New Hampshire Medicaid System Evaluation
DHHS Update

NEW HAMPSHIRE DHHS DEPARTMENT OF HEALTH & HUMAN SERVICES

Background & Overview

- May 10th 2022: DHHS released a competitive procurement for a comprehensive evaluation of the Medicaid Care Management (MCM) model and other complementary health and human services within the Department.
  - RFP-2023-DMS-01-MEDIC: Medicaid System Evaluation | New Hampshire Department of Health and Human Services (nh.gov)
- September 7th 2022: Governor and Executive Council approved a contract with the selected bidder, Mathematica, Inc.
  - sos.nh.gov/media/trulrrab/017-gc-agenda-09072022.pdf
- September 2022-January 2024: The evaluation work was completed and presented to DHHS leadership, incorporated into the recently completed Medicaid Care Management re-procurement as applicable.

Key Deliverables

- Identify major **strengths and weaknesses** of New Hampshire's current Medicaid Care Management model.
- Present **three potential innovative models** to best organize and finance delivery of benefits and services.
- Present **recommended best practices** to better align services with other human services from a programmatic and geographic perspective.

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Evaluation Methods and Approach

- A Core Team within DHHS met regularly with the Mathematica evaluation team to:
  - Direct strategic areas of inquiry
  - Facilitate research activities and stakeholder connections and;
  - Iteratively present deliverables for Division leadership feedback
- The Mathematica team engagement involved interviews, document reviews, onsite visits, and other research activities with:
  - Medicaid quality data and subject matter experts
  - Actuarial services vendors and financial reporting
  - Service beneficiaries, family members, and caregivers
  - Managed Care Organizations
  - District Office staff
  - Key provider associations and forums
  - School district and other community service providers

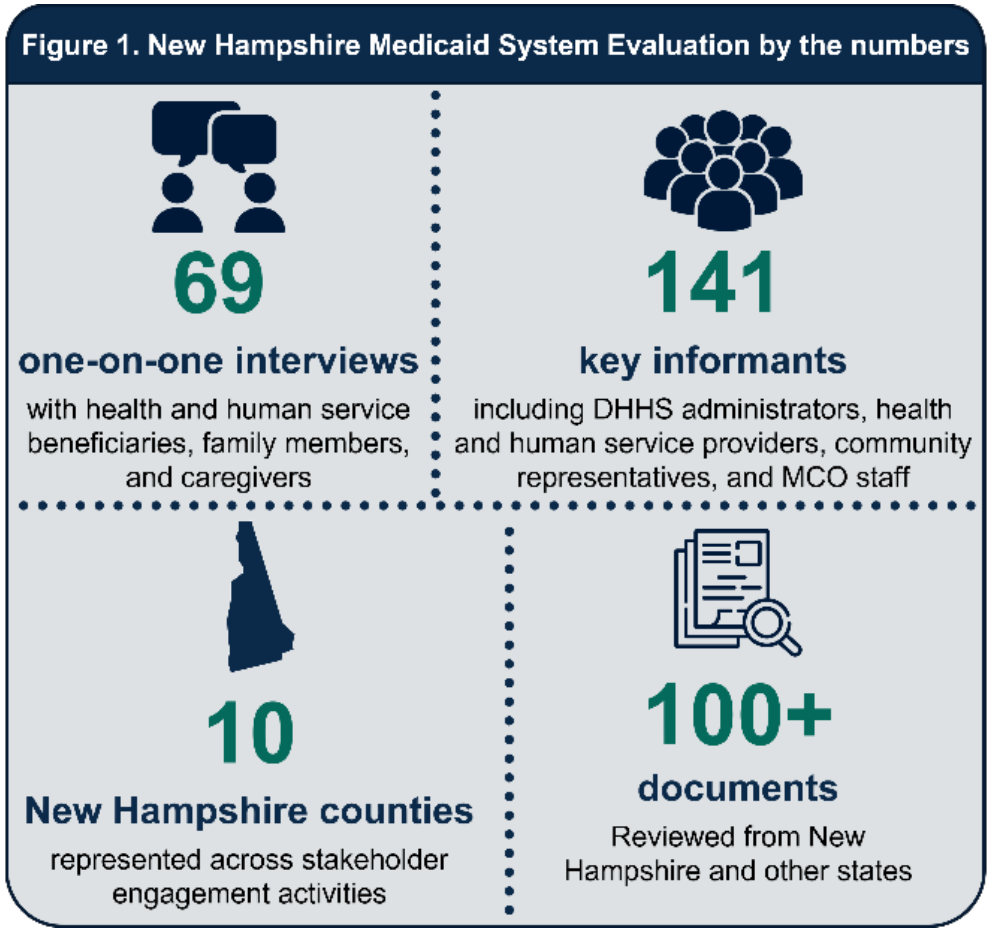

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Figure B.1. Journey map example for beneficiary with low health and human service needs

Jill

Beneficiary with low health and human services needs*

DEMOGRAPHICS

- Enrolled in categorically-needy Parent/Caretaker Relative MA
- Single parent with children under 18

HEALTH CARE SERVICES

- Preventative care, acute care, gynecology, and dermatology

HUMAN SERVICES

- Emergency Rental Assistance Program (in the past)
- Food stamps

HEALTH GOAL

- Stay healthy to be a strong support for her children

Benefits	DHHS	Health Care	Care Coordination	MCO	Human Services
Beneficiary Experience	Applied in person for food stamps and Medicaid and found the process hard due to tedious paperwork. Experiences long hold times when calling DHHS and has had paperwork mailed to DHHS lost. Now visits the office in person to drop off recertification paperwork and asks for a receipt.	Has no difficulty seeing a doctor when sick but has to call ahead a few weeks to schedule with a specialist. Feels like her providers are helping her to stay healthy. Finds it easy to get the prescriptions she needs.	Does not know what care coordination is. Isn't sure if her doctors talk to each other or if they need to.	Feels the plan is easy to get in contact with. Likes that she doesn't have co-pays.	Believes people in her community can get utility help or subsidized housing if they need it, but thinks it may be difficult to do so due to waitlists. Does not know if people can get help with or job coaching if they need it.
Beneficiary Perspectives Hard Sometimes Hard Unsure Mostly Easy Easy	*Sometimes Hard* *"It would be nice not to have to fill out so much paperwork for the state of New Hampshire."*	*Mostly Easy* *"Any time I make an appointment with [my primary doctor], I get scheduled right off and get seen... for the other kind of appointments, you have to wait a while."*	*Unsure* *"I don't know-- I haven't had any problems or anything with the doctors talking to each other."*	*Easy* *"[The MCO] has just been very easy- you apply online and no issues. If I need something, nine times out of 10 I get an answer. That's it."*	*Mostly Easy* *"I believe if you have access to a computer, and you have the information you need to apply, it's fairly easy to go through the site and apply for benefits."*
Beneficiary Suggestions for Improvement	Hire more staff at DHHS to process paperwork or reduce paperwork requirements to establish program eligibility.	Increase provider network.	None	None	Create a location that people can visit to learn available benefits if they can't access the information online.

* User personas are fictional characters that represent end user types.

Deliverable Spotlight: Member Journey Map

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Figure B.2. Journey map example for beneficiary with high health and human service needs

Lucy

Beneficiary with high health and human services needs*

DEMOGRAPHICS
- Enrolled in Aid to the Permanently & Totally Disabled (APTD) Medicaid
- Single with no dependent children

HEALTH CARE SERVICES
- Preventative care, acute care, neurology, pulmonology, and gastroenterology
- Psychiatry and therapy

HUMAN SERVICES
- Food stamps
- Fuel Assistance, Shelter services (in past)
- HUD Section 8 housing, Social Security, Disability Insurance (SSDI), Medicare

HEALTH GOAL
- Manage chronic health conditions and minimize daily discomforts

Benefits	DHHS	Health Care	Care Coordination	MCO	Human Services
Beneficiary Experience	Applied in person for food stamps and Medicaid and found the process hard due to tedious paperwork. Thinks the deadlines for submitting supporting documents are too short.	Does not drive so transportation to in-person appointments is challenging. Used Medicaid transportation in the past and found it unreliable. Often uses telehealth appointments for health care appointments.	Does not have care coordination, but thinks her CMHC offers the service if she wanted it. Thinks her providers coordinate routine matters, but sometimes feels like she relays messages back and forth to her providers.	Feels it is generally easy to get in contact with the health plan, but sometimes not easy to get complaints addressed. Has had a prior authorization issue delay care in the past.	Has been homeless in the past, and the shelter linked her with resources that she uses today. Feels like it is a full time job to get benefits she needs to support herself.
Beneficiary Perspectives *Hard* *Sometimes Hard* *Unsure* *Mostly Easy* *Easy*	*Hard* *"The [DHHS] application is like going through red tape. It is very long. Somebody that doesn't know the ins and outs will definitely need someone to help because if one little thing is wrong, and they send it back. It's just maddening."*	*Sometimes Hard* *"Every time I meet with my psychiatrist and therapist, it is through telehealth. I would like to meet in-person but without having a car, it's impossible. So I think telehealth is very convenient."*	*Sometimes Hard* *"I think a lot of [care coordination] is left up to me, which is okay. I think some people might not be able to navigate the system real well."*	*Mostly Easy* *"I've had [my health plan] for nine years now. I really have no complaints. One time I needed an MRI on my knee, and I had to go through quite a ringmarole to get them to approve that."*	*Hard* *"It seems like they're reaching out for the same paperwork and information over and over and over again."*
Beneficiary Suggestions for Improvement	Provide advocates who can help beneficiaries with applications and renewals.	Keep telehealth flexibilities and increase provider network.	Facilitate access to care coordination for people who want or need it.	Initiate more human contact with members to educate them about covered services, and identify a point person to help with health plan navigation if services are denied.	Improve coordination between health and human services to reduce duplication of paperwork.

* User personas are fictional characters that represent end user types.

Deliverable Spotlight: Member Journey Map

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Key Strengths of Medicaid and Human Service System

Program Operations	▪ Several entryways and referral pathways into programs and Department supports public awareness of services available, which reduces system barriers ▪ Continuous improvement in Managed Care through performance and contract management standards
Population Health, Quality, and Access	▪ Effective actuarial negotiations to realize cost-containment goals ▪ Reduced opioid related overdose death by 20 percent 2017-2020 overall in NH ▪ 10-Year Mental Health Plan provides a solid foundation for strengthening community-based mental health services ▪ Expanded Medicaid eligibility and covered benefits ▪ Relatively high performance on access to care measures for primary and specialty care compared to those commercially insured ▪ Strong Statewide performance on Medicaid quality measures such as medication-related indicators and adolescent immunization measures
Whole Person and Integrated Care	▪ Regional capacity to improve public health, population health management, and person-centered care

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Key Weaknesses

Program Operations	▪ Enrollment processes can be lengthy and complex ▪ Low rates for certain Medicaid services, including Home and Community Based Services*
Population Health, Quality, and Access	▪ Quality performance metrics do not always translate into action-oriented information for MCOs or providers, due to large number of measures. ▪ Gaps in availability of community-based services contribute to use of emergency department for behavioral health care
Whole Person and Integrated Care	▪ MCO prior authorization requirements hinder access to timely care ▪ Implementation of expanded local care management under MCM 2.0 was largely unsuccessful ▪ Navigation of system is not consistently clear to beneficiaries and providers ▪ Lack of sustainable funding for regional care management capacity to address population health and health related social need improvement

**Evaluation did not include assessment of recent legislated Medicaid rate increases*

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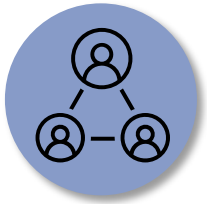
Key Insights

The short- and medium-term recommendations of the study largely reaffirm the strategies and updates introduced in the Medicaid Care Management re-procurement which will go into effect September 1, 2024

The feasibility of larger model changes explored in the three innovative models is reliant on the underlying Medicaid population being large enough to implement these models

The systemic challenges of delivering Medicaid and other human services programs are targeted in DHHS priorities, including Mission Zero, health care workforce initiatives, home and community-based services spending plan, the Department's 2024 Roadmap, the System of Care for healthy aging, and preventive care services model



Continuous engagement and partnership with providers and other critical stakeholders is key to exploring future potential models for delivering DHHS programs

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Environmental Scan – Selected Models

After a national scan of Medicaid system delivery models, the highlighted states below were selected for focused study with three models identified for consideration

Fully Capitated Managed Care Innovating on SDOH & Population Health

Regional Community Collaboratives Operating in Parallel with Medicaid MCOs

Provider ACOs Operating in Parallel with Medicaid MCOs

Regional fully capitated Medicaid Managed Care Plans

Regional Accountable Entities

Regional Primary Care Case Management Model

ASO Managed Fee for Service Model

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Model 1: Provider Accountable Care Organizations Operating in Parallel with Managed Care Organizations

- Comprehensive ACOs are provider organizations that are eligible to contract with the State's MCOs to deliver more cost-effective, coordinated, and population-focused care
- Moves the focus of care and controlling total cost of care from MCOs to provider groups

Builds on Strengths	Mitigates Weaknesses
• Leverages established relatively robust Medicaid health care provider networks, and health care quality improvements realized by managed care organizations • Strengthens capacity of local and regional entities by formalizing the creation of ACOs that may build upon the relationships established by regional public health networks and Integrated Delivery Networks under the Delivery System Reform Incentive Payment demonstration • In conjunction with a Closed Loop Referral Platform, creates a holistic, person-centered approach to connect individuals to health and human services	• Better aligns MCOs and health care providers by incentivizing higher value care • Anchors care management within the ACOs, thereby reducing redundancy of and confusion over care management responsibilities. • Promotes community-based living, a DHHS goal • Elevates the role of regional care delivery and management in the health care delivery system and may improve overall regional capacity to provide these services • Improves beneficiaries' ability to navigate the system by placing navigational responsibilities on ACOs

Model 2: Regional Medicaid Managed Care

- Regional Medicaid Managed Care Organizations serve defined regions of the state, allowing a focus on local control and regional variability while keeping services aligned within the MCO entity.
- Supports practice transformation and quality improvement by providing a capitated funding mechanism and integrated care structure.

Builds on Strengths	Mitigates Weaknesses
• Continues the approach to integrating physical and behavioral health under a single responsible entity (MCO) and supports implementation of 10-year mental health plan, particularly the continued use of regionally based Community Mental Health Centers • Builds on strong quality performance already identified under the current MCM program • Focuses care oversight at the regional level, which should help invigorate capacity of local and regional entities	• Facilitates tailored approaches to health and human service delivery and case management at the regional level • Focuses and aligns incentives across coordinating entities and providers through capitated or per member per month administrated fees • Increases the number of beneficiaries receiving local case management through required population health management plans and programs • Reduces administrative burden for providers by moving those responsibilities to the regional entity • Per member per month payment provides consistent funding to help build long-term regional capacity

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Model 3: Managed Fee-for-Service Model

- The state manages risk and processes claims, while statewide Administrative Service Organizations manage provider networks and provide core administrative functions under a fixed administrative fee.

Builds on strengths	Mitigates weaknesses
• DHHS possesses data and analytics expertise and is positioning for greater enterprise-wide data integration and to support analytics • Enables DHHS to influence areas of oversight more directly, such as spending growth, quality performance, and service offerings • Leverages stakeholder driven planning documents, such as the 10-year mental health plan, as strategy documents for ASO activities • Could leverage the Closed Loop Referral Platform as an integrated case management solution for ASOs, DHHS, and other community providers	• Directs staff towards program development and oversight while administrative functions are handled by ASOs • Increases delivery of local care management • Could be used to Implement enhanced provider payments • Reduces administrative burden for providers • Addresses critical gaps in community based behavioral health services

Recommendations and Actions: Short Term

Short Term Recommendations (1 – 2 years)		
1A. Strengthen MCO network adequacy requirements around community based behavioral health services.	• Bolster contract requirements on network adequacy for community-based services and build DHHS capacity to monitor compliance. • Require the MCOs to include a percentage of all mental health and SUD providers in the state within the network • Increase participation requirements for specific types of providers	MCM 3.0
1B. Advance population health by strengthening expectations and accountability of MCOs	• Include contract requirements for MCOs to develop a population health management strategy that promotes wellbeing and disease prevention, with a strong focus on addressing HRSN and reducing disparities. • Require MCOs to dedicate or designate health plan staff to lead the development of their population health efforts and include such staff as key personnel or other required staff in the MCM contract.	MCM 3.0
1C. Analyze and act on existing data on HRSN of Medicaid beneficiaries.	• Add a requirement for the MCOs to submit health risk assessment data, design a standardized format and process for doing so, and integrate these data with other data sources to improve analyses. • Ensure that data collected from New HEIGHTS and the closed loop referral system are available for analyses within the enterprise data warehouse.	Medicaid Enterprise Strategy
1D. If procured, define requirements for closed loop referral system.	• MCOs should be required in their contracts to use the closed loop referral system. • When MCOs use the system, they should (1) use a standardized social risk/needs assessment tool; (2) make referrals for their members related to HRSN through the closed loop referral system unless the beneficiary does not give consent; and (3) require any contracted entities who provide care management services to their enrolled Medicaid beneficiaries utilize the closed loop referral system.	CLR Contract Approved
1E. Engage in stakeholder engagement on potential move to managed FFS	• Before determining the future Medicaid delivery system, engage in extensive stakeholder engagement across New Hampshire. Hold town hall style meetings with the public, as well as listening session with targeted stakeholder types such as physicians, hospitals, and CBOs who help individuals enroll in Medicaid.	MCM 3.0

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Recommendations and Actions: Medium Term

Medium Term Recommendations (3 – 4 years)		
Title	Description	
2A. Design a unified advanced payment model (APM) strategy to strengthen investment in primary care.	• Develop and require all MCOs to use a uniform APM focused on primary care to incentivize greater use of under-utilized preventive care, address health-related social needs for Medicaid beneficiaries, and increase the potential for overall savings and better population health outcomes.	MCM 3.0
2B. Strengthen care management delivery in primary care settings.	• Take a more prescriptive approach to adopting and implementing a care management delivery model for primary care settings. Include contract provisions as part of MCM 3.0 that encourage, incentivize, or require MCOs to support and implement Patient Centered Medical Home (PCMHs) or another defined model of care.	MCM 3.0
2C. Coordinate existing DHHS housing initiatives and explore new funding sources.	• Identify all current supportive housing initiatives/services provided across the department • Communicate the landscape of these initiatives to all divisions, and • Develop better coordination mechanisms across these divisions. • Pursue innovative sources of additional financial resources to develop new affordable or supportive housing and to provide housing support services to beneficiaries.	1915(i) for Supportive Housing

Recommendations and Actions: Long Term

Long Term (5+ years)	
Title	Description
3A. Develop a Medicaid Health Homes model for beneficiaries with complex needs.	• Develop and implement a Medicaid Health Home program, a state benefit plan option available since 2011 (SSA §1945 State Plan Option). The health homes model provides intensive care management to Medicaid beneficiaries with one or more chronic health conditions, or a serious and persistent mental health condition.
3B. Move towards value-based purchasing (VBP) for CMHCs by implementing a quality bonus.	• Incrementally adopt elements of value-based payment (VBP) for CMHC providers, starting with structuring the payment model to include quality bonus payments (QBPs) tied to performance on quality measures. More advanced VBP models also could incorporate financial penalties or risk in addition to QBPs as behavioral health providers gain experience with VBP.
3C. Invest in infrastructure that enables local and regional cross-organization collaboration.	• Building off DHHS' past efforts and investments through DSRIP, support local investments in critical infrastructure that enables cross-organization collaboration, including HIT, health workforce capacity, and care coordination teams. DHHS should roster current and former regional entities such as the IDNs, regional public health networks, Department of Children, Youth, and Families offices, Aging and Disability Resource Centers, mobile crisis response teams, primary care practices, Federally Qualified Health Center (FQHCs), and other clinics and assess their readiness to facilitate care integration and coordination, either individually or as a larger local partnership.

MCM 3.0

Mobile Crisis; State Health Improvement Plan; System of Care

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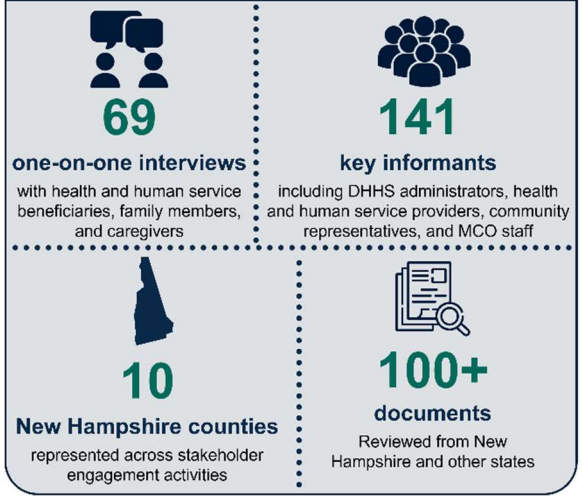
Executive Summary: New Hampshire Medicaid System Evaluation

I. Introduction and Purpose

The New Hampshire Department of Health and Human Services (DHHS) contracted with Mathematica in September 2022 to identify ways to improve program outcomes for Medicaid beneficiaries while increasing value in the MCM program and for other health and human services. Mathematica conducted a systemwide assessment of New Hampshire's Medicaid and health and human service delivery system to (1) identify the strengths and weaknesses of the MCM program and other health and human services, (2) review promising approaches used or developed in other states, and (3) develop a set of recommendations that address weaknesses and build on successful activities.

From September 2022 through January 2023, Mathematica conducted interviews with Medicaid beneficiaries and DHHS staff, reviewed public and internal DHHS documentation, and assessed the performance of the MCM system against national Medicaid performance indicator benchmarks. The interviews with community members explored their experiences and interactions with the MCM program and other health and human services programs to better understand the extent to which these programs met their needs. Additionally, we leveraged the expertise of Medicaid policy experts at Mathematica including former state staff to review current care delivery models in the nation; identify core components of three care delivery models that improve the likelihood of health and human service integration; and leveraged the experience of Medicaid and human services policy experts to identify promising practices for health and human service integration.

Figure 1. New Hampshire Medicaid System Evaluation by the numbers



II. Key Findings

Major strengths of the MCM and other health and human services programs

1. DHHS maintains several entryways and referral pathways into public benefit programs and supports public awareness of the array of benefits and services available, which reduce barriers to entry into the safety net system.
2. DHHS has shown a commitment to using managed care to improve beneficiaries' outcomes. DHHS has sought to improve the MCM program continually by extensively monitoring MCO performance and contract changes intended to clarify and strengthen performance standards and expectations.
3. DHHS has engaged in strong negotiations and used its actuaries to realize cost-containment goals of managed care.
4. New Hampshire's comprehensive efforts to address the opioid epidemic led opioid overdose deaths to decline by 20 percent from 2017 to 2020.

5. New Hampshire's 10-Year Mental Health plan provides a strong foundation to improve access to critically needed services. DHHS has made progress toward strengthening community-based mental health services.
6. DHHS continues to improve access to health care coverage by expanding Medicaid eligibility to more people with low-income and by offering additional Medicaid benefits.
7. Performance on access to care measures for primary and specialty care for Medicaid beneficiaries is comparable to those commercially insured.
8. The program has made steady improvement in key indicators of Medicaid beneficiaries' health and well-being. Statewide performance on many Medicaid quality measures is at or above the 75th percentile or the average nationally including for medication-related quality measures and immunizations for adolescents.
9. DHHS has built a foundation and strengthened regional capacity to improve public health, population health management, and person-centered care.

Major weaknesses of the MCM and other health and human services programs

1. Beneficiaries and Community Based Organization (CBO) leaders said enrollment in DHHS's health and human service programs requires extensive documentation, DHHS's application processing for certain groups is lengthy, and applying for multiple DHHS health and human service programs is complicated.
2. DHHS has significant workforce shortages, which limit the agency's ability to oversee, manage, and operate programs effectively and efficiently.
3. Low payment rates for certain Medicaid services, and the lack of a systematic process for reviewing and updating fee for service (FFS) rates, have exacerbated workforce shortages and limited access to critical behavioral health and Home and Community Based Services (HCBS).
4. Despite extensive collection and monitoring of quality performance metrics, many stakeholders said their efforts have not translated into action-oriented information for MCOs or providers, because the large number of quality measures dilutes focus and contributes to administrative burden.
5. Critical gaps in availability of community-based behavioral health services contribute to the use of emergency departments and hospitals for behavioral health care.
6. Variation among and high administrative burden in MCOs' prior authorization requirements hinder access to timely delivery of critical services and create undue burden on beneficiaries and providers.
7. DHHS' Long Term Services and Supports (LTSS) system for older adults and people with physical disabilities remains biased toward institutional care.
8. The implementation of expanded local care management and new care management requirements under MCM 2.0 was largely unsuccessful. Stakeholders report ongoing confusion about division of responsibility for care management between MCOs and other care management entities.
9. Medicaid beneficiaries and providers alike have difficulty navigating the health and human services system, understanding what benefits and services are available for people, and accessing services.
10. Intermittent and unsustainable funding streams have limited the effectiveness of investments in (1) building regional capacity to provide local care management; (2) sustaining long-term organizational relationships at the regional level to improve population health; and (3) expanding efforts designed to improve HRSN.

Alternative models for financing and delivering health and human services

Mathematica reviewed a range of alternative Medicaid and health and human service delivery system models across different states and geographies across the country. We narrowed our focus to three alternative delivery models for in-depth analysis based on two key criteria: (1) potential for the model to address the key challenges and build upon the strengths of New Hampshire's current system; and (2) strength of available evidence to support the model's ability to effectively focus on prevention, value, cost-effectiveness and enhanced delivery of health and human services for individuals and families in New Hampshire.

Model 1: Provider ACOs operating in parallel with MCOs

Provider Accountable Care Organizations (ACOs) operating in parallel with Medicaid Managed Care Plans is a health and human service delivery system model that many states, including Rhode Island, Minnesota, and Massachusetts have implemented. Mathematica focused our research on Rhode Island's Accountable Entities program, since Rhode Island was most comparable in terms of population and Medicaid enrollment size and because this model could be overlaid on the current MCM model.

The ACO program is a key enhancement of Rhode Island's Medicaid managed care program and is viewed by the state as a reinvention of Medicaid based on value-based care principals.[1] Comprehensive ACOs are provider organizations that, once certified by the state, are eligible to contract with one of the state's MCOs to deliver more cost-effective, coordinated and population-focused care. Rhode Island is moving through a five-year implementation plan (2018-2023) using a section 1115(a) demonstration waiver. As of State Fiscal Year 2022, the state has certified seven comprehensive ACOs for participation in the program. In addition to the comprehensive ACO program, Rhode Island has a Specialized ACO program that is focused on supporting implementation of Advanced Payment Models (APMs) for LTSS.[2]

The table below summarizes (1) core components of the provider ACO model and (2) how the model builds on strengths and mitigates weaknesses of the MCM program.

Core Components of the Provider ACO Model Operating in Parallel with Medicaid Managed Care	
• Moves the focus of care and control for quality, outcomes, and total cost of care from MCOs to provider groups • Clearly delineates roles and responsibilities and aligns financial incentives for care delivery, care coordination, and care management among provider groups, particularly primary care, ACOs, and MCOs • Focuses on regional needs and alignment of health care systems with community-based infrastructure	
Builds on strengths	**Mitigates weaknesses**
• Leverages established, relatively robust Medicaid health care provider networks, and health care quality improvements realized by managed care organizations • Strengthens capacity of local and regional entities by formalizing the creation of ACOs that may	• Better aligns MCOs and health care providers by incentivizing higher value care. • Anchors care management within the ACOs, thereby reducing redundancy of and confusion over care management responsibilities.

[1] "Medicaid ACOs Rhode Island." n.d. Accessed January 24, 2023. https://www.naacos.com/medicaid-acos-rhode-island.

