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JEFFREY A. MEYERS
COMMISSIONER

March 6, 2018

The Honorable Frank R. Kotowski, Chair
Health and Human Services Oversight Committee
Legislative Office Building, Room 205
107 North Main Street
Concord, NH 03301

Re: Implementation Plan for Medicaid Care Management

Dear Chairman Kotowski:

Attached please find the Department of Health and Human Services' "Implementation Plan for Medicaid Care Management – Nursing Facility/Choices for Independence Services." The plan, which meets the requirements per Senate Bill 553, enacted in June 2016, has been developed after much input from stakeholders and a collaborative review of models with the Association of Counties.

In order to improve care coordination and quality outcomes, as well as defer nursing facility placements, the Department's plan focuses on a hybrid model for the delivery of these services: a managed care model that will be delivered through health plans contracted by the State and locally established Programs for All-Inclusive Care for the Elderly, or PACE centers.

The Department would like to review this plan with the Health and Human Services Oversight Committee in April. I look forward to detailing this plan for new models of delivery and payment of nursing facility and Choices for Independence home and community based services.

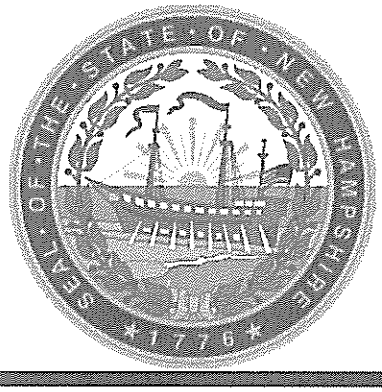
Please confirm the addition of this important topic on the agenda and call with any questions at (603) 271-9446.

Sincerely,

Jeffrey A. Meyers
Commissioner

Enclosure

New Hampshire Department of Health and Human Services



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

March 2018

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I. Executive Summary

On June 6, 2016, the Governor signed into law Senate Bill (SB) 553 instructing the Department of Health and Human Services (DHHS) to develop an implementation plan for Phase 2 of the Medicaid managed care plan as established in Revised Statutes Annotated (RSA) 126-A:5, XIX.

SB 553 indicates that nursing facility (NF) and in-home care services provided under the Choices for Independence (CFI) waiver shall not be incorporated into managed care ***until*** DHHS has prepared and adopted an implementation plan. Therefore, this implementation plan only addresses the process for transitioning services provided under the CFI waiver and NFs to managed care.

The following year, the legislature enacted Senate Bill 155 (2017 Laws Ch. 258), which requires the Department to incorporate both CFI waiver services and NFs into managed care beginning on July 1, 2019.

Consistent with these legislative directives, New Hampshire intends to expand the current Medicaid Care Management (MCM) program, through a competitive procurement, to integrate long-term services and supports (LTSS) provided by the CFI waiver and those services administered in NFs into the current MCM design. In addition, New Hampshire will further build community capacity and offer additional choice for community-based LTSS by developing the Program of All-Inclusive Care for the Elderly (PACE) throughout the State. A streamlined managed care program that is fully integrated and comprehensive offers individuals simplicity in plan selection and focused coordination on all their care needs versus an individual diagnosis.

The MCM – NF/CFI program implementation plan addresses key details regarding the incorporation of CFI waiver and NF services and explains how this process will achieve the legislative requirements. Additionally, the implementation plan includes descriptions of the following program design aspects, as required by SB 553:

1. Populations and Covered Services
2. Eligibility
3. Enrollment
4. Pharmacy
5. Transportation
6. Provider Network Adequacy and Credentialing
7. Case Management/Care Coordination
8. Transition Planning
9. Utilization Management and Prior Authorization
10. Grievances and Appeals
11. MLTSS Ombudsman
12. Member Services
13. Quality Metrics and Outcome Measurements
14. Patient Safety
15. Rates and Payments (Includes Finance and Reimbursement)
16. Claims Payment
17. Federal Waiver Authority

II. Implementation Plan Overview

A. Choices for Independence Waiver

The CFI waiver has been in operation since 1984. It provides home- and community-based services (HCBS) to older adults and persons with physical disabilities who require the intensity of supports consistent with those delivered in an NF, but who could safely remain in the community with the appropriate set of services.

The CFI waiver provides more than 19 different services (see Figure 2, Pg. 7 for a complete list of services) to approximately 4,000 individuals. Case management for CFI waiver participants is authorized as targeted case management under the New Hampshire State Plan. Targeted case management (TCM) is the collaborative process of assessment, planning, facilitation, advocacy, coordination, and monitoring

that is accomplished with a person-centered process. It assists members to gain access to needed State Plan or waiver services, as well as other medical, social, spiritual, vocational, educational, and community supports. TCM also coordinates member services to assure adequacy and appropriateness of care and cost effectiveness of planned services.

TCM is currently provided by seven case management agencies which meet DHHS qualifications:

- Area Agency of Greater Nashua, Inc. d/b/a Gateways Community Services,
- Brain Injury Association of NH,
- Community Crossroads, Inc.,
- Crotched Mountain Community Care, Inc.,
- Granite Case Management. LLC,
- Life Coping, Inc., and
- Pilot Health LLC.

Each case management agency is required to have a toll-free number for members; calls to that line must be returned within 24 hours during the week, and within 48 hours on weekends and holidays. Members are given a choice of case management agency. If one is not selected, members are assigned in rotation. Case managers employed by these agencies must meet the standards set forth in New Hampshire Administrative Rule He-E 805.06[1]. Once a case manager is assigned, the care plan development process begins.

Case managers receive information from the clinical eligibility determination and conduct a comprehensive assessment to help them develop a comprehensive care plan (CCP) in collaboration with the member. The CCP addresses the needs identified from the member's assessment and includes the member's strengths, capacities, preferences, and desired outcomes. Once services have been identified that address those needs and preferences, service authorizations are sent to DHHS for approval and members are given choice of providers from which to choose. Case managers are required to contact each member by phone monthly and in person at least every 60 days. The CCP is modified as needed based on changes in the member's circumstances.

Currently, case managers do not have access to members' medical records or real-time claims data to effectively coordinate and manage the member's acute and primary care needs. DHHS anticipates significant improvement in care coordination as this data will be available via a single platform in the MCM – NF/CFI program. Further, case managers will have more robust access to the care team under the capitated managed care organization (MCO) model.

B. Proposed Capitated MCO Model

The State proposes to integrate NF and CFI services into the capitated managed care model whereby contracted MCOs will assume financial risk for acute care and non-LTSS services upon program go-live; within six months, the plans will assume risk for CFI and NF services. Capitated managed care is a delivery system whereby the State Medicaid agency contracts with an MCO to provide Medicaid benefits to members, much like the current MCM program. New Hampshire will pay contracted MCOs a fixed (also known as capitated) per-member, per-month (PMPM) payment for each Medicaid member enrolled in that MCO's health plan for the contracted covered services and other administrative services prescribed in the State's contract.

Integrating CFI and NF payments into the risk arrangements and procuring for this new set of combined services allows the State to:

[1] http://www.gencourt.state.nh.us/rules/state_agencies/he-e800.html

- Build upon the existing managed care infrastructure and framework for areas such as acute medical care, internal Medicaid management information system (MMIS) design, external quality review organization (EQRO) contract, enrollment broker contracts and oversight protocols, and readiness,
- Address areas of concern with the MCM program by strengthening contract language where warranted, and
- Leverage market competition that addresses the new, fully integrated program design and procure MCOs who bring the best qualifications to meet the State's needs.

DHHS will work with CMS and interested providers to develop an implementation timeline for the PACE program which offer members expanded choice as timely as possible.

The State will work with its actuaries to develop risk-adjusted rates to allow for reimbursement that matches the anticipated needs of the covered members and encourages community-based care settings. Blended capitation payments are typically used to incentivize risk-bearers in promoting community choice and will be weighed and considered in the actuarial rate setting process. In the MCM – NF/CFI program, MCOs will have great flexibility to navigate within their reimbursement structures and readily provide LTSS as needed since New Hampshire does not have waiver "slot" limits. Further, MCOs under a capitated reimbursement will have more flexibility to deliver a limited set of LTSS services to defer full waiver eligibility and further delay nursing home placements for at-risk members who may not have qualified for waiver services prior to this program.

As of January 2018, 23 states use capitated MCOs to deliver at least some LTSS benefits. All but a handful have an integrated service delivery approach where the MCO is at risk to deliver both acute and LTSS services under one contract. The national trend is toward integrated service delivery, with increasing momentum on coordinating across all payers, and more opportunity to achieve savings when older adults and persons with disabilities are included in the capitated model. States who have implemented more comprehensive Medicaid managed long-term services and supports (MLTSS) experience better managed care for members, increased access to community-based care, improved member satisfaction and health outcomes, and improved budget predictability.

