August 24, 2023

Lori Weaver, Commissioner
NH Department of Health and Human Services
Brown Building
129 Pleasant Street
Concord, NH 03301

Re: Medicaid Care Management Procurement Draft Request for Proposals and Model Contract

Dear Commissioner Weaver:

On behalf of our 26 acute care hospitals and all of our specialty hospitals, the New Hampshire Hospital Association (NHHA) appreciates the opportunity to comment on the State of New Hampshire's Medicaid Care Management Procurement Draft Request for Proposals and Draft Model Contract. We support the focus of this procurement on optimal health, equitable access, and provider-delivered care coordination. There are several areas, however, where the contractual language should be strengthened to ensure Managed Care Organization (MCO) accountability and beneficiary access to services. Our specific comments are outlined below.

Primary Care & Preventative Services Model

Value-Added Services 4.1.11, Page 85

We commend the Department on their inclusion of value-added services language within the contract. This allows for reimbursement arrangements to maintain the coverage required for Medicaid beneficiaries while supporting innovative and clinically appropriate treatment for patients.

Pharmacy Management 4.2, Page 92

NHHA supports the Department's decision to implement a high-cost pharmacy risk pool. We appreciate the Department's commitment to ensuring that beneficiaries have access to new, high-cost drugs and gene therapies. However, we encourage the Department to closely monitor the MCOs' denials of high-cost medications, including those that are administered by hospitals. It has been the experience of our hospitals that under the current contract, some of the MCOs deny high-cost medications which can be a significant barrier to time sensitive care.

Single Pharmacy Benefit Manager 4.2.1.1, Page 92

NHHA appreciates the decision to monitor the experience of other state Medicaid programs while considering a single pharmacy benefit manager (PBM). We encourage the Department to evaluate the efficacy of an in-state, price-competitive option to ensure that the state has an efficient, cost-effective PBM in place.

Primary Care & Prevention Focused Care Model 4.11, Page 187

The primary care model in the draft model contract recognizes that primary care services are often delivered by a team rather than a single medical professional. In addition to the acknowledgement of the role of the team, we encourage the Department to consider the role of a primary care ***practice***. Specifically, the MCO draft model contract repeatedly refers to the patient and their primary care provider; however, within group practices, beneficiaries may see multiple providers. Expanding the care team to specifically include the practice will allow flexibility for providing services (e.g., wellness visits could be done by a nurse practitioner when the patient has a family medicine physician listed as the primary care physician) and ensuring timely access to care.

NHHA requests that the process for beneficiary attribution to a primary care provider be more fluid, including an easier process for transferring patients to a different primary care provider. Specifically, NHHA requests more triggers on claims data be evaluated to determine if a beneficiary is receiving primary care outside of their official attribution. If claims data demonstrates that the beneficiary has in effect changed primary care providers, the beneficiary should be automatically re-assigned to the primary care practice providing their care. Currently, the process to re-assign a primary care provider is triggered by the beneficiary; if the beneficiary fails to contact their MCO to request the change, there is a mismatch between the assigned primary care provider and the provider delivering the services. A more streamlined process for changing attribution will ensure appropriate reimbursement for care being delivered.

Health Risk Assessment 4.11.2, Page 190

NHHA appreciates the importance of the health risk assessment (HRA). However, we encourage the Department to take a broader view of how the HRA is completed. Medicaid beneficiaries are asked many of these questions time and time again. We are concerned that the repetition makes beneficiaries feel unheard and serves as an impediment to the patient/provider relationship. We ask that the Department consider a more holistic approach to completion of the HRA; one where the care team can document that the questions were asked throughout a period of care. We also request streamlining and standardization of assessments to be efficiently used and to be more beneficiary-friendly. Finally, we are concerned about the limited, at times non-existent, resources available to refer beneficiaries to once a need is identified. It is our hope that the MCOs and the Department will work with stakeholders across the state to further develop support services for at-risk populations.

Alternative Payment Models (APMs) 4.16, Page 281

Reimbursement innovation must keep pace with clinical care innovation. Alternative Payment Models (APMs) play an important role in reimbursement for new models of care. However, our hospital members are very concerned with how MCOs are going to ensure 50% of all MCO medical expenditures are in APMs within the first year of the contract because of the aggressive timeframe to stand up meaningful APMs. Additionally, are there specific APMs that each MCO

will be required to pursue, or will the MCOs have latitude when selecting APMs? Additional details about the APMs that will be put into place should be provided and available for provider evaluation and input before an MCO contract is finalized. Finally, because providers are working to reduce the cost of care and improve health outcomes, we strongly encourage that saved dollars be reinvested in programs and services that provide resources to beneficiaries and promote healthy lifestyles.

Care Coordination and Care Management Section 4.12, Page 192

NHHA strongly supports the Department's recognition of the critical role that primary care ***teams*** play in patient care coordination. The inclusion of primary care payments and alternative payment models focused on primary care is critical to the health of beneficiaries. As our providers are engaging in these activities today, it will recognize the value of these services to beneficiaries' health. However, it is essential that this work is adequately funded to incentivize these efforts. This is especially important as staffing challenges persist and medical professionals are called upon to provide a range of services to their patients.

MCO-Delivered Care Management for Required Priority Populations 4.12.2, Page 194

NHHA supports the focus of MCO care management to targeted populations (i.e., DCYF-involved infants and children, infants with low birthweight and/or neonatal abstinence syndrome, previously incarcerated individuals, and beneficiaries discharged from a behavioral health hospital admission). However, clarification is needed around the obligation of MCOs to assist providers with the management of beneficiaries ***outside*** of a priority population; it must be clear that the MCOs remain responsible for episodic care management for ***all*** populations, not just priority populations, on an as needed basis.