[2] Rhode Island Executive Office of Health and Human Services. n.d. "LTSS APM." Accessed January 27, 2023. https://eohhs.ri.gov/initiatives/accountable-entities/ltss-apm.

build upon the relationships established by regional public health networks and Integrated Delivery Networks under the Delivery System Reform Incentive Payment (DSRIP) demonstration • In conjunction with a Closed Loop Referral Platform, creates a holistic, person-centered approach to connect individuals to health and human services	• Promotes community-based living, a DHHS goal • Elevates the role of regional care delivery and management in the health care delivery system and may improve overall regional capacity to provide these services • Improves beneficiaries' ability to navigate the system by placing navigational responsibilities on ACOs

Model 2. Regional Medicaid managed care

Many Medicaid managed care models are structured so that contracted MCOs operate statewide and compete for enrollment of beneficiaries throughout the state. Other models are regionally designed so that contracted entities serve defined regions of the state. Mathematica focused our research on Colorado's regional managed care model because its design and focus aligns with New Hampshire health and human service delivery goals most closely.

The launch of Colorado's Accountable Care Collaborative (ACC) program included contracting with seven non-overlapping regional care coordination organizations tasked with engaging primary care medical providers, connecting members to primary care, providing care coordination, and supporting practice transformation and quality improvement. The state also contracted with five regional Behavioral Health Organizations (BHO) to manage community based behavioral health programs and the capitated behavioral health benefit.

After implementation and following an extensive stakeholder engagement process, the state moved to align the regions and bring the work of the ACC and BHO contractors into a single contract for a Regional Accountable Entity or RAE. The RAEs are considered managed care entities that administer the fully capitated community behavioral health benefit for Colorado Medicaid members. In addition, the RAEs operate as a primary care case management entity for all Medicaid beneficiaries and receive a per member, per month (PMPM) administrative payment to support provider engagement, care coordination and population health and quality improvement initiatives. The state, not the RAEs, pays claims for physical health services on a FFS basis.

The table below summarizes (1) core components of the regional Medicaid managed care model and (2) how the model builds on strengths and mitigates weaknesses of the MCM program.

Core Components of the Regional Medicaid Managed Care Model	
• Regional alignment of physical and behavioral health administrative, management, care coordination and delivery, and population improvement functions • Supports practice transformation and quality improvement by providing a funding mechanism (capitation and PMPM administrative payments) and integrated care structure.	
Builds on Strengths	**Mitigates Weaknesses**
• Continues the approach to integrating physical and behavioral health under a single responsible entity (MCO) and supports implementation of 10-year mental health plan, particularly the continued use of regionally based Community Mental Health Centers (CMHCs)	• Facilitates tailored approaches to health and human service delivery and case management at the regional level • Focuses and aligns incentives across coordinating entities and providers through capitated (BH) or PMPM administrated fees (physical health)

• Builds on strong quality performance already identified under the current MCM program • Focuses care oversight at the regional level, which should help invigorate capacity of local and regional entities	• Increases the number of beneficiaries receiving local case management through required population health management plans and programs • Reduces administrative burden for providers by moving those responsibilities to the regional entity • PMPM provides consistent funding to help build long-term regional capacity

Model 3. Managed FFS model

Most states organize and finance the delivery of Medicaid benefits and services through risk-based capitated arrangements with managed care companies. Some exceptions include Alabama, Connecticut, Idaho, Montana, South Dakota, and Wyoming. Connecticut's approach is described as managed fee-for-service and is implemented through contracts with four administrative services organizations (ASOs). Mathematica focused our research on Connecticut's model because of its alignment with the current goals, strengths, and weaknesses of the delivery of health and human services in New Hampshire.

Since 2012, Connecticut has operated a managed FFS model through contracts with three non-risk bearing ASOs for three major service types – medical, behavioral health, and dental – in addition to a non-emergency medical transportation broker.[3] ASOs are responsible for beneficiary support, outreach and referrals to providers, utilization management, and processing grievances and appeals. The ASO overseeing medical services has additional responsibilities including maintaining claims data across all categories of Medicaid services, monitoring performance, and analyzing data to inform efforts to reduce costs and increase quality.

The table below summarizes (1) core components of the managed FFS model and (2) how the model builds on strengths and mitigates weaknesses of the MCM program.

[3] Connecticut Department of Mental Health & Addiction Services. n.d. "Department of Mental Health & Addiction Services Behavioral Health Recovery Program Intensive Case Management (ICM) Services." Accessed January 19, 2023. https://www.abhct.com/Customer-Content/WWW/CMS/files/ICM_Program_Information_Revised_Final_9420.pdf.

Core components of the Managed FFS model	
• The state manages risk and processes claims, while single statewide ASOs by service area manage provider networks and provide core administrative functions • Relies on the ASOs to create and the state to effectively use programmatic data to manage the program	
Builds on strengths	**Mitigates weaknesses**
• DHHS possesses data and analytics expertise and is positioning for greater enterprise-wide data integration and to support analytics • Empowers DHHS to influence areas of oversight more directly, such as spending growth, quality performance, and service offerings • Leverages stakeholder driven planning documents, such as the 10-year mental health plan, as strategy documents for ASO activities • Could leverage the Closed Loop Referral Platform as an integrated case management solution for ASOs, DHHS, and other community providers	• Directs staff towards program development and oversight while administrative functions are handled by ASOs • Increases delivery of local care management • Could be used to Implement enhanced provider payments • Reduces administrative burden for providers • Addresses critical gaps in community based behavioral health services

Recommendations

Mathematica recommends New Hampshire maintain the current MCM program, and make the improvements discussed below. As most innovations to the MCM program have been designed to push MCOs further, DHHS will need to be precise and prescriptive with the MCOs by establishing goals related to increases in preventative care, value, cost-effectiveness, and enhanced service delivery.

Based upon the available evidence, expertise, and stakeholder input provided, there is not one best or clearly superior model for delivering Medicaid and other health and human services to beneficiaries. Therefore, if, during the oversight and management of the MCOs, DHHS determines that the state's goals cannot be achieved through that delivery model, we recommend that DHHS explore adopting a managed FFS model, beginning with the identification of an alternative source of funding for its Medicaid expansion program. A managed FFS model has the potential to be cost-effective, return greater control to DHHS in driving program outcomes, and should be feasible to implement in the state. In contrast, New Hampshire's provider community does not seem ready and willing to take on the responsibilities and risk necessary for a provider ACO model, and a regional managed care model would be difficult or impossible to achieve given the need to attract entities willing to bear the risk of serving a single region of the state. Mathematica believes that a managed FFS model, if properly implemented and aligned to the state's provider system, has the potential to be a model that can achieve strong results in the state of New Hampshire.

Below, we provide recommendations that incorporate best practices from other states that are both effective and feasible for DHHS to integrate into the current system. These recommendations position DHHS to continue to improve on the existing MCM program or pivot to a managed FFS program. Recommendations are broken into three time periods for implementation, with short-term (1-2 years), medium-term (3-4 years), and long-term recommendations (5+ years).

Short Term (1 – 2 years)	
Title	**Description**
1A. Strengthen MCO network adequacy requirements around community based behavioral health services.	DHHS should bolster contract requirements on network adequacy for community-based services and build DHHS capacity to monitor compliance. DHHS could (1) require the MCO to include a specific percentage of all mental health and SUD providers in the state within the network (the current contracts only include time and distance requirements as opposed to a target percent of providers) and (2) increase participation requirements for specific types of providers (e.g., MCOs are currently required to contract with at least 50 percent of residential SUD providers in the state).
1B. Advance population health by strengthening expectations and accountability of MCOs	DHHS should include contract requirements for MCOs to develop a population health management strategy that promotes wellbeing and disease prevention, with a strong focus on addressing HRSN and reducing disparities within New Hampshire's Medicaid population. DHHS could also consider requiring MCOs to dedicate or designate health plan staff to lead the development of their population health efforts and include such staff as key personnel or other required staff in the MCM contract.
1C. Strengthen care management delivery in primary care settings.	DHHS should take a more prescriptive approach to adopting and implementing a care management delivery model for primary care settings. DHHS can elect to include contract provisions as part of MCM 3.0 that encourage, incentivize, or require MCOs to support and implement Patient Centered Medical Home (PCMHs) or another defined model of care.
1D. Analyze and act on existing data on HRSN of Medicaid beneficiaries.	DHHS should (1) add a requirement for the MCOs to submit health risk assessment data, (2) design a standardized format and process for doing so, and (3) integrate these data with other data sources to improve analyses. DHHS should also ensure that data collected from New Hampshire Empowering Individuals to Get Help Transitioning to Self-Sufficiency (New HEIGHTS) and the closed loop referral system are available for analyses within the enterprise data warehouse.
1E. If procured, define requirements for closed loop referral system.	MCOs should be required in their contracts to use the closed loop referral system. We recommend that when MCOs use the system, they should (1) use a standardized social risk/needs assessment tool; (2) make referrals for their members related to HRSN through the closed loop referral system unless the beneficiary does not give consent; and (3) require any contracted entities who provide care management services to their enrolled Medicaid beneficiaries utilize the closed loop referral system. requirements for future specification.
1F. Engage in stakeholder engagement on potential move to managed FFS	Before determining the future Medicaid delivery system, DHHS should engage in extensive stakeholder engagement across New Hampshire. We recommend that DHHS hold town hall style meetings with the public, as well as listening session with targeted stakeholder types such as physicians, hospitals, and CBOs who help individuals enroll in Medicaid.
Medium Term (3 – 4 years)	
Title	**Description**
2A. Design a unified advanced payment model (APM) strategy to strengthen investment in primary care.	To support increased investment in primary care, incentivize greater use of under-utilized preventive care, address HRSN for Medicaid beneficiaries, and increase the potential for overall savings and better population health outcomes, DHHS should develop and require all MCOs to use a uniform APM focused on primary care. Pushing MCOs into a uniform APM of this type will acclimate primary care providers to a value-based care model that can be leveraged under a new delivery system.

2B. Coordinate existing DHHS housing initiatives and explore new funding sources.	To increase the effectiveness and impact of DHHS' work on housing in the short term DHHS should (1) identify all current supportive housing initiatives/ services provided across the department (2) communicate the landscape of these initiatives to all divisions, and (3) develop better coordination mechanisms across these divisions. Then in the medium to long term, to increase the impact of DHHS' efforts, the department should pursue innovative sources of additional financial resources to develop new affordable or supportive housing and to provide housing support services to beneficiaries.
2C. Clarify roles and responsibilities of care management providers	DHHS should define (1) the roles and functions of each entity in providing care management, (2) the range of services that will be coordinated, (3) standards and certification requirements for care management agencies, (4) criteria for identifying which beneficiaries are eligible for care management by tier or level of need, and (5) procedures for referring beneficiaries for care management.
Long Term (5+ years)	
Title	**Description**
3A. Develop a Medicaid Health Homes model for beneficiaries with complex needs.	To expand the availability and strengthen the quality of care management services provided to Medicaid MCO enrollees, we recommend that DHHS develop and implement a Medicaid Health Home program, a state benefit plan option available since 2011 (Social Security Administration (SSA) §1945 State Plan Option). The health homes model provides intensive care management to Medicaid beneficiaries with one or more chronic health conditions, or a serious and persistent mental health condition.
3B. Move towards value-based purchasing (VBP) for CMHCs by implementing a quality bonus.	DHHS should incrementally adopt elements of VBP for CMHC providers, starting with structuring the payment model to include quality bonus payments (QBPs) tied to performance on quality measures. More advanced VBP models also could incorporate financial penalties or risk in addition to QBPs as behavioral health providers gain experience with VBP.
3C. Invest in infrastructure that enables local and regional cross-organization collaboration.	Building off DHHS' past efforts and investments through DSRIP, the Department should support local investments in critical infrastructure that enables cross-organization collaboration, including health information technology (HIT), health workforce capacity, and care coordination teams. DHHS should roster current and former regional entities such as the integrated delivery networks (IDNs), regional public health networks, Department of Children, Youth, and Families offices, Aging and Disability Resource Centers, mobile crisis response teams, primary care practices, Federally Qualified Health Center (FQHCs), and other clinics and assess their readiness to facilitate care integration and coordination, either individually or as a larger local partnership.

New Hampshire Medicaid System Evaluation

Final Report

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I. Introduction and Purpose

The mission of the New Hampshire Department of Health and Human Services (DHHS) to join with communities and families to provide opportunities for residents to achieve health and independence. To support this mission, DHHS seeks to improve access to health care, ensure its quality, and control its costs. Central within the programs and services administered by DHHS is the Medicaid Care Management (MCM) Program, a capitated managed care delivery system that delivers physical and behavioral health benefits and services under New Hampshire Medicaid. New Hampshire provides long-term services and supports (LTSS) on a fee-for-service (FFS) basis, and under current state law, these services might not be carved in to managed care. Along with providing MCM services, DHHS's broad responsibilities include many other health and human services, such as programs for economic assistance, including Temporary Assistance for Needy Families (TANF), child care scholarship, and child support; nutrition assistance, including Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); homelessness prevention and assistance; services for adult and aging populations; disability services; and employment, population health, and family supports. The MCM program and other health and human services offer a critical lifeline for New Hampshire's most vulnerable people and families. It is incumbent on DHHS to ensure its Medicaid beneficiaries are receiving value-driven care of the highest quality to meet their physical and behavioral needs, including health services for mental health and substance use disorder (SUD) and health-related social needs (HRSNs).

Recognizing the complex landscape in which these services operate and a desire to improve system integration between health and human services, DHHS contracted with Mathematica in September 2022 to identify ways to improve program outcomes for Medicaid beneficiaries while increasing value in the MCM program and for other health and human services. Mathematica conducted a systemwide assessment of New Hampshire's Medicaid and health and human service delivery system to (1) identify the strengths and weaknesses of the MCM program and other health and human services, (2) review promising approaches used or developed in other states, and (3) develop a set of recommendations that address weaknesses and build on successful activities.

A. Key evaluation questions

Our assessment of New Hampshire's health and human service delivery system relied on key evaluation questions that aligned with the strategic questions outlined by DHHS for the Medicaid System Evaluation. These questions highlight a desire for a system that delivers health and human services in an integrated and coordinated manner, with efficacy and accountability throughout the system. The key evaluation questions are as follows:

1. What are the strengths and weaknesses of DHHS's current MCM and other health and human services programs with respect to access, quality of care, and cost trends?
2. What best practices have provided strong evidence to indicate they focus effectively on prevention, value, cost benefit, and enhanced delivery of services for people and families in New Hampshire? What three models show promise for organizing and financing the delivery of Medicaid and health and human services benefits and services?

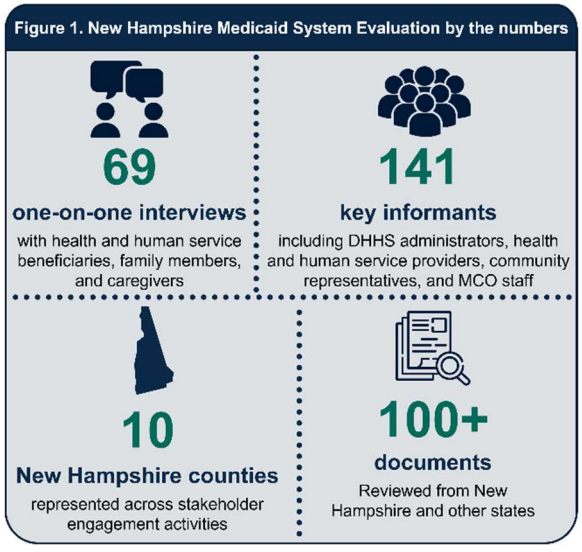
3. How can the organization and financing of Medicaid benefits and services be better aligned programmatically and geographically with other health and human services benefits, including economic assistance, nutrition assistance, housing assistance, employment, and family supports?

The answers to the key evaluation questions lead to recommendations to make improvements to the current MCM program or, if DHHS strongly desires, recommendations for transitioning to a different delivery system.

B. Methods and data sources

This report is based on information Mathematica gathered from a broad range of sources and stakeholders. It is grounded in the perspective of Medicaid beneficiaries who shared feedback on how well the Medicaid and other health and human service systems serve their needs. Our team collected information from September 2022 through January 2023, virtually and in person, in New Hampshire. The following sections describe each information source and offer an overview of the methodology we used to collect data.

To identify the strengths and weakness of the current MCM program and other health and human services programs (Evaluation Question 1), Mathematica conducted interviews, reviewed public and internal DHHS documentation, and assessed the performance of the MCM program against national benchmarks indicating Medicaid performance.



Mathematica conducted semi-structured interviews with a diverse range of stakeholders and Medicaid beneficiaries, their families, and caregivers to gather input for this report. We developed our approach to identifying interviewees in partnership by DHHS staff. Further details on this approach are available in Appendix A.

- **Beneficiary interviews.** The Mathematica team conducted two in-person site visits to New Hampshire. During these visits, the team interviewed 60 Medicaid beneficiaries or caregivers of beneficiaries, along with nine people who were applying for Medicaid or who had received Medicaid services in the past. Mathematica visited DHHS offices and community and provider organizations to interview Medicaid beneficiaries with high needs, such as those with behavioral health conditions, those experiencing homelessness, and parents of children with complex health care needs.[1] The perspectives from these interviews provided critical foundational insights that guided the conclusions in this report. We developed two illustrative beneficiary journey maps based on feedback shared during these interviews and include them in Appendix B.

[1] We also considered using administrative data to randomly identify beneficiaries to interview. Although the selected approach ensured we gathered perspectives from beneficiaries with characteristics identified as important, such as those experiencing homelessness, the alternative approach using a random sample might have led to interviews of beneficiaries with different views.

- **Providers and community-based organizations.** Our team gathered perspectives from inpatient and outpatient providers including those that provide primary, behavioral health, and LTSS care. We interviewed staff from community-based organizations (CBOs) that encompass a wide range of roles in the New Hampshire health and human services system, including advocating for families of children with complex conditions, providing support to people with SUD, and providing support to people experiencing homelessness. In total, we met with 31 service providers and community organizations, detailed in Appendix A.
- **DHHS staff and contractors.** We obtained input from DHHS senior leaders as well as division directors and program staff. Conversations covered how well the system works today, opportunities for improvement, and detailed topical areas. Our team also received insights from contractors who advise DHHS on an ongoing basis in areas including rate-setting and alternative payment models (APMs) (described in Appendix A).
- **Managed care organizations.** Mathematica met with representatives from the three current managed care organizations (MCOs) in New Hampshire. Discussions with MCOs included a range of topics, such as strategies to improve outcomes, quality, and cost; coordination of care and care management; and access to care and provider engagement. We also discussed opportunities and strategies for improving population health and integrating HRSNs.

Documentation on New Hampshire's health and human services system. Mathematica obtained reference documents relevant to this study by reviewing public information available on DHHS's public facing website, dhhs.nh.gov, requesting copies of reports and documents referenced in conversation by DHHS and other stakeholders, and conducting additional supplementary research. The types of documents reviewed included contracts; DHHS policies; reports; and plans developed by DHHS, prior contractors, and other stakeholders in New Hampshire. Key background documents reviewed are available in Appendix C and include the following:

- **MCM services contract.** The current contract between DHHS and Medicaid MCOs for July 1, 2019 – June 30, 2024, includes the base contract and nine amendments as of January 2023.
- **New Hampshire 10-Year Mental Health Plan.** Released in January of 2019, the plan identifies priority areas and 14 recommendations for improving New Hampshire's mental health system.
- **New Hampshire DHHS operations assessments.** Operations assessments of DHHS completed by Alvarez and Marsal Public Sector Services from August to December 2020 focused on the impact of the COVID-19 pandemic, increasing operational efficiencies, and improving the delivery of services and outcomes.
- **State health assessment and state health improvement plan.** The 2013–2020 report highlights key health areas and health outcome indicators that describe the most significant health issues facing New Hampshire residents. We also reviewed a progress report and summary of efforts to update the state health improvement plan.

Quantitative data used to benchmark Medicaid performance indicators. The team analyzed Medicaid performance indicators including quality and usage measures in New Hampshire compared with national benchmarks and neighboring states in New England. We based our analysis on quality and

financial data provided by DHHS and public resources, including Medicaid core set measures and statistics from the Medicaid and CHIP (Children's Health Insurance Plan) Payment and Access Commission (MACPAC) on Medicaid costs by state.

Review of potential alternative models. To identify the three potential care delivery models to best organize and finance the delivery of Medicaid and other health and human services benefits (Evaluation Question 2), we conducted a broad environmental scan. We also engaged Medicaid policy experts at Mathematica, including former state staff, to review current care delivery models across the nation, grouping models by similar delivery mechanisms. Our detailed analysis of each model relied on operational and policy documents published by states and other stakeholders, including summary reports by other research entities on the impact of these models.

To better align the organization and financing of Medicaid benefits and services programmatically and geographically with other health and human services benefits, we identified core components of each of the three care delivery models that improve the likelihood of service integration. We then engaged Medicaid and human services policy experts and former state staff to identify promising practices for health and human service integration (Evaluation Question 3).

II. Key Findings

Our systemwide assessment revealed that there is a strong foundation of programs and many successes that DHHS can build upon. There are also challenges and opportunities to improve the system to better meet the needs of beneficiaries and key stakeholders. The following sections list major strengths and major weaknesses of the MCM program and other health and human services programs, organized into three categories: (1) program operations; (2) population health, quality, and access; and (3) whole-person and integrated care.

A. Major strengths of the MCM program and other health and human services programs

Program operations

1. *DHHS maintains several entryways and referral pathways into public benefits programs and supports public awareness of the array of benefits and services available, which reduces barriers to entering the safety net system.*

DHHS's NH EASY Gateway to Services and district offices are an integrated system for people applying for many of DHHS's health and human services benefits and programs. DHHS has engaged in a variety of efforts to inform providers and beneficiaries about the array of services available. For example, when eligibility guidelines for SNAP changed, DHHS advertised these changes to providers to help increase referrals to SNAP. DHHS also maintains a web portal and phone number for people seeking mental health and SUD services that offers referral pathways into publicly funded services. All beneficiaries interviewed were aware of at least one human service provided by DHHS, and several participants (n = 10) found online applications for public benefit programs more accessible than paper applications.

> "I like the way [provision of DHHS services and assistance] have improved over the last couple of years, with being able to do just about everything online. I think that makes it a lot easier for most people."
>
> —Beneficiary

Since implementing the integrated eligibility system in 1998, DHHS continues to maintain and enhance the eligibility management system to incrementally improve integrated access to and delivery of benefits to New Hampshire residents. DHHS continues to update the systems software and functionality. The system is a key enterprise technology asset for DHHS that provides reusable business functions, such as eligibility determination; data exchange; and reporting for community members, health and human services providers, and DHHS staff.

2. *DHHS has shown a commitment to using managed care to improve beneficiaries' outcomes. DHHS has sought to improve the MCM program continually by extensively monitoring MCO performance and contract changes intended to clarify and strengthen performance standards and expectations.*

With the evolution of MCM 1.0 to 2.0, DHHS sought to improve administration and oversight, accountability, and care and service coordination. In addition, in 2019, DHHS stepped up its monitoring of MCOs by starting to formally enforce liquidated damages in 2021. As a result, MCO noncompliance decreased, with the total count of identified liquidated damages among all MCOs dropping from 113 in

the fourth quarter of 2020 to 38 in the first quarter of 2022.[2] In addition, the current MCM service contract, which went into effect July 1, 2019, exceeded minimum federal rules that require coordination of services for enrollees by requiring MCOs to (1) screen enrollees for social needs as part of the health risk assessment (HRA), (2) use a uniform set of questions concerning HRSN in their screening tools, and (3) make referrals to human services for those with health-related social risks and needs. These HRSN requirements put New Hampshire ahead of or on par with other states that place similar requirements on plans.[3]

3. *DHHS has engaged in strong negotiations and used its actuaries to realize cost-containment goals of managed care.*

New Hampshire's annual Medicaid spending growth has stayed in line with Medicaid enrollment growth because of strong fiscal management. For example, spending on managed care in state fiscal year (SFY) 2020 was lower than budgeted because DHHS used administrative flexibilities related to COVID-19 to renegotiate MCO capitation rates retroactive to September 2019. It also used a risk corridor based on depressed service use during the public health emergency. DHHS's actuary also assumes an annual managed care savings adjustment of 0.09 percent, which incentivizes the MCOs to look for greater efficiencies continuously. DHHS's medical loss ratio of around 90 percent also ensures that MCOs spend more on medical services and quality improvement than the federally required minimum of 85 percent.

Population health, quality, and access

4. *New Hampshire's comprehensive efforts to address the opioid epidemic led opioid overdose deaths to decline by 20 percent from 2017 to 2020.*

DHHS developed and implemented a comprehensive approach to the opioid epidemic, which helped to reduce overdose deaths and expand access to treatment for thousands of New Hampshire residents. The number of state residents receiving publicly funded services for any SUD increased by 25 percent from 2017 to 2022 (from about 8,000 to about 10,000), and the number of Medicaid opioid prescriptions decreased by 27 percent over this period.[4] According to the Governor's Commission on Alcohol and Other Drugs, progress is also due to increased access to screening, assessment, and referrals through the Doorway, a state-led program in nine sites across New Hampshire that provides assistance to people with a history of mental illness and substance misuse. The state also increased availability of telehealth and medication-assisted

[2] "NH Medicaid Care Management Medicaid Quality Levers Liquidated Damages and Performance Improvement Projects." March 2022.

[3] We did not obtain data regarding MCO compliance with these requirements. National data to compare New Hampshire MCO performance with that of other Medicaid MCOs are not yet available at the time of this report. In 2023, the National Committee for Quality Assurance added a Social Need Screening and Intervention measure new metric to the Healthcare Effectiveness Data and Information Set for Medicaid health plan reporting.

[4] New Hampshire Department of Health and Human Services. "Data Portal." n.d. https://wisdom.dhhs.nh.gov/wisdom/dashboard.html?topic=opioid-misuse&subtopic=opioid-crisis&indicator=opioid-crisis-services. Accessed January 2023.

treatment, resulting in greater provider availability than in most other states.[5] In addition, DHHS has used several Medicaid options, including SUD, serious mental illness (SMI), and serious emotional disturbance 1115(a) waivers, to expand services and increase access to care. For example, the SUD Treatment and Recovery Access demonstration allows short-term stays for SUD treatment services in residential and inpatient settings that qualify as an Institution for Mental Diseases. An interim evaluation of the demonstration showed that it improved access to care for beneficiaries with intensive SUD treatment needs, emergency department (ED) use declined in the 90 days following discharge from a qualifying institution compared with the 90-day period before admission, and utilization of SUD treatment services had increased.[6] However, opioid overdose deaths began increasing in late 2022 in New Hampshire; the uptick was attributed to fentanyl and xylazine being introduced into the illegal drug supply, reflecting national patterns.[7]

Laconia police department's prevention, enforcement, and treatment coordinator

Since 2013, the Laconia police department has funded a full-time coordinator to work directly with people who struggle with substance use. This coordinator provides broad support including helping people with the following activities:

- Signing up for Medicaid
- Navigating the court system
- Enrolling in and completing treatment programs
- Finding emergency housing

The innovative program has received praise from the people it has served and is now expanding into eight additional communities. Through a partnership with Amoskeag Health, it will also implement an Adverse Childhood Experiences Response Team to prevent and reduce trauma among children exposed to violence.◢

5. *New Hampshire's 10-Year Mental Health Plan provides a strong foundation to improve access to critically needed services. DHHS has made progress toward strengthening community-based mental health services.*

New Hampshire has continued to implement recommendations from its 10-Year Mental Health Plan. The plan reflects considerable input from stakeholders based on a previous evaluation of the capacity of New Hampshire's behavioral health system.[8] New Hampshire has already acted on key features of the plan, including expanding access to evidence-based services for high-need populations, such as First Episode Psychosis programs for people experiencing the onset of psychiatric symptoms (often young adults) and Critical Time Intervention to support transitions from psychiatric hospitalization and to help people stay connected to care. In addition, DHHS operates three regional mobile crisis response teams for adults with mental illness, and a centralized crisis call center, the Rapid Response Access Point. The center uses

[5] New Hampshire had the highest rate of in-network buprenorphine-prescribing primary care providers per 100,000 population among all states (11.8), compared with a national average of 3.2 and only 0.4 in Florida and 0.08 in Texas.