C. Program of All-Inclusive Care for the Elderly (PACE)

DHHS also believes that for the frailest older adults who are dually eligible for Medicare and Medicaid, local, community involvement through programs like PACE will be key to achieving desired LTSS outcomes. Dually eligible adults are the highest risk in terms of health outcomes and cost to treat. PACE programs offer the State an opportunity to:

- Further integrate federal, state, and local funding streams,
- Offer integrated service sites in local communities,
- Develop a more sustainable infrastructure and LTSS delivery system, and
- Promote enhanced community options for LTSS.

DHHS will work with interested providers and CMS to develop an implementation timeline for the PACE programs. PACE programs are local/regional collaboratives which receive approval to provide LTSS care under a capitated Medicare/Medicaid payment that is entirely separate from the MCM program. DHHS will seek letters of intent from interested parties and work with CMS and other stakeholders on planning and implementation of PACE by December 2019. The state is committed to working with and providing technical assistance to community partners interested in participating in the PACE option and will thus initiate the development process in sufficient time to meet the targeted December 2019 launch of the MLTSS program.

Both the State and the Centers for Medicare and Medicaid Services (CMS) will independently develop capitated rates for PACE program members. PACE programs will use the blended capitation payment to

cover the medical and LTSS needs of the PACE member. Similar to the MCM – NF/CFI program, the PACE programs are at risk for achieving savings and will have financial incentives to provide care in the least costly setting.

PACE sites are center-based, with a physical building at the heart of the model. Services are primarily delivered in the PACE center, with staff employed by and working at that site. The State currently does not have a PACE program; however, implementing a PACE model addresses a vital role in a developing LTSS system. As PACE sites are formed and approved, Medicaid members meeting NF Level of Care (LOC), residing in the geographical area will have a choice of enrolling with the PACE program or with an MCO. PACE sites can also enroll private pay individuals as well.

As of December 2017, 31 states offer PACE programs[2]. The New Hampshire PACE programs would be developed locally and/or regionally around existing LTSS providers who can demonstrate a long and successful history in helping the State meet the needs of its most frail and vulnerable adults needing LTSS. Key features of the PACE program include:

- ***DHHS administration and oversight***: Interested PACE centers would receive approval from DHHS and CMS to provide medical and LTSS care under a capitated Medicare/Medicaid payment model.

- ***Full integration of Medicaid and Medicare funding***: The PACE model allows the State to integrate Medicare and Medicaid payments at the provider level achieving integrated, comprehensive care delivered at the local level. PACE programs provide (or coordinate and pay for the provision of) the same required covered services including additional services such as, but not limited to, medical care, personal care, prescription drugs, social services, audiology, dentistry, optometry, podiatry, home health care, transportation, physical therapy, occupational therapy, recreational therapy, meals, nutritional counseling, speech therapy, respite care, hospital, and nursing home care when necessary.

- ***Local provider and community engagement:*** PACE programs are, by design, locally oriented and target a subset of the dually eligible populations – primarily frail older adults who meet nursing home LOC. Given that PACE programs are at risk for all covered services (similar to those provided by an MCO), they have similar financial incentives to provide care in the least costly setting. Further, the hands-on approach of PACE programs is instrumental in addressing members' needs and deferring nursing home placement. The interdisciplinary care team – which encompasses not only medical providers but LTSS providers as well – is a linchpin to providing just the right services at the right time.

- ***Promotes competition and member choice:*** PACE would serve as a voluntary alternative to enrollment with a managed care entity for dual eligible adults, aged 55 and older, living in the PACE service area, requiring nursing home LOC. Typically, these individuals have multiple, complex conditions and would most benefit from the PACE model of comprehensive, individualized care delivered in their own communities.

Key to a robust PACE program is the State's strong choice counseling program, which can be accessed face-to-face. Prospective members can access clear explanations of the benefits of the PACE, allowing them to select between a local PACE center or one of the MCOs.

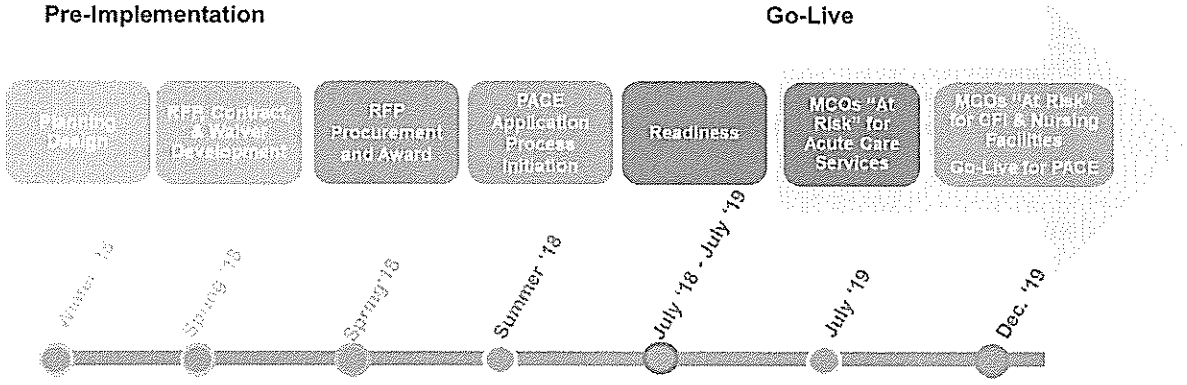
D. Implementation Timeline

All CFI and NF eligible persons will receive their acute care and medical services through the MCM programs when MCO contracts go live on July 1, 2019. When the PACE program is available, people will

[2] https://www.medicare.gov/your-medicare-costs/help-paying-costs/pace/pace.html#1422

be given an option to enroll in PACE. The State will phase in the financial risk associated with providing NF and CFI services to the MCOs for six months, with the MCOs assuming full risk in December 2019. The six-month implementation would operate as illustrated in the following figure.

Figure 1. High-Level Implementation Timeline



July 1, 2019. Reprocure New MCO Contracts to include NF/CFI Services

In preparation for July 1, 2019, DHHS will issue a Request for Proposals (RFP) for both acute care and LTSS (inclusive of CFI waiver and NF services) on or about May 30, 2018. DHHS is now reviewing LTSS provider capacity, workforce staffing, and a number of other requirements that will be addressed in the RFP and will further inform the program design and implementation. Because MCOs would not assume risk for LTSS services until December 2019, LTSS readiness items would need to be resolved after the contract award and prior to taking on responsibility for the LTSS services in December 2019.

DHHS will also seek letters of intent from interested parties in Summer of 2018 and work with CMS and other stakeholders on planning and implementation of PACE by December 2019. Concurrent with the MCO readiness assessment process, DHHS will work with CMS and other interested parties.

December 31, 2019. MCO Assumes Full Capitated Risk for NF/CFI Services

While MCOs will be responsible for the medical care of all members July 1, 2019, DHHS recognizes that the provision of LTSS is vitally important to members relying on these services to be active participants in their communities. As such, DHHS has determined that the MCOs will utilize the transition period between July 2019 and December 2019 to fully assess member needs, identify unmet needs and gaps in the provider network, and to prepare for the transition of members' LTSS services. DHHS will confirm the readiness of the MCOs' ability to provide MLTSS and will work closely with the MCOs, the MLTSS Ombudsman, and key stakeholders to communicate progress, as well as identify and address any concerns. DHHS' priority is the health, safety, and welfare of members transitioning into MLTSS, and the Department may delay full implementation if it determines that contracted MCOs are unable to appropriately provide LTSS. MCOs will be contractually obligated to meet performance measures and rebalancing goals. An inability to meet any deadlines and performance measures may result in financial penalties and corrective action.

III. Medicaid Care Management – Nursing Facility/CFI Services Program Descriptions

Under the MCM – NF/CFI program, MCOs will assume full responsibility to provide comprehensive medical, behavioral, and LTSS services to members. Below are additional details on program design and MCO requirements for the following aspects, as required by SB 553:

1. Populations and Covered Services
2. Eligibility
3. Enrollment
4. Pharmacy
5. Transportation
6. Provider Network Adequacy and Credentialing
7. Case Management/Care Coordination
8. Transition Planning
9. Utilization Management and Prior Authorization
10. Grievances and Appeals
11. MLTSS Ombudsman
12. Member Services
13. Quality Metrics and Outcome Measurements
14. Patient Safety
15. Rates and Payments (Includes Finance and Reimbursement)
16. Claims Payment
17. Federal Waiver Authority

A. Populations and Covered Services

New Hampshire currently administers the CFI waiver and NF services on a fee-for-service (FFS) basis. As outlined in Figure 2 below. Refer to Appendix A for a complete list of covered services across Medicaid populations.

