

NH Medicaid
Care Management Program
Public Forum

Manchester, NH
September 23, 2011

Disclaimer

Please note that the comments and priorities that follow reflect the opinions of participating workgroups and not necessarily those of the Department of Health and Human Services.

Photos of charts reflect workgroup work process and product. Items crossed out typically reflect brainstormed suggestions that were combined with others.

Note: In this Forum the first exercise was skipped and the definition of Quality of Life was used from the first two forums. We have documented them as Exercises 1 and 2, while the flip charts may be labeled Exercises 2 and 3.

Program Users Perspective - Exercise 1

What's needed to increase # with high quality of life/health?

- Progression and stability as acceptable outcomes
- Eligibility based on recipient not caregiver income
- Doctors free from outside pressure
- Patient/Family Control
- Appeal rights on denial
- Community Cultural Change of Attitude
- Access to range of info making it geographically convenient and accessible
- Consistent standards implemented across all agencies and users
- Integrated whole family approach
- Wellness versus treatment
- Quality customer service follow up with enough personnel
- Quality and individual control meaning individual and provider or doctor make decisions. Not a one size fits all approach. In particular do not want services to be stopped simply because program user is not showing improvement.
- Communication to user in an easy to understand way. With someone they can talk to who knows them.
- Need to decide as a society on a common value...an agreed baseline in health and service access should be established as a right to every citizen.
- Person centered system that gives consumers choices and variety of health care providers (an increased pool of providers that are adequately reimbursed)
- A proactive case managed system that integrates services across the health and services program including prevention, education, and services all in one stop environment
- Different models of delivery (rural versus city) based on needs of a diverse population (including transport, mental health, substance abuse)

Provider Perspective – Exercise 1

What's needed to increase # with high quality of life/health

- Accessibility
- Preventative Care
- Accountability
- Fair and stable reimbursement including payment reform for innovation
- Comprehensive array of services to make appropriate referrals
- Better accountability at DHHS including an organization chart so providers know who to go to and can eliminate administrative barriers
- Guaranteed access
- Sufficient state and federal funding
- Face to face appeals based on medical necessity with focus on care improvement rather than denials.
- More education and follow up
- Funding and regulatory flexibility
- Integrated system of care using evidence based guidelines
- Access to quality providers – including transportation, home based care
- Care coordination utilizing a HUMAN response system to manage interagency coordination and referrals.

Program User Perspective – Exercise 2

In a care management program, what must happen in order to create **knowledgeable and informed** recipients?

- Access to benefits specialist, case manager who is an advocate.
- Easy and timely to get in, no fear of immigration and other reprisal
- Communication: clear, concise, in client language, and web based
- Case managers who are knowledgeable, proactive, and flexible to client needs
- Patient control of decisions and services
- Local Control and family involvement to encourage communication and involvement
- Better informed providers and a constant give and take so that they can communicate what they need. Bottom up rather than top down approach.
- Dissemination of info: understandable, easy to interpret, multiple media and outreach programs, local community access, informed providers (not just Medicaid users), peer support groups, survey to determine consumer limitations (i.e. no access to internet or English)
- User Accountability – they need to be open and willing to take in information (advocates needed for those with issues that limit accountability)
- Informative newsletters (electronic or paper) that are mailed out so they can have info readily accessible
- Accessible informational seminars and forums with transportation availability.
- More support groups with access to legislators
- Single point of access to care through medical home or PCP
- Succinct, understandable 4th grade level information
- Need to help users navigate the system (ideally through Medical Home)