Meiselbach, M.K., C. Drake, B. Saloner, J.M. Zhu, B.D. Stein, and D. Polsky. "Medicaid Managed Care: Access to Primary Care Providers Who Prescribe Buprenorphine." *Health Affairs,* vol. 41, no. 6, 2022. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01719

[6] The Pacific Health Policy Group. "State of New Hampshire Substance Use Disorder Treatment and Recovery Access Section 1115 Medicaid Demonstration 11-W-00321/1 Draft Interim Evaluation Report." 2022. https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/sed-extention-request-app3.pdf

[7] Callery, Tim. "Opioid-Related Deaths up in Manchester, Nashua as Officials Warn of New Drug. First Responders Say Animal Sedative Increasingly Found in Overdose Deaths." WMUR9ABC, January 6, 2023. https://www.wmur.com/article/opioid-related-deaths-manchester-nashua-1623/42421256

[8] Human Services Research Institute and Technical Assistance Collaborative. "Final Report: Evaluation of the Capacity of the New Hampshire Behavioral Health System." 2017. https://www.hsri.org/files/uploads/publications/nh-final-report-12222017.pdf

phone calls, text messages, and a two-way real-time chat; provides clinical crisis resolution; and triages calls with regional crisis services. Finally, community mental health centers (CMHCs) receive a sub-capitated per member per month (PMPM) payment for beneficiaries attributed to their region from the MCOs. This payment provides stable and predictable funding and additional state funds for services Medicaid does not cover. The combination of these and other efforts to improve access to community-based mental health services and supports is believed to help address long emergency room waits for psychiatric care (known as ED boarding). It also decreases people's reliance on institutional care and helps DHHS comply with the Community Mental Health Settlement Agreement.

6. *DHHS continues to improve access to health care coverage by expanding Medicaid eligibility to more people with low income and by offering additional Medicaid benefits.*

Since 2014, DHHS has increased access to health care coverage for more than 219,000 New Hampshire residents under the Medicaid expansion option Granite Advantage.[9] After years of collaborative efforts, legislation was passed to expand the adult dental benefit to cover comprehensive oral examinations, preventive care, restorative dental care, and oral surgery, funded by a legal settlement. DHHS began to implement the adult dental benefit April 1, 2023, to address a long-standing and critical need for these services. DHHS has also authorized several health-related services to address HRSNs that MCOs can cover as in lieu of services (meaning their costs are factored into the capitation rate), such as medical nutrition and help finding and keeping housing (not including rent). Effective July 1, 2022, the Division for Behavioral Health, Bureau of Homeless Services was authorized to provide a new Medicaid benefit, called Housing Stabilization Services, which will offer care management services to develop a housing stability plan, work with housing providers to document or verify eligibility for housing supports; and provide help with housing and rental applications, barriers to housing, housing search and placement, and finding move-in supports. An estimated 50 people will receive help in the first year of the program.[10]

7. *Performance on access to care measures for primary and specialty care for Medicaid beneficiaries is comparable to those commercially insured.*

Stakeholders reported that most providers in New Hampshire will see at least a limited number of Medicaid beneficiaries. When there is a challenge accessing a particular type of provider (such as a specialist in obstetrics or gynecology), it is typically due to general provider shortages and not providers' willingness to treat Medicaid beneficiaries. The 2022 New Hampshire External Quality Review Technical Report includes measures reflecting access to care for Medicaid MCOs and commercial insurance, based on the State Health Employee Plan offered by Anthem BlueCross BlueShield. For a sample of primary care providers participating in plan networks, two of the three Medicaid MCOs accepted new patients at rates similar (58.8 percent) or superior (78.0 percent) to commercial insurers (59.2 percent).[11] A

[9] New Hampshire Fiscal Policy Institute. "The Effects of Medicaid Expansion in New Hampshire." January 17, 2023. https://nhfpi.org/resource/the-effects-of-medicaid-expansion-in-new-hampshire/

[10] The Housing Stabilization benefit operates under section 1915(i) HCBS federal authority. See the state plan amendment for details.

New Hampshire Department of Health and Human Services. 2022. "New Hampshire State Plan Amendment (SPA) 21-0027." https://www.medicaid.gov/medicaid/spa/downloads/NH-21-0027.pdf.

[11] Health Services Advisory Group. "2022 New Hampshire External Quality Review Technical Report." State of New Hampshire Department of Health and Human Services, April 2023. https://medicaidquality.nh.gov/sites/default/files/2022%20NH%20EQR%20Technical%20Report.pdf.pdf

MACPAC study on physicians' acceptance of new patients by the patients type of insurance found that 87 percent of New Hampshire physicians would accept Medicaid beneficiaries, a statistically significant difference from the national average of 74 percent.[12]

8. *The program has made steady improvement in key indicators of Medicaid beneficiaries' health and well-being. Statewide performance on many Medicaid quality measures is at or above the 75th percentile of the national average including for medication-related quality measures and immunizations for adolescents.*

The overall trend shows statewide MCO performance making steady progress toward performance targets established by DHHS. However, there is still room for improvement. The overall progress holds both for quality-of-care measures (such as Healthcare Effectiveness Data and Information Set [HEDIS] measures) and administrative measures, such as MCOs' compliance with report submission requirements, encounter data reporting, and DHHS's External Quality Review Organization process. Areas of strength include medication-related quality measure scores, most of which are either above the 75th percentile nationally (for example, adhering to antipsychotics for schizophrenia, or managing antidepression medication) or above the median (for example, asthma medication ratio). For adult Medicaid beneficiaries, the state has average or above average performance on most behavioral health quality measures relative to comparator states.[13] For children and youth, state performance for well child visits in the third, fourth, fifth, and sixth years of life is above the 75th percentile nationally, and immunizations for adolescents are at the median percentile nationally.[14] For maternal health, state performance on access to postpartum care is above the 75th percentile nationally.[15] The state's strategy to improve the quality of its MCM program has been effective. A June 2021 analysis summarized progress meeting 25 objectives within seven goals of the quality strategy. Of the 25 objectives, 20 met their targets (often at the Medicaid 75th percentile nationwide or the nationwide Medicaid average); three did not fully meet the target, but the evaluation identified progress; and two were partially met (these are less easily quantifiable objectives). In almost all cases, the 20 objectives that met their targets demonstrated improvements in performance over baseline.[16]

[12] Medicaid and CHIP Payment and Access Commission. "Physician Acceptance of New Medicaid Patients: Findings from the National Electronic Health Records Survey." June 2021. https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf

[13] Mathematica analysis of Medicaid and CHIP Adult Core Set data

[14] Mathematica analysis of Medicaid and CHIP Child Core Set data

[15] Mathematica analysis of Medicaid and CHIP Adult Core Set data

[16] Medicaid Quality Program. "New Hampshire Medicaid Care Management Quality Performance Report." Division of Program Quality and Integrity, New Hampshire Department of Health and Human Services, 2021. https://medicaidquality.nh.gov/sites/default/files/Quality%20Strategy%20Effectiveness%20Analysis%20June%202021%20F1.pdf

Whole-person and integrated care

9. DHHS has built a foundation and strengthened regional capacity to improve public health, population health management, and person-centered care.

> "If we interacted with a client who needed mental health services, we could call the care coordinator at the CMHC, and they would know we were part of the team. [Through the IDNs,] we created this very functional team that was able to resolve issues for patients through integrated care management."
>
> —Stakeholder

DHHS funds and oversees a network of regional entities that provide direct services and foster collaboration across health and human service programs. These entities include regional public health networks, offices of the Division for Children, Youth, and Families (DCYF), Aging and Disability Resource Centers, and mobile crisis response teams. The Delivery System Reform Incentive Program (DSRIP) demonstration, which ran from 2016 to 2020, also created seven regional integrated delivery networks (IDNs), comprising health and human service providers who collectively assumed responsibility for the care of Medicaid beneficiaries in their region. The DSRIP funds supported investments in critical infrastructure that allows cross-agency collaboration, including health information technology (IT), health workforce capacity, and care coordination teams focused on Medicaid beneficiaries with SUD. An evaluation of the DSRIP demonstration found it helped to build the capacity of regional and local agencies to coordinate care across providers, settings, and agencies by spurring new partnerships, increasing the use of social needs screening, and improving information exchange.[17] Stakeholders affirmed the value of the IDN care management teams. Although the IDNs no longer exist due to a lack of sustainable funding, the work done to build relationships across health and human services providers could potentially be relaunched.

[17] M.L. Smith, et.al. "Summative Evaluation Report by the Independent Evaluator for the New Hampshire Delivery System Reform Incentive Payment (DSRIP) Program." University of Southern Maine, Catherine Cutler Institute, June 30, 2022.

Findings from the evaluation's quantitative analyses showed mixed results, highlighting areas for improvement. For example, the demonstration population was 3.8 percent times more likely to have an ambulatory care visit than those in the comparison group, but the likelihood of follow-up care within 30 days after hospitalization for mental illness decreased by 5.0 percent, and beneficiaries in the demonstration group were nearly four times more likely to have a hospital readmission for any cause than those in the comparison group.

B. Major weaknesses of the MCM program and other health and human services programs

Program operations

1. *Beneficiaries and CBO leaders said enrollment in DHHS's health and human service programs requires extensive documentation, DHHS's application processing for certain groups is lengthy, and applying for multiple DHHS health and human service programs is complicated.*

Despite the availability of DHHS's NH EASY Gateway to Services, a single-entry point for receiving multiple public benefits, beneficiaries described challenges with enrollment in health and human service programs. Nearly half of beneficiaries said it was difficult to get or maintain Medicaid eligibility (n = 29), citing challenges associated with filing eligibility paperwork, obtaining the documentation needed for initial eligibility or redetermination, and maximum income thresholds that disqualify those with income just over the limit.[18] These processes and requirements are dictated primarily by federal regulations and requirements. Several beneficiaries found online application systems (such as NH EASY) more accessible than paper applications. Many said they had to wait too long to be approved for urgently needed services, such as SNAP.

> "The application is like going through red tape... It's very invasive. It is very long. And for somebody [who] doesn't know the ins and outs, you definitely need someone to help you with the application, because [if] one little thing is missing, they send it back… It's just maddening."
>
> —Beneficiary

Processing times to determine Medicaid eligibility are similar to the national average for nondisabled children, pregnant women, parents and adults without children; from January to March 2022, 66 percent of these applications were processed within seven days (similar to the national average) and 92 percent within 30 days.[19] Stakeholders reported these timelines are much longer for those who are blind, disabled, or older adults; applying for LTSS; or dually eligible for Medicare and Medicaid. One community-based agency that helps people apply for LTSS said that lately, it

> "Nothing is straightforward...There's just a mountain of paperwork I have to do. And then to find out nobody can help me; I have to do another mountain of paperwork to see if I'm eligible for anything. 'Oh, no. Sorry. We can't help you because of your situation.' I've killed at least a dozen trees in the last two days over filling out paperwork that did absolutely nothing to help me in my situation at all."
>
> —Beneficiary

[18] A survey sponsored by the Rights and Democracy Institute found similar results. Most respondents said they experienced long wait times and difficulty in navigating the cumbersome application process. Immigrants, those not fluent in English, and those living in rural areas faced greater difficulties.

Vitulli, E. "Sick of Waiting: Barriers to Medicaid Keep Healthcare Out of Reach." The Center for Popular Democracy, January 2022. https://drive.google.com/file/d/1CadmBWxuS_NUiX4WJh-K2lQtS7aaF0Bz/view?usp=embed_facebook

[19] Center for Medicaid and CHIP Services. "MAGI Application Processing Time Snapshot Report: January–March 2022." Centers for Medicare & Medicaid Services, 2022. https://www.medicaid.gov/sites/default/files/2022-09/magi-app-process-time-snapshot-rpt-jan-mar-2022.pdf.

Federal regulations require application eligibility determinations to be completed within 45 days for applicants who apply for Medicaid on a basis other than disability (42 CFR 435.912(c) and 457.340(d)). About 7 percent of the applications in New Hampshire in this category took longer than 45 days to process, on par with the state national average of 7 percent.

takes at least six months[20] for enrollees to be approved for LTSS, even if they submit all required documents. This delay increases the risk of nursing home admission and health and functional decline among these applicants.

2. *DHHS has significant workforce shortages that limit the agency's ability to oversee, manage, and operate programs effectively and efficiently.*

Many staff members at DHHS and community agencies said there are too few staff to manage programs effectively and efficiently. Persistent staffing shortages leaves gaps in important day-to-day program and beneficiary service operations, limiting managers' ability to delegate operational duties to the appropriate level of the organization. Stakeholders expressed skepticism about the department's ability to manage systems change in light of the substantial challenges they see with its capacity to manage the operation of the existing system. Stakeholders said there are too few DHHS staff to manage and oversee the home and community-based services (HCBS) system, reiterating the findings of recent assessments of DHHS's LTSS management and operations.[21] According to beneficiaries and some stakeholders, staffing shortages in district offices and the Bureau of Family Assistance (the organization responsible for determining eligibility) can lead to long wait times to speak with customer service representatives, frustrating beneficiaries and leading them to abandon calls. Providers and community-based agencies noted that staff turnover at DHHS and the departure of some longtime staff can make it challenging to resolve issues when they arise.

> "I think it comes down to the bandwidth of the department, because there are a lot of waivers that Medicaid wants to operationalize. But waivers take a lot of work, and that's a lot of staff time. I don't know how much bandwidth DHHS has to support what [it wants] to do so that we can ensure this population has the services [and] support [it needs]."
>
> —Stakeholder

3. *Low payment rates for certain Medicaid services, and the lack of a systematic process for reviewing and updating FFS rates, have exacerbated workforce shortages and limited access to behavioral health and HCBS.*

Many stakeholders reported that Medicaid reimbursement rates in the FFS and MCM programs are low in New Hampshire (acknowledging that Medicaid rates are low nationally), and too low for community behavioral health and HCBS to attract an adequate workforce to address beneficiaries' needs. Many beneficiaries said they cannot obtain the full range of behavioral health services they need in a timely manner, and in some cases, they cannot obtain any behavioral health services. The rates are especially inadequate for HCBS delivered in the FFS system. For example, stakeholders said that Medicaid provider reimbursement rates for HCBS waiver services have not been updated for years, and the low rates are the

[20] Federal regulations require application eligibility determinations within 90 days if they require a disability determination

[21] Guidehouse. "New Hampshire Long Term Supports and Services (LTSS) for Seniors & Individuals with Physical Disabilities, Findings and Recommendations." March 12, 2021.

Alvarez and Marsal Public Sector Services. "NH DHHS Operations Assessment." November 2020 and January 2021 *(Shared with Mathematica).*

Sletten, Phil. "Long-Term Services and Supports in New Hampshire: A review of the State's Medicaid Funding for Older Adults and Adults with Physical Disabilities." New Hampshire Fiscal Policy Institute, July 2022. https://nhfpi.org/assets/2022/11/NHFPI-Long-Term-Services-and-Supports-in-New-Hampshire_Older-Adults-and-Adults-with-Physical-Disabilities-July-2022.pdf

major reason for the gap between authorized and paid (received) services in the Choices for Independence (CFI) HCBS waiver program.[22] A recent report by the New Hampshire Fiscal Policy Institute concluded that nursing home rates have better kept up with the cost of providing care than the rates for CFI services, incentivizing institutional over HCBS care.[23]

The Bureau of Developmental Services is currently engaged in a comprehensive update of reimbursement rates for providers who deliver services in three of DHHS's 1915(c) HCBS waivers that serve people with intellectual or developmental disabilities (IDDs). This work might help expand the availability of services for all who are eligible for developmental disability services. However, DHHS has not conducted a comprehensive rate review for the CFI waiver or other HCBS covered under the state plan. The one-time rate increases made during the COVID-19 pandemic, funded by federal relief funds, were helpful but, in many cases, not enough to make up for the lack of rate increases over many years. If New Hampshire does not make these rate increases permanent, availability of HCBS (already reported as insufficient by stakeholders interviewed for this report) might decline.

Medicaid payment rates for behavioral health, and dental services for children are also low, contributing to low Medicaid participation rates among behavioral health and dental professionals. The 10-year Mental Health Plan, released in 2019, also cited low Medicaid reimbursement rates, which were about 58 percent of the rates paid by commercial insurers and lower than rates paid in neighboring states, exacerbating the shortage of mental health professionals who participate in the program. In SFY 2019, DHHS temporarily raised the Medicaid fee schedule for mental health services by $6 million, but it was not enough to raise rates to the national average. The SFY 2024/2025 budget included $134 million for increased Medicaid rates, translating to a 3 percent increase for most services.[24]

Population health, quality, and access

4. *Despite extensive collection and monitoring of quality performance metrics, many stakeholders said their efforts have not translated into action-oriented information for MCOs or providers, because the large number of quality measures dilutes focus and contributes to administrative burden.*

DHHS's Medicaid Quality Strategy sets forth the quality goals and objectives of the MCM program, and explains the roles of each organization involved in managed care quality oversight. DHHS makes all the performance measures publicly available on the NH Medicaid Quality website and produces brief reports comparing each MCO's performance on 10 key measures to help beneficiaries choose plans. It also regularly analyzes progress toward quality goals.[25] Although DHHS has reduced the number of measures it uses to monitor Medicaid MCO performance from 450 to about 200, DHHS staff and MCO representatives challenged the need to collect data, because little of the information is used for program

[22] From SFY 2018–2022, the average share of services authorized that were received (indicated by claims submitted and paid) fell below 25 percent, with the exception of SFY 2020, which covered the initial phase of the COVID-19 pandemic when the state allowed family members to be paid caregivers.

[23] Sletten, Phil. "Long Term Services and Supports in New Hampshire." New Hampshire Fiscal Policy Institute, July 2022.

[24] Office of New Hampshire Governor Chris Sununu. "Governor Chris Sununu Signs Historic Bipartisan Budget." June 20, 2023. https://www.governor.nh.gov/news-and-media/governor-chris-sununu-signs-historic-bipartisan-budget

[25] The most recent analysis reported on progress toward 25 objectives within seven goals from September 2019 to June 2021. New Hampshire Medicaid Quality Program. "New Hampshire Medicaid Care Management Quality Performance Report." Division of Program Quality and Integrity, New Hampshire Department of Health and Human Services. 2021. https://medicaidquality.nh.gov/sites/default/files/Quality%20Strategy%20Effectiveness%20Analysis%20June%202021%20F1.pdf.

management. In addition, DHHS's MCO oversight model is dispersed, with MCM subject matter experts distributed across the department. Staff members collaborate across program areas to ensure that the appropriate subject matter experts are made aware of and can interpret the significance or impact of results for many performance measures. Accordingly, some MCM program oversight staff are poorly positioned to evaluate the design of, effectiveness of, or approach to monitoring MCO quality improvement projects.[26] Consequently, they cited a need for greater cross-division involvement from program experts to identify opportunities and develop action-oriented steps to improve performance.

> "Sometimes the [APM] measures are more trouble than they're worth... It's kind of this pointless exercise that doesn't really amount to much in terms of benefiting our patient."
>
> —Stakeholder

In addition, MCOs are required to design qualifying APMs in alignment with MCM contract provisions and DHHS's Medicaid APM Strategy Guidance. The incentives and quality metrics vary for providers participating in more than one MCO provider network, diluting the power of these payment models to achieve DHHS's quality goals. The volume of quality measures in the MCO's APM programs, along with provider reporting requirements and performance standards across MCOs, add to providers' administrative burden. For example, across all the MCOs, 25 quality measures are included in various APMs, yet only three are included by all MCOs.

5. *Critical gaps in availability of community-based behavioral health services contribute to the use of EDs and hospitals for behavioral health care.*

> "I think it's easy [accessing health care], except for mental health care. It's just nonexistent… I don't see any mental health people [anymore] because there [are] no psychiatrists or psychologists. When I lived in Washington, I saw the same psychiatrist for 13 years… But here, there [are] none."
>
> —Beneficiary

Stakeholders identified the need to build provider capacity and improve access to crisis services, Assertive Community Treatment (ACT), and a greater range of step-up and step-down services such as residential treatment, partial hospitalization programs, and intensive outpatient services. ED boarding for psychiatric treatment is a longstanding challenge in the state and nationally.[27] [28] [29] Of the stakeholders interviewed, most think the underlying problem in New Hampshire is poor access to community-based services to alleviate pressures on EDs and hospitals. Psychiatric hospitals in the state often admit people they perceive could be served in the community if sufficient

[26] The Medicaid Quality Strategy, SFY 2020, requires MCOs to conduct four performance improvement projects: (1) one to reduce psychiatric boarding in EDs, (2) one focused on delivering SUD services, (3) one on a performance indicator for which they fall below the 50th percentile, and (4) a non-clinical performance-improvement project related to social determinants of health and integrating physical and mental health.

[27] New Hampshire Department of Health and Human Services. "New Hampshire 10-Year Mental Health Plan." 2019a. https://www.dhhs.nh.gov/programs-services/health-care/behavioral-health/10-year-mental-health-plan

[28] The Joint Commission. "Quick Safety 19: ED Boarding of Psychiatric Patients –A Continuing Problem." July 2021. https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety--issue-19-alleviating-ed-boarding-of-psychiatric-patients/alleviating-ed-boarding-of-psychiatric-patients/#.Y9gdTmDMKUk

[29] Ramer, Holly. "NH Hits ER Boarding Milestone Amid Litigation." *Foster's Daily Democrat,* April 2020. https://www.fosters.com/story/news/2020/04/02/nh-hits-er-boarding-milestone-amid-litigation/1417301007/

services existed, and they often struggle to identify appropriate aftercare options, which can delay discharge. Stakeholders offered differing opinions on focusing solely on community care versus an approach that includes investing in inpatient psychiatric bed capacity to alleviate the ED boarding issue, noting that some facilities have unused beds. All agree staffing shortages in inpatient and community-based services are more impactful than physical infrastructure needs.

DHHS prepares quarterly reports on compliance within the terms of the Community Mental Health Settlement Agreement. These reports have highlighted (1) gaps in the availability of ACT services, (2) access to and use of supported employment services, (3) problems with transition planning from institutional care and insufficient community-based alternatives for people exiting long-term inpatient psychiatric care, and (4) inadequate permanent integrated community living options. These problems are exacerbated by reported tensions between community behavioral health providers and MCOs. CMHCs and other behavioral health providers have limited staff and overhead resources to navigate MCO contracting and billing requirements. Although MCOs are required to cover behavioral health services for all members, case managers who serve people with IDDs said MCOs frequently deny authorization for behavioral health services for this population, saying such services should be covered by the HCBS 1915(c) waivers.

6. *Variation among and high administrative burden in MCOs' prior authorization requirements (PA) hinder access to timely delivery of critical services and place an undue burden on beneficiaries and providers.*

State Medicaid agencies and MCOs commonly use PA requirements to control excessive or unnecessary use of services. PA requires providers to obtain advance approval from the state Medicaid agency or a health plan before providing a specific service to an enrollee to qualify for payment coverage. Many stakeholders said differences in MCO PA policies and burdensome requirements hinder access to care. For example, despite using a uniform preferred drug list, the MCOs maintain their own PA criteria for pharmaceuticals, which leads to confusion among providers and misalignment with the DHHS's own PA policies, as each MCO updates its PA criteria on different schedules. Behavioral health providers and community health clinics also cited the burden of dealing with variation in MCO PA processes.

Home health providers and the state contractor that manages the personal care attendant services (PCAS)[30] benefit also cited burdensome PA requirements. For example, home health services delivered on a short-term or post-acute care basis and PCAS are covered in the MCM benefit package and require PA before initiating services. Stakeholders indicated that PA delays for home health services and physical therapy routinely result in hospital discharge delays.

Stakeholders said DHHS will get involved in escalation and resolving these issues on a case-by-case basis, but they have not seen DHHS offer a systemic response to stakeholders' concerns about MCOs' PA requirements. For example, at the request of home health agencies, DHHS required MCOs cover the first

[30] Like 34 other states, New Hampshire covers personal care under its State Medicaid plan. However, the PCAS state plan benefit is available only to a group of about 200 people, most of whom are paraplegic and use a wheelchair more than 90 percent of the time. New Hampshire uses a self-direction model in which clients hire and fire their own personal care attendants. DHHS contracts with a single organization—Granite State Independent Living—to manage the PCAS benefit. Its nurses conduct clinical assessments, develop person-centered care plans, bill MCOs for self-directed PCAS, and help clients find personal care attendants.

six home care visits without PA. However, because each MCO has interpreted the requirement differently, home health agencies "pretty much have to get PA for everything." Similar problems are common in private duty nursing, which is commonly provided to children with medically complex conditions, and in the PCAS program. Even though these people need ongoing intensive care, MCOs require PAs for private duty nursing services every two months, and for PCAS every three to six months, requiring beneficiaries and their families to endure repeated nursing assessments and obtain recurrent physician signatures and attestations.

7. *DHHS's LTSS system for older adults and people with disabilities remains biased toward institutional care.*

Medicaid is the primary payer both nationally and in New Hampshire for LTSS for older adults and people with disabilities who have low income and limited assets. LTSS includes both (1) institutional care provided in nursing homes and intermediate care facilities for people with intellectual or developmental disabilities (ICFs-IDD); and (2) HCBS, which help people perform activities of daily living in their home or community residence.[31] Prompted by a series of court rulings and legislative action and concerted efforts by the federal and state governments over the last several decades, national spending on HCBS as a share of total Medicaid LTSS spending—a key indicator of success in LTSS system rebalancing—increased from 27 percent in FY 2000 to 59 percent in FY 2019.[32] By contrast, New Hampshire spent 47.2 percent of total Medicaid LTSS expenditures (including services for all populations under the state's 1915(c) waivers, personal care services, and home health services) on HCBS in FY 2019, placing it in the bottom quartile of all states and lagging neighboring states Maine (63.8 percent), Vermont (68.2 percent), and Massachusetts (72.3 percent). The number of people receiving HCBS as a share of all Medicaid LTSS users in 2019 was also lower in New Hampshire (78.3 percent) than the national average (85.0 percent).[33] Stakeholders interviewed for this report said payment rates for personal care assistance and CFI waiver services are so low, sufficient staff cannot be hired to serve all beneficiaries seeking this support.

DHHS and independent organizations have completed recent and comprehensive reviews of the DHHS's LTSS rebalancing efforts and outcomes. Mathematica did not perform an additional in-depth analysis of the issue to avoid unnecessary duplication, opting instead to review the existing literature.[34] Based on our review of their reports and recommendations, interviews with stakeholders, and more recent data, we found LTSS rebalancing for adults with disabilities and seniors remains a persistent challenge for New Hampshire.

[31] NH does not have an ICF-IDD for adults; Cedarcrest is a pediatric ICF-IDD.

[32] Murray, C., A. Tourtellotte, D. Lipson, and A. Wysocki. "Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2019." Mathematica, December 9, 2021. https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf

[33] Kim, M., E. Weizenegger, and A. Wysocki. "Medicaid Beneficiaries Who Use Long-Term Services and Supports: 2019." Mathematica, July 22, 2022. https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-user-brief-2019.pdf

[34] The three reports are cited in footnote 18.

Whole-person and integrated care

8. *The implementation of expanded local care management and new care management requirements under MCM 2.0 was largely unsuccessful. Stakeholders reported ongoing confusion about division of responsibility for care management between MCOs and other care management entities.*

DHHS made notable efforts to require and encourage MCOs to increase the enrollment of their members into MCO care management programs under the original MCM 2.0 contract. MCOs, however, did not meet DHHS's expectations. Although MCOs were required to provide care management to 15 percent of their members in five priority populations (see box); MCOs had only enrolled about 2 percent of their members in care management as of April 2020. The percentage has grown since then but remained at less than 4 percent in November 2022.[35] In addition, MCOs did not provide local care management in accordance with original contract MCM requirements. Consequently, DHHS reduced the requirement from 15 to 3 percent, effective January 1, 2021.[36]

Stakeholders reported frustration with the lack of clarity about the roles and responsibilities of each entity in providing care coordination and care management to priority populations. With some exceptions, most interview respondents said MCO care managers, primary care providers, and community agencies that serve people with behavioral health conditions and enrollees in HCBS waiver programs communicate and coordinate with each other on an ad hoc rather than systematic basis. In addition, some providers expressed frustration about administrative requirements and billing complexities for providing care management services.

[35] Members Enrolled in Care Management at Any Time During the Month (nh.gov)

[36] MCO Contract Amendment 5 and Amendment 6. As of June 2021, MCOs provided CC/CM to less than 3 percent of all members and virtually no LCM services. https://medicaidquality.nh.gov/sites/default/files/Quality%20Strategy%20Effectiveness%20Analysis%20June%202021%20F1.pdf

MCOs offered several practical reasons why implementing enhanced care management requirements was challenging, including operational constraints on which activities constituted creditable care management, limitations for identifying beneficiaries eligible or in need of care management, and persistent low engagement or responsiveness by beneficiaries. None of the MCOs offered a path to providing care management at the volume (15 percent of beneficiaries) DHHS originally sought to achieve or an approach to building provider capacity to assume responsibility for providing local care management. When beneficiaries receive care management, they say they find it helpful.