Figure 2. CFI and Nursing Facility Services and Populations

Program or Provider Type	Key Features	Populations
Choice for Independence	• Targeted case management provided by seven case management agencies • Services include: o Adult medical day services o Home health aide o Homemaker o Personal care o Respite o Supported employment o Financial management services o Adult family care o Adult in-home services o Community transition services o Environmental accessibility services o Home-delivered meals o Non-medical transportation o Participant directed and managed services o Personal emergency response system o Residential care facility services o Skilled nursing o Specialized medical equipment services o Supportive housing services	• Serves approximately 4,000 individuals • Serves individuals 65 years or older and individuals who have physical or other disabilities (18-64 years)
Nursing Facility	• 60 private NFs • 10 counties operate 11 public NFs	

If a member is dually eligible for Medicare and Medicaid, and requires covered services that are included under the MCM – NF/CFI program, but are not covered by Medicare, and the services are ordered by a Medicare provider who is a non-contract provider, MCOs will pay for the ordered, medically necessary service if it is provided by a contracted provider.

B. Eligibility

The current processes for eligibility determination will remain the same under the MCM – NF/CFI program. The State will retain Medicaid eligibility determinations for NF and CFI waiver services. Qualifications for the State's Medicaid program will include three types of eligibility requirements:

- General (e.g., citizen status/immigration, residency, age, social security number),
- Financial (e.g., household income, household resources, potential income), and
- Medical eligibility requirements.

DHHS is considering opportunities to allow MCOs to provide a limited array of home- or community-based services for member who do not yet meet level of care, but through the provision of these services, may delay the need for more costly supports in the future.

C. Enrollment

After the State determines that a member is eligible for MCM – NF/CFI program services, he or she will receive support through the State's beneficiary support system (BSS), which provides support to members both prior to and after enrollment in an MCO for choice counseling[3] and support for members in understanding managed care options. The BSS will provide prospective members written materials[4], as appropriate, about their PACE or MCO enrollment options.

Choice counseling will be available by phone or email from the State's enrollment broker, Maximus. For members who prefer in-person assistance, the State's Aging and Disability Resource Center (ADRC), ServiceLink, will be trained to provide the same information. ServiceLink capacity will be expanded to provide for home visits in limited circumstances. However, Maximus will process actual plan selections forwarded by ServiceLink.

Prospective members will be able to access the BSS in the following ways:

1. By phone through DHHS' current customer service center (CSC) call center,
2. Through the CSC's website,
3. In-person using ServiceLink, and
4. Through auxiliary aids and services when requested.

The BSS will also have cultural and linguistic competence and outreach for members with limited English proficiency and/or cognitive disabilities. Call center responsibilities include but are not limited to the following:

- Provide information to members about the Medicaid application process,
- Provide information to members about the enrollment process,
- Respond to questions regarding the MLTSS program,
- Provide choice counseling and enrollment activities, enrollment in a non-discriminatory manner on the basis of health status, the need for health services, or on the basis of race, color, or

[3] Choice counseling is the provision of information and services designed to assist members in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing among MCOs and primary care providers. Choice counseling does not include making recommendations for or against enrollment into a specific MCO.

[4] All member materials developed to support enrollment are subject to review and approval by the State to comply with federal requirements (42 CFR 438.10) and confirm that all information is a manner and format that is easily understood and readily accessible.

national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origins,
- Provide enrollment services including processing enrollment, changes, disenrollment, and using the State's software,
- Provide outreach and education, and
- Make oral interpretation services available free of charge and notify that it is available and where to access.

For the first year of the program, prospective members will have an opportunity to choose an MCO during the initial enrollment period and then will have an annual enrollment period to changes plans if desired. For individuals who do not make a choice within thirty (30) days, the State will use an auto-assignment methodology consistent with Federal regulations and will seek to preserve existing provider relationships. The State will aim to match members to providers participating in an MCO to promote continuity of care. For example, if an individual's provider is only under contract with a single MCO, the member will be assigned to that MCO. If the provider is under contract with more than one MCO or the member has no usual source of primary care, the State will use a predetermined algorithm to assign the member appropriately to one MCO. The member's MCO will provide ***all Medicaid covered services, inclusive of NF/CFI waiver services.*** Once PACE programs are operational, prospective members will be able to select a PACE center in lieu of an MCO.

Once a selection is made, each MCO (or PACE plan) will provide standardized information – approved by the State on format and content – on how to use the managed care system and on how members can resolve issues, including the MCO's specific grievance and appeal process, the State MLTSS Ombudsman Program, and the State fair hearing process.

Members may disenroll from the MCO only when authorized by DHHS. These disenrollment options will be clearly communicated to members. MCOs will not be able to disenroll a member for any reason without first working with the State and/or the MLTSS Ombudsman Program and obtaining approval from the State. The State retains all member disenrollment decisions.

Continuity of Care

To support continuity of care for members who transition into MLTSS, or disenroll from one MCO and enroll into another MCO, MCOs will designate a sufficient number of persons with appropriate training and experiences to effectively coordinate and oversee all transition issues, responsibilities, and activities. The individual appointed to this position must be a health care professional or an individual who possesses the appropriate education and experience, and has on-the-ground experience and knowledge in home- and community-based LTSS. This individual from the "sending" MCO shall collaborate closely with the transition staff of the "receiving" MCO to ensure a safe, timely, and orderly transition, as appropriate. A new MCO who receives members from another MCO shall ensure a smooth transition for members by not discontinuing a member's service plan for 180 days after the member transition unless mutually agreed to by the member or responsible party.

During the first year of program operations, MCOs must honor existing authorizations for all covered services for a minimum of one-hundred and eight days (180) calendar days, with enrolled Medicaid providers. MCOs will receive information on any current service authorizations, utilization data, and other applicable care coordination information from the State.

In addition, MCOs will complete a full care plan assessment for all current CFI waiver members and those in NFs within the first six months of the program. Doing so will allow the MCO to become more familiar with the member's current care plan and be better prepared to offer a seamless transition at the time the MCO assumes financial responsibility for these services.

Between July 1, 2019, when MCOs will be responsible for acute care services only, and December 31, 2019, when the MCOs accept full risk for NF/CFI Waiver services, CFI case managers will remain in

place to manage CFI waiver services. Between December 31, 2019 and June 30, 2020 (first 180 days of the MCM – NF/CFI program), each MCO will be required to offer a contract to any willing and qualified case CFI case management agency.

As part of any enrollment transition into an MCO (from either the FFS program or another MCO), transition staff will regularly collaborate, communicate, and coordinate with the member, their family/guardians, LTSS providers, social workers, discharge planners, and other parties relevant to the member's care.

D. Pharmacy

As part of the current reprocurement process, the State will make a determination regarding the operation of the statewide preferred drug list (PDL) and the administration of the rebate program. The State's Drug Utilization Review board (DUR), which sets prior authorization criteria for the PDL, will review the PDL, and MCOs will be invited to participate on the DUR. For individuals residing in NFs, pharmacy benefits will be covered as it has been under FFS – i.e., not included in the NF per diem rate. To promote continuity of care for members, DHHS will require contracted MCOs to honor existing service authorizations, as further described in Section III.C.

As appropriate, the MCO shall adjudicate pharmacy claims for its members utilizing a point of service system. The MCO must also provide all necessary pharmacy encounter data to the State to support the rebate billing process.

E. Transportation

For the first year, the MCOs will be required to maintain the current CFI transportation for CFI recipients that are specific to waiver services. The Department will require MCOs to propose, in the second year of implementation, at least one alternative transportation service for CFI recipients to better ensure integration in their community as identified in the member's person-centered service plan (PCSP). There will be no change to the provision of Medicaid non-emergency transportation services as specified in the State plan.

F. Provider Network Adequacy and Credentialing

Currently, 10 counties operate 11 public NFs to provide needed care for residents with physical, emotional, and/or mental impairments. New Hampshire is focusing on ensuring that nursing home residents are living in the appropriate setting.

The MCM – NF/CFI program will build upon existing infrastructure, expanding access to providers and improving quality outcomes for the covered populations. MCOs will have the following minimum responsibilities specific to the provider network:

- Monitor network provider compliance with policies and rules of the MCM – NF/CFI program,
- Evaluate the quality of services delivered by network providers,
- Arrange for medically necessary covered services when one or more network providers terminate their participation,
- Monitor the adequacy, accessibility, and availability of its provider network to meet the needs of its members,
- Provide training for its providers and maintain records of such training,
- Track and trend provider inquiries, complaints and requests for information and take systemic action as necessary and appropriate, and
- Operate a provider call center for provider inquiries.

