GRANITE STATE
Home Health Association
An Affiliate of the Home Care Association of New Hampshire

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January 7, 2015

Nicholas A. Toumpas
Commissioner
NH Department of Health and Human Services
Brown Building
129 Pleasant Street
Concord, NH 03301

Dear Commissioner Toumpas:

I'm writing on behalf of New Hampshire's home health agencies to offer suggestions in regard to Medicaid Care Management Step 2.

Home Health agencies throughout the Granite State are committed to helping vulnerable seniors and adults with disabilities remain as independent as possible in their homes. We actively participate in the Choices for Independence program, and we believe this waiver program is an important option for many people to remain in their communities, close to their friends and families.

For the past year, many home health agencies have participated in Step 1 of Medicaid Care Management. Our experience with prior authorizations and care coordination for Step 1 Medicaid enrollees has provided us with insight that we believe is valuable to the transition to Step 2. Here are some comments and recommendations:

- In general, the Managed Care Organizations (MCOs) had little understanding of the types of services provided by home health agencies or the importance of the timely provision of services to the client's overall health needs. This lack of understanding frequently resulted in delayed authorizations, fewer visit approvals than medically necessary, services denials, and an increased administrative burden for providers. In order to avoid similar disruptions of care, **it's imperative that MCOs have authorization and care management staff that have direct experience and knowledge of long term care services and supports.**
- Home care agencies frequently experience delays in determination and redetermination of eligibility for CFI services. In addition, once eligibility has been determined, service authorizations are also often delayed. This puts agencies in the awkward position of having to "trust" that they will be reimbursed for care provided, or discontinuing

services upon which clients rely. Our understanding is that BEAS will still be responsible for determining eligibility, but MCOs will be responsible for service authorizations and provider payments. We are extremely concerned that client services and provider payments will be compromised during the handoff between BEAS and the MCOs. **DHHS should develop a proactive process to assure that determinations and redeterminations are conducted in an appropriate time frame in order for MCOs to grant service authorizations. The contract should also include a mitigation process to assure continuity of care and payment when handoffs between BEAS and MCOs are compromised.**

- **The contract should require that BEAS and/or the MCOs promptly inform the provider of record when a clients' eligibility has been discontinued.** Agencies serve many, many clients and provide multiple visits each week. It is unreasonable to require providers to check a client's eligibility prior to each visit.
- Since the Choices for Independence program is a Long Term Care program, **it is imperative that service authorizations be granted for extended periods of time.** Our experience in Step 1 is that MCOs generally authorize services for much shorter time frames than agencies consider reasonable. This has created an unnecessary administrative burden on agencies to request additional services.
- We understand that existing services authorizations will be honored when the CFI clients transition to MCO coverage on September 1st. If a client's authorization expires shortly after the transition, there may not be enough time for the provider or the MCO to renew the authorization without disrupting care. **DHHS should establish a 30 to 60-day threshold for continuation of all expiring services authorizations during the initial coverage period and during the time when clients can switch MCOs.**
- In order to assure a thorough understanding of clients' needs, **DHHS should require MCOs to assign care coordinators – whether in-house or outsourced to existing case managers – who are knowledgeable about the client's individual needs.** To the extent possible, the care coordinators should remain consistently assigned, to ensure that clients' needs and providers' services are understood.
- Our experience with Step 1 is that MCOs require unreasonable amounts of clinical documentation when authorizing services for home care. The documentation requests far exceed our experience with other medical insurers. **DHHS should work with the MCOs to develop a template of standard documents that both MCOs require, with the goal of minimizing administrative burdens for providers.**
- While home care agencies that offer services to Step 1 enrollees are familiar with the contracting, authorization and billing practices of the MCOs, providers who are not involved in Step 1 may need assistance with managed care processes. **We urge DHHS to provide tutorials for contracting with the MCOs, and require that MCOs provide authorization and billing training for all providers.**
- Ultimately, the success of New Hampshire's transition to care management for long term care services and support will depend on the MCOs having a qualified network of providers. Adequate provider reimbursement is essential to the development of qualified networks. While DHHS has stated publicly that the MCOs must honor DHHS payment rates for at least one year, we are concerned that – given how low the

payment rates are already – any attrition in rates after the first year will undoubtedly result in deterioration of the existing provider network. **We encourage DHHS to require a constant floor for reimbursement rates, or extend the payment floor for a longer period of time to maintain stability in the provider networks.** Without providers, the availability of CFI services cannot be assured.

Home care agencies are hopeful for a smooth CFI transition to care management. We look forward to an ongoing dialogue with NH DHHS and the MCOs to assure that our clients receive the services they need, and that our agencies can be successful partners in this important initiative.

Respectfully,

Gina Balkus
Chief Executive Officer

cc: Mary Vallier Kaplan, Chairman, Governor's Commission on Medicaid Care Management
Diane Langley, Director, BEAS