9. *Medicaid beneficiaries and providers have difficulty navigating the health and human services system, understanding what benefits and services are available for people, and accessing services.*

Priority populations for MCM care management

- **Adults with special health care needs**: those with chronic health and mental health conditions, people with IDDs, people with SUD, and those with chronic pain
- **Children with special health care needs**: those with serious or chronic conditions, children in foster care, infants in neonatal intensive care units with neonatal abstinence syndrome (NAS), and those receiving family-centered early supports and services
- **HCBS waiver participants**
- **Members identified as those with rising risk**, as approved by DHHS
- **Other people with a high unmet need for resources**: recently incarcerated people, mothers of babies born with NAS, pregnant women with SUD, intravenous drug users, people who have been in the ED for an overdose event in the last 12 months, people who attempted suicide in the last 12 months, and members diagnosed with an IDD ◢

Beneficiaries reported different experiences getting and coordinating the services they need to address multiple health care and social needs. People who reported receiving any care management typically received it from a provider or community agency (n = 26 of 69). Some people reported receiving care management from a health plan (n = 6 of 69). Those who reported receiving any care management generally said it is helpful in navigating the procedures required to obtain services.

> "You get handed all these different pieces of help [health care and human services assistance], and we have to figure out how to put them all together to make it work, to get the help."
>
> —Beneficiary

Of beneficiaries using behavioral health services (n = 22 of 69) most reported barriers to care, due to lack of availability of appointments with existing providers, a general lack of providers in their area, and long wait times. About half of interviewees shared one or more complaints about the administration of their Medicaid plan (n = 29 of 69), including PAs that delayed needed care, poor customer service, and an insufficient provider network. Several participants with complex health needs said they seek care out of state (n = 13 of 69), most often in Boston, because of the limited availability of specialty care in New Hampshire. Participants receiving care out of state cited improved quality and availability of specialty coverage (n = 8 of 69) and convenience from their location (n = 5 of 69).

Providers and community organizations cited similar challenges with system navigation. Many said that few beneficiaries understand the breadth of services and benefits covered by Medicaid and other human service programs operated by DHHS. Respondents indicated that many providers do not know which benefits are covered under Medicaid outside of their scope of practice, so they are not effective benefit navigators or counselors for beneficiaries with complex or varied needs. Although DHHS operates many public benefit programs, people face barriers to obtaining services either because they cannot navigate the application system or lack transportation, especially in rural areas of the state. Workforce problems—attributed in part to low Medicaid payments, according to stakeholders interviewed—mean providers cannot serve everyone who seeks them out. Stakeholders said too many "disconnects and siloes" across health and human service systems create delays, confusion, and duplication of efforts.

> "I have chronic problems with my heart, my respiratory system, and spine. The trouble with getting care is the limited availability of providers and specialists in New Hampshire. The specialists I need to see for my conditions are in Boston. But [the MCOs] make you prove there is no one in New Hampshire. They exist here [in New Hampshire] but it's much more difficult for me to get there versus Boston."
>
> —Beneficiary

10. *Intermittent and unsustainable funding streams have limited the effectiveness of investments in (1) building regional capacity to provide local care management; (2) sustaining long-term organizational relationships at the regional level to improve population health; and (3) expanding efforts designed to improve HRSN.*

Many stakeholders expressed preferences for community-driven care management and health care delivery over statewide solutions and decision making to account for the unique aspects of local regions. However, regions have not identified independent funding sources to support and build capacity of local entities and still require significant state investment. To help DHHS achieve population health goals, consistent statewide funding and support is required to (1) build and maintain statewide enterprise technical systems that connect beneficiaries, health and human service providers, and care management entities and (2) provide technical assistance to build the local capacity and skills needed to operationalize local care management activities. Without broad and consistent statewide support, variability in capacity and sophistication among local and regional entities might contribute to regional disparities in health and human service access and beneficiary health outcomes.

> "When you have no sustainability plan moving forward, great projects like IDN dry up when there's no money available to support the services."
>
> —Stakeholder

Although DHHS's DSRIP waiver established credible investments in locally driven, whole-person care through IDNs, these relationships and connections have not been maintained for several years. Reestablishing IDNs or something similar would require additional start-up funding and effort comparable to the initial DSRIP implementation. Further, some stakeholders indicated that the lack of sustained investment in DSRIP initiatives will present challenges in building trust when exploring new local and regional opportunities.

> "We made some real progress with the DSRIP 1115 waiver, with the IDNs. It's really a tragedy that that program was allowed to fade away without ongoing support."
>
> —Stakeholder

Thirteen regional public health networks operate through contracts with DHHS. Goals of these networks include expanding regional infrastructure, delivering services to prevent SUD and chronic disease prevention, and engaging activities to promote health. They have the potential to be anchoring entities for greater regional control. However, after years of pandemic-induced, high-intensity efforts by the networks, some stakeholders described these networks as exhausted or out of capacity. Although DHHS will still be required to invest in capacity building, the relationships and infrastructure maintained by the public health regions represent a framework and baseline from which DHHS can build local delivery networks.

All MCOs in the MCM program identified ongoing relationships and efforts to address HRSN; most were limited in scale, episodic, and not evaluated for long-term investment and impact. When asked for examples of HRSN initiatives implemented in New Hampshire, one MCO cited a mobile pantry (seven events cited), a mobile vision screening van (12 site visits), and meals after hospital discharge for people with diabetes and heart disease (48 members served). Another MCO provided examples of HRSN initiatives but did not provide evidence of impact and outcomes. Although several stakeholders offered positive feedback on certain MCO HRSN initiatives, most did not seem to be aware of MCO efforts in this area.

C. Alternative models for financing and delivering health and human services

Mathematica reviewed a range of alternative Medicaid and health and human service delivery system models across different states and geographies. Through our broad environmental scan and guidance provided by subject matter experts, we identified options and approaches to financing and delivering health and human services for Medicaid beneficiaries. We identified similarities across models and grouped them into the following categories:

- Fully capitated managed care models innovating on population health and HRSN
- Regional community collaboratives operating in parallel with Medicaid managed care models
- Provider ACOs operating in parallel with Medicaid managed care models
- Regional Medicaid managed care models
- Regional primary care case management models
- Managed FFS models

We narrowed our focus to three alternative delivery models for in-depth analysis based on two criteria: (1) the potential for the model to build upon the strengths and address key challenges of New Hampshire's current system and (2) the strength of available evidence to support the model's ability to focus on prevention, value, cost-effectiveness, and enhanced delivery of health and human services for people and families in New Hampshire.

The three models are (1) provider ACOs operating in parallel with Medicaid managed care, (2) regional Medicaid managed care, and (3) Managed FFS. We describe these models through the lens of their financing mechanisms; approaches to prevention and population health, care coordination and management, payment innovation, and value; and approach and capacity to integrate with health and human services. Where possible, we also identify opportunities to align each model with New Hampshire's current health and human service delivery system.

D. Model 1: Provider ACOs operating in parallel with MCOs

Provider ACOs operating in parallel with Medicaid managed care plans is a health and human service delivery system model that many states, including Rhode Island, Minnesota, and Massachusetts have implemented. Mathematica focused our research on Rhode Island's Accountable Entities program, because Rhode Island was most comparable to New Hampshire in terms of population and Medicaid enrollment size, and because this innovative model could be overlaid with the current MCM program.

1. Core model components, alignment with strengths and weaknesses of the MCM program, and key considerations

The table below summarizes (1) core components of the provider ACO model and (2) how the model builds on strengths and mitigates weaknesses of the MCM program.

Core components of the provider ACO model operating in parallel with Medicaid managed care	
• Moves the focus of care and control for quality, outcomes, and total cost of care from MCOs to provider groups • Clearly delineates roles and responsibilities and aligns financial incentives for care delivery, care coordination, and care management among provider groups (particularly primary care), ACOs, and MCOs • Focuses on regional needs and aligning health care systems with community-based infrastructure	
Builds on strengths	**Mitigates weaknesses**
• Uses established and relatively robust Medicaid health care provider networks and health care quality improvements realized by MCOs • Strengthens capacity of local and regional entities by formalizing the creation of ACOs that might build on the relationships established by regional public health networks and IDNs under the DSRIP demonstration • In conjunction with a closed-loop referral platform, creates a holistic, person-centered approach to connect people to health and human services	• Better aligns MCOs and health care providers by incentivizing higher value care • Anchors care management within the ACOs, thereby reducing redundancy of and confusion over care management responsibilities • Promotes community-based living, a DHHS goal • Elevates the role of regional care delivery and management in the health care delivery system and might improve overall regional capacity to provide these services • Improves beneficiaries' ability to navigate the system by placing navigational responsibilities on ACOs

2. Background

Rhode Island's Medicaid ACO program began as a pilot in 2016 and fully launched in 2018 under the state's Health System Transformation Project (HSTP). The ACO program is a key enhancement of Rhode Island's Medicaid managed care program, and the state views it as a reinvention of Medicaid based on value-based care principles.[37] Officials from the Rhode Island Executive Office of Health and Human

[37] "Medicaid ACOs Rhode Island." n.d. https://www.naacos.com/medicaid-acos-rhode-island. Accessed January 24, 2023.

Services (EOHHS) designed the ACO program to address limitations of the state's Medicaid system of care and to achieve the following objectives:[38]

- Transition away from FFS models.
- Define Medicaid-wide population health goals, and, where possible, tie them to payments.
- Maintain and expand on Rhode Island's record of excellence in delivering high-quality care.
- Deliver coordinated, accountable care for populations with rising and high costs and needs.
- Ensure access to high-quality primary care.
- Shift Medicaid expenditures from high-cost institutional settings to community-based settings.

Rhode Island's goals for population health, care coordination, high-quality primary care, and community-based settings align with New Hampshire's goals. Comprehensive ACOs are provider organizations that, once certified by EOHHS, are eligible to contract with one or more of the state's MCOs to deliver more cost-effective, coordinated, and population-focused care. Rhode Island is moving through a five-year implementation plan (2018–2023) using a Section 1115(a) demonstration waiver, with waiver-financed infrastructure grants available to certified ACOs. As of SFY 2022, EOHHS has certified seven comprehensive ACOs for participation in the program.

In addition to the comprehensive ACO program, Rhode Island has a specialized ACO program that focuses on supporting implementation of APMs for LTSS.[39] The program has three overarching goals: (1) to encourage and enable LTSS-eligible and aging populations to live in their communities, (2) to improve and ensure equitable access to HCBS that prevent LTSS-eligible populations from needing institutional LTSS, and (3) to foster a sustainable network of high-quality HCBS providers equipped to meet the diverse needs of LTSS members. The initial phase of the Specialized ACO program aligns with the current Medicare–Medicaid Program demonstration in the state. The program is designed to build the capacity of home care agencies to participate in APMs. Both home care agencies and the MCOs participating in the specialized ACO program have defined measures for their performance and payment including a focus on readiness and outcomes. The outcome measures are focused on workforce-related outcomes, such as employee retention, services delivered versus services approved, and hospital avoidance measures.

Integrated Rhode Island ACO

Integrated Healthcare Partners (IHP) is one of the seven ACOs currently operating in Rhode Island. IHP comprises five Federally Qualified Health Centers and four CMHCs. In addition to physical and behavioral health providers, IHP's partner network also includes multiple community action agencies and other CBOs to support the delivery of whole-person care.◢

[38] Rhode Island Executive Office of Health and Human Services. "Attachment H - Accountable Entities Certification Standards – Comprehensive AE (Program Year 6)." n.d. https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-12/Attachment%20H%20-%20AE%20Certification%20Standards_PY6_Final.pdf.

[39] State of Rhode Island Executive Office of Health and Human Services. "LTSS APM." n.d. https://eohhs.ri.gov/initiatives/accountable-entities/ltss-apm. Accessed January 27, 2023..

3. ACOs' responsibilities

EOHHS established certification standards for ACOs to promote the development of new forms of provider organizations, care integration, payment, and accountability. Certified ACOs are multi-disciplinary in composition, interdisciplinary in practice, and focused on population health; they offer programs tailored to varying levels and types of needs.[40] Current ACOs include those organized by a community health center, an academic health system, and a coalition of Federally Qualified Health Centers (FQHCs) and CMHCs. Certified ACOs are responsible for coordinating a full continuum of health care services for defined populations and must also have distinct competencies to recognize and address the special needs of subgroups at high risk and rising risk. Based on our qualitative research, most New Hampshire provider organizations lack the ability and willingness to take on the responsibilities to become an ACO. Thus, if the state were to pursue this route, it would need to provide practices with additional financial support to develop the skills necessary to meet these requirements.

EOHHS provides specific contractual requirements for how MCOs and ACOs should coordinate teams of providers to align financial incentives, improve capacity to manage complex conditions, and better address social needs. MCOs are responsible for ensuring ACO contractual compliance. MCOs are required to retain responsibilities for network contracting, provider payment, claims processes, member services, and grievance and appeals functions. MCOs are also required to establish processes for overseeing and monitoring any functions they delegate (for example, care management).[41]

4. Financing

In October 2016, the Centers for Medicare & Medicaid Services (CMS) approved EOHHS's request to amend the Rhode Island Comprehensive 1115(a) Waiver Demonstration to create a pool of funds focused on designing, developing, and implementing the infrastructure needed to support ACOs.[42] HSTP included $129.8 million in federal matching funds over a five-year period (October 2016–December 2020), and $76.8 million of this funding was directed toward ACO program implementation incentives.[43]

5. Prevention and population health

Central to the ACO model is a systematic population health approach that improves the health status of the attributed population while segmenting subpopulations with complex health and social needs to implement targeted strategies to improve health. DHHS could use the former IDNs as a starting place to

[40] State of Rhode Island Executive Office of Health and Human Services. "Attachment H - Accountable Entities Certification Standards – Comprehensive AE (Program Year 6)." n.d. https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-12/Attachment%20H%20-%20AE%20Certification%20Standards_PY6_Final.pdf.

[41] State of Rhode Island Executive Office of Health and Human Services. "2017-09 Contract Between State of Rhode Island EOHHS and UnitedHealthcare of New England for Medicaid Managed Care Services Amended July 1, 2022." 2022. https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-11/UHC%20Full%20Contract%20Managed%20Care_Amendment%209-CLEAN_fully%20executed%2020220928.pdf

[42] State of Rhode Island Executive Office of Health and Human Services. "Attachment K – Infrastructure Incentive Program: Requirements for Managed Care Organizations and Certified Accountable Entities Program Year 6." n.d. https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-12/Attachment%20K%20-%20Incentive%20Program%20Requirements_PY6_Final.pdf

[43] Center for Health Care Strategies, Inc. "Rhode Island Accountable Entity Coordinated Care Pilot: Early Lessons and Recommendations." State of Executive Office of Health and Human Services, 2018. https://eohhs.ri.gov/media/15941/download?language=en

identify community organizations interested in integrating under a broader organization to become an ACO focused on behavioral health. Based on regional need, these reconstituted IDNs could focus on targeted strategies to accomplish goals, such as to increase community-based behavioral health services or to implement components of the 10-Year Mental Health Plan. ACOs are required to complete a population health and HRSN assessment, including evaluating the social needs of its members and taking actions to ensure they receive appropriate care and follow-up. ACOs are also required to implement processes for completing HRSN screenings for attributed members using an EOHHS-approved screening tool. Further, ACOs are required to evaluate HRSNs through regular analysis of claims, encounters, and clinical data in partnership with MCOs. ACOs must establish protocols with CBOs to ensure members receive supportive human services through warm handoffs, closed-looped referrals, navigation, and care coordination and management.

Rhode Island used the ACO model to focus on key state and regional priorities, such as health equity. Since 2015, Rhode Island has focused on building a place-based community infrastructure dedicated to improving the local environment to support health and well-being and strengthening community clinical linkages.[44] Health Equity Zones (HEZ) are geographic areas with community-based collaborations that conduct assessments and implement actions plans to address identified needs and opportunities. The Rhode Island Department of Health has been the lead state agency supporting the establishment and growth of HEZ. However, some of HEZ have worked closely with Rhode Island Medicaid. In the state's most recent 1115(a) waiver extension request and in the upcoming managed care procurement, there is a focus on strengthening the connection between ACOs and HEZ.

Through a two-year, extensive community engagement process, the Rhode Island Department of Health collaborated with members of Rhode Island's Community Health Assessment group to develop a set of 15 measures in five domains that affect health equity: (1) integrated health care, (2) community resiliency, (3) physical environment, (4) socioeconomics, and (5) community trauma.[45] These measures are intended to measure the impact of health equity interventions from initiatives such as HEZ, by providing baseline data and informing an outcomes evaluation. HEZ have adopted strategies to tackle projects across the five domains. However, initiatives across each zone vary because the needs of people within each zone are different. For example, the Washington County HEZ seeks to improve behavioral health by providing training in mental health literacy to increase screening and access to behavioral health services; supporting direct therapy campaigns, such as preschool mental health through the Incredible Years program; and implementing a Crisis Intervention Team comprising behavioral health providers, law enforcement officers, and first responders. Through these efforts, 356 community members in Washington County completed training in Mental Health First Aid; three local police departments now have 20 percent of officers trained in crisis intervention; and 13 families have completed the Incredible Years program.[46]

[44] State of Rhode Island Executive Office of Health and Human Services. "The Rhode Island 1115 Waiver Extension Request." https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-12/RI%201115%20Waiver%20Extension%.20Request%20for%20Website.pdf. Accessed January 27, 2023

[45] RIDOH Community Health Assessment Group, "The Rhode Island Health Equity Measures." https://health.ri.gov/publications/factsheets/HealthEquityIndicators.pdf

[46] Rhode Island Department of Health. "Rhode Island's Health Equity Zone Initiative. Annual Report Executive Summary for Fiscal Year 2020-2021" https://health.ri.gov/publications/annualreports/2020-2021HEZ.pdf

6. Care coordination and care management

A goal of DHHS is to move toward a person-centered system of care inclusive of medical, behavioral health, and social needs. The ACO program was designed to do just that. The primary care team acts as the primary point of contact as members navigate their care. For members with complex needs, the ACO provides tailored supports as an extension of the primary care team, such as complex care management, Integrated Health Home and ACT teams, or other specialized programs for subpopulations. The ACO is the primary source of referral, navigation, and coordination between primary care and other health care and community-based services within and outside of the ACO's network. ACOs are expected to work closely with MCO partners to coordinate care management programming and system navigation for all attributed members.

ACOs are expected to plan and implement a range of care programs (detailed in Table II.1) in coordination with the ACO's contracted MCO partner. This coordination reduces confusion about care management—a challenge identified by New Hampshire stakeholders—and uses the unique strengths of ACOs and MCOs. ACOs are encouraged to implement a Joint Operating Committee management structure with each contracted MCO to lead coordination as care programs are planned and implemented. ACOs are also expected to formalize working partnerships with outside providers and institutions to enable coordination across care settings, collaboration, and information sharing. For high and rising risk members, teams must develop an Individualized Care Plan (ICP) with active member and family participation that reflect the results of a comprehensive health needs assessment, including plans to address HRSNs.

Table II.1. ACO care programs

Care program	Description	ACO's role and responsibility
Health promotion	Innovative and evidence-based educational resources, prevention and self-management tools, and information for members in formats that meet the needs of all members, promote self-care, and empower members.	ACOs are encouraged to promote improved health among members independently or jointly with a contracted MCO.
Care coordination	Examples include help scheduling appointments; arranging transportation; and referrals to community services, programs, and resources.	ACOs must deploy care coordination activities, at a minimum, for members with chronic, acute, specialty, behavioral health, and social needs
Care management (CM)	A team-based, person-centered approach designed to improve the health of members. CM is a set of activities tailored to meet a member's health-related needs according to their individual goals and as documented in the ICP.	ACOs must deploy care management teams and offer CM services tailored to meet the health needs of members at high and rising risk. ACOs must develop ICPs for all members in care management, with members and families actively involved in identifying care goals and interventions.
Complex care management (CCM)	Evidence-based CM services for members with multiple or complex conditions and populations at high risk. CCM includes at a minimum a comprehensive initial assessment; delineation of available benefits and resources; development of an ICP and prioritized goals; and monitoring and	ACOs are encouraged to provide or otherwise facilitate access to CCM services by working with contracted MCOs and providers.

Care program	Description	ACO's role and responsibility
	follow-up. It should address preventive care in addition to treating complex conditions.	

7. Payment innovation and values

If DHHS adopted an ACO-type model, DHHS could develop a payment structure similar to Rhode Island's that incentivizes value-based care delivery and is described below.

Total cost of care APMs. Fundamental to EOHHS's initiative is progressive movement from volume-based to value-based arrangements and to increase provider risk and responsibility for the cost and quality of care. Certified ACOs are required to enter into total cost of care (TCOC) APMs with MCOs in alignment with EOHHS requirements.[47] EOHHS's TCOC methodology was designed to (1) provide ACOs an opportunity for a sustainable business model, (2) create financial flexibility for ACOs, (3) promote fiscal responsibility, (4) recognize and address the challenge of small populations, (5) incorporate quality metrics, (6) require timely data exchange and performance improvement reporting, and (7) include progression toward providers taking on meaningful risk.[48]

ACO Incentive Program. Certified ACOs that participate in a qualified APM are also eligible to participate in Medicaid's ACO Incentive Program. EOHHS establishes an ACO-specific incentive pool with the total incentive dollars that each ACO may earn. MCOs must verify whether an ACO achieves the milestones or metrics to earn incentive funding, and implement and operate the ACO incentive pool in coordination with EOHHS. The MCO awards earned funds to the ACO for performance on defined measures; funds are intended to advance ACOs' program success through capacity building and to support the transition to performance-based outcome metrics.

8. Approach and capacity to integrate with health and human services

EOHHS uses ACOs to layer and scale up care coordination and management across health and human services. Incentives and contract structures help ensure partnerships between MCOs and ACOs and reduce the likelihood of service duplication. Taking a similar approach in New Hampshire would be in line with the state's recent efforts to procure a closed-loop referral system to strengthen care coordination and connections between health care providers and CBOs. The Rhode Island model funded technical infrastructure to support the exchange and use of data via electronic health records, patient registries, population analytics, and data integration with care plan technology. This model assumes (1) the ACOs establish relationships with CBOs to deliver services to address HRSN identified through standardized screening and described in the ICP; (2) CBOs have capacity to deliver the referred services; (3) financial arrangements between ACOs and CBOs are sufficient to meet current and future beneficiary needs; and (4) the reduction in unmet HRSNs results in overall cost savings to the MCO.

[47] State of Rhode Island Executive Office of Health and Human Services. "Attachment J – Accountable Entity Total Cost of Care Requirements." n.d. https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-12/Attachment%20J%20-%20TCOC%20Requirements_PY6_Final.pdf

[48] Rhode Island Executive Office of Health and Human Services. "Attachment J – Accountable Entity Total Cost of Care Requirements." n.d. https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-12/Attachment%20J%20-%20TCOC%20Requirements_PY6_Final.pdf

9. Available evidence

An interim evaluation of Rhode Island's 1115(a) demonstration found the overall effect of the ACO program on quality and usage metrics was mixed. ACO-attributed members had lower rates of all-cause readmissions and improved rates of seven-day follow-ups after hospitalizations for mental illness. However, ACO-attributed members also had increases in hospitalizations and potentially avoidable ED visits and lower rates of 30-day follow-ups after hospitalizations for mental illness. ACOs had reductions in total spending between the baseline and performance periods, but this reduction likely reflects national trends that show declines in use during the COVID-19 pandemic.[49]

10. Key considerations for provider ACOs operating in parallel with MCOs

- **Availability of willing and capable provider groups.** An ACO model requires willing provider groups with enough Medicaid patients to obtain certification and to take on new responsibilities, including risk-based arrangements. For example, Rhode Island's certified ACOs require 5,000 attributable lives across all MCOs and at least 2,000 members per MCO–ACO contract.

  Interviewees in the New Hampshire provider community and current MCOs said the MCM program today offers ***limited provider capacity, limited willingness, and insufficient rates to enter into downside risk arrangements***.

- **Engagement, commitment, and alignment of MCOs.** Because the ACO model operates in parallel with the fully capitated managed care model in Rhode Island, the MCO partners must work collaboratively with the state to develop and implement the model.

  If New Hampshire pursues an alternative model that is implemented alongside MCOs, DHHS will need to assess MCOs' commitment in pursuing the development of an ACO model. ***A disconnect between DHHS's expectation of what MCOs should do, and what New Hampshire's MCOs can (or are willing to) do to manage health care services, might make it challenging to add in a coordinating entity.***

- **Federal authority and financing within Medicaid and community-based infrastructure.** The ACO model uses federal flexibilities and more than $75 million in funds from the 1115(a) demonstration waiver for ACO program incentives. To pursue an ACO system transformation, DHHS will need to determine the necessary level of financial and human capital resources (DHHS staff and consultants) required to plan and implement transformation. Steps would likely include (1) estimating the cost of short-term consultants to help develop and submit an 1115(a) or other waiver application; and (2) estimating the number of additional DHHS full-time equivalent positions needed during planning and implementation. DHHS will then need to work in partnership with the legislature to determine whether there is a viable financing strategy for the state's share of all costs.

  Without identifying a state funding source, it is not clear where funding would come from to develop and implement an 1115(a) waiver.

[49] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-09/Interim%20Evaluation.pdf

E. Model 2: Regional Medicaid managed care

Many statewide Medicaid managed care models are structured so contracted MCOs operate statewide and compete for enrollment of beneficiaries throughout the state. Other managed care models are regional, and contracted entities serve defined regions of the state. Colorado's regional managed care model aligns with DHHS's interest in aligning health and human services geographically and focusing on prevention, value, cost-effectiveness, and enhanced delivery of services for people and families.

1. Core model components and alignment with strengths and weaknesses of the MCM program

The table below summarizes (1) core components of the regional Medicaid managed care model and (2) how the model builds on strengths and mitigates weaknesses of the MCM program.

Core components of the regional Medicaid managed care model	
• Aligns administrative, management, care coordination and delivery, and population improvement functions in physical and behavioral health, regionally • Supports practice transformation and quality improvement by providing a funding mechanism (capitation and PMPM administrative payments) and integrated care structure	
Builds on Strengths	**Mitigates Weaknesses**
• Continues the approach to integrating physical and behavioral health under a single responsible entity (MCO) and supports implementation of 10-Year Mental Health Plan, particularly the continued use of regionally based CMHCs • Builds on strong quality performance already identified under the current MCM program • Focuses care oversight at the regional level, which should help strengthen capacity of local and regional entities	• Facilitates tailored approaches to health and human service delivery and case management at the regional level • Focuses and aligns incentives across coordinating entities and providers through capitated (behavioral health) or PMPM administrated fees (physical health) • Increases the number of beneficiaries receiving local case management through required population health management plans and programs • Reduces administrative burden on providers by moving responsibilities to the regional entity • Uses PMPM as consistent funding source to help build long-term regional capacity

2. Background

Colorado launched its Accountable Care Collaborative (ACC) as a limited pilot program in 2011 to test a new model of beneficiary and provider support with a FFS delivery system for physical health services. Based on the success of the pilot, the first iteration of a statewide model of the program included contracting with seven non-overlapping regional care coordination organizations that were tasked with engaging primary care medical providers, connecting members to primary care, coordinating care, and helping providers transform their practices and improve quality.

The model's regional structure built on Colorado's strong focus on local control and regional variability. The original regions were drawn to align with county boundaries (Colorado has 64 counties) and to ensure roughly equivalent numbers of Medicaid members in each region. At initial implementation, the state also contracted with five regional behavioral health organizations (BHOs) that managed the community-based behavioral health programs and the capitated behavioral health benefit.

After the initial model was in full implementation, the state engaged extensively with stakeholders to evaluate the model's success. The misalignment of the seven ACC regions and the five BHO regions and the bifurcation of responsibilities for physical and behavioral health services were identified as critical limiting factors. In Phase II of the model, the state moved to align the regions and bring the work of the ACC and BHO contractors into a single contract for a Regional Accountable Entity (RAE).

