurance.*
- *Payments will continue to be calculated by the Department under an acuity-based payment model.*

Next Steps

- We have scheduled 5 public sessions in December when we will present further detail for discussion. The presentation materials will be posted on the web before the first session. The dates are:
 - *December 1 in the Brown Building Auditorium at 1:30*
 - *December 2 at the Keene Public Library at 1:30*
 - *December 8 at the Genesis Health Center in Lebanon at 1:00*
 - *December 10 at the Littleton Area Senior Center at 12:45*
 - *December 16 in the Brown Building Auditorium at 1:30*
- The feedback received throughout this period will be used as we continue to develop the design concepts.
- Another round of public sessions will be scheduled for early 2015.
- Information will be posted on the Department's Medicaid Care Management, Step 2 website: <http://www.dhhs.nh.gov/ombp/caremgmt/step2.htm>
- You can send e-mail concerning Step 2, Phase I, to the Bureau of Elderly and Adult Services at: beasmcmstep2@dhhs.state.nh.us



NH Health Protection Program
&
Other Updates

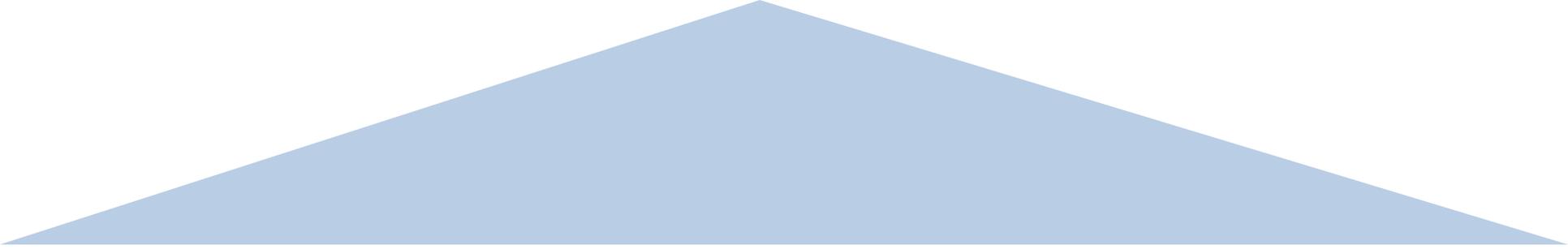
Premium Assistance Waiver Update

- Third phase of NHHPP program is Premium Assistance Program
 - Transition population from managed care coverage to Qualified Health Plans on FFM beginning on January 1, 2016 (per SB 413)
 - Public hearings and comment period on waiver just concluded on 10/31
 - Final waiver application submitted to Fiscal on 11/10/14
 - Waiver must be approved by CMS by 3/31/15 for program to continue

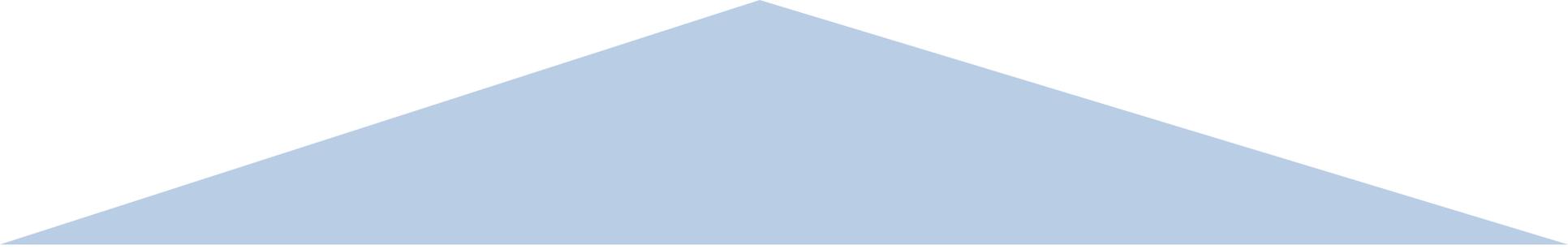
1115 Waiver

Building Capacity for Transformation

- Application was submitted to CMS at the end of May 2014
- CMS is now requiring all states to demonstrate how delivery and payment systems will change with new Federal funding
- DHHS is working to reformulate waiver requests and will hold public information sessions in December



Questions?