NHHA commends the Department for the increased accountability and transparency surrounding MCO delivered care management. It is our hope that the results from the MCO's Comprehensive Assessment required for priority populations and the quarterly reports of unmet resource needs will lead to increased accountability for the care management delivered by the MCOs as well as transparency in what the MCOs are doing to ensure beneficiaries are connected with the necessary community-based resources.

NHHA supports, 4.12.6.2, the requirement for the MCOs to maintain and operate a formalized discharge planning program that includes effective post-discharge transitional care management for all beneficiaries, including appropriate discharge planning for short-term and long-term hospital and institutional stays. In order for the discharge planning program to have a meaningful impact, the MCO discharge planning program must enhance the work to reduce barriers to care that is currently underway. The model contract makes great effort to ensure that the MCO care management program does not duplicate, rather complements, the work being done by other providers. In order to ensure that this is in fact happening, there must be increased accountability and transparency into the effectiveness of MCO discharge planning to ensure that Medicaid beneficiaries are promptly and appropriately moved out of an acute care bed when that level of care is no longer needed. A key component of those metrics must be evaluating how the MCOs work with other providers supporting beneficiaries.

In Lieu of Services 4.1.4, Page 80

NHHA supports the Department's inclusion in lieu of services (ILOS). However, we are concerned about the limited nature and number of existing ILOS as well as the optionality for MCOs to embrace these services. ILOS are an important tool in the reduction of health disparities and as an avenue to address unmet health-related social needs. However, as noted above, there is a very real risk that providers will identify beneficiary needs where no service (or scarce services) exists. We strongly encourage the Department to engage providers when further developing NH Medicaid's ILOS.

Behavioral Health

NHHA supports the focus on behavioral health in the model contract. However, NHHA has a number of concerns about the potential for cost-shifting to providers. Increased accountability and transparency for MCOs surrounding their role in the reduction in behavioral health and substance misuse readmissions is essential to ensuring beneficiaries receive the right care, in the right place, at the right time.

Community Mental Health Services 4.13.20, Page 225

The model contract recognizes the role that Community Mental Health Centers (CMHCs) play in the state-wide mental health program. NHHA supports the requirement for a State-defined, standardized contract between MCOs and CMHCs.

Psychiatric Boarding 4.13.20.17, Page 235

NHHA supports the requirement that MCOs provide a monthly report on the number of its beneficiaries in the ED or hospital setting awaiting appropriate placement for psychiatric treatment. However, the current threshold for reporting on patients awaiting placement for twenty-four (24) hours or more is too long and should be reduced to those who have not been accepted to be transferred within 6 hours to align with the commitments the state has made to end psychiatric boarding.

Transportation

As the Department is well aware, medical transportation is at a breaking point. Patients in need of time sensitive transportation are often forced to wait for hours to find an available transportation provider. It is the hope of our hospital members that the Department will require MCOs to build and maintain a robust transportation network, in particular for wheelchair vans, ambulettes, and ambulances. We encourage the Department to hold MCOs accountable for providing safe, reliable, and timely transportation to all beneficiaries.

Authorization & Claims Payment Process

Prior Authorization Section 4.9.3.4, Page 175

NHHA supports the efforts to reduce the administrative burden of prior authorizations; specifically, the requirement that the MCO use a standard prior authorization form and the requirement that providers "shall be able to submit the Prior Authorizations forms electronically, by mail, or fax." We encourage the Department to monitor and to hold plans accountable not

only for the percentage of authorizations denied, but also for the percentage of initial denials that are ultimately overturned, and for the timelines for authorization. Delays and denials in prior authorization add costs and create unnecessary barriers to care.

Claim Submission 4.18.1.5, Page 293

NHHA recommends that the timely claims filing limits should mirror CMS' timely filing limit policy which is one year. We do not believe the proposed timely claims filing limit of 120 days is reasonable. In addition, we recommend there be timely filing language included for secondary claims.

Claims Payment Standards Section 4.21, Page 316

NHHA has concerns regarding the payment standards of the MCOs, and as such, are recommending that the Department revise this section. Currently it states:

"The MCO shall pay or deny ninety-five percent (95%) of Clean Claims within thirty (30) days of receipt, or receipt of additional information."
"The MCO shall pay ninety-nine percent (99%) of Clean Claims within ninety (90) days of receipt."

NHHA recommends that 99% of ALL claims should have to be paid or denied within 90 days to ensure reasonable and timely processing of all claims. Of note, this timeframe should only pertain to **paper** claims. In the event of **electronic** filing, 95% of clean claims should be paid or denied within 15 days of receipt and 99% of ALL claims should be paid or denied within 45 days of receipt.

NHHA also recommends that MCO subcontractors be held to the same timely standards as if it were the MCO paying the claim.

Prevent Fees for Electronic Payments

Payors now routinely require providers to pay an administrative fee of as much as 5% to be paid electronically. The final contract must include language that prevents MCOs from passing along this fee to providers.

Metrics

The federal government has recently signaled a desire to standardize and better align measures used to report quality performance across its many health care programs. The 2023 release of the Universal Performance Measurement Set, the language in recent the Medicare Advantage rules, and proposed Medicaid and Managed Care rules provide a road map for the direction CMS expects federally supported health programs to go. The Department should require MCOs to adopt a common set of performance measures across all of the plans.

Conclusion

NHHA supports the key objectives of the Medicaid Care Management re-procurement. On behalf of our hospitals, the New Hampshire Hospital Association thanks the Department for the opportunity to comment on New Hampshire's Medicaid Care Management draft procurement

documents. If you have any questions, please feel free to contact me or Brooke Belanger, Vice President of Financial Policy and Compliance at (603) 415-4253 or bbelanger@nhha.org.

Sincerely,

Steve Ahnen
President