3. RAE responsibilities

The four primary responsibilities of a RAE are (1) building networks for primary care and behavioral health providers, (2) administering the state's capitated behavioral health program, (3) supporting initiatives to transform practices and improve their quality, and (4) implementing care coordination and efforts to improve population health. New Hampshire could use the IDNs as a foundation on which to build RAEs; however, aside from the state's familiarity with the challenges with and potential options to improve primary care and behavioral health integration, the IDNs would require significant technical and financial support to operate as RAEs, even more so than under provider ACOs.

4. Financing

RAEs are considered managed care entities that administer the fully capitated community behavioral health benefit for Colorado Medicaid members. RAEs are eligible to receive incentives tied to performance on a set of behavioral health measures. In addition, they operate as a primary care case management entity for all Medicaid beneficiaries. RAEs receive a $12 PMPM administrative payment to support their provider engagement, care coordination, population health, and quality improvement initiatives. The state, not the RAEs, pays claims for physical health services on an FFS basis.

5. Prevention and population health

A core focus of RAEs is improving the health of its members and the overall population. The contract for the RAEs includes specific areas of focus for population health improvement based on data analyzed by the state. The areas of focus include weight, tobacco use, family planning, anxiety and depression, and prenatal and postnatal care to reduce premature births and infant mortality. Each RAE is required to submit a Population Health Management Plan that outlines its key activities for care management and coordination, how it plans to use technology for wellness and prevention, and major health concerns among the local population. The RAE should stratify its plan to address concerns by varying health risks and complexities of the population it serves. Examples from RAEs include efforts to promote smoking cessation, prevent injury and suicide, and support appropriate use of the health care system by increasing the use of nurse advice lines and reducing ED use. RAEs must submit a biannual Prevention, Wellness, and Member Engagement Report. RAEs are also responsible for outreach related to Medicaid's Early and Period Screening, Diagnostic and Treatment (EPSDT) benefit, including outreach to pregnant women and families with children eligible for EPSDT services in accordance with state and federal requirements. Beyond reaching out and educating members about the importance of prevention and screening benefits, RAEs are responsible for providing referrals to Title V Maternal and Child Health, Early Intervention, WIC, school health, and other health and human services programs. RAEs are required to submit a quarterly EPSDT outreach report to the state.

To support prevention and behavioral health and well-being, Colorado also uses 1915 (b) waiver authority to implement alternative services that enhance the continuum of services available in the community, such as clubhouses, drop-in centers, psychosocial rehabilitation, ACT, intensive outpatient psychiatric care, and day treatment services. In the current contract, all five key incentivized performance indicators (indicators with payment attached to them) focus on behavioral health: (1) engagement in outpatient SUD treatment, (2) follow-up appointment within seven days after an inpatient hospital discharge for a mental health condition, (3) follow-up appointment within seven days after an ED visit for an SUD, (4) follow-up after a positive screening for depression, and (5) behavioral health screening or assessment for children in the foster care system.

6. Care coordination and care management

RAEs are responsible for ensuring that care coordination is available to members in alignment with the RAEs' Population Health Management Plan and the department's Population Management Framework. The care coordination activities must use a person- and family-centered approach that aligns with the members' preferences and goals. Care coordination activities are performed by contracted primary care medical providers and by care coordination staff employed by the RAE. Members enrolled in LTSS receive case management support from separate contracted case management agencies for their LTSS needs. RAEs support collaboration among all providers within locally defined Health Neighborhoods.

Colorado defines Health Neighborhoods as a network of Medicaid providers ranging from specialists, hospitals, oral health providers, LTSS providers, home health care agencies, ancillary providers, local public health agencies, and county social or human services agencies that support members' health and wellness. The contract outlines specific responsibilities including strengthening relationships among network providers and entities within the Health Neighborhood, aligning the priorities of the Health Neighborhood with those in the Population Health Management Plan, addressing barriers to providers' participation in the Health Neighborhood, sharing data, and working on referral processes and member navigation to increase efficiency and reduce use of inappropriate services. The implementation of Health Neighborhoods in New Hampshire would be an expansion of the IDNs. RAEs are required to submit a biannual Health Neighborhood and Community Report to the state.[50]

A specific focus of care coordination requirements for RAEs is providing care transition supports to people involved in the criminal justice system. In addition, RAE contracts clearly define how RAEs' care coordination activities must align with services that unique populations might be accessing, including populations with IDDs, with SUDs, and who access crisis services (see Appendix F for relevant contract requirements for the RAEs). Care management activities are reported to the department every six months.

7. Payment innovation and value

Support for care delivery improvement and innovation is a core focus for RAEs. Each RAE is required to submit an annual Practice Support Plan as part of its responsibility to improve health outcomes and increase value in its respective region. The plans must include the types of information and administrative support, provider trainings, and data and technology support offered and implemented with network

[50] Colorado Department of Health Care Policy & Financing. "Contract Amendment #11." 2022. https://hcpf.colorado.gov/sites/hcpf/files/Region%202%20-%20Northeast%20Health%20Partners%20November%202022.pdf.

providers; practice transformation strategies offered to network providers to help advance the whole-person framework and to implement the Population Management Strategy; and the administrative payment strategies used to support network providers financially and expand their capacity.[51]

In addition to practice transformation support, RAEs support statewide APMs. Colorado is implementing two APMs for primary care providers: one focused on pay for performance, and the other offering practices PMPM payments and the opportunities for shared savings. The state is also working on major hospital transformation and recently implemented a maternity bundled payment.

One of the original goals of the ACC was to avoid unnecessary and costly care, such as ED visits and inpatient hospitalizations, by having members engage with their primary care providers. The state evaluated the impact of primary care engagement on costs with the hypothesis that members who engaged with their medical home would incur lower than expected costs. Engagement was defined as having at least one visit with any primary care provider during FY 2020–2021 or FY 2021–2022. The department compared the expected per member cost in FY 2021–2022 with its observed cost. It estimated the expected annual costs for members using an assigned risk score produced by IBM that considers a member's diagnoses, eligibility category, and demographics. The analysis found that members who engaged with a primary care provider in FY 2020–2021 or FY 2021–2022 incurred lower costs than expected, estimating that those members who engaged with primary care helped the department avoid as much as $189 million in costs.[52]

8. Approach and capacity to integrate with health and human services

The regional approach to managing and coordinating services creates a focus on relationship building and systems alignment that can be tailored to a region's needs; it is more manageable than a statewide model. RAEs were not designed to increase the likelihood that beneficiary HRSN are met. However, they might increase referrals to human service providers as a result of requirements outlined in the Population Health Management Plan. As the model expands, HRSN might become a greater focus that RAEs' geographically based partnerships can address.

9. Available evidence

RAEs are held accountable for a series of key performance indicators (KPIs) focused on population health and prevention. In FY 2021–2022, the KPIs measured ED visits, behavioral health engagement, prenatal care engagement, dental visits, and well child visits.[53] As Table II.2 illustrates, RAE performance varied widely on KPI targets. For example, six of seven RAEs improved performance on ED usage by 10 percent, while only one RAE met targets for child and adolescent well visits.

[51] Colorado Department of Health Care Policy & Financing. "Northeast Health Partners Annual Practice Support Plan." 2021. https://hcpf.colorado.gov/sites/hcpf/files/ACC%20RAE%202%20FY21-22%20Practice%20Support%20Plan%20October%202021.pdf.

[52] Colorado Department of Health Care Policy & Financing. "Colorado Accountable Care Collaborative FY 2021-22." 2022. https://hcpf.colorado.gov/sites/hcpf/files/HCPF%202022%20ACC%20Implementation%20Report.pdf.

[53] Colorado Department of Health Care Policy and Financing. "HCPF 2022 Accountable Care Collaborative Implementation Report." 2022. https://hcpf.colorado.gov/sites/hcpf/files/HCPF%202022%20ACC%20Implementation%20Report.pdf.

Table II.2. KPI Performance by RAE, 12-month performance period from April 2021 to March 2022[54]

RAE	ED visits per 1,000 members per year	Behavioral health engagement[a]	Prenatal engagement[b]	Dental visits[c]	Child and adolescent well visits[d]	Well-child visits: first 15 months	Well-child visits: 15–30 months
1	495.8	21.68%	56.80%	40.40%	40.71%	69.11%	64.66%
2	599.5	14.87%	64.23%	37.43%	33.73%	64.88%	53.87%
3	538.6	17.37%	62.81%	41.28%	43.01%	68.38%	60.64%
4	460.6	17.01%	67.54%	36.74%	36.71%	61.57%	56.41%
5	600.3	20.84%	72.71%	41.95%	49.55%	70.04%	63.95%
6	460.0	18.86%	60.00%	37.50%	40.77%	62.18%	56.48%
7	595.8	17.58%	64.05%	37.19%	34.62%	59.95%	56.18%

Key:

Green = RAE improved by 5 percent or more over baseline.

Yellow = RAE improved by 10 percent or more over baseline or met the target for gap closure.

White = Did not meet a minimum of 5 percent improvement over baseline.

a. Behavioral health engagement: Percentage of members who receive at least one behavioral health service delivered in a primary care setting or under the capitated behavioral health benefit.

b. Prenatal engagement: Percentage of members who have at least one prenatal visit within 40 weeks before delivery and are Medicaid enrolled at least 30 days before delivery.

c. Dental visits: Percentage of members who receive at least one dental service (medical or dental claim).

d. Child and adolescent well visits: Percentage of child and adolescent members who have the appropriate minimum number of well visits based on their age and according to HEDIS standards. (This is a composite measure that comprises two HEDIS measures: one for children 0 to 30 months, and one for children and adolescents ages 3 to 21 years.)

10. Key considerations for a regional managed care model

- **Regional definition and ensuring sufficient patient and provider population.** Defining the regions for a regional model requires ensuring sufficient population size in each region to spread risk adequately and achieve efficiencies in administrative activities; accounting for the service regions of major health care providers, such as hospitals and health systems; accounting for preferences of the population in each region; and considering how the new regions will overlay with existing regional entities including public health regions and district offices. Achieving the number of patients needed to form a region might necessitate grouping communities that have not consolidated services historically, and where links between CBOs, providers, and other stakeholders are not as strong. To identify regions, DHHS should determine what criteria will be used to develop regions, how those criteria will be ranked, and which stakeholders outside of DHHS will be part of the conversation. DHHS should then conduct an analysis using the chosen criteria and ranking to determine one or more options for potential regions and make a final decision on regional structure.

  Based on the number of managed care plans participating in the MCM program and the population densities across New Hampshire, ***it is unlikely the state could create enough regions to balance community need with sufficient covered lives to make managing risk financially viable at a regional level.***

- **Willing model partners capable of meeting managed care federal requirements.** National managed care insurance plans might have low interest in bidding to serve rural regions and might not be the

[54] https://hcpf.colorado.gov/sites/hcpf/files/HCPF%202022%20ACC%20Implementation%20Report.pdf

preferred bidder for the state's urban areas. New entities will likely have to be created and could be developed by hospital or health care systems, FQHCs, or other provider partnerships. In addition to being willing to assume risk, these entities will need the capabilities to meet the myriad federal requirements of 42 CFR 438, including rules about network adequacy, enrollees' rights, program integrity, and quality measurement.

Our qualitative research reveals that most provider groups we talked with are not mature enough to meet federal managed care requirements and are unwilling to assume risk.

- **Short-term disruption in patient and provider contracting and relationships.** Although providers might welcome a reorientation of the MCM program into regions, in the short term, such a change will be disruptive. Providers will have to negotiate contracts with one or more new regional plans, an administratively burdensome task that might also be particularly intensive when working with a newly created health plan. Patients will be enrolled in a plan based on their region instead of having a choice between three plans. If the new regional plan does not include all of a patient's current providers, they will have to switch to providers available under the new plan.

  If a regional model is implemented, DHHS should ensure support is provided to complex and high-risk Medicaid beneficiaries and their providers to ensure continuity of care and, where appropriate, care transitions during plan enrollment.

F. Model 3: Managed FFS model

Most states organize and finance the delivery of Medicaid benefits and services through risk-based capitated arrangements with managed care companies. Some exceptions include Alabama, Connecticut, Idaho, Montana, South Dakota, and Wyoming. Connecticut's approach is described as managed FFS and is implemented through contracts with four administrative services organizations (ASOs). Mathematica focused its research on Connecticut's model because it aligns with the goals, strengths, and weaknesses of health and human services delivery in New Hampshire.

1. Core model components and alignment with strengths and weaknesses of the MCM Program

The table below summarizes (1) core components of the managed FFS model and (2) how the model builds on strengths and mitigates weaknesses of the MCM program.

Core components of the managed FFS model	
• The state manages risk and processes claims, while statewide ASOs by service area manage provider networks and provide core administrative functions. • ASOs create programmatic data, and the state uses those data to manage the program.	
Builds on strengths	**Mitigates weaknesses**
• Expertise in data and analytics positions DHHS for greater data integration enterprise-wide and to support analytics • Empowers DHHS to influence areas of oversight more directly, such as spending growth, quality performance, and service offerings	• Directs staff toward program development and oversight while ASOs handle administrative functions • Increases delivery of local care management • Could be used to implement enhanced provider payments • Reduces administrative burden for providers • Addresses critical gaps in community-based behavioral health services

- Uses stakeholder-driven planning documents, such as the 10-Year Mental Health Plan, as strategy documents for ASO activities
- Could use the closed-loop referral platform as an integrated case management solution for ASOs, DHHS, and other community providers

2. Background

The managed FFS approach in Connecticut began in 2008 when contracts with managed care entities operating in the state were terminated. At that time, the state took over certain functions that the managed care companies had been performing, including provider rate setting, PA criteria, and provider enrollment criteria. The state contracted with ASOs for member services, provider enrollment, claims processing, care management, and outreach and education. Legislative action in 2010 converted the program formally from an MCO model to an FFS model.[55]

Since 2012, Connecticut has operated a managed FFS model through contracts with three non-risk-bearing ASOs for each of three major service types—medical, behavioral health, and dental—in addition to a non-emergency medical transportation broker.[56] The managed FFS model means Connecticut uses ASOs to maintain accountability for care quality and patient and provider satisfaction, but the ASOs are not financially liable for service provision.

3. ASO responsibilities

ASOs are responsible for beneficiary support, outreach and referrals to providers, usage management, and processing grievances and appeals. The ASOs serve all Medicaid beneficiaries in Connecticut seeking their service type (those seeking any behavioral health services for the behavioral health ASO), including those also receiving services through the LTSS system. The ASO overseeing medical services, the Community Health Network of Connecticut (CHNCT), has additional responsibilities including maintaining claims data across all categories of Medicaid services, monitoring performance, and analyzing data to inform efforts to reduce costs and increase quality. This ASO has its origins as a not-for-profit organization comprised of FQHCs and was previously one of the state's managed care plans. CHNCT is also a certified Quality Improvement Organization entity, enabling Connecticut to obtain additional federal match for certain medical and quality review functions. The centralized data stream under one ASO enables the state Medicaid agency to receive accurate data quickly, and thus assess Medicaid performance more efficiently.

Beacon Health Options Connecticut (Beacon) serves as the behavioral health ASO. Beacon is responsible for organizing and integrating clinical management processes across the behavioral health payer streams, supporting access to community services, promoting practice improvement, ensuring the delivery of quality services, and preventing unnecessary institutional care. In addition, Beacon is expected to enhance

[55] Fitzpatrick, Mary, and Katherine Dwyer. "Medicaid Managed Care in Connecticut and Other States." n.d. Accessed January 24, 2023. https://www.cga.ct.gov/2015/rpt/2015-R-0010.htm.

[56] Connecticut Department of Mental Health & Addiction Services. "Department of Mental Health & Addiction Services Behavioral Health Recovery Program Intensive Case Management (ICM) Services." n.d. Accessed January 19, 2023. https://www.abhct.com/Customer-Content/WWW/CMS/files/ICM_Program_Information_Revised_Final_9420.pdf.

communication and collaboration within the behavioral health delivery system, assess network adequacy on an ongoing basis, improve the overall delivery system, and provide integrated services supporting health and recovery by working with the Connecticut Department of Social Services to recruit and retain traditional and nontraditional providers. [57]

BeneCare Dental Plans administers the dental plan for Connecticut's Medicaid program. The dental ASO has critical responsibilities to recruit and support an adequate oral health network and engage members in oral health services.

4. Financing

Under the Managed FFS model, the state pays the ASOs a fixed administrative fee and withholds a percentage of the payment that can be earned back by achieving performance targets related to health outcomes, quality, and patient and provider satisfaction. In addition, ASOs may lose the withheld percentage by failing to adhere to data reporting requirements.

5. Population health

The contract with the medical ASO in Connecticut identifies population health improvement as its primary goal. A major focus in Connecticut is connecting to and engaging in primary care. The medical ASO is required to ensure that each member has an ongoing source of primary care by helping members choose a provider or attributing a member to a medical home, if needed.

In addition, the quality improvement initiatives led by the medical ASO focus on prevention and primary care services that support population health, including cancer screening, tobacco cessation, depression screening, child and adult well visits, prenatal and postnatal care, and care for chronic conditions such as pain, diabetes, and asthma. The medical ASO is also required to improve population health by addressing challenges with HRSN including initiatives to improve members' access to healthy foods.

In 2017, the medical ASO created 73 Community Engagement Help Understanding Benefits (HUBs) in communities with the highest concentration of members. HUBs are a central location for members who need help understanding the health and community-based resources available to them. HUB sites and partners include a variety of organization types, including CBOs and local government entities. At the sites, staff assess members' social needs, provide on-the-spot resources and referrals, and connect members with immediate needs to resources (for example, to address homelessness, food insecurity, and other concerns). In 2021, the medical ASO launched a pilot closed-loop referral system with Unite Us and financing from the Connecticut Hospital Association with plans for statewide expansion.[58]

The dental ASO offers the Oral Health Navigation program and community engagement teams that work to increase oral health literacy, develop community partners, and meet member's needs. The state reports that dental service rates are higher for prevention than treatment, and the state ranks third nationally for

[57] Connecticut BHP and Beacon Health Options. "2021 CT BHP/ Beacon CT Quality Management and Clinical Program Evaluation." n.d. https://s18637.pcdn.co/wp-content/uploads/sites/53/M.3.3-2021-CT-QM-and-Clinical-Programs-Evaluation.pdf. Accessed January 24, 2023.

[58] Community Health Network of Connecticut, Inc. "Presentation to the Medical Assistance Program Oversight Council (MAPOC)." 2022. https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&%20Presentations/20220114/CHNCT%20Presentation.pdf

preventive dental care for children. The dental ASO leads member engagement campaigns each year for people who have not accessed dental services with a focus on engaging new members, pregnant women, members with type 1 diabetes, and members with end-stage renal disease.

6. Care coordination and care management

The philosophical underpinning of Connecticut's approach to care coordination and care management is that these functions should be performed in primary care settings, as well as other points of care in the service delivery system. New Hampshire stakeholders who expressed skepticism about MCOs' ability to perform care coordination and care managements functions well, would welcome a care management approach focused on primary care. Beneficiaries also reported valuing care management when they received it, and most of that care management was provided at the provider or local CBO level. The medical ASO provides the state with ongoing assistance administering the Patient Centered Medical Home Plus (PCMH+) program, including measuring access, usage, and quality of entities participating in the PCMH+ program; evaluating participating entities' performance conducting required activities to enhance care coordination and integrating with partner organizations to address HRSNs; analyzing program savings; and engaging in other activities as designated by the state.

For members with more complex needs, the medical ASO operates an Intensive Care Management (ICM) program. The state defines ICM as a comprehensive program that provides a multidisciplinary approach and patient care activities for people with significant clinical conditions or complex needs that impact their daily lives severely. These members might have one or more chronic conditions with or without co-occurring behavioral health conditions, or nonclinical circumstances that prevent them from using medically necessary care. ICM nurses work with providers and patients directly on a person-centered care plan, and community health workers help families access community resources for HRSNs, such as housing, food, and clothing assistance. Beyond ICM, the medical ASO is contractually obligated to provide transitional care management for members in acute inpatient care and receiving hospital care for chronic conditions, and to monitor follow-up care for members discharged from an inpatient setting. The behavioral health ASO operates an ICM program for people with high SUD or mental health needs.[59]

7. Payment innovation and value

The state's PCMH+ program is a shared savings and quality improvement program for eligible PCMH practices. Under this program, participating entities must provide specified enhanced care coordination activities beyond those required of PCMHs. They also have financial incentives for providing care coordination, improving the quality of care, and containing costs for their assigned members.[60]

There is evidence that Connecticut's managed FFS model resulted in lower costs of care as the state diverted funds toward clinical services and quality improvement rather than administrative, overhead, and marketing costs typically associated with MCOs.

[59] Intensive Case Management (ICM) Services. Department of Mental Health & Addiction Services Behavioral Health Recovery Program. https://www.abhct.com/Customer-Content/WWW/CMS/files/ ICM_Program_Information_Revised_Final_9420.pdf

[60] Connecticut Department of Social Services. "Medical Administrative Services Organization Request for Proposals." 2021. https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/DSS-RFPs/CT-MEDICAL-ASO-RFP-06032021.pdf.

8. Approach and capacity to integrate with health and human services

The ASO model addresses HRSNs through the creation of Community Engagement HUBs, the dental engagement teams, and a community health worker initiative. Community health workers help beneficiaries navigate the health care system while finding community resources to help meet their basic needs. In addition, the state is launching a new Community Transition Program for members recently released from correctional facilities. Through this program, the medical ASO will help eligible beneficiaries with medical and HRSN support to maximize the opportunity for a successful transition back into the community.[61] Connecticut piloted and plans to expand a closed-loop referral system.

9. Available evidence

In SFY 2017, Connecticut reduced ED usage for members engaged in the medical ASO ICM program by nearly 19 percent, inpatient admissions by more than 43 percent, and readmissions by more than 53 percent for members who received Intensive Discharge Care Management services.[62]

Connecticut's advisory council estimates that Connecticut's Medicaid program had one of the lowest medical loss ratios nationwide in FFY 2019, at 2.8 percent. A 2015 analysis found that despite increasing enrollment, Medicaid expenditures remained consistent and PMPM costs trended downward. A 2019 analysis found that the PMPM remained consistent or decreasing. However, more recent data show PMPM increasing. In the last quarter of 2022, enrollment across Connecticut Medicaid program was approximately 967,000 people with an average PMPM of $672. The state's ability to control cost growth under its ASO model provides evidence that managed care might not be necessary to constrain costs.

10. Key considerations for a managed FFS Model

- **Responsibilities for and areas of program delivery provided by ASOs.** Connecticut contracts with three ASOs and a transportation broker to administer benefits within the Medicaid program. If New Hampshire were to move to an ASO model, DHHS would need to decide how services would be organized and how many ASO contractors would be engaged. DHHS will need to assess what entities are available and interested in becoming ASOs for the state and their capabilities. DHHS will also need to determine whether to have one ASO provide a broader range of services (for example, covering the physical health and behavioral health services provided by two ASOs in Connecticut), or whether having more ASOs each specialized in a specific area would lead to better care and outcomes.

  DHHS has managed FFS programs in the past, but providing administrative services, such as call centers, is challenging for states, partly because of staffing shortages. ***Placing administrative services currently offered by MCOs into an ASO might enable DHHS to focus on program innovation and continuous quality improvement and monitoring, activities aligned with the department's strengths.***

- **Short-term disruption in provider contracting and relationships.** Transitioning from MCOs to ASOs might disrupt the provider contracting and relationships in the short term, because providers (1) will no longer contract with MCOs, (2) will receive FFS payment for rendered services from DHHS,

[61] Connecticut Department of Social Services. "Medical Administrative Services Organization Request for Proposals." 2021. https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/DSS-RFPs/CT-MEDICAL-ASO-RFP-06032021.pdf

[62] Connecticut Department of Social Services. 2018. "Five Key Points About Connecticut HUSKY Health (Medicaid and CHIP)." https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Communications/HUSKY-Health---Five-Key-Points.pdf

and (3) need to establish new relationships with the ASO entities. Because a transition away from a capitated managed care model would shift some roles and responsibilities that are currently performed by the MCOs back to DHHS and ASOs, ***DHHS will need to keep providers informed and aware of the shifting responsibilities within this model.***

- **Although providers would likely welcome a transition back to FFS, timing of such a change would be critical.** Some New Hampshire providers reported being understaffed, suffering workforce shortages, and still working to recover from the public health emergency. Implementing a delivery system change now or during a similarly intense time might push some providers beyond their ability to manage change.

  DHHS should use the post-pandemic recovery period to explore how providers would view a managed FFS program and what supports they would need to do so effectively.

- **Impact to Medicaid expansion financing.** Because New Hampshire funds the non-federal portion of its Medicaid expansion by collecting taxes on the MCOs, DHHS ***would likely need to face the barrier of finding a new financing mechanism for expansion coverage*.**[63]

[63] New Hampshire Fiscal Policy Institute. "The Effects of Medicaid Expansion in New Hampshire." New Hampshire Fiscal Policy Institute. January 17, 2023. https://nhfpi.org/resource/the-effects-of-medicaid-expansion-in-new-hampshire/

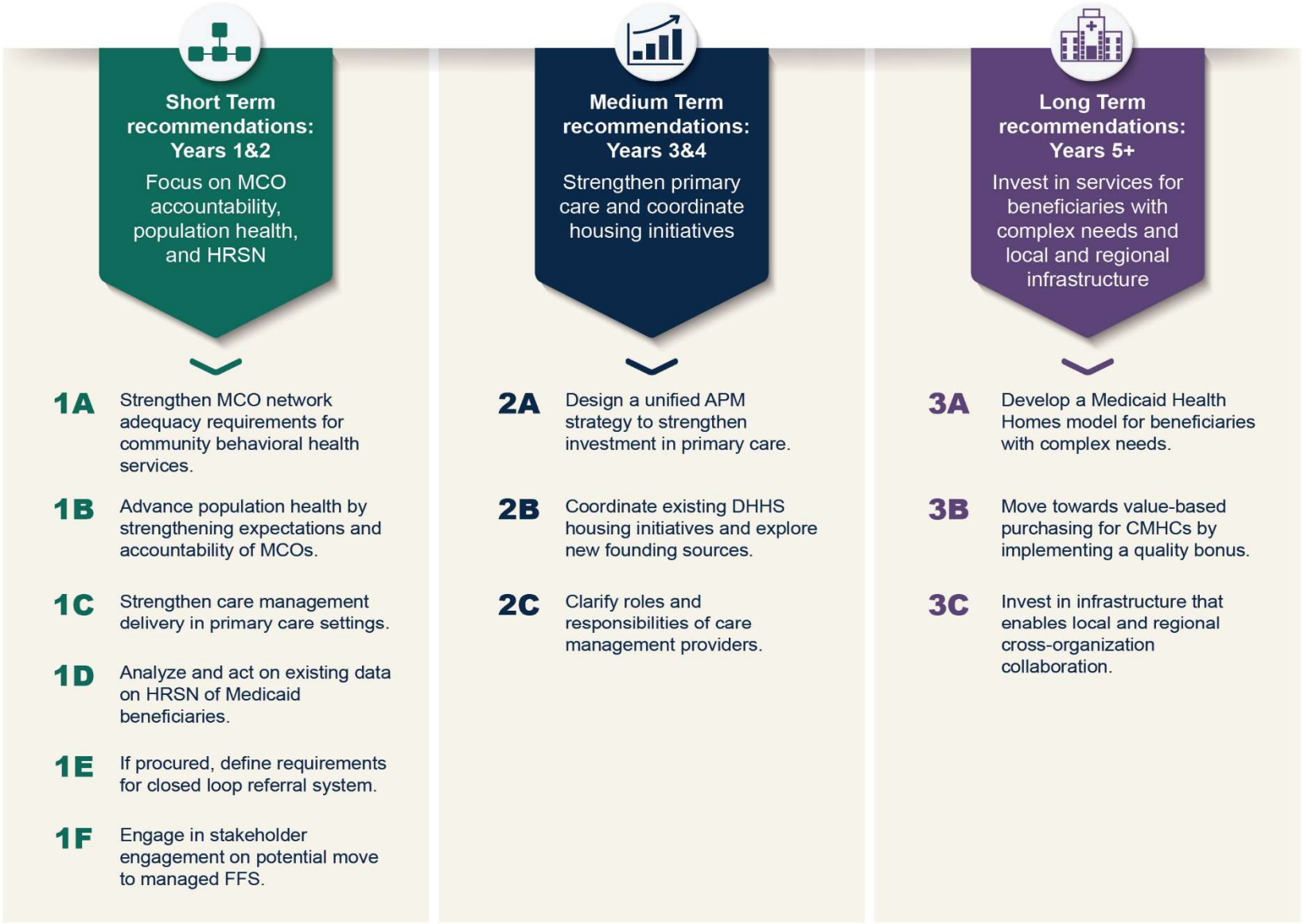
III. Recommendations

Mathematica recommends New Hampshire maintain the current MCM program and make improvements. As most innovations to the MCM program have been designed to push MCOs further, DHHS will need to be precise and prescriptive with the MCOs by establishing goals related to increases in preventive care, value, cost-effectiveness, and enhanced service delivery.