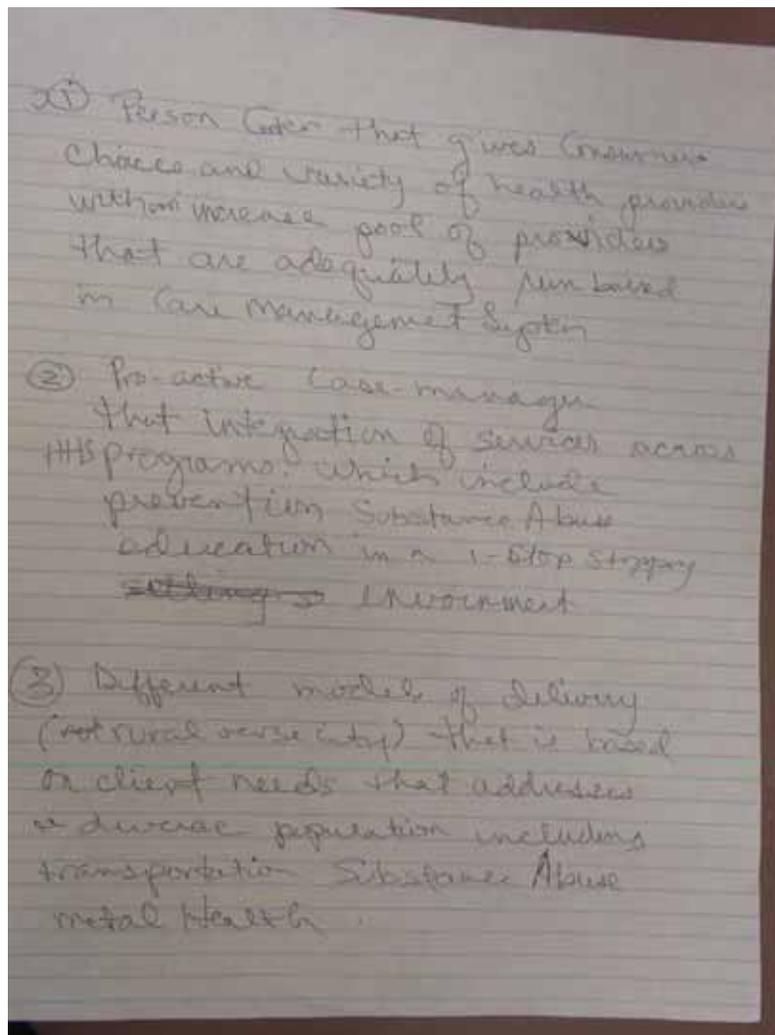
Provider Perspective – Exercise 2

In a care management program, what must happen in order to **create satisfied providers** instead of dissatisfied (or **Resistant**) providers?

- Eligibility process is a nightmare and no access until found eligible. Can take 6 months to a year.
- Adequate reimbursement for everyone.
- Case Manager oversight provided by DHHS – someone watching them.
- Providers need fair and equitable reimbursement
- Clear guidelines for providers and less red tape
- Access to a comprehensive set of services so that they can make appropriate referrals
- Sufficient state and federal funding
- Fair and adequate funding
- Face to face appeals based on care improvement
- Adequate compensation
- Client care coordination with a team approach
- Consumer input and responsibility – look at what they need and want
- Communication between state and providers (specifically regarding Medicare rules and regulations)
- Community capacity to provide services

Program User Perspective - Exercise 1

What's needed to increase # with high quality of life/health?



Q1 Summarized USERSA Q1

- ① Access to range of info-geographically easy
- ② Consistent standards consistently implemented across systems
- ③ Integrated, holistic, family/team (VA) approach
- ④ Qual. customer service / follow up / enough personnel
- ⑤ Wellness vs treatment / independent choices
- ⑥ Consumer-centered providers

PROGRAM USERS (A)

- Q1
- access to ^{range of} information ^{family team} approach
 - education
 - local - geographical access
 - enable independence for consumer
 - less red tape
 - uniform standards
 - compassion
 - knowledgeable decision-makers
 - shared information across programs
 - replicate VA integrated care system
 - having enough ~~peop~~ personnel
 - more wellness plans (as opposed to treatment plans)
 - quality customer service
 - holistic treatment
 - follow reqs consistently
 - follow up

USERS B Q1

- ③ #. Doctors free from outside pressures
- ③ #. Patient/family control
- ⑤ #. Community cultural change of attitude
- ⑤ #. DHHS needs to adopt #13
- ⑤ #. Appeal rights when denied Services