Network Adequacy

DHHS will maintain responsibility for setting network adequacy standards for CFI waiver and NF services provided by the MCOs. Consistent with Federal regulations, DHHS will establish time and distance, as well as availability standards for providers to which members travel to receive services. For services in which providers travel to the member's residence, the State will ensure that standards (to the maximum extent practicable):

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

DHHS will use a variety of methods to provide oversight and monitoring of the MCOs' compliance with these standards, including comparisons to the current providers delivering CFI waiver and NF services, as well as assessing the gaps in care that occur for members' receiving services in their home due to lack of available and qualified providers. Network adequacy will also include consideration of the MCO's ability to provide all services identified in the beneficiary's care plan in effect in the year preceding the commencement of LTSS services by the MCO.

MCOs must demonstrate that the providers in their network are knowledgeable and experienced in providing services to members receiving NF/CFI waiver services, and that those providers comply with the accessibility standards of the Americans with Disabilities Act. Providers must demonstrate cultural competency to serve culturally and linguistically diverse member populations. In instances where there are identified deficiencies, DHHS will establish a waiver and exceptions process for circumstances when MCOs are unable to meet the provider network standards, in accordance with Federal regulations (42 CFR 438.68). If the MCO's provider network is unable to provide necessary services covered under the MCM – NF/CFI program, the MCO must adequately and timely cover these services on an out-of-network basis for the member, for as long as the MCO's provider network is unable to provide them.

As a component of the State's readiness process, MCOs will first provide a network development and outreach plan that aligns with the staged integration of CFI waiver and NF services. DHHS will continuously monitor the MCO network development prior to go-live of the initial program and as services are integrated. MCOs will submit documentation to DHHS demonstrating that the provider network is sufficient in number, mix, and geographic distribution.

Contracting

Accompanying their bids for the re-procurement, MCOs must submit non-binding letters of intent (LOI) from providers demonstrating the ability to deliver a provider network capable of providing CFI waiver and NF services. Following selection by DHHS, DHHS will specify timeframes for submitting evidence of fully executed contracts with qualified providers that demonstrates full network adequacy. DHHS will develop a LTSS provider contract template that each MCO must use to minimize the burden on NF/CFI waiver providers, which ensures that all state and federal regulations are addressed. For the first year of the program, MCOs will be required to use rates established by the State. Such rates will be no less than the rates paid to providers in SFY 2018.

Provider Credentialing

The State will set the criteria for provider qualifications consistent with State regulatory provisions and the approved CFI waiver. DHHS will develop a standardized credentialing application, or use a third-party vendor who can standardize credentialing activities. MCOs must credential providers based on federal requirements (42 CFR 438.206 (b)(6)), current National Committee for Quality Assurance (NCQA) standards, and State regulations (RSA 420-J:4).

Credentialing CFI waiver providers will include verification of licensure and/or certification (as applicable); background checks and compliance with the settings provisions of the CMS HCBS regulations detailed in 42 CFR § 441.301(c)(4) and 42 CFR § 441.301(c)(5). Applicable NF and CFI rules include:

- RSA 151-E-Long Term Care,
- He-E 801- Choices for Independence Waiver,
- He-E 802- Nursing Facility Services,
- He-E 805- Targeted Case Management, and
- He-E 806 Nursing Facility Reimbursement.

Providers must be licensed and certified in accordance with New Hampshire laws and regulations as well as be enrolled as a New Hampshire Medicaid provider for the FFS program. A provider's first original credentialing, including application and verification of information, must be completed before the effective date of the provider's initial network provider agreement. Recredentialing must occur at least every three years.

Provider Assistance

MCOs must establish and maintain a provider services function to respond timely and adequately to provider questions, comments, and inquiries. As part of this function, MCOs will operate a toll-free telephone line (provider service line) during generally accepted business hours (e.g., 8 a.m. to 5 p.m. Monday through Friday) to respond to provider questions, comments, and inquiries.

To promote a seamless transition to managed care, for a period of at least twelve (12) months following implementation of the MCM – NF/CFI program, each MCO shall develop and make available provider support services which includes at a minimum:

- A website with information and a dedicated contact number to assist and support LTSS providers who are unfamiliar with managed care or who are interested in becoming providers,
- Ability for providers to contact MCO regarding contracting, billing, and service provisions,
- Training specific to MLTSS services, supports, quality, CFI waiver requirements, NF/CFI rules, and person-centered service planning (MCOs must offer provider training on topics such as person first language and independent living philosophy, as well as relevant training based on geography, demographics, and/or social/culturally relevant topics.),
- Assure providers comply with Electronic Visit Verification (EVV) and home- and community-based settings requirements per CMS, and
- Assistance and/or guidance on identified opportunities for quality improvement.

The MCO shall ensure that LTSS providers are appropriately notified regarding how to access the dedicated assistance. DHHS may extend the required dedicated assistance timeframe if necessary to include additional support beyond generally accepted business hours.

MCOs will also issue provider handbooks, provide education and training, establish a provider complaint system, and operate a secure website portal for providers, as detailed in the MCM – NF/CFI program RFP and contract.

Compliance with HCBS Settings Rule

The MCOs will be responsible for ensuring ongoing compliance with the HCBS settings rule. This will include regularly assessing providers during credentialing and recredentialing activities, onsite reviews and audits, and any other activities required by DHHS.

Specifically, as agents of DHHS, the MCOs will ensure that each provider setting:

1. Is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
2. Is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
3. Ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
4. Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
5. Facilitates individual choice regarding services and supports, and who provides them.

In a provider-owned or controlled residential setting under contract with the MCO, in addition to the qualities specified above, the MCO must ensure that the following additional conditions are met:

1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement, or other form of written agreement will be in place for each CFI waiver participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
2. Each individual has privacy in their sleeping or living unit:
   - Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
   - Individuals sharing units have a choice of roommates in that setting.
   - Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
3. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
4. Individuals can have visitors of their choosing at any time.
5. The setting is physically accessible to the individual.

Terminations

In the case of provider network terminations, MCOs will actively assist members in transitioning to another provider when there are changes in providers. The member's service coordinator or service coordination team will provide this assistance to members who have chronic or acute medical or behavioral health conditions, members who are receiving LTSS services, and members who are pregnant. To minimize disruptions in care, the MCO must:

- With the exception of members in their second or third trimester of pregnancy, provide continuation of the terminating provider for up to ninety (90) calendar days or until the member may be reasonably transferred to another provider without disruption of care, whichever is less, and
- For members in their second or third trimester of pregnancy, allow continued access to the member's prenatal care provider and any provider currently treating the member's chronic or acute medical or behavioral health condition or currently providing LTSS services, through the postpartum period.

In the case of a NF/CFI provider that is no longer willing or able to provide services to a member, the provider must cooperate with the member's service coordinator to facilitate a seamless transition to another provider and is required to provide services to the member until the member has been transitioned to another provider, as determined by the MCO, or as otherwise directed by the MCO.

Finally, when a MLTSS provider network termination occurs, DHHS will also permit members to disenroll and switch to another MCO or PACE if the loss of a provider would result in a disruption in their residence or employment, per federal regulations (42 CFR 438.56(d)(2)(iv)).

G. Case Management/Care Coordination

Service or care coordination is the continuous process of: (1) assessing a member's physical, behavioral, functional, and psychosocial needs; (2) identifying the physical health, behavioral health, and LTSS services and other social support services and assistance (e.g., housing or income assistance) that are necessary to meet identified needs; (3) ensuring timely access to and provision, coordination, and monitoring of physical health, behavioral health, and LTSS needed to help the member maintain or improve his or her physical or behavioral health status or functional abilities and maximize independence; and (4) facilitating access to other social support services and assistance needed to ensure the member's health, safety, and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement.

As part of service coordination services for members, MCOs must:

- Coordinate care among PCPs, specialists, behavioral health providers, and LTSS providers,
- Perform preventive health case management services, have mechanisms to assess the quality and appropriateness of services furnished, and provide appropriate referral and scheduling assistance,
- Monitor members with ongoing medical or behavioral health conditions,
- Identify members using emergency department services inappropriately to assist in scheduling follow-up care with PCPs and/or appropriate specialists to improve continuity of care and establish a medical home,
- Maintain and operate a formalized hospital and/or institutional discharge planning program;
- Coordinate hospital and/or institutional discharge planning that includes post-discharge care, as appropriate, and
- Maintain an internal tracking system that identifies the current preventive services screening status and pending preventive services screening due dates for each member.

