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TO: Henry Lipman, Director, NH Medicaid

FR: Gina Balkus, CEO, Granite State Home Health Association

DT: May 31, 2018

RE: Medicaid Home Health MCO Contract Recommendations

Henry, here are recommendations for discussion during our meeting today:

MCO Prior Authorizations for Home Health Services

1. **The contract should stipulate that prior authorizations are not required for the first six skilled nursing and/or rehabilitation visits during a client's home health episode of care.** If the client's clinical needs call for more than 6 visits, agencies will submit prior authorization requests. This is the current practice that has been arranged, after careful data analysis, by the MCOs and home health providers. It is conducive to the delivery of timely and necessary health care services. The contract should include this requirement as a best practice
2. **The contract should stipulate the prior authorizations for private duty nursing care should be effective for at least six months.** Clients who require PDN care usually have long-term needs that do not change. For the first several years, the current MCOs were authorizing just eight weeks of care, which places an administrative and clinical documentation burden on home care agencies. The MCOs positions have evolved on this issue, and both are currently authorizing care for 6 months or more. The contract should include this requirement as a best practice.

MCO Audit and Appeal Requirements for Home Health Services

1. **Audit Reasonableness –** The MCO will meet state audit requirements through concurrent review. The audit magnitude will not exceed more than 10% of the total annual claims received from a home health agency. The MCO will conduct the audit through audit requests made monthly. In no circumstance shall the MCO make audit request for more than 3 months of the 12-month volume. The MCO shall give home health providers at least 30 days from the date of the audit request receipt to respond to the audit request.
2. **Audit Exemption for Good Conduct –** The MOC shall reduce or exempt a provider that has had no audit findings of erroneous claims or recoupment of payment within the prior year.

3. **Compliance with Managed Care Law –** The MCO shall comply with the conditions stated in Title XXXVII Chapter 420-J Managed Care Law. If this is not possible, then specifically, the contract should require that MCOs agree to the following:
   a. The MCO will use a different person to decide a grievance or claims appeal than the person making the initial determination. The person shall have medical knowledge of home health.
   b. The MCO shall allow a claimant up to 180 days following the receipt of a claims denial to file an appeal.
   c. The MCO shall make a non-expedited claim appeal decision no more than 30 days after receipt of a claimant's appeal. The MCO shall make a decision on an expedited claimant appeal of a denial within 72 hours.
   d. The MCO shall make a determination for service authorization within 24 hours of provider request.
   e. The MCO shall make a payment to home health providers within 30 days of receipt of a clean claim submitted non-electronically and within 15 days of a receipt of a clean claim received electronically.
   f. The MCO shall not pursue recoupment of a previously paid claim beyond 18 months from the date of original claim payment to provider.

MCO Payments to Home Health Providers

Despite DHHS's statements that MCOs may contract for higher payments rates with providers, the current MCOs pay the standard fee-for-service Medicaid rates that were in effect when managed care was implemented in 2013. **The Medicaid FFS rates are outdated – some have not changed in 19 years – and reimburse providers from 30% to 57% of the cost of providing care.** The Medicaid rates are below the rates paid for CFI home health services, which are usually a lower level of care. DHHS has no mechanism in place to determine the adequacy of home health provider reimbursement in order to assure clients' access to timely and necessary care.

The attached spreadsheet provides information on the current rates. GSHHA respectfully requests that DHHS implement a meaningful update to home health reimbursement rates in the MCM actuarial process and in the MCO contracts, including the conversion to visit rates for rehabilitation therapy services. We are willing to work with you to determine more appropriate rates for specific services.

NH Medicaid Home Health Rates - May 2018

	NH Average Medicare Cost per Visit*	NH Medicaid Payment	Last Medicaid Rate Update	NH CFI Payment	Last CFI Rate Update
Skilled Nursing Care	$171.86	$90.16/visit	2010	$94.67/visit	2015
Physical Therapy	$162.03	$23.25/15-mins	1999	NA	
Occupational Therapy	$163.28	$21.45/15 mins	1999	NA	
Speech Language Pathology	$198.15	$16.80/15 mins	1999	NA	
Home Health Aide	$65.74	$29.60/visit under 2 hours;	Visit rate established in 2010	$31.08/visit under 2 hours	2015
Home Health Aide	$65.74	$5.74/15 mins for visit 2 hours or more	2006	$6.03/15 mins for visit 2 hours or more	2015
Private Duty RN - daytime	NA	$52/hour	2016	NA	
Private Duty RN - night/weekend/intensive	NA	$58/hour	2016	NA	
Private Duty LPN - daytime	NA	$48/hour	2016	NA	
Private Duty LPN- night/weekend/intensive	NA	$56/hour	2016	NA	

*Source: BerryDunn, "New England VNAs - Operational Indicators," based on last completed fiscal years as of December 31, 2017