PROGRAM USERS B Q1

- ① Completely Insured
- ③ Agency has high standard of Care
- ⑤ #. Money
- ④. Lessons learned from history
- ③ #. Opportunities to get proper care
- ③ #. ~~13~~ Access to more information about adult family members who use the system
- ④ #. Understanding Spend-downs & deadlines
- ④ #. Better communication between providers & caregivers
- ③ #. Free choice of providers
- ① #. No denial of necessary care

Ex #1

USER C1

2/3 Different Model for different communities

PROGRAM USERS C Q1

9/1 Person Centered

- 1 Consumer choice of specialist (not geographically)
- 3 Welcoming to diverse population

1 Variety of choice for healthcare provider

6/2 Prevention

2 Integration of services across programs

1 More providers accepting Medicaid

2 Education of consumers/dignity

2 One Stop Shopping

1 Adequate reimbursement of provider

3 Healthcare for Substance Abuse

3 Transportation

2 Pro-active Case Management

(CASE MGR?)

Q1 ~~FOCUS~~ PROGRAM USERS' D
**PROGRESSION/STABILITY AS
 ACCEPTABLE OUTCOMES**

**ELIGIBILITY BASED ON
 RECIPIENT INCOME**

**CONSUMER CONTROL OVER
 TREATMENT PROVIDERS**

STRONG OVERSIGHT
 COORDINATED CARE BY TEAM

10 STRONG OVERSIGHT ✓

11 PREVENTION → STABILITY ✓
 ↓
 PROGRESSION

12 RECIPIENT-BASED RE: INCOME ✓

13 CARE MGMT ↑ IN MEDICAL HOME MODEL ✓

14 INDIVIDUALIZED PLANNING ✓

PROGRAM USER'S D

Q1

1 OUTREACH

2 INTEGRATION

3 INDEPENDENCE

4 CHOICE

5 COST EFFECTIVE

6 ACCESSIBILITY

7 COORDINATED CARE ✓
 off team

8 CAPS on med cover

9 CONSUMER CONTROL ✓

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Provider Perspective - Exercise 1

What's needed to increase # with high quality of life/health

WHAT'S NEEDED TO SATISFY PROVIDERS IN A CARE MGMT PROGRAM

① SUFFICIENT STATE / FED FUNDING PROVIDERS A

② FAIR EQUITABLE PAYMENT

③ FACE TO FACE APPEALS (MEDICAL NECESSITY) W/ FOCUS ON CARE IMPROVEMENT RATHER THAN DENIALS → BASED ON DEFINED CP. CONTROLLED OUTCOMES

PROVIDERS A

Q1 PROVIDER:

* GOOD SERVICE PROVIDERS
~~BACKUP PERS OF EQUIPMENT~~

① FUNDING / REG FLEXIBILITY ③
~~CHECK PRIOR AUTHORIZATIONS ON LMS~~

~~AUTOMATIC PAYMENT POSTING~~ ①
* ELECTRONIC TRANSACTIONS
~~FACILITATE ACCESS TO CARE~~

~~FOR HEALTH CARE THAT WOULD~~
~~SENSE → TO AVOID~~
~~REDUNDANCY, GAPS~~

PROVIDERS
 ↑ PROVIDER ACCESS TO
 ST. INFORMATION
 * GUARANTEE ACCESS TO CARE
 ↳ RURAL AREAS → TOO! (MISA)
 * CASE MANAGEMENT AS A
 STAPLE.
 * IMPROVED ACCESS TO TRANSPORTATION
 TO FOLLOW UP CARE (ALL CARE)
 * MORE EDUCATION AND FOLLOW UP
 SO CONSUMERS DON'T LOSE
 BENEFITS (AND PICK RIGHT PLAN)
 * PROVIDE LOCAL ACCESS

PROVIDERS
 CONTINUED ELIGIBILITY
 SO PEOPLE DON'T LOSE SUES
 * HELP PEOPLE PICK "BEST" PLAN
 FOR THEM.
 * INFORMED SERVICES BY
 WHOLE FAMILY TO MAKE
 FOCUS ON PREVENTIVE / PREVENTIVE
 MODALS OF CARE (3)
 MECHANISM TO APPEAL
 CARE DECISIONS (MEDICAL NECESSITY)
 STAY AWAY FROM THE
 BASED SYSTEM THAT DICTATES