Between July 1, 2019, when MCOs will be responsible for acute care services only, and December 31, 2019, when the MCOs accept full risk for NF/CFI Waiver services, each MCO will be required to provide service coordination to members, including those enrolled in the CFI waiver and those in NFs, using a risk stratification approach that provides more intensive service coordination to members with the most serious conditions or highest health costs.

On December 31, 2019, the MCO will take responsibility for CFI waiver case management, including the development of the member's person-centered service plans (PCSP), and authorizing the services contained therein. The MCO shall provide service coordination services for each CFI waiver participant and members in NFs. DHHS will establish case manager to member ratios in the contract.

Each MCO will develop a PCSP, consistent with Federal requirements (42 CFR 441.301), and all applicable NF and CFI state rules and regulations.

The written PCSP must:

- Reflect that the current residential setting was the individual's choice and is integrated in, and supportive of, full access of the individual to the greater community,

- Reflect the individual's strengths and preferences,
- Reflect clinical and support needs that have been identified through a functional needs assessment,
- Include individually identified goals and outcomes,
- Reflect the (paid/unpaid) services/supports, and providers of such services/supports, that will assist the individual to achieve identified goals,
- Reflect risk assessment, mitigation, and backup planning,
- Be understandable (e.g. linguistically, culturally, and disability considerate) to both the individual receiving HCBS/the individual's support system,
- Identify the individual and/or entity responsible for monitoring the PCSP,
- With the written, informed consent of the individual, be finalized, agreed to, and signed by all individuals/providers responsible for implementation of the PCSP,
- Be distributed to the individual and others involved in the PCSP,
- Include services that afford the individual the option to self-direct,
- Prevent service duplication and/or the provision of unnecessary services/supports, and
- Document that any modifications to compliance with the home- and community-based settings requirements for provider owned/operated residential settings are supported by a specific assessed need and justified in the PCSP in the following manner:
    - Identify a specific and individualized assessed need,
    - Document previous positive interventions and supports utilized prior to any modifications to the PCSP,
    - Document less intrusive methods of meeting the need(s) of the individual that did not work,
    - Include a clear description of the condition that is directly proportionate to the specific assessed need,
    - Include a regular collection and review of data to measure the ongoing efficacy of the modification,
    - Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated,
    - Included informed consent of the individual, and
    - Include an assurance that interventions and supports will cause no harm to the individual.

To minimize impacts to members, DHHS will require MCOs to:

1. Maintain existing PCSPs for at least the first 180 days after the MCOs have full responsibility for all CFI waiver services,
2. Permit members to continue accessing any willing and qualified CFI case manager for at least 180 days (MCOs may choose to hire those individuals as MCO employees or may engage in a contract with one or more of the seven CFI case management agencies), and
3. Honor service authorizations, including pharmacy, medical, and waiver services that are currently in place for no less than 180 days. Moreover, any changes will be supported by a reassessment and revision to a PCSP.

If a member's redetermination comes due within that 180-day period, the MCO shall take responsibility for the development of the PCSP.

In addition, each MCO must ensure that its case managers have experience with complex populations and undergo thorough training on CFI program, waiver services, and the landscape of service delivery in the State. Finally, DHHS will require each MCO to seek NCQA's LTSS distinction, because it aligns with the Department's goals for conducting comprehensive assessments, managing care transitions, performing person-centered assessments, and planning and managing critical incidents.

H. Transition Planning

As part of its service planning and care coordination processes, MCOs must have a formalized program to support members as they transition from hospitals or NFs. At a minimum, MCO transition planning programs must:

- Coordinate appropriate follow-up services from any inpatient or facility stay,
- Complete a face-to-face visit to complete a needs assessment and update a member's PCSP when a member receiving LTSS services is hospitalized,
- Evaluate members for necessary mental health and substance abuse services upon discharge from a psychiatric inpatient facility or residential treatment center,
- Coordinate with inpatient discharge planners for members referred to treatment in a NF by completing all applicable screening and/or intake processes immediately to facilitate timely transition to the most integrated and cost-effective delivery setting appropriate for the member's needs, and
- In the case of a member already admitted into a NF without the MCO's knowledge, complete an assessment of the member's interest and ability to transition into a more integrated community setting.

MCOs must have an established process to work with providers (including hospitals regarding notice of admission and discharge planning) to ensure appropriate communication among providers and between providers and the MCO to make certain that members receive appropriate follow-up care and are in most integrated and cost-effective delivery setting appropriate for their needs. CFI waiver participants will be given the opportunity to consent to the sharing of their PCSP with their MCO prior to the MCO assuming full financial risk for these services. MCOs will receive all current PCSPs so that coordination with medical services can occur.

I. Utilization Management and Prior Authorization

MCOs must develop, operate, and maintain a utilization management (UM) program that is documented through a program description and defined structures, policies, and procedures that are reviewed and approved by DHHS. The UM program must have criteria that:

- Are objective and based on medical, behavioral health, and/or LTSS evidence, to the extent possible,
- Are applied based on individual needs (including social determinants),
- Are applied based on an assessment of the local delivery system,
- Involve appropriate practitioners in developing, adopting, and reviewing them, and
- Are annually reviewed and up-dated as appropriate.

For LTSS, the MCOs UM program shall have criteria that take into consideration the member's preference regarding cost-effective LTSS and settings. The UM program descriptions, associated work plan, and annual evaluation of the UM program will be annually submitted to DHHS for review and approval prior to go-live. MCOs will also communicate any changes to UM processes at least 30 days prior to implementation.

The UM program must assign responsibility to appropriately licensed clinicians, including a behavioral health and a LTSS professional for those respective services. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease or, in the case of LTSS, an LTSS professional who has appropriate expertise in providing LTSS. The MCO must also have mechanisms in place to ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope

solely because of the diagnosis, type of illness, or condition. MCOs must comply with all relevant Federal regulations regarding inappropriate denials or reductions in care.

MCOs will issue written denial notices within timeframes specified by Federal regulations and the MCM – NF/CFI program RFP. Members will be able to appeal service determinations based on the grievances and appeals process required by Federal law and regulations.

J. Grievances and Appeals

MCOs must have a formal Grievance System in place for handling member grievances and appeals, in accordance with Federal requirements (42 CFR §438.402(a)-(b) and 42 CFR §438.228(a)). MCOs will send members written notice of any adverse action (i.e., denial or limitation of services) which informs members of their right to appeal through the MCO as well as their right to access DHHS' State fair hearing system. MCOs will provide all network providers and subcontractors information about the grievance and appeals systems to the specifications at the initiation of all contracts (42 CFR § 438.414). Through the member handbook, each MCO must also inform members of grievance, appeal, and State fair hearing procedures and timeframes (42 CFR § 438.10). The member handbook will also provide information on accessing the BSS as appropriate.

DHHS' BSS will also provide the following support to members who use or express a desire to receive LTSS:

- An access point for grievances and appeals, or other concerns about MCO enrollment, access to covered services, and other related matters,
- Education on members' grievance and appeal rights within the MCO, the State fair hearing process, member rights and responsibilities, and additional resources outside of the MCO, and
- Assistance, upon request, in navigating the grievance and appeal process within the MCO, as well as appealing adverse benefit determinations by the MCO to a State fair hearing. The system may not provide representation to the member at a State fair hearing but may refer members to sources of legal representation.

Prior to the inclusion of CFI and NF services within the MCM program, MCOs will not be responsible for handling grievances and appeals for these services as they are not providing benefit determinations. However, to the extent that MCOs provide care coordination for these services prior to December 2019, members will be able to file grievances with the MCO or State, as appropriate.

Each MCO will track and trend member grievances, complaints, appeals, and resolutions and shall have a designated portion of a public website devoted to dashboarding these as well as other appropriate performance measures, as determined by the DHHS.

The State has systems in place to prevent, detect, report, investigate, and remediate abuse, neglect, and exploitation, and to adequately monitor and track complaints. The State will train MCO staff and providers on abuse, neglect, and exploitation and all prevention, detection, reporting, investigation, and remediation procedures and requirements. Reports of abuse, neglect, and exploitation, among other events, must be formally reported to the Department. This process aids in understand the causes of such events and how to reduce their occurrence in the future. MCOs will participate in the critical incident management process and will implement quality improvement activities to reduce adverse events for members.