Based upon the available evidence, expertise, and stakeholder input provided, there is not one best or clearly superior model for delivering Medicaid and other health and human services to beneficiaries. Therefore, if, during the oversight and management of the MCOs, DHHS determines that the state's goals cannot be achieved through that delivery model, we recommend that DHHS explore adopting a managed FFS model, beginning with the identification of an alternative source of funding for its Medicaid expansion program. A managed FFS model has the potential to be cost-effective, return greater control to DHHS in driving program outcomes, and should be feasible to implement in the state. In contrast, New Hampshire's provider community does not seem ready and willing to take on the responsibilities and risk necessary for a provider ACO model, and a regional managed care model would be difficult or impossible to achieve given the need to attract entities willing to bear the risk of serving a single region of the state. Mathematica believes that a managed FFS model, if properly implemented and aligned to the state's provider system, has the potential to be a model that can achieve strong results in the state of New Hampshire.

In this section, we provide recommendations that incorporate best practices from other states that are effective and feasible for DHHS to integrate into the current system. These recommendations position DHHS to continue improving the MCM program or to pivot to a managed FFS program. We have broken recommendations into three time periods for implementation—short term (one to two years), medium term (three to four years), and long term (five or more years)–as displayed in Figure III.1. Implementing these recommendations should be prioritized against DHHS's current and planned activities, many of which are listed in Appendix D.

Figure III.1. Proposed time frame for implementing recommendations



1. Short-term recommendations (Years 1 and 2)

1A. Strengthen MCO network adequacy requirements for community-based behavioral health services.

DHHS should bolster contract requirements on network adequacy for community-based behavioral health services and build DHHS's capacity to monitor compliance. As discussed, stakeholders interviewed for this report cited poor access to community-based services as a factor in the state's ED boarding issues. In addition, beneficiaries noted difficulties accessing community behavioral health services. DHHS could (1) require the MCO to include a specific percentage of all mental health and SUD providers in the state within the network (the current contracts only include time and distance requirements as opposed to a target percentage of providers) and (2) increase participation requirements for specific types of providers (for example, MCOs are currently required to contract with at least 50 percent of residential SUD providers in the state). Partial hospitalization programs do not explicitly define requirements for network adequacy and those definitions can be added. Changing network adequacy standards might encourage and incentivize MCOs to create services, such as respite and drop-in centers, that could help fill gaps in care.

Many of the beneficiaries offered positive feedback about using telehealth to access services. DHHS should clearly define telehealth's role in network adequacy for behavioral health care. DHHS can look to an emerging model from Medicare for how to incorporate telehealth into network adequacy standards. Starting in 2021, Medicare Advantage and Part D plans that contract with telehealth providers for certain specialties (including psychiatry) receive a "credit" toward meeting Medicare Advantage's time and distance standards. When defining how telehealth can be used to meet network adequacy, it will be important to avoid substituting telehealth for services that are better delivered in person.

1B. Advance population health by strengthening expectations and accountability of MCOs.

We recommend DHHS use MCM 3.0 to advance disease prevention and population health. DHHS should include contract requirements for MCOs to develop a population health management strategy that promotes well-being and disease prevention, with a strong focus on addressing HRSN and reducing disparities within New Hampshire's Medicaid population. States such as Colorado, Ohio, and Minnesota have adopted similar contract requirements for MCOs, and as discussed, Rhode Island requires the ACOs to develop a population health and HRSN assessment.[64] As part of the population health strategy, DHHS should encourage MCOs to work with their stratified quality measure performance rates by demographic indicators such as race, ethnicity, urban or rural location, language, and disability status to identify disparities, to develop and implement specific strategies that reduce identified disparities and improve the health of the population. DHHS could also consider requiring MCOs to dedicate or designate health plan staff to lead the development of their population health efforts and include such staff as key personnel or other required staff in the MCM contract.

1C. Strengthen care management delivery in primary care settings.

For Medicaid beneficiaries with uncomplicated care needs who receive most of their care in ambulatory settings, care management is often best delivered through primary care practices. Some New Hampshire

[64] Bailit Health. "Medicaid Managed Care Contract Language: Health Disparities and Health Equity." State Health & Value Strategies, 2021. https://www.shvs.org/wp-content/uploads/2021/02/SHVS-MCO-Contract-Language-Healthy-Equity-and-Disparities_February-2021.pdf

stakeholders indicated that care coordination and care management is happening at the provider level today, but a systematic approach or defined set of standards is not currently in place, and practices have varying levels of capacity to provide these services. Given that MCOs have not been able to implement the local care management requirements originally included in MCM 2.0, DHHS should take a more prescriptive approach to adopting and implementing a care management delivery model for primary care settings.

In Mathematica's review and assessment of the three alternative models, all three models include a state-defined and prescriptive approach for delivering care coordination and care management at the provider level. Connecticut and Rhode Island use a PCMH model, and more than two dozen states require or incentivize PCMHs to be recognized by the National Committee for Quality Assurance (NCQA).[65] DHHS can elect to include contract provisions as part of MCM 3.0 that encourage, incentivize, or require MCOs to support and implement PCMHs or another defined model of care. In addition, DHHS could use the future encounter notification system as an exchange mechanism that uses standard formats, such as Fast Healthcare Interoperability Resources-based care coordination documents, to move data on patients from one care team or provider to another. In the long term, strengthening the delivery of care management in the primary care setting is foundational.

1D. Analyze and act on existing data on HRSN of Medicaid beneficiaries.

The current MCO contract requires health plans to submit data to DHHS after completing health risk assessments for their beneficiaries.[66] However, they are not required to submit the results of that screening (the information on Medicaid beneficiaries HRSNs) itself. DHHS should (1) add a requirement for the MCOs to submit these data, (2) design a standardized format and process for doing so, and (3) integrate these data with other data sources to improve analyses. DHHS should also ensure that data collected from the integrated eligibility system and the closed-loop referral system are available for analyses within the enterprise data warehouse. This approach will help DHHS conduct analytics across Medicaid, SNAP, WIC, TANF, and DCYF data to gain a more comprehensive view of the needs of the population DHHS serves.

1E. If procured, define requirements in managed care contracts for the use of the closed-loop referral system.

DHHS should ensure the MCOs have a seat at the table during the design and implementation of the closed-loop referral system. MCOs should also be contractually required to use the closed-loop referral system for any social or community service. We recommend MCOs using the system (1) use a standardized social risk or needs assessment tool, (2) use the closed-loop referral system to make referrals for members related to HRSNs, unless the beneficiary does not consent, and (3) require any contracted entities that provide care management services to their enrolled Medicaid beneficiaries to use the closed-loop referral system. As the system is still a concept, DHHS could also use placeholder language in the

[65] NCQA "Resource Directory of Incentives for NCQA Recognition." n.d. https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/benefits-support/payer-support/directory/. Accessed January 24, 2023.

[66] According to the New Hampshire Medicaid Quality website, the rate of "successful completion of MCO Health Risk Assessment" increased from 14.0 percent in September 2021 to 19.7 percent in September 2022. Although the statewide average is below the contract requirement (25.0 percent), New Hampshire could begin analyzing data for nearly 45,000 Medicaid managed care enrollees to identify the most common health and social risks to set priorities for future investments.

MCO contract indicating that MCOs will be required to implement closed-loop referral requirements once the system is operational.

1F. Engage stakeholders in a discussion about migrating to managed FFS.

Backing away from managed care and returning to FFS would impact a broad array of New Hampshire stakeholders, most importantly Medicaid beneficiaries and providers serving the Medicaid population. Before determining the future of the state's Medicaid delivery system, DHHS should engage in extensive stakeholder engagement across New Hampshire. We recommend DHHS hold town hall style meetings with the public, as well as listening sessions with stakeholders such as physicians, hospitals, and CBOs that help people enroll in Medicaid. During this time, in addition to gathering feedback on support or concerns for this type of change, DHHS should start discussions with CMS and managed FFS states, such as Connecticut, to prepare for a potential transition.

2. Medium-term recommendations (Years 3 and 4)

2A. Design a unified APM strategy to strengthen investment in primary care.

DHHS should develop and require all MCOs to use a uniform APM focused on primary care.[67] Requiring MCOs to use a uniform APM of this type will acclimate primary care providers to a value-based care model that can be used under a new delivery system. It will also support increased investment in primary care, incentivize greater use of underused preventive care, address HRSN for Medicaid beneficiaries, and increase the potential for overall savings and better population health outcomes. States such as Ohio, Tennessee, and Washington have pursued unified primary care APMs that have standard requirements across MCOs.[68] In addition to supporting primary care, requiring the MCOs to use the same payment methods and quality measures ensures "all boats are rowing in the same direction," streamlines provider reporting, and reduces administrative burden.

> "Primary care should be affordable, accessible, and should be the most robust feature of the program."
>
> —Stakeholder

Developing a unified primary care APM involves defining goals related to primary care; determining provider types that should be engaged in the APM model; consulting with and securing buy-in from MCOs and targeted providers on the payment model, the quality metrics, performance rates that qualify for bonuses, and monitoring and reporting requirements; and defining how the arrangement will align with other APMs that are operational today. DHHS should consider raising payment levels for the providers or services included in the APM, and can use state-directed payments allowable under

[67] To require MCOs to use the same APM model, DHHS must submit a state-directed payment (SDP) application and obtain CMS's approval to ensure the payment arrangement complies with federal requirements that the SDP be linked to service use, relate to quality or access goals in DHHS's Medicaid Quality Strategy, and be financed with allowable non-federal funding sources.

Centers for Medicare & Medicaid Services. "State Directed Payments | Medicaid." n.d. https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/index.html. Accessed January 19, 2023.

[68] Center for Health Care Strategies. "Advancing Primary Care Innovation in Medicaid Managed Care: Using State Levers to Drive Uptake and Spread." 2022. https://www.chcs.org/media/PCI-Toolkit-Part-2-Update_081622.pdf#page=8.

42CFR438(6)(c) and MCO contract provisions to ensure costs of such services are incorporated into MCO rates and MCOs are compelled to pass that funding onto primary care providers.

2B. Coordinate existing DHHS housing initiatives and explore new funding sources.

Beneficiaries and other stakeholders frequently cited access to affordable or supportive housing as an unmet need of New Hampshire's Medicaid beneficiaries. Given the scale of the housing need, as well as progress through DHHS efforts to date, including adding the new supportive housing benefit, DHHS should prioritize efforts to address housing needs. To increase the effectiveness and impact of DHHS's work on housing in the short term, DHHS should (1) identify all current supportive housing initiatives and services provided across the department, (2) communicate the landscape of these initiatives to all divisions, and (3) develop better coordination mechanisms across these divisions.

In the medium to long term, to increase the impact of DHHS's efforts, the department should pursue innovative sources of additional financial resources to develop new affordable or supportive housing and to provide beneficiaries with housing support services.

State profile: Arizona's Housing and Health Opportunities Demonstration

Arizona Health Cost Containment System Housing received approval in fall 2022 to provide housing services through its Housing and Health Opportunities Demonstration, under an amendment to its 1115 Waiver.

- Eligible beneficiaries are those experiencing homelessness or at risk of being homeless as defined by the U.S. Department of Housing and Urban Development.
- Groups of interest include young adults who have aged out of foster care, people with an SMI or behavioral health needs, and those determined to be high risk based on service use or health history.
- Services provided will cover the continuum for obtaining and keeping housing, including care management, financial support to obtain housing, and support services to maintain housing. The following list details all planned services:
  - Outreach services that connect with eligible members, improve screening and discharge coordination with care management and educational services, develop discharge and care plans, establish linkages to other systems, and enhance data support to connect data across systems, using a closed-loop referral system
  - Funding for short-term transitional housing, financial assistance for move-in expenses, and eviction-prevention services
  - Home modification services and pre-tenancy and tenancy supportive services, to ensure housing stability
- Arizona's MCOs will be required to (1) ensure members are assessed for housing needs and have access to services in the least restrictive community environment; (2) support coordination of referrals, housing placement, and post-housing wraparound services; and (3) provide closed-loop referrals to additional human services and community-based organizations to provide a full set of social support services in addition to housing services.◢

Federal funds for HRSNs are available through Medicaid 1115(a) and 1915(b) in lieu of services and settings (ILOS) waivers. Under Medicaid Section 1115(a) demonstration waivers, states have opportunities to pursue federal funding to pay for services that address HRSN that would not typically be allowable Medicaid expenses, such as short-term rental assistance and capacity investments in IT, workforce development, and stakeholder convening. States must ensure that such investments have

proven to be cost-effective, and must raise payment rates for primary care, behavioral health, and obstetrics services if they are below 80 percent of Medicare rates. As with all Section 1115(a) demonstrations, states must comply with numerous reporting and evaluation requirements. Given that beneficiaries and stakeholders most frequently identified affordable housing as the biggest unmet need among New Hampshire Medicaid beneficiaries, Mathematica reviewed Arizona's recent 1115(a) waiver focused on housing services. Arizona's approach is summarized in the box describing Arizona's Housing and Health Opportunities and in Appendix E.

In addition to Medicaid 1115(a) authorities, states with Medicaid managed care programs can provide services to address HRSN using ILOS.[69] This option allows MCOs to provide less expensive services, such as medically tailored meals, that substitute for state plan-covered services or can be shown to reduce or prevent the need for more expensive care. The ILOS option requires states and actuaries to estimate ILOS spending as a share of total Medicaid managed care expenditures, and states proposing to spend 1.5 percent or less on ILOS will be subject to streamlined monitoring and evaluation.

2C. Clarify roles and responsibilities of care management providers.

DHHS should define (1) the roles and functions of each entity in providing care management, (2) the range of services that will be coordinated, (3) standards and certification requirements for care management agencies, (4) criteria for identifying which beneficiaries are eligible for care management by tier or level of need, and (5) procedures for referring beneficiaries for care management. DHHS should also consider how to support all responsible entities with data sharing tools and analytic assistance to help them understand performance and how to coordinate care outreach to members, and identify gaps in care. Lastly, DHHS should develop a monitoring and evaluation plan that assesses the effectiveness of the overall care management system by tying enrollment in care management with specific quality, access, and health outcomes.

3. Long-term recommendations (Year 5 and later)

3A. Develop a Medicaid Health Homes model for beneficiaries with complex needs.

To expand the availability and strengthen the quality of care management services provided to Medicaid MCO enrollees, we recommend DHHS develop and implement a Medicaid Health Home program, a state benefit plan option available since 2011 (SSA §1945 State Plan Option).[70] This model (which may also be implemented as part of a managed FFS delivery system) provides intensive care management to Medicaid beneficiaries with one or more chronic health conditions, or a serious and persistent mental health condition.[71] Medicaid health homes coordinate care across the full spectrum of health, behavioral health, LTSS, and human services systems and typically have multidisciplinary care teams and high case manager-to-beneficiary ratios that ensure frequent, person-centered engagement. Qualified Medicaid Health Home providers must provide six core services: (1) comprehensive care management, (2) care coordination, (3) health promotion, (4) transitional care, (5) patient and family support, and (6) referral to

[69] Tsai, Daniel. "Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care." SMD#23-001. Centers for Medicare & Medicaid Services, January 4, 2023. https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf

[70] Medicaid health home programs currently operate in 18 states and the District of Columbia.

[71] A new Medicaid health home option became available in 2019 that allows states to establish health homes for children with medically complex conditions.

community and social support services. The program can be designed to operate within the existing managed care program to avoid duplicating services and payment, as Washington State's Medicaid Health Homes program does. Or DHHS can carve this service out of managed care benefits entirely and pay qualified providers FFS rates or PMPM payments for a bundle of care management services, adjusted for acuity.

Evaluations of the Medicaid health home program demonstrate its effectiveness in improving care management, care transitions, behavioral health integration, and connecting enrollees to human services to address HRSN. They also help to reduce unnecessary ED visits and hospital inpatient admissions, lower costs, and improve quality.[72] In addition to its proven effectiveness, there are several advantages to adopting a Medicaid health home program. States are eligible to receive a 90 percent enhanced Federal Medical Assistance Percentage for the first eight quarters of the program, if the services meet the definitions specified in federal statute.[73] States have flexibility to determine which entities are eligible to be health home providers.[74] Consequently, DHHS can certify existing providers, clinics, CMHCs, and other entities as Medicaid health homes if they can carry out the six core functions and meet state certification requirements. This means New Hampshire can designate Health Home providers for the priority population groups specified in the MCM contract, based on their experience providing care management through (1) CMHCs for people with serious and persistent mental illness, (2) area agencies and HCBS waiver programs for people who use long-term care in home and community settings, (3) primary care practices for people with multiple chronic health conditions, and (4) pediatric specialty practices for children with medically complex conditions.

The Medicaid health home option can be designed to complement an existing managed care program in ways that avoid duplicating services and payment to health homes providers and MCOs. For example, New York's Medicaid program has operated Health Homes within its MCO program and established a set of standards and requirements for Health Homes, care management agencies, and MCOs. These standards clarify the roles and responsibilities of each of these entities in providing services for MCO members with SMI, children with special health care needs, and beneficiaries with SUD and developmental disabilities.[75] New York adjusts capitation rates paid to MCOs to account for Health Home services and administrative costs, and all Health Home services are billed to the member's Medicaid MCOs. (The plans may not charge additional administrative fees to the Health Home providers.)

Nationally standardized quality measures for Medicaid health homes are a mix of process and expected outcomes of intensive care management that must be reported annually. They avoid the need for New Hampshire to establish its own quality measures and allows DHHS to compare its performance rates with those of other states with Health Homes programs serving the same focus populations.

[72] Office of the Assistant Secretary for Planning and Evaluation. "Report to Congress on the Medicaid Health Home State Plan Option." U.S. U.S. Department of Health and Human Services. May 2018. https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/medicaidhomehealthstateplanoptionrtc.pdf

[73] The enhanced match does not apply to regular Medicaid services provided to people enrolled in a health home.

[74] Health Home providers might be (1) physicians, clinical or group practices, community health clinics, CMHCs, or home health agencies; (2) a team of health professionals, including physicians, nurse care coordinators, nutritionists, social workers, and behavioral health professionals in one or multiple locations; or (3) a broader multidisciplinary health team.

[75] See https://health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf.

To adopt this state plan benefit, DHHS would need to prepare a state plan amendment. Before engaging a third-party for assistance with this process, Mathematica recommends DHHS engage CMS for guidance and no-cost technical assistance in designing a Health Homes program and submitting all required documentation.

3B. Move toward value-based purchasing (VBP) for CMHCs by implementing a quality bonus.

DHHS should adopt elements of VBP incrementally for these providers, starting with structuring the payment model to include quality bonus payments (QBPs) tied to performance on quality measures. In the Certified Community Behavioral Health Clinic Demonstration (CCBHC) demonstration, some states use relatively simple quality bonus payment structures with few measures while others are much more complex (see Appendix B, Table B.37, of the CCBHC evaluation report for a summary of QBP structures). For example, some states were awarded QBPs if performance on the measures met or exceeded state or national averages. Other states specified targets for particular measures (for example, a minimum 10 percent improvement toward a specified goal) or required CCBHCs to improve from year to year without a specified target. States also varied in how they tied measure performance to the amount of the QBPs. Some states created a sliding scale whereby the lowest scoring CCBHC received no payment and the highest scoring CCBHC received the maximum payment for a particular measure. Some states also tied the amount of QBPs to the magnitude of improvement on a measure.

The measures that showed the most improvement during the CCBHC demonstration were those that clinics could directly impact (for example, suicide screening, tobacco and alcohol screening, depression remission, time to initial evaluation). HEDIS or other state-level measures were not originally intended for provider-level reporting or accountability. DHHS should start by selecting a few measures CMHCs could impact, potentially prioritizing measures with good historical data on which to base performance targets. DHHS should adjust performance targets and layer additional measures as the payment system matures.

Part of that maturity could include aligning the incentives of CMHCs with hospitals and allowing other providers to share in the QBPs. In the CCBHC demonstration, hospitals or other community providers did not share in the QBPs. Therefore, they did not have a direct financial incentive to invest in partnerships with CCBHCs. These types of partnerships are necessary to impact system-level measures, such as follow-up after ED visits for mental health or SUD, or follow-up after discharge from hospitalization. Although the SMI Innovations Project in Pennsylvania is nearly a decade old, it provides a good example of how the state, health plans, and CMHCs worked together to select measures that aligned incentives to improve care for people with SMI and had a positive impact on ED visits and hospitalization rates.[76] However, expanding VBP to other behavioral health providers or shared accountability models is a long-term endeavor. More advanced VBP models also could incorporate financial penalties or risk in addition to QBPs as behavioral health providers gain experience with VBP.

3C. Invest in infrastructure that enables local and regional cross-organization collaboration.

Building off DHHS's past efforts and investments through DSRIP, the department should support local

[76] Mathematica Policy Research. "SMI Innovations Project in Pennsylvania: Final Evaluation Report." October 2012. http://www.chcs.org/media/Mathematica-RCP-FinalReport-2012.pdf.

investments in critical infrastructure that enables cross-organization collaboration, including health IT, health workforce capacity, and care coordination teams. These partnerships could be designed in the spirit of Colorado's Health Neighborhoods and Rhode Island's Health Equity Zones. Long-term integration of health and human services requires regional and local agencies to coordinate care across providers, settings, and agencies by developing new partnerships, increasing the use of HRSN screening, and improving information exchange. DHHS should engage current and former regional entities, such as IDNs, regional public health networks, DCYF offices, Aging and Disability Resource Centers, mobile crisis response teams, primary care practices, FQHCs, and other clinics, and assess their readiness to lead care integration and coordination, either individually or as a larger local partnership.

Appendix A

Summary of Community Engagement Activities

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Understanding the lived experiences of those that offer and use Medicaid and health and human services is critical to understanding current program operations and assessing opportunities for improvement. We sought to obtain the perspectives of a range of invested Granite Staters through conversations with beneficiaries, family members and caregivers, frontline staff, and staff from advocacy and service organizations.

We pursued three sets of data collection activities for this task: individual interviews with beneficiaries and their families across the state and virtually, interviews with health and human service providers and other community representatives, interviews with representatives from the three current Medicaid MCOs, and interviews with DHHS staff from across a range of divisions and bureaus.

Interviews with beneficiaries

Approach. Mathematica asked a diverse group of New Hampshire Medicaid beneficiaries to share their experiences accessing Medicaid and other human services through DHHS programs. The team aimed to interview at least 60 beneficiaries and to complete at least 45 of the interviews in-person.

In collaboration with DHHS, the team identified two strategies for recruitment: (1) engaging beneficiaries through DHHS District Offices, and (2) working with CBOs to meet beneficiaries who may not often visit District Offices in-person. Together with DHHS staff, Mathematica identified priority populations for interviews—including people receiving behavioral health services, who are housing insecure, parents of children who have complex medical conditions, and who have limited English language proficiency (LEP)—whom we engaged through CBOs. Based on this strategy, the team conducted two in-person, week-long participant engagement trips (November 14-18 and December 5-9) across New Hampshire in order to engage beneficiaries who were currently accessing DHHS programs. We supplemented our in-person recruitment by working with two CBOs to recruit beneficiaries for virtual interviews. As beneficiaries interviewed were not selected through a random sample, their opinions and feedback may not be representative of all New Hampshire beneficiaries.

During the first in-person trip, Mathematica visited five DHHS District Offices (Concord, Keene, Littleton, Manchester, and Rochester) to engage beneficiaries with varied backgrounds visiting their District Office for a variety of reasons. In total, we recruited 41 participants, including people applying for benefits for the first time; beneficiaries visiting an office to submit documentation, ask routine questions, or address benefits-related problems; and beneficiaries involved with the Division for Children, Youth and Families (DCYF) as foster parents, birth parents, or guardians of justice-involved youth.

During our second trip, we visited four community-based locations (Cross Roads House in Portsmouth, H.E.A.R.T.S Peer Support Center of Greater Nashua, NeighborWorks in Manchester, and White Horse Recovery in Center Ossipee) and recruited 28 participants, including individuals receiving BH services, those who are housing insecure, parents of children who have complex medical conditions, and individuals with LEP. To engage LEP beneficiaries, we partnered with Manchester's Public Health and Safety Team (PHAST) Program to recruit members of Bhutan and the Democratic Republic of Congo refugee community for interviews at NeighborWorks. To conduct the interviews with people who do not speak English, we contracted with interpreters from Language Bank who spoke Nepalese, Spanish, and Swahili.

Mathematica interviewed a total of 60 Medicaid beneficiaries and 9 individuals eligible for Medicaid but not currently enrolled. Fifty-two of these interviews were completed in person and 17 were conducted virtually by phone or through a video-conferencing platform (i.e., WebEx). All participants provided consent to participate and were compensated for their time with a $100 gift card. See **Table A.1** below for a breakdown of our evaluation participants by recruitment strategy, recruitment entity, and sample size.

Table A.1. New Hampshire Medicaid Systems evaluation sample recruitment entity and size

Recruitment strategy	Recruitment entity	Total sample	In-person interviews	Virtual interviews
Beneficiaries interacting with their local DHHS District Office	Concord DHHS District Office	9	7	2
	Keene DHHS District Office	11	9	2
	Littleton DHHS District Office	7	5	2
	Manchester DHHS District Office	7	4	3
	Rochester DHHS District Office	7	5	2
Receiving behavioral health services	H.E.A.R.T.S. Peer Support Center of Greater Nashua	3	3	0
	National Alliance on Mental Illness (NAMI)	4	0	4
	White Horse Recovery	6	6	0
Who are housing insecure	Cross Roads House	7	7	0
Parents of children with complex medical conditions	Council for Youths with Chronic Conditions (CYCC)	2	0	2
With limited English proficiency	NeighborWorks Southern New Hampshire[a]	6	6	0
Total beneficiaries engaged		**69**	**52**	**17**

[a] Manchester's Public Health and Safety Team (PHAST) Program aided in the recruitment of participants with LEP.

Protocol. In collaboration with DHHS, we iteratively developed a semi-structured beneficiary interview protocol designed to encourage beneficiaries to share anecdotes about how they utilize services provided through Medicaid, other health and human services programs, and local CBOs to meet their health and human service needs. Our protocol consisted of a consent protocol to explain the purpose of our research and open-ended questions and probes that asked individuals to share their experiences with state-funded human services, medical services, MCOs, and care management and care coordination. Within each of these topical sections, we prompted beneficiaries to detail their perceptions of the availability and accessibility of medical and human services, to describe how services are accessed, to assess service quality, and to provide suggestions for service delivery improvements. All materials were translated into Nepalese, Spanish, and Swahili to facilitate interviews with beneficiaries with LEP.

Analysis. We used two types of analyses for the data collected through beneficiary interviews. First, we coded responses to open-ended questions into broad categories of themes. Second, we calculated descriptive statistics (means, percentages, and counts) to describe responses. We further examined these descriptive statistics by respondent type to observe differences across perspectives. Table A.3 provides a thematic summary of key findings.

Limitations. While we interviewed a diverse group of Medicaid beneficiaries, our sample may not represent all current and potential beneficiaries of NH DHHS programs. Our recruitment strategy primarily involved engaging participants who visited District Offices or who received services from specific CBOs, most of which provide behavioral health or housing services. Therefore, we may have under sampled eligible individuals who face barriers to visiting District Offices in-person, such as those with physical disabilities or limited transportation options, as well as those who are not regularly engaging with CBOs in-person. We also did not intentionally recruit individuals receiving home- and community-based services (HCBS) or individuals residing in facilities, given several other recent reports and current focus on the needs of these populations. Finally, we conducted recruitment during the middle of the day, which may have led to an under sampling of individuals who work within regular business hours, including those beneficiaries enrolled in Medicaid for Employed Adults with Disabilities (MEAD) and Medicaid for Employed Older Adults with Disabilities (MOAD).