10 ACCESSIBILITY ①

PROVIDERS B

- accessibility
- transportability
- quicker referrals for necessary services & better follow-up
- 2. synthesis of decisions
- level of care
- ~~transportability~~ communication

3 PREVENTATIVE CARE

- outreach/communication
- education
- list of all possible options
- pursuit of joy
- holistic care

9 ACCOUNTABILITY

- consumer directed
- transparent performance measures
- honesty in referrals clinical integrity
- response from the state
- state regulations
- decrease fragmentation
- consistency
- compensation
- independence of choices

PROVIDERS B

- Qd accessibility
- x education
- cost-effective
- consumer directed
- transportation
- independence in choices
- engagement in all levels of care
- fairness ↑
- accountability regulation
- quicker referrals for necessary services & better follow-up
- better communication or resources available
- x integration/outreach
- consistency
- pursuit of joy fulfillment of resident
- respect choices
- provide for sociability
- timeliness of decisions
- evaluator of meeting needs
- appropriate level of care
- list all possible options
- x preventative care
- transparent performance measures

response from state
decrease fragmentation
reimbursement
honesty in referrals

Question \neq PROVIDERS

- ① (A) - FAIR; STABLE REIMBURSEMENT
including payment reform
inclusion of innovative + new ideas
- ② (B) → interstate funding (med. marketplace)
- ③ (C) Better organizational chart
who is accountable - (Division) - eliminate Admin Barriers
- (D) Access to ^{comprehensive} necessary services
- ~~(E)~~