K. MLTSS Ombudsman

The MLTSS Ombudsman will be an independent conflict-free qualified entity which will be selected in a competitive procurement and will operate completely independently of the Department. The services of the MLTSS Ombudsman will be available to all MCM – NF/CFI program members who are receiving CFI waiver services or are residing in an NF. The MLTSS Ombudsman will be accessible through multiple

entryways (e.g., phone, internet, office) and will reach out to members and/or authorized representatives through various means (e.g., mail, phone, in person), as appropriate. The MLTSS Ombudsman will have a service delivery structure that includes a hotline, an interactive website, and an email address to contact the MLTSS Ombudsman.

The MLTSS Ombudsman will assist members in navigating and accessing covered health care services and supports and will:

1. Serve as an access point for complaints and concerns about MCO enrollment, access to services, and other related matters,
2. Work as an advocate on behalf of the members to informally resolve problems with their providers or MCO,
3. Help members understand their:
    a. MCO's grievance and appeal process, and
    b. Right to a second review by the State through a State fair hearing after an adverse decision by the MCO,
4. Assist members with the process of filing an MCO appeal or State fair hearing, and
5. Refer members to legal counsel if necessary.

The MLTSS Ombudsman may not represent members at a State fair hearing or other review process outside the MCO.

In the event member refuses to interact with an MCO, a referral shall be made to the MLTSS Ombudsman seeking assistance to identify whether member has any potential issues or concerns.

On a quarterly basis, the MLTSS Ombudsman will provide information about systemic problems to the State and MCOs, along with the State's Medical Care Advisory Committee (MCAC) and State Committee on Aging (SCOA), by implementing a robust data collection system that documents the volume and type of member contacts/complaints. By providing high-quality services, the MLTSS Ombudsman assists DHHS in achieving its State and Federal goals to improve benefit coordination, quality of care, and positive member outcomes over the full range of services, inclusive of LTSS.

L. Member Services

MCOs will support members through a toll-free telephone line that is available 24 hours per day to respond to various member concerns, PCP selection, LTSS provider selection, grievances and appeals processes, health crises, inquiries (e.g., covered services, provider network), and other general questions regarding the MCM – NF/CFI program. These calls may be generated from a MCM member, the member's family, member's legal representative, or the member's provider. The call center will work efficiently to effectively resolve issues and be adequately staffed with qualified personnel who are trained to accurately respond to members.

MCOs will also provide supports such as health coaching, assistance with social determinants of health, access to a nurse advice line, and a member portal.

In addition, MCOs will also comply with the following requirements to support members:

- Establish written policies and procedures regarding Member rights,
- Participate in any DHHS efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds,
- Establish a Member Advisory Committee comprising a reasonably representative sample of LTSS members or other individuals representing members including family members, independent advocates, inclusive of a representative from the State Committee on Aging (SCOA), and other

caregivers that reflect the diversity of the MCM program population, including individuals with disabilities and individuals residing in NFs, and meets quarterly to provide regular feedback to the MCO on issues related to MCM program management and member care,
- Develop a member handbook using the State's model handbook,
- Submit to DHHS for review and approval all enrollment, disenrollment, and educational documents and materials made available to members by the MCO,
- Confirm that all documents distributed to members, such as the member handbook, are comprehensive and are written to comply with readability requirements, and
- Make available a provider directory in electronic form and in paper form upon request.

The State reserves the right to review and approve all MCO policies and procedures and other materials that will impact members. The State will work in collaboration with the Medical Care Advisory Committee as stipulated in the Committee's by laws as part of this review and approval process.

M. Quality Metrics and Outcome Measurements

Current New Hampshire Efforts

Federal regulations (42 CFR 438.340) require every state that operates a managed care program to develop and implement a strategy to improve the quality of care for members. New Hampshire's MCM Quality Strategy specifies the types of performance improvement projects and performance measures that the MCOs will have to report. The MCM Quality Strategy lists these measures and is available at: https://www.dhhs.nh.gov/ombp/quality/documents/quality-strategy.pdf.

In addition, Federal regulations (42 CFR 438.350) also require an external quality review of each MCO by an independent entity, referred to as an external quality review organization (EQRO). The external quality review includes elements such as an assessment of each MCO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid members, recommendations for improving the quality of health care services furnished by each MCO, and comparative information across the State's MCO programs, among other topics.

To date, the two current MCOs, New Hampshire Health Families (NHHF) and Well Sense, have undergone three external quality reviews.[5] The MCM program uses performance measures, such as the Healthcare Effectiveness Data and Information Set (HEDIS). Out of 48 HEDIS performance measures in the 2016 EQRO Technical Report, NHHF and Well Sense ranked at or above the national Medicaid 50th percentile for 29 measures (60%) and 39 measures (81% percent) respectively. Figures 3 and 4 below display a representative sample of the rates achieved by the MCOs according to the comparison of their rates to the national benchmarks.

Figure 3. Summary of Scores for 2015 HEDIS Measures with National Comparative Rates for NHHF

Measure Domain	Met or Exceeded 90th Percentile	Met 75th Percentile and Below the 90th Percentile	Met 50th Percentile and Below the 75th Percentile	Met 25th Percentile and Below 50th Percentile	Under 25th Percentile	Total
Prevention	1	5	7	5	3	**21**
Acute and Chronic Care	0	3	3	4	4	**14**
Behavioral Health	3	4	3	2	1	**13**
All Domains	**4**	**12**	**13**	**11**	**8**	**48**
Percentage	**8.33%**	**25.00%**	**27.08%**	**22.92%**	**16.67%**	**100%**

[5] https://medicaidquality.nh.gov/external-quality-review-organization-eqro-technical-report-0

Figure 4. Summary of Scores for 2015 HEDIS Measures with National Comparative Rates for Well Sense

Measure Domain	Met or Exceeded 90th Percentile	Met 75th Percentile and Below the 90th Percentile	Met 50th Percentile and Below the 75th Percentile	Met 25th Percentile and Below 50th Percentile	Under 25th Percentile	Total
Prevention	2	8	8	1	2	21
Acute and Chronic Care	2	3	6	2	1	14
Behavioral Health	0	7	3	2	1	13
All Domains	4	18	17	5	4	48
Percentage	8.33%	37.50%	35.42%	10.42%	8.33%	100%

DHHS has a robust online reporting tool, the Medicaid Quality Information System (MQIS), which it utilizes to support its monitoring efforts. There are more than 400 measures available for evaluating preventive care, acute care, behavioral health care, and care management for children, adults, and older adults enrolled in the MMC program. MQIS includes results from HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS) (member satisfaction data), encounter data, call center data, appeals, and grievances. All this data is aggregated on DHHS quality website (https://medicaidquality.nh.gov/).

As a condition of receiving approval from CMS to enroll specific vulnerable populations into MCM, DHHS was required to undertake an independent assessment of the program within the first two years. The independent assessment, conducted by the Institute for Health Policy and Practice at the University of New Hampshire, summarized data from the MQIS as well as the EQR technical report. Their analysis determined that quality of care was good and that the two MCOs were performing well. Few areas for improvement were noted.[6]

Expand Quality Efforts to NF/CFI Program

The MCM – NF/CFI program provides a tremendous opportunity to integrate quality measures and oversight mechanisms for enrollees' acute and primary care services along with their LTSS. DHHS will look to expand medical care measures, including HEDIS, to include CFI waiver participants. DHHS will identify improvements in health outcomes for CFI and NF enrollees using measures that can be readily measured under the program design. A combination of the measures currently in use, with new more person-centered outcome measures, will provide assurances that the MCM – NF/CFI program is meeting its goals.

DHHS will place particular attention on keeping members living well in their communities and deferring the need for NF care and will carefully consider how to design a measurement that reflects deferral of nursing home placement. A robust program to defer NF placement requires coordination with a variety of resources; therefore, the MCOs will be expected to establish relationships, memorandums of understanding, and as needed, contracts with programs, like ServiceLink, Assisted Living Facilities, Meals on Wheels, and Adult Day Programs. Relationships like these confirm that members are integrated, not isolated, in the home and community.

Other key factors for deferring NF placement that DHHS will also consider in the development of quality measures are:

- Maintaining mobility and health status,

[6] https://www.dhhs.nh.gov/ombp/caremgt/documents/1915b-independent-assessment.pdf

- Integration of early warnings and incident management (IM) reporting and tracking for reduction of falls in home,
- Careful utilization management to track trends for emergency room admissions and avoidable admissions related to dehydration or other concerns that may stem from lack of community integration,
- Person-centered care coordination, and
- Provider network and community options.