Summary of beneficiary interviews

Table A.2 below summarizes demographic characteristics of the 69 individuals interviewed about New Hampshire's Health and Human Services system. A majority of the 69 participants were female (n=52), non-elderly (n=60), English-speaking (n=61), and are parents (n=40).

Table A.2. New Hampshire beneficiary participant characteristics (n=69)

Item	Category	Count	Percentage
Gender [a]	Female	52	75%
	Male	17	25%
Age	Non-Elderly	60	87%
	Elderly [b]	9	13%
Language [c]	English	61	88%
	Spanish	3	4%
	Swahili	3	4%
	Nepalese	2	3%
County of Residence [d]	Hillsborough County	15	22%
	Merrimack County	12	17%
	Cheshire County	10	14%
	Rockingham County	9	13%
	Carroll County	8	12%
	Strafford County	7	10%
	Grafton County	6	9%
	Belknap County	1	1%
	Coos County	1	1%
Participant Status	Beneficiary [e]	43	62%
	Beneficiary and Caretaker	22	32%
	Caretaker [f]	4	6%
Disability Status	Not Disabled	53	77%
	Disabled [g]	16	23%

Item	Category	Count	Percentage
Parental Status	Parent [h]	40	58%
	Non-Parent	29	42%
Beneficiary who Speaks about Child Medicaid Experience [i]	No	54	78%
	Yes	15	22%
Medicaid Coverage	Has Medicaid Coverage	60	87%
Medicaid Health Plan [j]	WellSense	28	38%
	NH Healthy Families	17	23%
	Amerihealth Caritas	6	8%
	Unidentified Medicaid Plan	13	18%
	No Medicaid coverage	9	12%
Medicare Coverage	Dually Eligible	14	20%
	Medicare-only	5	7%
Other Insurance	Private (two individuals are dually eligible with Medicaid)	4	6%
	VA (dually eligible with Medicaid)	1	1%
	Uninsured	2	3%

Source: Mathematica New Hampshire Medicaid System Evaluation beneficiary primary data collection.

[a] Gender identified using the voice of the participant from the interview recording.

[b] Elderly refers to a participant who explicitly shares that they are elderly, have Medicare coverage due to their age, or are dually eligible; otherwise, the participant is labeled as Non-Elderly.

[c] Language refers to the language spoken by the participant during the interview.

[d] County of Residence refers to the county where a participant resides, collected as part of the mailing address to which incentives are sent.

[e] Beneficiary refers to a participant who receives state-funded health and human services (e.g., Medicaid, Medicare, food assistance).

[f] Caretaker refers to a participant who provides care for a parent, child, or other family member; they may also be labeled as a Beneficiary.

[g] Disabled refers to a participant explicitly shared that they are disabled or dually eligible due to disability; otherwise, they are labeled as Not Disabled.

[h] Parent refers to a participant who is a parent and has shared their parental status either explicitly or implicitly (e.g., granddaughter helping them answer interview questions); otherwise labeled as a Non-Parent.

[i] Beneficiary who Speaks about Child Medicaid Experience: Yes refers to a participant who speaks about their child(ren), who is enrolled in Medicaid; No refers to a participant who does not speak about this topic, whether they are a parent or not.

[j] Four participants spoke about their Medicaid health plan experience and that of their children, with their children having different plans. As a result, the total count for this Medicaid Health Plan section, as well as the denominator for the corresponding percentages, is 73.

Overall experience with the Health and Human Services system

Table A.3 below summarizes beneficiaries overall experience engaging with New Hampshire's Health and Human Service Delivery System as well as key themes regarding beneficiary's experience with healthcare services specifically. Further below, Table A.4 provides more detailed beneficiary feedback on specific health and human services, organized by positive/natural feedback and constructive feedback.

Table A.3. Summary of beneficiary interview themes

Topic	Summary of beneficiary feedback
Engaging with DHHS	• 29 people discussed that it was difficult to get or maintain Medicaid benefits. Reasons included paperwork needed to establish eligibility, quick turnaround times on requests for information during redeterminations, and that the income thresholds were not high enough. Beneficiaries suggested that DHHS should look to streamline their documentation requests, reduce documentation requests, and align the timing of redeterminations for DHHS benefits, to prevent multiple redetermination cycles. Three beneficiaries emphasized that DHHS needed to react faster in emergency situations, to help get people benefits quickly during a crisis. • 11 people discussed how the income threshold for Medicaid was not high enough, citing examples of struggling families who did not have enough money yet made "too much" money for Medicaid. • Eight people suggested that DHHS could do a better job helping beneficiaries with system navigation and to understand what the available benefits are and who qualifies for them. Seven beneficiaries mentioned wishing they had a point person at either DHHS or their health plan to go to when they had questions. • Nine beneficiaries mentioned they felt DHHS was understaffed and needed more workers.
Engaging with Healthcare Services	• Behavioral health services are both unavailable and difficult to access. Of the 32 people interviewed who use behavioral services, 21 people discussed how behavioral health services are difficult to access (e.g., not enough providers, long wait times, denials for service) and suggested improvements, such as a bigger network, more support for providers entering the field, expanding telehealth for behavioral health services, and more education from the plan about covered behavioral health services. • Participants reported dental services were unavailable within Medicaid. 11 people mentioned the lack of dental coverage. • Several beneficiaries travel out of state for healthcare. Thirteen people discussed going out of state for care, most often Boston/Massachusetts. Participants received care out of state due to specialty coverage (n=8) and convenience from their location (n=5). Nine people talked about traveling far distances to receive needed care. • Dually eligible individuals (n =14), as compared to people with Medicaid only (n =44), were more likely to say that basic health care is difficult to access (50% vs. 36%), that they had to wait for appointments (50% vs. 39%), and that accessing/maintaining Medicaid was difficult (50% vs. 34%). They were also much more likely to mention that they had trouble finding doctors who accept their insurance (36% vs. 20%). • Coverage Denial. Several (n= 11) people mentioned their health care was delayed, either due to a coverage denial or issues getting a prior authorization from their health plan.

Table A.4. Detailed beneficiary feedback on Health and Human Services

Positive/Neutral feedback	Constructive feedback
Telehealth care	
• The majority of (n=43) beneficiaries had used telehealth. Of those, 27 liked it and thought it had its place in their care. The other 16 preferred in person appointments.	• Ten beneficiaries were against trying telehealth entirely; another 9 had not used it but either felt neutral or positive about the option. People who liked telehealth mentioned that it was convenient to have an appointment at home and travel to far away locations.
HCBS	
• Several individuals in our sample used HCBS or a community-based mental health service (n =7) • A few individuals described traditional HCBS waiver services (in-home nursing) (n=4)	*None provided*
Medical equipment utilization	
• Many beneficiaries have used Durable Medical Equipment (DME) provided by public insurance programs (Medicaid or Medicare) (n=28). Several beneficiaries have used cane/crutches/walker (n=8), a CPAP machine (n=6), or a nebulizer (n=5)	• Several beneficiaries found DME inaccessible (n=5) and several beneficiaries found bureaucratic hoops to be a barrier to access DME (n=5)
Medication accessibility	
• Most beneficiaries have used prescription medication covered (or partially covered) by their health plan (n=46). The majority of beneficiaries said prescription medications are accessible through their given health plans (n=37)	• Several beneficiaries believe these medications are inaccessible through their plans (n=10)
MCO services	
• Most two commonly expressed positives about the health plans were: • The coverage of services and low co-pays for members (n=14) • Easy to get in touch with people at the plan (n=33) • People who were dually eligible were less likely to have a complaint (n=5, 36%) about their MCO than those on Medicaid only (n=24, 55%)	• About half of the people interviewed who received Medicaid had a complaint about their MCO/ Medicaid plan administration (n=29). (Note: some people had more than 1 complaint) • The three main criticisms of the health plans included: • A desire for less bureaucracy to get services covered (n=12). Of these, 11 mentioned that a service denial or waiting for a prior authorization request delayed the healthcare treatment they needed. • Requests for improvements to customer service functions (n=18), such as less phone trees, access to online portals, or less wait time when calling the health plan • Wanting an increased network of providers (n=16). These people mentioned that they did not think their plan's network was large enough and that they had difficulty finding providers that took their insurance.

Positive/Neutral feedback	Constructive feedback
	• There were no large differences between complaints based on plan enrollment.
Care coordination from MCO	
• Several beneficiaries received care coordination through the health plan (n=6). 5 of these beneficiaries were on WellSense; 1 did not specify their Medicaid plan. • None were dually eligible for Medicare and Medicaid. • Two beneficiaries had limited English proficiency and said they had care coordination through the health plan. One beneficiary says she has someone who calls her once every 6 months. • The other 4 English-speaking beneficiaries found the services to be very helpful.	• One beneficiary with LEP said they communicate on an "as-needed basis" with the health plan but did not find these services to be particularly helpful.
Care coordination from other organization	
• Many received some sort of care coordination from a non-health plan entity (n=26). Two also received care coordination from the health plan (duplication of services). Nine were dually eligible beneficiaries (64% of all duals) • Members described how they primarily use care coordination/care management for logistical issues (help with paperwork, system navigation, questions on healthcare/human service system procedures) but value that this help comes from a consistent person that they can initiate contact with and who is empathic and there when things are overwhelming.	*None provided*
Care coordination from provider	
• Many (n=25) feel like their providers coordinate with one another to ensure quality care	*None provided*
Nutrition assistance	
• Most beneficiaries have or are currently accessing SNAP (n=56), and many have or are accessing local food pantries (n=27). • SNAP was accessible for many beneficiaries (n=17) because they could apply online, the wait time was not too long, the benefit is administered through a card now, and because of co-enrollment with Medicaid. WIC (n=8) and food pantries (n=8) are also accessible for several beneficiaries.	• SNAP was inaccessible for many beneficiaries (n=16) because their EBT cards did not arrive in the mail, people never answer phone lines, it is difficult to get in-person support—partially due to COVID restrictions limiting in-office appointments. • The SNAP application process is difficult for many beneficiaries (n=18)
Housing assistance	
• A majority of beneficiaries receive publicly funded housing assistance (n=40); of these beneficiaries, many have received, are receiving, or have applied for Section 8 housing assistance (n=26). • Several beneficiaries believe housing assistance is accessible (n=12). • Of those who are not currently receiving or applying for housing assistance, several beneficiaries believe housing assistance is available (n=12).	• Many beneficiaries believe housing assistance is inaccessible (n=21) due to long waitlists, required trainings, and income eligibility requirements. Additionally, some beneficiaries cite a lack of affordable housing (n=10).

Positive/Neutral feedback	Constructive feedback
Homeless shelter assistance	
• Many beneficiaries have interacted with the homeless shelter system in New Hampshire (n=22), with some beneficiaries stating they've had good or positive experiences • Many beneficiaries who have not interacted with the homeless shelter system in New Hampshire know that homeless shelters are available in the state (n=29). • Several beneficiaries believe homeless shelters are accessible (n=11).	• Many beneficiaries do not believe homeless shelters are accessible in New Hampshire (n=22). • Several beneficiaries complained about their experiences with homeless shelters (n=9), raising issues such as that they do not feel safe due to the other people using them, have an intimidating environment, or have too many rules that feel arbitrary Several beneficiaries believe that a lack of homeless shelter capacity and funding (n=15), along with one's personal background (e.g., SUD vs no SUD, employment status, criminal record) (n=7), are barriers to accessing homeless shelters in NH.
Utilities assistance	
• Of the various types of utility assistance available in New Hampshire, many beneficiaries utilize or have utilized electrical assistance (n=20) and fuel assistance (n=16). • Many beneficiaries found New Hampshire utility assistance accessible (n=17). • Several beneficiaries access utility assistance through private community-based organizations (n=12), public entities (e.g., Affordable Connectivity Program, COVID-19 Biden relief) (n=10), and public housing assistance programs (e.g., Section 8, COVID-19 rental assistance, HUD housing) (n=9). • Several beneficiaries were introduced to utility assistance available in New Hampshire through DHHS emails, caseworkers, coordinators, and programs (n=7).	• Several beneficiaries found this assistance inaccessible (n=10).
Transportation assistance	
• Many beneficiaries utilized transportation assistance (n=27). • Many beneficiaries utilized medical transportation assistance (n=17), and several beneficiaries used public transportation (n=7).	• Most beneficiaries did not utilize this assistance (n=31). • Many beneficiaries found NH's transportation assistance inaccessible (n=19). • Many beneficiaries deemed NH's transportation assistance a low-quality service (n=14), with many beneficiaries citing vendor challenges as the main culprit behind this low-quality service (n=15) due to the vendor's unreliability and tardiness.
Employment assistance	
• Many beneficiaries know employment assistance is available (n=18) and believe employment assistance is accessible (n=22) • Several believe employment assistance is high quality (n=9) and several believe the plethora of available jobs helps facilitate employment assistance (n=8).	• Several beneficiaries had complaints about employment assistance they received (n=5) and several beneficiaries experience employment assistance barriers due to their disability and/or transportation challenges (n=7).

Interviews with service providers and other community representatives

Approach. Mathematica conducted 45–60-minute semi-structured interviews with providers, community-based organizations (CBOs) and other community members (e.g., consumer advocates, first responders, etc.) to obtain an in-depth understanding of their experiences providing services or engaging with the New Hampshire health and human service delivery system, and opportunities for improvement. Mathematica collaborated with DHHS to identify service providers and community-based organizations from a range of different disciplines (e.g., behavioral health providers, SUD providers, primary care physicians, hospitals, HCBS providers, homeless shelters, resource centers, etc.) and geographic regions to ensure we captured a diverse and representative perspective.

Protocol. We developed different interview protocols individually tailored for each respondent type, taking into consideration their role and perspective of the New Hampshire health and human service delivery system. The protocols covered the following topics:

1. Strengths and challenges of the current health and human service delivery system
2. Frequently needed health and human services and supports for Medicaid beneficiaries
3. Beneficiaries' ability to navigate and access needed health and human services and supports
4. Potential changes and suggestions to improve the New Hampshire health and human service system

Analysis. To analyze the data collected through service provider and community representative interviews, we coded responses to open-ended questions into broad categories of themes. We further examined these themes by respondent type to observe differences across perspectives.

Limitations. Although the interviews provided a unique, in-depth understanding of respondents' experience providing services and engaging with the health and human service delivery system, the information provided reflects only the experiences of sample members, not the experiences of all Granite Staters.

Summary of Key Themes. Mathematica conducted interviews with 28 different organizations, and 46 participants, between October 2022 and January 2023, summarized in Table A.5 below. Key takeaways and themes from the interviews are included in Table A.6.

Table A.5. Service provider and community stakeholder interviews

Respondent type	Service provider or organization	Number of participants
Providers	Amoskeag Health	1
Providers	Bi-State Primary Care Association	1
Providers	Coös County Family Health Services	1
Providers	Dr. Eric Kropp	1
Providers	Dr. Marie Ramas	1
Providers	Dr. Sally Kraft	1
Providers	Dr. Travis Harker	1
Provider	Granite State Independent Living	1
Providers	HEARTS Nashua	1
Providers	Home Care, Hospice & Palliative Care Alliance	1
Providers	New Hampshire Community Behavioral Health Association	1
Providers	New Hampshire Hospital Association	4
Providers	New Hampshire Medical Society	1
Providers	Valley Regional Hospital	1
Providers	White Horse Recovery Resource Center	1
CBO or Community Representative	Community Action Partnership of Southern New Hampshire	2
CBO or Community Representative	Connected Families New Hampshire	1
CBO or Community Representative	CrossRoads House	5
CBO or Community Representative	Gorham Family Resource Center	2
CBO or Community Representative	Greater Sullivan Regional Public Health Network	2
CBO or Community Representative	Laconia ServiceLInk	2
CBO or Community Representative	North Country Consortium	2
CBO or Community Representative	TLC Family Resource Center	2
CBO or Community Representative	Tri-County CAP	5
CBO or Community Representative	New Hampshire Family Voices	1
CBO or Community Representative	Council for Youth with Chronic Conditions	1
CBO or Community Representative	NAMI New Hampshire	2
CBO or Community Representative	Officer Eric Adams	1
Total	**28**	**46**

Table A.6. Summary of key themes from interviews with service providers and community stakeholders

Theme	Service providers	CBOs/Community representatives
Strengths of the health and human service system	• DHHS has made strides in improving the behavioral health system, particularly around crisis response • Local and regional community-based service providers are trusted in their communities	• There has been progress in better integrating health and human service programs and benefits • There are multiple access points for services and programs • DHHS worked collaboratively with stakeholders during the COVID-19 pandemic • DHHS is an accessible and responsive partner
Challenges in the health and human service system	• There is a lack of funding and fragmentation within the system • Due to vacancies and limited DHHS capacity, some lack confidence in the ability to make significant changes • Teaching self-advocacy and how to navigate the system • Medicaid beneficiaries have higher rates of chronic conditions, co-morbidities, and HRSNs, which makes it more difficult to care for these patients	• Lack of DHHS staff capacity impacts agency operations, negatively impacts beneficiaries, and results in strained relationships with system stakeholders • There is inequity in the system for people with developmental disabilities, who have greater resources available, than those with physical disabilities
Provider Workforce Capacity	• Low reimbursement rates for Medicaid service providers contribute to workforce capacity challenge • There are workforce shortages across a range of provider types including behavioral health providers (particularly psychiatry), dental providers, entry-level staff, physicians, office managers, physicians, personal care staff, and OBGYNs • Provider capacity challenges lead to long wait lists, referring beneficiaries to other areas to receive services (in or out of state), beneficiaries accessing care in inappropriate settings (e.g., the ED), and beneficiaries foregoing care	• Provider capacity challenges lead to long wait lists, referring beneficiaries to other areas to receive services (in or out of state), beneficiaries accessing care in inappropriate settings (e.g., the ED), and beneficiaries foregoing care
Health and human service access and availability	• There is limited availability of behavioral health services (including addiction and peer recovery services) • Service access challenges are exacerbated in rural areas • There is a lack of affordable housing capacity across the state • Transportation is a big barrier to care for beneficiaries • Lack of childcare options is an unmet need for beneficiaries • Few dental clinics accept Medicaid due to low reimbursement rates, which negatively impacts access to oral health care	• Enrolling in health and human services programs is challenging due to required paperwork; this is exacerbated for those with high needs, HRSNs, or who have limited-English proficiency • There is a lack of affordable housing capacity across the state • Navigating NH Easy can be challenging, especially for older individuals • Respite care is an area of significant unmet need • Public transportation is limited • Medicaid transportation can be unreliable

Theme	Service providers	CBOs/Community representatives
	• There is limited availability of providers that speak languages other than English	• Resources in rural areas are limited • Beneficiaries have difficulty accessing oral health care
Experience with MCOs	• Some providers said that MCOs had improved and evolved since the implementation of managed care • Some providers shared they had positive relationships with MCOs while others expressed frustration with MCOs • Variation and requirements of MCO administrative processes for prior authorization and provider credentialling are burdensome for providers	• MCOs need more training on specialized systems of care • Variation and requirements of MCO administrative processes are burdensome
Care coordination and care management	• Service providers offered varying perspectives on the capacity of providers to deliver local care management • Some felt that providers do not have capacity to address beneficiaries HRSN • Lack of reimbursement for care management is a barrier	• Collaboration and partnership with other CBOs helps improve efficiencies and makes interactions with families more successful • Varying perspectives on the effectiveness and value of MCO care management
Alternative Payment Models	• New Hampshire's small population size is a barrier to implementing risk-based APM arrangements • There is provider burden associated with collecting data and meeting quality targets • Downside risk is a disincentive to providers	*This topic was not addressed in discussions with CBOs and other community representatives.*
Recommendations for system changes and solutions	• DHHS should facilitate shared learning and convene system stakeholders early and more often • Regional collaboration could leverage existing infrastructure that was developed through the IDNs • The current MCM system should be made less administratively burdensome for providers • A centralized resource database (i.e. a closed loop referral system with a directory) would make it easier for beneficiaries and providers to find available services • CHWs should be reimbursed by Medicaid	• Beneficiaries should have one point of contact at DHHS to get the information they need to reduce duplicative work, help them understand benefits and options, reduce inconsistency, and shorten customer service wait times • There is a need for better life skills training as well as health literacy to help beneficiaries understand insurance/benefits

Interviews with DHHS staff and vendors

Approach. Mathematica conducted 60-minute semi-structured interviews with DHHS staff from various divisions and bureaus to obtain to obtain an in-depth understanding of their roles within and experiences with the New Hampshire health and human service delivery system, and opportunities for improvement. Mathematica also conducted semi-structured interviews with a select number of current DHHS vendors to obtain historical perspectives and context for specific topic areas that DHHS has focused recent efforts (e.g., MCM program, care management, behavioral health, and LTSS).

Protocol. We developed an interview protocol individually tailored for each DHHS division and bureau, taking into consideration their role and perspective at DHHS. The protocols covered the following topics:

1. Coordination between each DHHS division and the Division of Medicaid Services
    - The role of DHHS divisions in engaging with various stakeholders, including Medicaid beneficiaries, providers, MCOs, and other DHHS divisions
    - Strengths and challenges of the current health and human service delivery system
    - Potential changes and suggestions to improve the New Hampshire health and human service system

Analysis. To analyze the data collected through DHHS staff and vendor interviews, we coded responses to open-ended questions into broad categories of themes. Table A.8 provides a thematic summary of key findings.

Limitations. Although the interviews provided a unique, in-depth understanding of respondents' experience with the health and human service delivery system, the information provided reflects only the experiences of sample participants, not the experiences of all DHHS staff.

Summary of Key Themes. Mathematica conducted interviews with 21 different divisions and bureaus, and 64 participants, between October 2022 and January 2023, summarized in Table A.7 and A.8 below. Key takeaways and themes from the interviews are included in Table A.9. Summary of Key Themes from Interviews with DHHS staff and vendors.

Table A.7. DHHS Division interviews

Respondent type	DHHS Division/bureau or organization	Number of participants
DHHS staff	Bureau of Child Development and Head Start Collaboration	3
DHHS staff	Bureau of Child Support Services	2
DHHS staff	Bureau of Employment Supports, Family Assistance, Comprehensive Family Support Services, and the Integrated Eligibility System	7
DHHS staff	Bureau of Information Services	4
DHHS staff	Bureau of Program Quality: Data Analytics and Reporting	1
DHHS staff	Communications Bureau	1
DHHS staff	DHHS Facilities (Hampstead Hospital and New Hampshire Hospital)	2
DHHS staff	Division for Behavioral Health	1
DHHS staff	Division for Children, Youth, and Families	4
DHHS staff	Division for Program Quality and Integrity	3
DHHS staff	Division for Behavioral Health, Homeless Services	2
DHHS staff	Division of Finance & Procurement	2
DHHS staff	Division of Legal & Regulatory Services	2
DHHS staff	Division of Long Term Supports and Services	4
DHHS staff	Division of Medicaid Services	10
DHHS staff	Division of Public Health	1
DHHS staff	Office of Health Equity	6
DHHS staff	Rate Setting Unit and Federal Reporting	2

Table A.8. DHHS partner contractor interviews

Respondent type	DHHS partner contractor	Number of participants
DHHS vendor	Alvarez & Marsal	2
DHHS vendor	Milliman	2
DHHS vendor	University of New Hampshire	3
Total	**21**	**64**

Table A.9. Key Themes from DHHS staff and partner contractor interviews

Theme	Description
Staffing and capacity	• State funding shortfalls impact ability to fully staff and retain positions • COVID exacerbated high vacancy rates, leading to challenges in managing programs and providing oversight, monitoring, and enforcement of vendor obligations • Staff expressed commitment to the mission of the Department • Some staff noted that DHHS leaders must devote time and attention to projects more appropriately run at a staff level due to staffing shortfalls • Staffing limitations make staff reactive instead of pro-active
Department Organizational structure	• Over the past few years, communication across the Department has improved, but there are still opportunities and gaps • At times, there is duplication across programs due to the department's decentralized structure • Some staff felt that the level of collaboration and communication between the Division of Medicaid and other divisions is sufficient. Others shared there is room to improve communication and increase collaboration • Some note a disconnect between the division who has expertise in a particular area and their level of involvement in determining MCO contract provisions
Data Systems and Infrastructure	• Aging and outdated IT infrastructure presents challenges (e.g., for example, one staff shared that the technology for third party liability is so outdated that the unit can't complete data analytics or access necessary information; another staff shared that the usability of the MMIS system is not user friendly and much of the day-to-day work of the unit is manual when it could be automated)
Transition from FFS to MCM	• Generally, the transition from FFS to managed care resulted in program improvements (e.g., systems, improved quality scores, improved service utilization) • DHHS is actively involved in oversight and problem solving with the MCOs, for example getting involved on individual service denials
LTSS	• With LTSS being carved out of managed care, sometimes it is unclear where a service is or should be covered (under managed care or out) • There is limited communication or coordination between MCOs and LTSS providers
Monitoring and Oversight of MCOs	• MCOs are most responsive (some say ONLY responsive) to DHHS priorities when there is a performance related incentive or penalty applied • MCOs act as DHHS staff extenders (e.g., running beneficiary call centers) • DHHS spends significant time on training and oversight of MCOs in areas where the MCOs should be self-sufficient
MCO performance and innovation	• MCOs' understanding of NH's needs and local context is evolving but is viewed by many as insufficient • Many staff expressed frustration around MCOs ability/willingness to develop and implement innovative solutions • MCOs consider their performance strong and lack motivation to improve if the plan is doing well against national benchmarks (e.g., quality measures), even if the national benchmark reflects poor performance nationwide

Interviews with MCO representatives

Approach. Mathematica conducted 60-minute semi-structured interviews with representatives from the three current Medicaid MCOs to obtain to obtain an in-depth understanding of their experiences with the New Hampshire health and human service delivery system, and opportunities for improvement.

Protocol. Protocols for MCO representatives covered the following topics:

1. MCO strategies to improve outcomes, quality, and cost
2. Approach to coordination of care and care management
3. Access to care and provider engagement
4. Opportunities and strategies for population health improvement and integration of HRSNs

Analysis. To analyze the data collected through MCO interviews, we coded responses to open-ended questions into broad categories of themes. Table A.10 provides a thematic summary of key findings.

Limitations. Although the interviews provided a unique, in-depth understanding of respondents' experience with the health and human service delivery system, the information provided reflects only the experiences of sample participants, not the experiences of all MCO representatives.

Summary of Key Themes. Mathematica conducted interviews with the 3 current MCOs, and 31 participants, between November 2022 and December 2023, summarized in Table A.9 below. Key takeaways and themes from the interviews are included in Table A.10. Summary of Key Themes from Interviews with MCO representatives.