stickies

Q1 PROVIDER

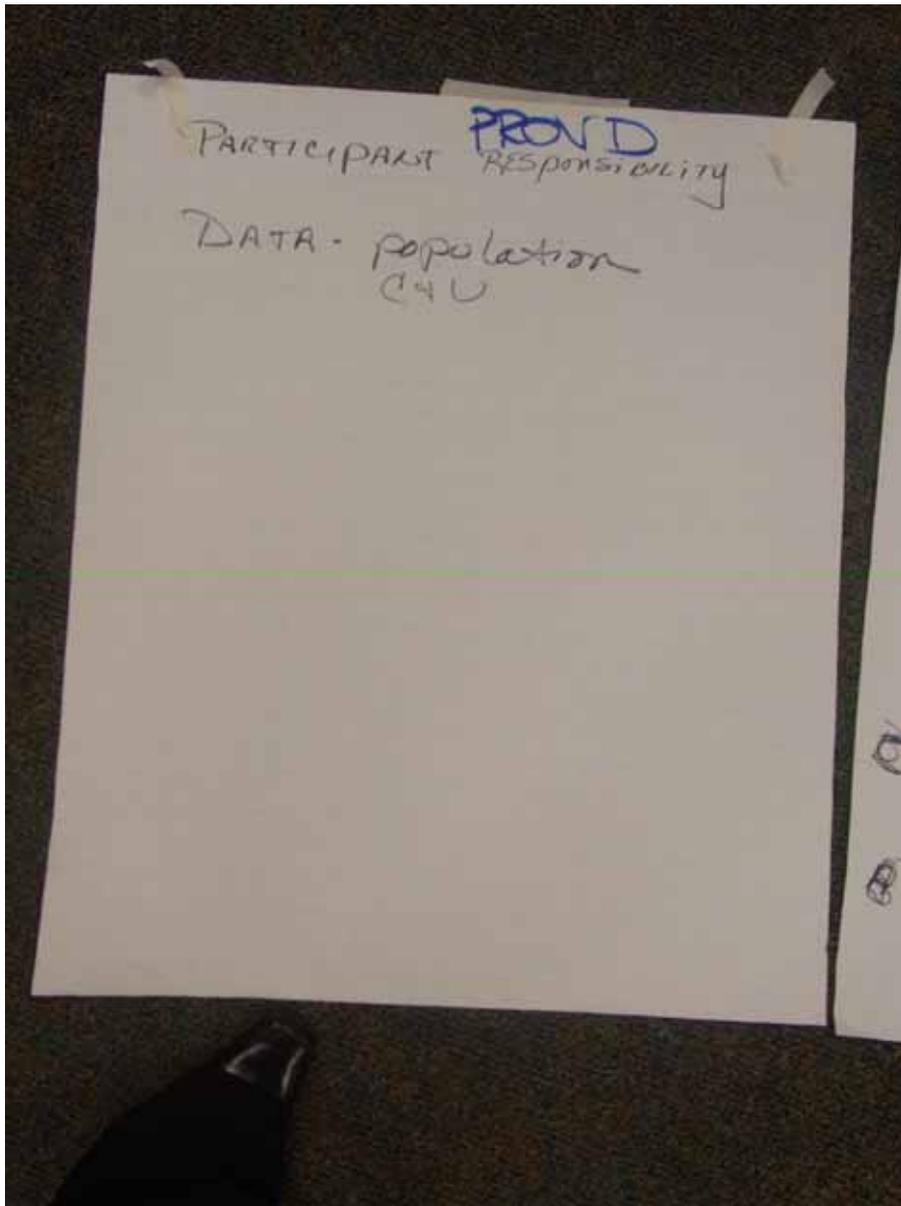
SYSTEMS OF

1. Integrated CARE based ~~on~~ using EVIDENCE based guidelines
2. ACCESS TO CARE using quality PROVIDERS
 - * Transportation
 - * Home Based / chronic dis
 - * Information / COMMUNICATION
3. CARE COORDINATION utilizing ~~via~~ a HUMAN RESPONSE System - ~~to~~ to manage interagency coordination + RESOURCES.

PROVIDERS Q1 PROV D

- A Systematic approach - evidence based guidelines
- B Access to quality Transportation providers
- B Home based sites for chronic disease
- A Shift resources quickly if needed
- Well trained providers
- C Human Response system
- CARE COORDINATION
- B Access to ^{well trained} providers
- B Access to info. from multiple SOURCES