Finally, the CFI waiver under the 1915(c) authority is required to identify and maintain waiver assurance measures and assess performance against them as a requirement for receiving approval from CMS. These measures are largely administrative, focusing on provider training, timeliness of assessments and reassessments, and reporting of critical incidences. DHHS will look to the MCOs to administer these requirements and meet these assurances and while also including enhanced quality oversight activities in collaboration with DHHS.

Implementing a new comprehensive quality management and performance improvement program is imperative, and will include elements such as:

- Performance improvement projects,
- MCO achievement of NCQA accreditation with LTSS distinction[7] within one year of operation,
- Collection and reporting of performance measures, including HEDIS[8] and CAHPS[9],
- Collection and reporting of member quality of life surveys for CFI members, such as the National Core Indicators – Aging and Disability[10] (NCI-AD) survey,
- Performance of quality reviews for the CFI waiver,
- Critical incident monitoring,
- Pay-for-performance program for MCOs, and
- Value-based payment models for acute care and LTSS.

DHHS will continue to utilize the NH Medicaid Quality website to provide transparency about the performance of its MCOs.

To support DHHS' comprehensive quality management and performance improvement program, MCOs will be required to have a written Quality Management/Quality Improvement (QM/QI) program that clearly defines its quality improvement structures and processes and assigns responsibility to appropriate individuals and will at a minimum include the following elements:

- Address physical health, behavioral health, and LTSS,
- Be accountable to the MCO's board of directors and executive management team,
- Have substantial involvement of a designated physician and designated behavioral health practitioner,
- Have a QM/QI committee that oversees the QM/QI functions,
- Have an annual work plan,
- Have resources – staffing, data sources, and analytical resources – devoted to it, and
- Be evaluated annually and updated as appropriate.

This QM/QI program will use as a guideline the current NCQA Standards and Guidelines for the Accreditation of MCOs with LTSS distinction and shall include the MCO's plan for improving patient

[7] http://www.ncqa.org/programs/accreditation/accreditation-of-case-management-for-ltss/long-term-services-and-supports-distinction-for-health-plans
[8] http://www.ncqa.org/hedis-quality-measurement/hedis-measures
[9] https://www.ahrq.gov/cahps/about-cahps/index.html
[10] https://nci-ad.org

safety. The MCO shall use the results of QM/QI activities to improve the quality of physical health, behavioral health, and LTSS delivery with appropriate input from providers and members. The QM/QI program description, work plan, and program evaluation will be exclusive to MMC – NF/CFI Services and shall not contain documentation from other state Medicaid programs. The annual work plan and evaluation shall be subject to DHHS review and approval.

N. Patient Safety

To assure patient safety and protections, MCOs must, in coordination with DHHS, develop and implement a critical incident[11] reporting and management system in accordance with reporting incidents for 1915(c) HCBS waivers and any other established DHHS requirements. Subject to DHHS review and approval, MCOs must develop and implement policies and procedures to:

- Address and respond to incidents,
- Report incidents to the appropriate entities per required timeframes,
- Track and analyze incidents, and
- Demonstrate reduction in future critical incidents due to quality improvement initiatives.

Each MCO shall have designated staff located in New Hampshire to be responsible for ensuring the MCO will use this information to identify both case-specific and systemic trends and patterns, identify opportunities for improvement, develop and implement appropriate strategies to reduce the occurrence of incidents, and improve the quality of care delivered to patients. MCOs will submit summary reports to DHHS monthly that will allow DHHS to track the number of critical incidents, confirm that MCOs are reporting incidents to the appropriate entities, and confirm that MCOs are appropriately responding to patient safety concerns. This individual, or their designee, will also participate in quarterly DHHS sponsored Critical Incident Review Team meetings to work on and address statewide systemic issues identified through critical incident management and other statewide initiatives around preventing and/or protecting vulnerable adults from abuse, neglect, and exploitation. Each MCO should propose specific initiatives it will use to protect and reduce the risk of abuse, neglect, and exploitation of members, including how it proposes to work with the State's protective services.

O. Rates and Payments

As previously noted, the primary payment for the State will be a capitated, risk-based payment to the MCOs. The State will then encourage MCOs to manage within the capitation while promoting quality of care and effective service utilization. MCOs, as part of their network development strategy, will have some flexibility in structuring reimbursement arrangements with providers.

Nursing Rates and Reimbursement

NFs in New Hampshire receive payments through as many as three different funding streams:

- **Base payments.** NFs receive base payments in an amount equal to their per diem rate—calculated based on costs and acuity—reduced to account for state appropriations.

- **Medicaid Quality Incentive Payments (MQIP).** All NFs receive an additional payment that brings them up to their full per diem rate. The Medicaid Quality Incentive Payment is funded by the Nursing Facility Quality Assessment (NFQA)—a 5.5% tax on revenue.

[11] Critical incidents are events or situations that cause or may cause harm to a patient's health or welfare, such as abuse, neglect, and exploitation.

- **ProShare Payments.** County NFs receive a third payment to cover the difference between the full Medicaid per diem rate and the Medicare nursing NF rate. The ProShare payments are funded with intergovernmental transfers (IGTs) from the counties.

Federal rules prohibit states from making additional payments directly to providers for services covered under managed care contracts (42 CFR 438.6). Accordingly, New Hampshire may not make MQIP and ProShare payments directly to NFs once NF services are included in the MCO contract.

However, in the Medicaid Managed Care final rule, CMS authorized states to direct plans to use particular provider payment methodologies that promote access, quality, and delivery system reform—referred to as "directed payments." States may, among other things, require MCOs to pay state-specified fee levels for certain providers. In the preamble to the final rule, CMS clarified that states are not required to treat public and providers the same; instead, states must ensure that payments are directed equally and using the same terms of performance for a class of providers, such as public NFs.

Accordingly, although the State may not make MQIP and ProShare payments to NFs directly after the full implementation of the MCM – NF/CFI program on December 31, 2019, the State may require that the MCOs make certain payments to NFs as a permissible "directed payment." Specifically, the State could consider the following types of directed payments:

- Set Medicaid per diem rates—the "full acuity rate"—as the minimum rate for all NFs, or,
- Set Medicare rates, using the same methodology used in ProShare today, as the minimum rate for all public NFs.

The existing financing mechanisms, MQIP and ProShare may be used to access the funding that would inform directed MCO payments. MCOs will be required to use rates established by the State. Such rates will be no less than the rates paid to providers in SFY 2018.

CFI Waiver Services:

To further encourage continuity of care and limit disruptions for providers, for at least the first year, MCOs will utilize the approved FFS rate for CFI waiver services. These rates will serve as the "floor" or minimum provider reimbursement. As necessary, the MCO may negotiate a higher rate with individual providers, to ensure adequate coverage, to expand coverage outside of a service region, or if the current rate is insufficient to meet the care needs of the member. In the event the MCO identifies unmet needs and there are no state rates, the MCO may negotiate these rates directly.

P. Claims Payment

The MCM contracts will include detailed requirements on timely and accurately processing provider claims. With the inclusion of NF/CFI services, MCOs will need to demonstrate ability to work with and sustain non-traditional HCBS providers. As the financial stability of these providers is more volatile than that of acute care providers, DHHS will carefully evaluate MCOs and their ability to process these claims.

DHHS will also establish robust standards for encounter data file submission addressing standards for accuracy and completeness. Given the reliance of accurate and timely claims processing and encounter data reporting on all aspects of MCO operations, DHHS will heavily test these systems as part of readiness. The development of these systems is time consuming, often requiring 12 months of development prior to testing, with testing of these systems often occurring six months prior to go-live. With these timelines in mind, DHHS plans for frequent and continual technical assistance with the MCOs to test and evaluate these systems and to promote successful program implementation.

Q. Federal Waiver Authority

For efficiency purposes, DHHS will amend its existing 1915(c) CFI and 1915(b) waivers adding the LTSS services that the MCOs will be delivering. DHHS will need to allow time for both waiver amendments and approval (i.e., get CMS approval) prior to go-live. Considering CMS also indicates readiness review findings should be completed 90 days before go-live, the State will need to coordinate activities such that waiver approval aligns with readiness and enrollment. DHHS expects that approval will take between six and nine months.