Table A.10. MCO representative interviews

Respondent type	DHHS division/bureau or organization	Number of participants
MCOs	AmeriHealth	6
MCOs	New Hampshire Healthy Families	14
MCOs	WellSense	11
Total	**3**	**31**

Table A.11. Summary of key themes from interviews with MCO representatives

Theme	MCO representatives
Strategies to Improve Health, Access, and Cost	• MCOs use a data-driven approach to identifying members that are high-risk, high-cost, and/or high-utilizers • Provider engagement helps to increase access and reduce administrative burden
Alternative Payment Models	• New Hampshire's small population size and provider sophistication/limited infrastructure are barriers to implementing risk-based arrangements • The Medicaid fee schedule is very low compared to the rest of the country, which impacts providers' ability to invest in necessary infrastructure
Care Management	• The original CM engagement and HRA completion requirements in the MCM 2.0 contract were not representative of industry experience or feasible. MCOs expressed the adjusted requirements were more reasonable, but one mentioned receiving accurate member demographic data was a challenge • Some CM requirements lead to duplication of services with other DHHS CM programs or through providers • Limited flexibility to help the Department define the program or discuss nuances and challenges
Health Related Social Needs	• Some of the most pressing human service needs for their members were around housing, transportation, and food insecurity • Some MCOs expressed that they have limited ability to address member's needs due to limited community resources and capacity • The health plans identified individual and ad hoc efforts to address HRSNs
Behavioral Health	• Another MCO shared that provider workforce shortages create challenges in communities. The same MCO shared that lack of intermediate care facilities in the BH system create challenges around ED Boarding. • The CMHC capitation arrangement limits the MCOs ability to control costs and should include quality measures
Financial Incentives	• Withhold measures change too frequently to make progress • The punitive withhold program and liquidated damages create challenges in rewarding providers for meeting quality targets and impedes innovation
Access to Care	• Provider capacity and infrastructure constraints are barriers to care and impact ability to address HRSNs • There are limitations for MCOs to implement preventative programs that address member's mental health and SDOH needs if services are not reimbursable

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Appendix B

Beneficiary Journey Maps

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Figure B.1. Journey map example for beneficiary with low health and human service needs

Jill

Beneficiary with low health and human services needs*

DEMOGRAPHICS
- Enrolled in categorically-needy Parent/Caretaker Relative MA
- Single parent with children under 18

HEALTH CARE SERVICES
- Preventative care, acute care, gynecology, and dermatology

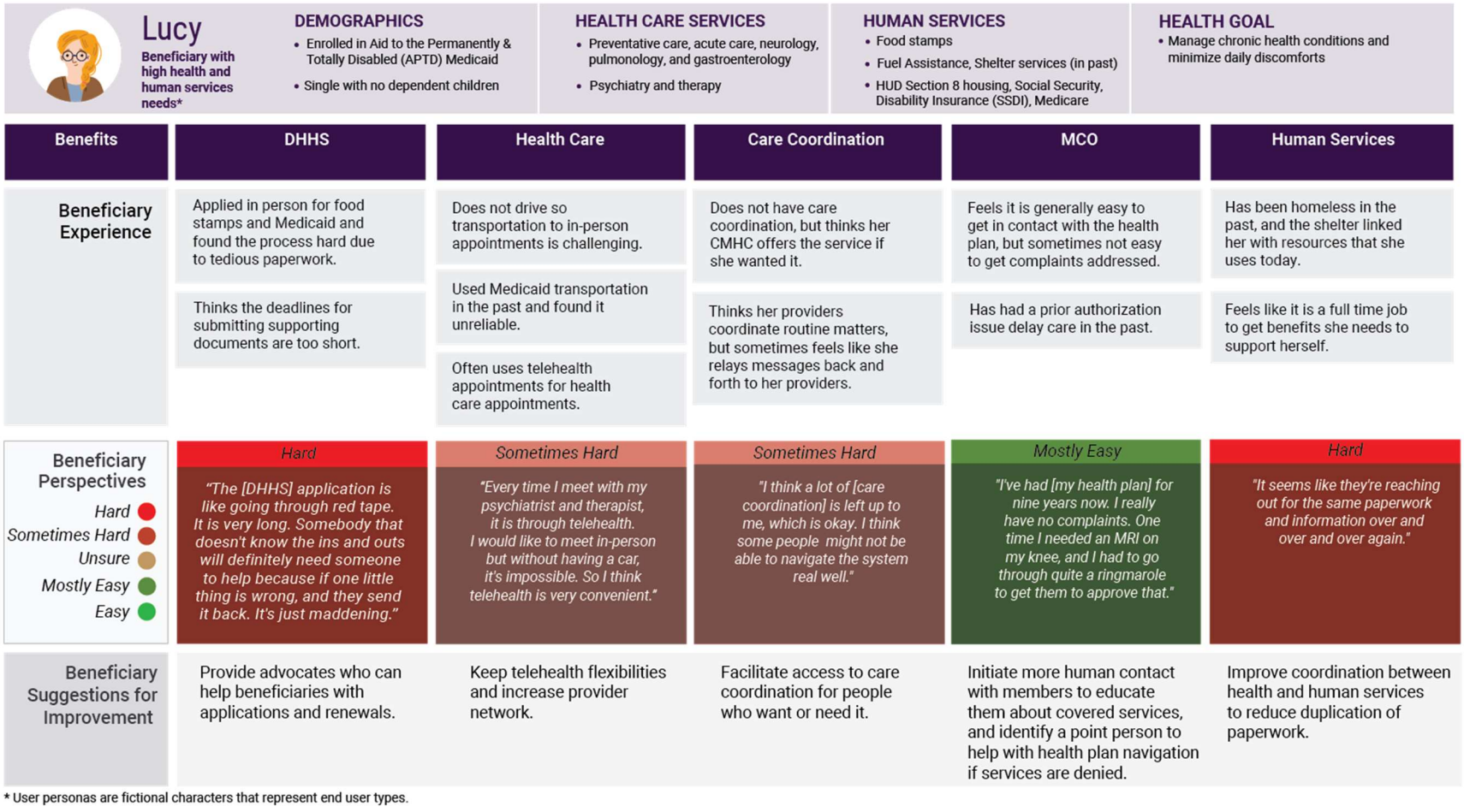
HUMAN SERVICES
- Emergency Rental Assistance Program (in the past)
- Food stamps

HEALTH GOAL
- Stay healthy to be a strong support for her children

Benefits	DHHS	Health Care	Care Coordination	MCO	Human Services
Beneficiary Experience	Applied in person for food stamps and Medicaid and found the process hard due to tedious paperwork. Experiences long hold times when calling DHHS and has had paperwork mailed to DHHS lost. Now visits the office in person to drop off recertification paperwork and asks for a receipt.	Has no difficulty seeing a doctor when sick but has to call ahead a few weeks to schedule with a specialist. Feels like her providers are helping her to stay healthy. Finds it easy to get the prescriptions she needs.	Does not know what care coordination is. Isn't sure if her doctors talk to each other or if they need to.	Feels the plan is easy to get in contact with. Likes that she doesn't have co-pays.	Believes people in her community can get utility help or subsidized housing if they need it, but thinks it may be difficult to do so due to waitlists. Does not know if people can get help with or job coaching if they need it.
Beneficiary Perspectives Hard Sometimes Hard Unsure Mostly Easy Easy	*Sometimes Hard* *"It would be nice not to have to fill out so much paperwork for the state of New Hampshire."*	*Mostly Easy* *"Any time I make an appointment with [my primary doctor], I get scheduled right off and get seen... for the other kind of appointments, you have to wait a while."*	*Unsure* *"I don't know-- I haven't had any problems or anything with the doctors talking to each other."*	*Easy* *"[The MCO] has just been very easy- you apply online and no issues. If I need something, nine times out of 10 I get an answer. That's it."*	*Mostly Easy* *"I believe if you have access to a computer, and you have the information you need to apply, it's fairly easy to go through the site and apply for benefits."*
Beneficiary Suggestions for Improvement	Hire more staff at DHHS to process paperwork or reduce paperwork requirements to establish program eligibility.	Increase provider network.	None	None	Create a location that people can visit to learn available benefits if they can't access the information online.

* User personas are fictional characters that represent end user types.

Figure B.2. Journey map example for beneficiary with high health and human service needs



* User personas are fictional characters that represent end user types.

Appendix C

Background Documents

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The below documents were (1) shared by DHHS or other New Hampshire stakeholders engaged during the project; or (2) identified by the Mathematica team as relevant background materials. All of these documents were reviewed by the Mathematica team and used to inform our recommendations to DHHS. In addition to being listed here, some of these documents are also cited throughout the report.

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Appendix D

Current DHHS Initiatives that Impact the Timeline to Implement a New Model of Care Delivery

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As DHHS considers the implementation of the recommendations included in this report, it is important to note current major initiatives of the Department that require the strategic attention of leaders, extensive staff time, and that are critical for the overarching success of Medicaid and health and human services programs.

Initiative	Description
Adult Dental Benefit Implementation	The state will implement dental benefits for adults enrolled in Medicaid beginning April 1, 2023. In preparation for this work the state is procuring a vendor, promulgating administrative rules and working to obtain needed federal authorities.
Bureau of Developmental Services Systems Work	The Bureau of Developmental Services is working on several initiatives to improve and strengthen the system of supports and services for individuals with developmental disabilities. This includes changes to the 1915 (c) home and community-based services waivers, reimbursement rate changes, and information systems updates.
Closed Loop Referral System Procurement and Implementation	In collaboration with the Department of Military Affairs and Veterans Services, DHHS is seeking a vendor to implement a closed loop referral system that will enhance care coordination for individuals by enabling health care and community services providers to connect on single statewide technology platform.
Critical Time Intervention Implementation	DHHS should be commended for piloting the Critical Time Intervention (CTI) program with CMHCs to keep people connected and engaged in care. In 2023, the state will be exploring how to add CTI as a permanent Medicaid benefit through either a state plan amendment or waiver.
Electronic Asset Verification System	The Division of Medicaid Services is in the process of implementing a Asset Verification System, in compliance with federal requirements, that will verify financial assets for purposes of determining and re-determining Medicaid eligibility for aged (age 65 or over), blind or disabled individuals.
Independent Clinical Review Services Procurement and Implementation	In January 2023, the Department of Health and Human Services released a request for proposals for a vendor to perform Independent Clinical Review Services for the state Medicaid program. The new vendor will begin on July 1, 2023.
Medicaid Care Management Procurement	DHHS has already started to plan for the next iteration of the MCM program as the current contracts with the Medicaid MCOs expire on June 30, 2024.
MES Modernization	The state is building a re-procurement strategy to modernize their Medicaid Enterprise System.
Money Follows the Person (MFP)	In fall 2022, DHSS was awarded an MFP Demonstration Grant to support older adults and adults with chronic illnesses to continue living independently and continues CPP's focus to provide the necessary services and supports for people to age in place. Through this work, DHHS has convened a consultative group of internal and external stakeholders to support the planning and implementation of the MFP Demonstration. The Department will contract with The Center on Aging and Community Living at the University of New Hampshire to support the system assessment and gap analysis of (HCBS) and facilitate a process to develop an MFP Operational Protocol (OP). The OP will be a clear plan for using funds to advance state rebalancing strategies, including direct service workforce challenges. The OP will also outline a strategy for identifying and enrolling participants, including partnering with and training transition coordination and housing support providers. The OP will outline how BEAS will collaborate with providers and ensure services are delivered in a person-centered, coordinated fashion and will leverage cross-agency collaboration with state and local housing

Initiative	Description
	agencies, community-based organizations, social service agencies, aging/disability networks, and HCBS beneficiaries. During the planning phase, DHHS will use MFP funds to engage technical experts and build its capability to assess HCBS system capacity, nursing facility bed needs and capacity, and determine what additional providers or services are needed, particularly for self-directed services and equitable care for historically underserved communities. This process will include identifying racial, ethnic, and other disparities and developing partnerships and strategies to address them.
New Hampshire 10-year Mental Health Plan	In January 2019, DHHS released New Hampshire's second 10-year Mental Health Plan. Unlike the previous 2008 plan, the 2019 plan focuses on services and supports across the lifespan and includes child-focused strategies and recommendations. DHHS plays a critical role in ongoing implementation of the plan.
Post-Pandemic Benefits Changes	The Consolidated Appropriations Act, 2023 dictates the end of the Medicaid continuous coverage requirements. States can now begin to process Medicaid redetermination and terminations beginning April 1, 2023. DHHS has extensively prepared for the end of the continuous coverage requirements and post-pandemic benefit changes and will begin to implement those plans over the next year.
SUD SMI SED TRA Demonstration Extension	The state has requested an extension of the current 1115 demonstration waiver focused on providing services for individuals with substance use disorder, serious mental illness, serious emotional disturbance. The extension includes using Medicaid federal matching funds for the provision of a tailored set of services for individuals involved in the criminal justice system and transitioning to community release. Additional implementation work includes information systems improvements, utilization review processes and monitoring of services. Negotiations with CMS for approval are ongoing.
2022 State Health Assessment and Improvement Plan	The New Hampshire State Health Assessment and State Health Improvement Plan Advisory Council is in the process of developing the 2022 State Health Improvement Plan to guide decision makers in choosing where to allocate resources that will address New Hampshire residents' greatest needs.

Appendix E

Arizona Health Cost Containment System Housing (AHCCS) and Health Opportunities Demonstration

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AHCCCS received approval in fall 2022 to provide housing services through their Housing and Health Opportunities (H2O) demonstration, as an amendment to their 1115 waiver. Arizona has been providing housing services to people experiencing serious mental illness since a lawsuit in 1989 required the state to provide assertive community treatment, supportive housing and other services to people experiencing SMI in Maricopa County. In addition to the SMI population, limited housing supports are available for some of those with a general mental health or substance use condition. Since then, oversight has been designated to AHCCCS as the state integrated behavioral and physical health delivery systems in 2016.[77]

Two independent evaluations of the housing program for people with SMI found those who received services had a reduction in psychiatric hospitalizations, emergency department utilization, and decrease in total cost of care per member.[78] While these housing services have been successful, they are not meeting the increased housing needs of Arizonans, including the 80 percent of those experiencing homelessness that do not have SMI.[79]

Arizona's H2O program is designed to realize these positive outcomes for people experiencing homelessness and accrue savings to the system by providing housing supports. Eligible beneficiaries are those experiencing homelessness or at risk of being homeless as defined by the U.S. Department of Housing and Urban Development. Additionally, members must have one of the following: SMI or behavioral health need, determined to be high risk based on service utilization or health history, repeat avoidable emergency department visits, or chronic health conditions. Young adults who have aged out of foster care, those at high risk of experiencing homeless upon release of an institutional setting, or Arizona Long Term Care System (ALTCS) members who can reside in their homes but require transition supports are also eligible.

The stated goals of H2O are to: increase positive health outcomes, including members' mental health conditions, substance use and utilization of prevention services; reduce the cost of care by reducing psychiatric, inpatient and emergency department utilization; and reduce homelessness and maintain housing stability.

H2O design and roles and responsibilities

Arizona has a robust housing program in place, the AHCCCS Housing Program (AHP), with delineated roles and responsibilities and detailed housing policies and procedures.[80] The H2O program outlines a structure for providing housing services that leverages the AHCCCS Housing Program (AHP), a program which consists of five entities to provide safe, high quality housing services to member. Within AHP,

[77] AHCCCS. "AHCCS Housing and Health opportunities (H2O) Draft Waiver Amendment." 2021. Available at :https://www.azahcccs.gov/Resources/Downloads/HousingWaiverRequest/AHCCCSHousingHealthOpportunitiesH2OWaiverProposal_FINAL.pdf. Retrieved on January 22, 2023.

[78] AHCCCS. "AHCCS Housing and Health opportunities (H2O) Draft Waiver Amendment." 2021. Available at :https://www.azahcccs.gov/Resources/Downloads/HousingWaiverRequest/AHCCCSHousingHealthOpportunitiesH2OWaiverProposal_FINAL.pdf. Retrieved on January 22, 2023.

[79] AHCCCS. "AHCCS Housing and Health opportunities (H2O) Draft Waiver Amendment." 2021. Available at :https://www.azahcccs.gov/Resources/Downloads/HousingWaiverRequest/AHCCCSHousingHealthOpportunitiesH2OWaiverProposal_FINAL.pdf. Retrieved on January 22, 2023.

[80] AHCCCS. "AHCCCS Housing Program guidebook." (2022). Available at: https://www.azahcccs.gov/AHCCCS/Downloads/HousingPrograms/AHCCCSHousingProgramGuidebook.pdf

AHCCCS is the primary funder for services and directs provides oversight of the Housing Administrator. Similarly, AHCCCS will administer the H2O program, and provide funding to contractors and support program administration through policy development and monitoring and oversight.

Arizona's MCO's primary role is to ensure members are assessed for housing needs and have access to services in the least restrictive community environment. They work with other entities to ensure their members have housing services. In the H2O model, MCO's will contract with providers to deliver services, and develop a network of providers with sufficient experience, and will support coordination of referrals, housing placement, and post-housing wrap around services. The MCOs will provide care coordination for people in the H2O program, along with their provider networks. As a part of the care planning process, MCOs will be required to provide closed-loop referrals to additional human services and community-based organizations to provide a full set of social support services in addition to housing services. The state is required to partner with state and local entities to assist individuals served by the H2O program, such as HUD continuum of care program, local housing authorities, and SNAP state agency.

AHCCSS will leverage the Housing Administrator, Arizona Behavioral Health Corporation and HOM Inc., a permanent support housing and rapid rehousing provider, which were contracted to the role in October 2021.[81] They support a variety of housing functions in the AHP, including waitlist management, utilization, legal compliance, landlord payment and more. They will provide these same services for people receiving housing supports through the H2O. In turn, the Housing Administrator works with CLP housing providers, who own properties purchased by providers with the State SMI Housing Trust Funds and ensure the properties are managed appropriately.[82] Additionally, scattered site properties may be used, which are private sector housing owners, landlords, and managers who lease to members.

Services provided under H2O

AHCCCS has outlined three strategies for H2O and the services that will help them accomplish the strategies. The first is to strengthen homeless outreach and service engagement. Under this strategy, AHCCCS will offer outreach services to connect to eligible members, improve screening and discharge coordination with care management and educational services, develop discharge and care plans, establish linkages to other systems, and enhance data support to connect data across systems, leveraging a closed loop referral system.

The second strategy is to secure housing funding for eligible members. Under this strategy, AHCCCS will fund the provision of short-term transitional housing, and provide financial assistance for move-in expenses, and eviction prevention services. The third strategy is to enhance wraparound services and support to ensure housing stability by providing home modification services and pre-tenancy and tenancy supportive services.

In addition to direct service provision, AHCCCS has been approved to claim FFP for infrastructure costs to support the development of services, including:

[81] ACHHHS. "AHCCCS Housing Programs (AHP)." 2023. https://azabc.org/ahp/

[82] AHCCCS. "AHCCCS Housing Program guidebook." 2022. https://www.azahcccs.gov/AHCCCS/Downloads/HousingPrograms/AHCCCSHousingProgramGuidebook.pdf.

- Technology, such as electronic referral systems or screening tool and/or care management systems.
- Development of business or operational practices, such as planning for referral management or quality improvement.
- Workforce development, such as cultural competency training or worker certification.
- Outreach, education, and stakeholder convening, such as design of outreach and education materials or investments in stakeholder convening.[83]

H2O financing

Arizona is authorized to spend $441 million for its HRSN program, with 13.5 million of that specifically designated for annual HRSN infrastructure costs.[84] The HRSN programs includes H2O services and infrastructure costs, as well as another program called Targeted Investments 2.0 Program (TI 2.0). The funds will come through Designated State Health Programs (DSHP), which historically have been used to free up state dollars to be used for system improvements by providing federal funds for services not covered by Medicaid.[85] In the case of the AHCCCS demonstration, Arizona is approved to provide a covered set of services to address HRSN with federal matching funds for DSHP if budget neutrality requirements are met, and any freed-up dollars are spent on initiatives consistent with Medicaid goals.

Recently, CMS has changed their approach to 1115 budget neutrality calculations while approving waivers in a variety of states.[86] The CMS approval letter for AHCCCS applied these new approaches to calculating budget neutrality that depart from the previously described process outlined in the 2018 SMD letter. Two of the key changes to the neutrality calculations, though not the only, include:

- **Calculate the WOW baseline using a weighted average.** In this case, CMS calculated the without waiver (WOW) baseline using a weighted average of the historical WOW PMPM and its recent actual PMPM. Historically, CMS used only the recent actual PMPM costs. This results in a likely higher WOW baseline, which will likely lead to generated savings.[87]

1. **Treat HRSN expenditures as hypothetical for the purposes of budget neutrality calculations**. In this case, the hypothetical HRSN expenditures are included in the budget neutrality WOW baseline. This allows for states to not have to use budget neutrality savings to finance the HRSN programs because the HRSN expenditures are added to the WOW baseline.[88]

[83] CMS. "Arizona Health Care Cost Containment System." 2022. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-ca-10142022.pdf.

[84] CMS. "Arizona Health Care Cost Containment System." 2022. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-ca-10142022.pdf.

[85] Medicaid and the Law. "CMS to Phase Out Designated State Health Program (CSHP) Funding." 2018 https://www.medicaidandthelaw.com/2018/02/01/cms-to-phase-out-designated-state-health-program-dshp-funding/.

[86] State Health & Value Strategies. "Recent Updates to Section 1115 Waiver Budget Neutrality Policy: Overview and Implications for States." 2022. https://www.shvs.org/wp-content/uploads/2022/12/SHVS_Recent-Updates-to-Section-1115-Waiver-Budget-Neutrality-Policy.pdf.

[87] State Health & Value Strategies. "Recent Updates to Section 1115 Waiver Budget Neutrality Policy: Overview and Implications for States." 2022. https://www.shvs.org/wp-content/uploads/2022/12/SHVS_Recent-Updates-to-Section-1115-Waiver-Budget-Neutrality-Policy.pdf.

[88] State Health & Value Strategies. "Recent Updates to Section 1115 Waiver Budget Neutrality Policy: Overview and Implications for States." 2022. https://www.shvs.org/wp-content/uploads/2022/12/SHVS_Recent-Updates-to-Section-1115-Waiver-Budget-Neutrality-Policy.pdf.

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Appendix F

Colorado RAE Care Coordination Contract Requirements

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The below excerpt from the contract between the State of Colorado, Department of Health Care Policy and Financing and a RAE provides specific requirements and responsibilities of the RAE in providing care coordination services.[89]

11.3. Care Coordination

11.3.1. The Contractor shall ensure Care Coordination is available to Members in alignment with the Contractor's Population Management Strategic Plan and the Department's Population Management Framework. The Contractor shall use its own resources and Department insights to ensure active Care Coordination for Complex Members.

11.3.2. The Contractor shall have a specific process to ensure that infused specialty drugs are managed away from outpatient hospitals into home infusion, where appropriate.

11.3.3. The Contractor's Care Coordination activities shall comprise:

11.3.3.1. A range of deliberate activities to organize and facilitate the appropriate delivery of health and social services that support Member health and well-being.

11.3.3.2. Activities targeted to specific members who require more intense and extended assistance and includes appropriate interventions.

11.3.4. The Contractor shall use a person- and family-centered approach to Care Coordination, which takes into consideration the preferences and goals of Members and their families, and then connects them to the resources required to carry out needed care and follow up.

11.3.5. The Contractor shall ensure that care is coordinated for the Member within a practice, as well as between the practice and other Health Neighborhood providers and Community organizations.

11.3.6. The Contractor shall not duplicate Care Coordination provided through LTSS and HCBS waivers and other programs designed for special populations; rather, the Contractor shall work to link and organize the different Care Coordination activities to promote a holistic approach to a Member's care.

11.3.7. The Contractor shall ensure that Care Coordination:

11.3.7.1. Is accessible to Members.

11.3.7.2. Is provided at the point of care whenever possible.

11.3.7.3. Addresses both short and long-term health needs.

11.3.7.4. Is culturally responsive.

11.3.7.5. Respects Member preferences.

11.3.7.6. Supports regular communication between care coordinators and the practitioners delivering services to Members.

[89] https://hcpf.colorado.gov/sites/hcpf/files/Region%201%20-%20Rocky%20Mountain%20Health%20Plan%20November%202022.pdf

11.3.7.7. Reduces duplication and promotes continuity by collaborating with the Member and the Member's care team to identify a lead care coordinator for Members receiving Care Coordination from multiple systems.

11.3.7.8. Addresses potential gaps in meeting the Member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial and spiritual needs in order to achieve optimal health, wellness or end-of-life outcomes, according to Member preferences

11.3.7.9. Is documented, for both medical and non-medical activities.

11.3.7.10. The Contractor shall ensure Care Coordination is documented in the form of a care plan for Members who require more intense or extended assistance including Complex Members.

11.3.7.10.1. The Contractor shall ensure Care Coordination care plans are regularly and sufficiently monitored and include the following:

11.3.7.10.2. A lead care coordinator,

11.3.7.10.3. Goals and outcomes,

11.3.7.10.4. Be member and/or caregiver driven.

11.3.7.10.5. Aligns with the Contractor's Population Management Strategic Plan.

11.3.7.10.6. Protects Member privacy.

11.3.8. The Contractor shall ensure that care coordinators in the Contractor's network reach out and connect with other service providers and communicate information appropriately, consistently and without delay.

11.3.9. The Contractor shall reasonably ensure that all Care Coordination, including interventions provided by Network Providers and Subcontractors, meet the needs of the Member.

11.3.10. The Contractor shall ensure that Care Coordination is provided to Members who are transitioning between health care settings and populations who are served by multiple systems, including, but not limited to, children involved with child welfare, Medicaid-eligible individuals transitioning out of the criminal justice system, Members receiving LTSS services, and Members transitioning out of institutional settings. To meet the needs of these Members, the Contractor shall:

11.3.10.1. Designate staff persons to serve as the Contractor's single point of contact with the different systems and settings.

11.3.10.2. Give designated staff persons the appropriate level of knowledge of the assigned system/setting to serve that population and solve Care Coordination problems for that population, including knowledge regarding out-of-state medical care as described in 10 CCR 2505-10 8.013, and out-of-state NEMT as described in 10 CCR 2505-10 8.014.7.

11.3.10.3. Provide specific guidance to care coordinators about each setting, regarding how to identify Members in the system/setting; how to provide Care Coordination services in the system/setting; and how to communicate with contact people in the system/setting to plan transitions, coordinate services, and address issues and Member concerns.

11.3.10.4. Participate in special workgroups created by the Department or other state agencies to improve services and coordination of activities for populations served by multiple systems.

11.3.10.4.1. The Contractor shall partner with the Department and the Colorado Department of Corrections (CDOC) to identify and provide services to Medicaid-eligible individuals being released from incarceration to enable them to transition successfully to the community. Services shall include, but are not limited to, in-reach services, care transition support, and care coordination.

11.3.10.4.2. The Contractor shall receive and process a list from the Colorado Department of Corrections containing information about incarcerated individuals who have recently been released or will be released in the near future.

11.3.10.4.2.1. The Contractor shall process the list to identify individuals who are assigned to the Contractor or will be released to the Contractor's region and are likely to be assigned to the Contractor.

11.3.10.4.2.2. The Contractor shall provide timely outreach and transitional support to individuals assigned to or who are likely to be assigned to the Contractor to support their successful transition to the community.

11.3.10.4.2.3. The Contractor shall coordinate transitional support between CDOC and other RAEs for individuals who were likely to but ultimately were not assigned to the Contractor.

11.3.10.4.2.4. The Contractor shall safely destroy the Department of Corrections list following processing to ensure privacy protections.

11.3.10.5. Implement programs and/or procedures to reduce unnecessary utilization of the emergency department for Members residing in Nursing Facilities and Members receiving end of life care.

11.3.11. For Members with intellectual and developmental disabilities who require services for conditions other than a mental health or substance use disorder, the Contractor shall assist the Member in locating appropriate services.

11.3.12. For Members with substance use disorders who require services not covered by Medicaid, the Contractor shall coordinate care with the state's Managed Service Organizations.

11.3.13. The Contractor shall coordinate care with the Colorado Crisis System to ensure timely follow-up outreach and treatment for enrolled Members who accessed crisis services.

11.3.14. The Contractor shall assist care coordinators within the Contractor's network with bridging multiple delivery systems and state agencies.

11.3.15. The Contractor shall require additional support and guidance when the systems and providers engaged with a Member's complex care require leadership and direction.

11.3.16. The Contractor shall ensure that Care Coordination tools, processes, and methods are available to and used by Network Providers as described in Section 15.2.1.

11.3.17. The Contractor shall ensure that clinical and claims data feeds, including but not limited to admission/discharge/transfer (ADT) data received from a Colorado health information

exchange, monthly claims data, and the CMA case manager data feeds, are actively used in providing care coordination for Members.

11.4. Care Coordination and Complex Care Management Report

11.4.1. The Contractor shall submit a Care Coordination and Complex Care Management Report to the Department in a format agreed to by the Department and the Contractor. The report shall include extended care coordination activities for Complex Members performed by the Contractor, Network Providers and Partners, and Subcontractors.

11.4.1.1. DELIVERABLE: Care Coordination and Complex Care Management Report

11.4.1.2. DUE: Every six (6) months, by August 15th and February 14th

11.5. Condition Management Report

11.5.1. The Contractor shall provide information about their strategy and progress on programs to address Members with specific health conditions as identified by the Department in the Condition Management Report.

11.5.2. The Contractor shall submit a Condition Management Report in a format agreed upon by the Department and the Contractor.

11.5.2.1. DELIVERABLE: Condition Management Report

11.5.2.2. DUE: Every six months, by November 21 and May 21

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