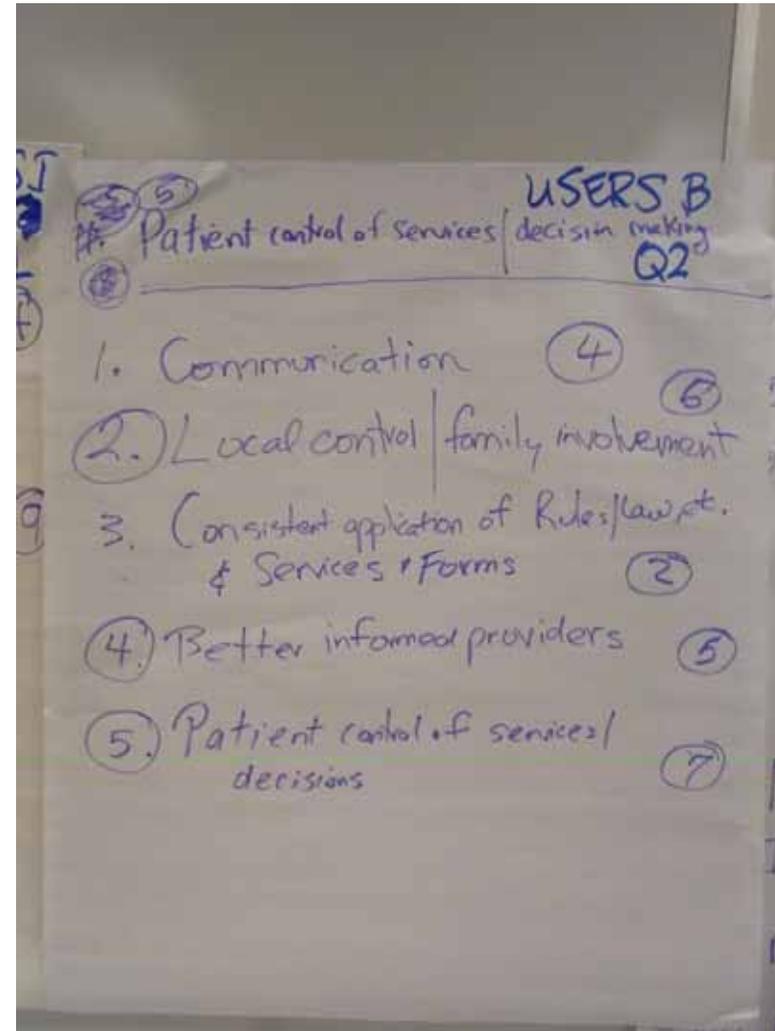
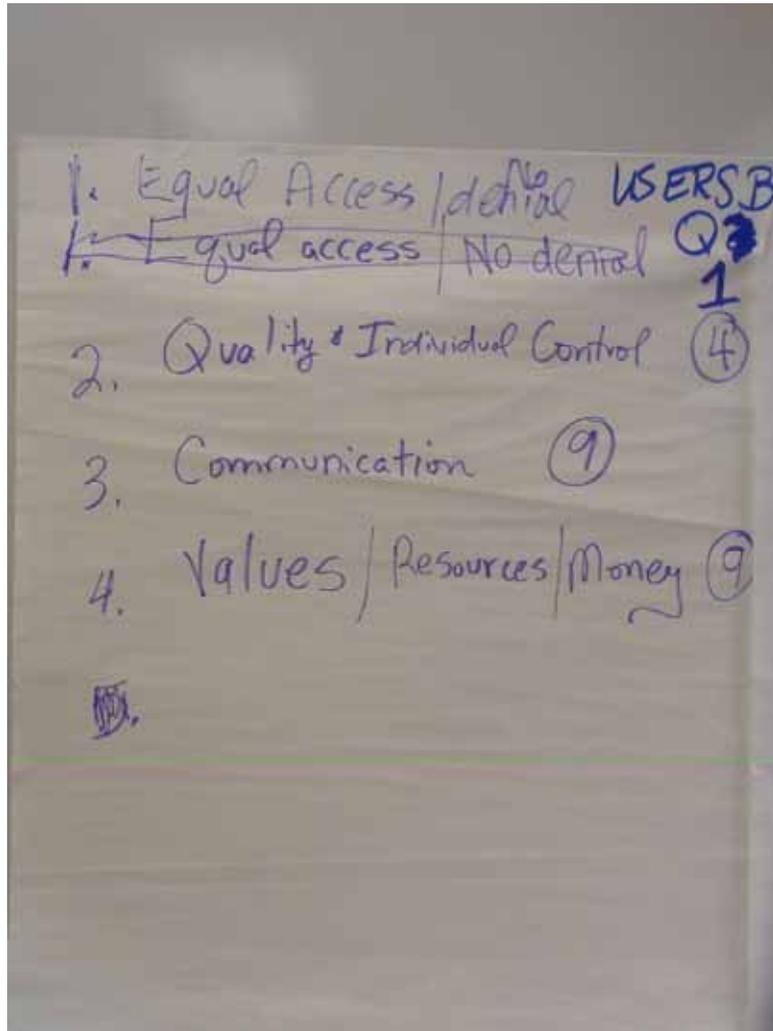
- C Interagency coordination
- A Clear guidance + expectations
- C Clear REFERRAL PROCESS



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Program User Perspective – Exercise 2

In a care management program, what must happen in order to create **knowledgeable and informed** recipients?