IV. Appendix A: New Hampshire Medicaid Covered Services[12]

Service Category	Authority and CFR	Rule/RSA	Current Utilization Management Strategies	Notes on Included Services
Mandatory Services				
Intermediate Care Facility Nursing Home	Federal Mandate (440.60)	He-E 802, He-E 806 & He-E 807	Clinical eligibility must be established by BEAS prior to placement.	
Skilled Nursing Facility Nursing Home	Federal Mandate (440.40)	He-E 802, He-E 806 & He-E 807	Clinical eligibility must be established by BEAS prior to placement.	
Skilled Nursing Facility Nursing Home Atypical Care	Federal Mandate (440.40)	He-E 802, He-E 806 & He-E 807	Clinical eligibility must be established by BEAS prior to placement.	
Intermediate Care Facility Nursing Home Atypical Care	Federal Mandate (440.40)	He-E 802, He-E 806 & He-E 807	Clinical eligibility must be established by BEAS prior to placement.	
Inpatient Hospital Swing Beds, Skilled Nursing Facility	Federal Mandate (440.40)	He-E 802 & He-E 806	Clinical eligibility must be established by BEAS prior to placement.	

[12] https://www.dhhs.nh.gov/ombp/caremgt/documents/12-DHHS-CM-01.pdf

Inpatient Hospital Swing Beds, Intermediate Care Facility	Federal Mandate (440.40)	He-E 802 & He-E 806	Clinical eligibility must be established by BEAS prior to placement.	
Outpatient Hospital, General	Federal Mandate (440.20)	He-W 543	Currently 12 visits per SFY ; Transitioning to 4 ED and 8 urgent care visits per SFY.	
Inpatient Hospital, General	Federal Mandate (440.10)	He-W 543	Limited to QIO approved;OOS; inpatient requires PA unless an emergency. Includes LTCH care with PA as of 10/08.	
Physicians Services	Federal Mandate (440.50)	He-W 531	PA not required by rule; some services require PA (transplants, bariatric surgery, potentially cosmetic procedures).	
Rural Health Clinic	Federal Mandate (440.20)	He-W 537		Includes Federally Qualified Health Centers.
Home Health Services	Federal Mandate (440.70)	He-W 553	Selective contracting for incontinence supplies.	DME and Supplies are considered part of home health and are therefore federally mandated.
Dental Service	Federal Mandate (440.50)	He-W 566	No "service limit," but there are other timing/limit criteria in the rule; ortho requires PA-see rule for any other PA's or limits.	Dental in schools falls under dental for state plan
Laboratory (Pathology)	Federal Mandate (440.30)	He-W 577		
Advanced Practice Registered Nurse	Federal Mandate (440.165, 166)	He-W 534	Mental Health APRN visits count toward psychotherapy service limits.	
X-Ray Services	Federal Mandate (440.30)	He-W 569	15 (radiation therapy not counted); PA for certain types of high-tech diagnostic imaging.	
Family Planning Services	Federal Mandate (440.40)	He-W 541		
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services for Persons <Age 21	Federal Mandate (440.40)	He-W 546		All "coverable services" must be covered by Medicaid if medically necessary; these are subject to prior authorization.
Optional Services				
Prescribed Drugs	(440.120)	He-W 570	PBM; PA's, PDL, dose consolidation, maintenance programs, lock in, quantity limits, refill edits, mandatory generic prescribing, new drugs to market restrictions	
Optometric Services Eyeglasses	(440.120)	He-W 565	No "service limit," but 1 exam/12 mo, glasses only if 1/2 Diopter change.	

Service Category	Authority and CFR	Rule/RSA	Current Utilization Management Strategies	Notes on Included Services
Mental Health Center	42 CFR	He-M 401, He-M 426, RSA 135-C	See Service Grid Table 2 for service limits. In addition, individuals who are determined not eligible for community mental health services are limited to $1,800 a year in services. Individuals determined eligible for community mental health services but in the Low Utilizer category have a $4,000 a year service limitation.	Community Mental Health Services as described in He-M 426 can only be provided by designated community mental health programs.
Ambulance Service	(440.170)	He-W 572		Might be considered mandatory due to requirement to provide transportation to medically necessary services.
Adult Medical Day Care	(440.130)	He-E 803	N/a	
Furnished Medical Supplies & Durable Medical Equipment	(440.120 prosthetics; 440.70 home health)	He-W 571	PA is required for some DME and also for some supplies, i.e., incontinence products. All ACD require PA.	Feds consider this mandatory falling under the home health benefit.
Physical Therapy	(440.110)	He-W 568	80 15-min unit combo of PT/ST/OT.	
Occupational Therapy	(440.110)	He-W 568	80 15-min unit combo of PT/ST/OT.	
Speech Therapy	(440.110)	He-W 568	80 15-min unit combo of PT/ST/OT.	
Private Duty Nursing	(440.80)	He-W 540	PA required.	
Medicaid in the Schools	(440.130)	RSA 186-C:27; I-II He-M 1301	Participation in the medical assistance program is discretionary on the part of school districts and school administrative units. Medicaid match is paid by the SAUs and not BDS/DHHS.	
Day Habilitation Center	He-W 510			This is Early Supports and Services previously known as Early Intervention
Medical Services Clinic	(440.90)	He-W 536	Subject to the service limits of the provider type doing the service.	Falls under clinic in the state plan, but is not really a clinic as envisioned under federal regulations. Methadone maintenance services fall under medical services clinics.
Psychotherapy	(440.60)	He-W 535	Psychotherapy limits effective 10/14/11 18 visits (adults) ,24 visits (children). Per SFY	
Personal Care Services	(440.167)	RSA 161-E:2 He-W 552		
Wheelchair Van	(440.170)	He-W 573	24 trips/year whether 1 way or round trip, thereafter trips are PA	Might be considered mandatory due to requirement to provide transportation to medically necessary services.

Service Category	Authority and CFR	Rule/RSA	Current Utilization Management Strategies	Notes on Included Services
Podiatrist Services	(440.60)	He-W 532	4 visits/sfy	
Nursing Facility Services for Children with Severe Disabilities			Cedarcrest – prior approval is required for all admissions	
Inpatient Psychiatric Facility Services Under Age 22	(440.160)		In-state psych is not PA'd OOS psych is PA'd.	
Audiology Services	(440.110 and 120)	He-W 567		
Outpatient Hospital, Mental			Outpatient services from a mental hospital would require a PA	This service has been billed by one VT provider only
Acquired Brain Disorder Home and Community Based Services (HCBS) Waiver		RSA 137-K:3 He-M 522 He-M 517 He-M 506 He-M 507 He-M 513 He-M 518 He-M 519 He-M 521 He-M 525 He-M 1001 He-M 1201	All services are Prior Authorized by BDS. Clinical eligibility must be determined prior to authorization of services	
Developmentally Disabled HCBS Waiver		RSA 171-A:3; 18, IV He-M 503 He-M 517 He-M 506 He-M 507 He-M 510 He-M 513 He-M 518 He-M 519 He-M 521 He-M 525 He-M 1001 He-M 1201	All services are Prior Authorized by BDS. Clinical eligibility must be determined prior to authorization of services	
Choices for Independence HCBS Waiver		RSA 151-E He-E 801	Clinical eligibility must be established by BEAS prior to initiation of services.	

Service Category	Authority and CFR	Rule/RSA	Current Utilization Management Strategies	Notes on Included Services
In Home Supports HCBS Waiver		RSA 161-I:7; 171-A:3; 18, IV He-M 524 He-M 503 He-M 510	All services are Prior Authorized by BDS. Clinical eligibility must be determined prior to authorization of services. There is a cap of $30K per year per person for services authorized	
Inpatient hospital, NF, ICF over age 65 in IMD's (440.140)	(440.140)			
Prenatal child/family health care support	(440.130)	He-W 549	Effective. Jan 2012, limits are 12 units for child health support and 16 units for CSHCN nutrition; Units are per 15 minutes	
Early Intervention	20 U.S.C. 1400 et seq.) (440.130)	RSA 171-A:18 He-M 510		
Newborn Home Visit	(440.130)	RSA 167:66-68 He-W 547		
Extended Services for Pregnant Women	(440.220)	He-W 548		
Targeted Case Management (1915g(1) & (g)(2)		HE-E 805	Through He-E 805, this service is limited to individuals eligible for CFI services, under He-E 801.	
Hospice 1905(o)		RSA 126-A:4-e He-W 544		Oversight follows the federal Medicare program.
Private Non-Medical Institution For Children	(440.130)	He-C 6350 and He-C 6420	Prior authorization required.	DCYF Service
Crisis Intervention	(440.130)	He-C 6350 and He-C 6420	Prior authorization required and entered by State Office staff only.	DCYF Service Not Currently in Use.
Intensive Home and Community Services	(440.130)	He-C 6339	Prior authorization required.	DCYF Service
Placement Services	(440.130)	He-C 6355 and He-C 6420	Prior authorization required.	DCYF Service
Home Based Therapy	(440.130)	He-C 6339	Prior authorization required.	DCYF Service
Child Health Support Service	(440.130)	He-C 6339	Prior authorization required.	DCYF Service