Appendix of
Key Indicator Report Details

November 2014

MCM Key Indicators Report

- DHHS tool for monitoring program performance
- Organized by various domains that represent indicators of the health of the program
 - This provides foundation for comparison of the two MCOs.
- Some indicators and metrics have prescribed benchmarks such that performance and compliance is illustrated.
- Some indicators require a trend in order to show performance and compliance over time.
- Some indicators are reported monthly, some quarterly and still more are reported annually.
- User Guide is integrated into the body of the report

MCM Key Indicators

Metrics in the Key Indicators Report include:

- Access & Use of Care
- Customer Experience of Care
- Provider Service Experience
- Utilization Management
- Grievance & Appeals
- Preventative Care
- Chronic Medical Care
- Behavioral Health Care
- Substance Use Disorder Care
- General

Notable Results

Access and Use of Care

1. Figure 1-1: Requests for both Primary Care and Specialists are trending downward suggesting members have an increasing understanding of how to access care in their MCO's network.
2. Figure 1-4: 25.6% of August transportation requests were not approved or not delivered. The most common reason transportation was not delivered, was that the ride was delivered in the following month, and not represented in the month it was requested. The Department is reviewing this measure with changes anticipated in early 2015. Rides that are not delivered will be categorized in part to include:
 - Ride cancelled by member;
 - Ride cancelled by the provider;
 - The member failed to show up for transportation, or
 - The provider of transportation failed to show up.
3. 99.1% of transportation request in Quarter 2 of 2014 have been approved.

Notable Results

Customer Experience of Care

1. Figure 2-1: Member calls are being answered quickly and within MCM contract standards.
2. Figure 2-2: Member average calls times are increasing. The Department will monitor this trend.

Measures removed or replaced:

- New Welcome Calls Measures was removed. The measure is more important during a new program implementation. Measure will be considered for reinstatement after Step 2 implementation.
- Member Average Call Time has replaced Member Hold Time. The Member Hold Time measure was duplicative with the Average Speed to Answer Measure. Member Average Call Time may be driven by a smaller number of overall calls lasting for longer times. The Department will monitor this measures and drill down to better understand this number.

Notable Results

Provider Service Experience

1. Figure 3-1 and 3-3: Clean provider claims are being paid, accurately and within MCM contract standards for timeliness.
2. Figure 3-4: The trend in answering provider calls within 30 seconds is downward indicating that a rising number of calls are being answered in more than 30 seconds. The Department will monitor this trend.

The Department will explore reporting additional data in future reports on claims such as:

- Claims Paid;
- Claims Pending; and
- Claims Denied.

Measures removed or replaced:

- Provider Average Call Time has replaced Provider Hold Time. The Provider Hold Time measure was duplicative with the Average Speed to Answer Measure. Provider Average Call Time is a unique Key Indicator in the report.

Notable Results

Utilization Management

1. Figure 4-1 and 4-2: Urgent and routine service authorizations are being processed very close to MCM contract standards for timeliness.
2. Figure 4-3: The pharmacy service authorization processing rate is trending upward toward the contract standard. The Department will continue to monitor this indicator.
3. Figure 4-4: An increase in the service authorizations, both approvals and denials, reflects the close of the initial 90 day transition into the MCM program. The health plans have begun to review services according to DHHS approved utilization management policies. An increase in denials may represent more appropriate utilization management.
 - In Quarter 2, the health plans received 37,448 requests for **NEMT**. The percentage of denied requests for NEMT has decreased from Quarter 1 to Quarter 2. Initial denials for NEMT were in part due to a lack of adherence to prior authorization procedures. A reduction in denials may represent an increasing understanding in how to access services from the MCOs.
 - While the number of **therapies** reviewed increased from Quarter 1 to Quarter 2, the percentage of denied requests for therapies has remained essentially the same from Quarter 1 to Quarter 2.
 - The percentage of denied requests for **inpatient surgery** and **drugs** has increased. The Department will continue to monitor these trends.
4. Figure 4-5: Generic drug utilization is increasing and could contribute to program cost savings.

Notable Results

Grievances and Appeals

1. Figure 5-1: Grievances have decreased.
2. Figure 5-2: Inpatient admission and therapy service appeals have fallen; pharmacy and transportation appeals have increased. The increase in pharmacy appeals primarily relates to a change in one MCO's pharmacy utilization management. A review of pharmacy service authorizations is underway. The Department will continue to closely monitor this indicator.
3. Figure 5-3 – 5.5: Grievances and appeals (standard and expedited) are being resolved within MCM contract standards.
4. Figure 5-6: There have been nine State Fair Hearing requests for Q1 and Q2 of 2014. All fair hearings requests were either settled prior to the hearing or were withdrawn because of a reversed decision by the MCO.

Notable Results

Chronic Medical Care

1. Figure 6-3: In June, 28% of members filled at least one medication prescription. An increased number of medications used correlates with complex health needs. The Department will review polypharmacy* rates with the MCOs.

* Polypharmacy is a new measure in the November KI report.

Notable Results

Behavioral Health Care

1. Figure 7-1: Members with Follow-up Appointment 7 Calendar Days Post Discharge – The Department is working to assure accurate reporting of this measure.
2. Figure 7-2: Readmission to New Hampshire Hospital at 30 days -Excluding New Hampshire Health Protection Program (NHHPP) Members - The Department is working to assure accurate reporting of this measure.

The Department will be revising this measure to include both the number of appointments **scheduled** and the number of appointments **attended** with data available in early 2015.