USERS BOQ

- ① Computer Access / List Serve
- ② Understandable language of the rules
- ③ Frequent workshops
- ④ Meeting of case managers
- ⑤ Family involvement
- ⑥ Local control / local boards
- ⑦ Fewer brochures / more 1-t talk
- ⑧ In forming community organizations / sharing information w/ community organizations
- ⑨ More info. w/ Medicaid Health / more offices
- ⑩ Knowledgeable st informed program providers
- ⑪ Uniform forms / consistent paperwork / less paperwork

5 Access ^{Group C} USER ~~PROV~~ C Q2

- * Benefits Specialist
- * Case Manager / Advocate
- * Easy & Timely
- * No fear of reprisal immigration / medical

1. Communication

- Clear and Simple rules
- Client language
- Web based option
- Clear-written materials

Case Manager
proactive and flexible to individual's needs

Question 2 USER C

- 1 Clear and Simple Rules for benefits and eligibility
 - Proactive Case Manager / Advocate
 - Flexibility to meet clients needs
- 1 Mandated delivery of services in client's language
 - Web based options for Medical Home
- 1 Clear communication materials focused on prevention
- 2 Easier Access to case management
 - Access ~~to information~~ ^{for questions} of the Manager / Care provider / Benefits Specialist
 - No fear of reprisal / Immigration / Medical
- 2 Timely access to Case Manager

Q2 USERS D

INFORMATIVE NEWSLETTERS
(E-based + otherwise)

ACCESSIBLE INFORMATIONAL
CLASSES OR SEMINARS/PUBLIC
FORUMS

SUPPORT GROUPS INCLUDING
SPECIALIZED SPEAKERS/LEGISLATORS

UTILIZE PEER SUPPORT

CENTRAL REPOSITORY FOR INFO/FAQ'S
(CASE MGR?)

PROGRAM USERS' D
STABILITY AS

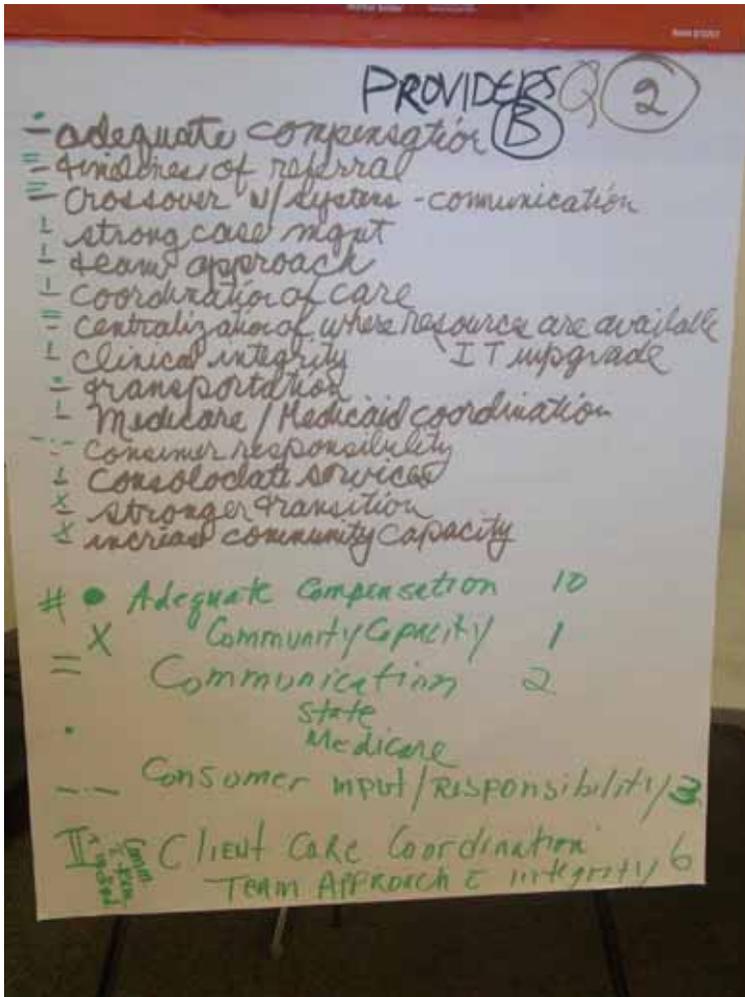
PROGD Q2

- 1 UTILIZE PEER SUPPORT ✓
- 2 INFORMATIVE NEWSLETTERS ✓
E-based/other ✓
- 3 CENTRAL REPOSITORY/CASE
FOR INFO ✓ ✓/MGR
- 4 ACCESSIBLE INFORMATIONAL CLASSES
OR SEMINARS/PUBLIC FORUMS ✓ ✓ ✓
- 5 SUPPORT GROUPS ✓ ✓
↓

INCLUDES SPECIALIZED
SPEAKERS + LEGISLATORS
INCL.
~~ACCESSIBLE~~ PUBLIC
FORUMS

Provider Perspective – Exercise 2

In a care management program, what must happen in order to **create satisfied providers** instead of dissatisfied (or **Resistant**) providers?



WHAT TO DO TO POSITIVELY IMPACT COHORT 22

PROVIDERS A

- ① GUARANTEED ACCESS TO A
 (COMPREHENSIVE, COORDINATED) FAMILY
 (CENTRAL) CARE (INCLUDING: MENTAL
 HEALTH & SUBSTANCE ABUSE) IN
 URBAN AND RURAL AREAS
- ② MORE EDUCATION & FOLLOW UP REGARDING
 RIGHTS, BENEFIT PLANS & RESOURCES
 SO PATIENTS DON'T LOSE BENEFITS
 & PICK THE RIGHT PLAN
- ③ FUNDING & REGULATION
 FLEXIBILITY

WHAT'S NEEDED TO PROVIDERS A

SATISFY PROVIDERS: A
 IN A CARE MGMT PROGRAM 22

- ① FAIR/EQUITABLE PAYMENT
~~SET FEE SCHEDULES~~
- EASY ACCESS TO PT INFO &
 BILLING MODELS
- FACE TO FACE APPEALS (MEDICAL
 NECESSITY)
- FOCUS ON CARE IMPROVEMENT
 RATHER THAN ON DENIALS ^{of} _{continued}
 → BASED ON ~~THE~~ DEFINED OUTCOMES
- ⑩ SUFFICIENT FED/STATE FUNDING
- INCENTIVIZES CONSUMER TO
~~② FOLLOW-UP - FOLLOW THROUGH~~
1. MANDATE PROVIDER COORDINATION
~~DEFINE "GOOD OUTCOMES"~~

PROVIDERS C

Q-3

What can DHHS allow us to do to improve educating users

- 5 } - educ on a fourth grade level - multi languages 2
- success info
- 3 - learn to ^{navigate} educate the return 3
- 10 - single point of access - primary care 1

PROVIDERS C

Q3 STOP The Bleeding

- provider referrals for sub. abuse tx
- A receive rate = to service provided
- A fin. healthy provider network
- need better organizational chart (DHHS)
- comprehensive array of integrated services - medical, mental health, sub. abuse and health
- A equitable reimbursement
- accountability for quality of care
- able to provide services w/out admin barriers
- men/phy health issues
- A payment reform + msa managed care
- cohesive system of care
- eliminate gaps in system
- A interstate availability - Both ways
- payment + service access

Q2 ~~OVERSIGHT~~ PROVIDER

1. ELIGIBILITY

2. ADEQUATE REIMBURSEMENT
~~FOR PT EDUCATION~~
~~PRO ACTIVE DIS. MGT~~

3. OVERSIGHT + QUALITY ASSURANCE
PROVIDED BY HHS

FOR ALL PROVIDERS

Q2

PROVIDER ID

A EASY ELIGIBILITY PROCESS

LENGTH OF TIME TO DETERMINE
ELIGIBILITY

AVAILABILITY OF ^{INCENTIVES} MANAGED CARE
PROGRAM + REQUIREMENTS - CARE MGT
COORDINATION

REIMB. - FOR PT EDUCATION
PRO ACTIVE DIS. MGT

ABILITY TO TRACK OUTCOMES

ABILITY TO TRACK PPTS

~~Open to~~

HHS MUST PROVIDE CLEAR OVERSIGHT
OF VENDORS

BROAD LIST OF AVAILABLE PROVIDERS

REIMBURSEMENT TO SUPPORT ROBUST
NETWORK OF PROVIDERS