Association of Counties

February 23, 2018

Governor Christopher Sununu
Office of the Governor
Senator Chuck Morse
Speaker Gene Chandler
State House
107 North Main Street
Concord, NH 03301

Dear Governor Sununu, President Morse and Speaker Chandler:

The New Hampshire Association of Counties is happy to provide you with a preliminary report of our work examining long term care and supports in New Hampshire. Our report: New Hampshire Long Term Care Services and Supports: Assessment of the Current System and Implications for Reform is attached.

This work arises from a legislative directive established in HB 517 (2017) which directed the NH Association of Counties and the NH Department of Health and Human Services to collaborate and examine critical issues associated with the future of long term care considering the potential management of these services by third party Medicaid Managed Care Organizations.

The details of the legislative authorization are found at section 156;176 of the legislation (below):

> 156:176 New Hampshire Partnership for Long-Term Care Plan. The New Hampshire Association of Counties, in consultation with the county-state finance commission, shall develop a New Hampshire partnership for long-term care plan. The plan shall address services for New Hampshire's population that is eligible for Medicaid for nursing home level of care, including those services provided under the choices for independence program. The plan shall account for demographic changes in New Hampshire, availability of non-nursing home community-based services, and ensuring the least restrictive care available. The plan shall include methods for funding and management of programs that balance the interests of county, state, and federal payers into the system. Development of the plan shall include a process for meaningful input from affected persons. The New Hampshire Association of Counties shall submit to the governor, the speaker of the house of representatives, and the president of the senate a preliminary report by March 1, 2018 and a final report by July 1, 2018

The report offers a review of the group's work to date, a detailed background on the current system and highlights both risks and opportunities associated with various reforms.

It is the hope of the NH Association of Counties that this report and the ongoing work of the Association and the State will continue for the next several months and that a final report will be crafted by July 1, 2018. This collective work will likely offer long term policy direction for the state's Medicaid system and the Counties' financial and operational planning.

If you have any questions about this report or the process that is underway, we are happy to connect with you in person or by phone or through email.

Again, thank you for the opportunity to be engaged in the process and we look forward to your continued support of our efforts.

Sincerely,

George Maglaras
NH Association of Counties, Immediate Past President

New Hampshire Association of Counties

New Hampshire Long Term Services and Supports: An Assessment of the Current System and Implications for Reform

FEBRUARY 2018

REPORT PREPARED IN COLLABORATION WITH HEALTH MANAGEMENT ASSOCIATES PURSUANT TO HOUSE BILL 517

EXECUTIVE SUMMARY

This report by the New Hampshire Association of Counties (NHAC) was commissioned by the New Hampshire State Legislature in HB 517 (2017) to examine the viability of moving the Long Term Care Services and Supports (LTSS) to managed care, or establish an alternative approach.

The research in this report illustrates that the New Hampshire LTSS system is in dire need of reform; however, the current Managed Care Organization (MCO) proposal is insufficient to address the needs of the system. Preliminary review indicates that Managed Care is not a solution for all system problems. Managed Care programs are complex and require significant planning and resources on the part of a state to monitor Managed Care Plans; to establish and ensure adherence to contract language; define delivery models; and how these programs are financed. This financial consideration is of importance to the County governments who fund most of the non-federal share of LTSS in New Hampshire. New Hampshire's own experience with Phase One of Managed Care reveals that the State has not saved money, and in fact has driven up costs for the Phase One population and services. As the primary funders of the LTSS in the State, County governments are significantly concerned about rising costs and the impact that would have on the county tax payers. Additionally, if the State moves to a Managed Care system, it is unclear how the Department will handle ProShare and Medicaid Quality Incentive Program (MQIP) payments, which are important supplemental payments to the County nursing homes, and as we learned in our analysis, are not allowed under the Managed Care delivery model being contemplated, as stated in the April 2016 Centers for Medicare and Medicaid Services (CMS) Medicaid Final Rule. Managed Care programs have not demonstrated to the NHAC that they save money. In fact, they can potentially escalate costs, a fact which has led several states throughout the country to end their experiments with Managed Care programs.

Additionally, the current proposal only addresses Medicaid populations, not Medicare. A large majority of members (90%) who receive LTSS services in New Hampshire are dual eligible, qualifying for both Medicaid and Medicare. Studies have shown across the nation that programs that include dual eligible individuals result in more appropriate use of services and a reduction in use of high-cost services. These types of dual eligible programs would, on the surface, provide the most promise of a dynamic delivery model for New Hampshire.

NHAC would suggest that a more appropriate place to begin reform would be to explore the creation of a county-based Program of All-Inclusive Care for the Elderly (PACE). PACE has demonstrated great success across the country. The primary principle of PACE is that it is better for older adults to remain in the community for as long as possible, as opposed to institutionalization. PACE is an alternative to traditional Managed Care and utilizes the dual eligibility of participants. Results in other states have proven PACE is effective in delaying and even preventing the need for institutional care for some older adults, thus systemically saving money. PACE has the potential to help New Hampshire control the costs associated with the LTSS program; however, more analysis is required in order to develop this model to fit New Hampshire's unique characteristics, both geographical and population-based.

NHAC believes that the current Managed Care proposal is inadequate and does not put New Hampshire on a path to meaningfully reform the delivery of LTSS services in a manner that controls rising costs without jeopardizing the nationally recognized quality of care LTSS recipients currently receive.

The current proposal does not address the viability of ProShare and MQIP , two programs that are not only essential components to the funding scheme of the LTSS program, but equally important in the controlling of costs to tax payers throughout New Hampshire.

NHAC stands ready to continue working with the Department of Health and Human Services (DHHS) to explore alternative options for reform of long-term care services and supports, and the financing thereof, in New Hampshire.

1. Overview

The New Hampshire Association of Counties (NHAC) represents the interests of county government in New Hampshire. In New Hampshire, a significant portion of the state Medicaid program, including nursing facility services and certain long-term care services and supports (LTSS), is financed by county taxes. In addition, counties act as providers of nursing facility and other LTSS.

The Department of Health and Human Services (DHHS), which oversees the Medicaid program, established a managed care program in 2013, pursuant to legislation passed in 2011. This is referred to as "Phase 1" of the implementation of managed care. DHHS is now planning significant reforms to the LTSS system, which involves expanding its current managed care program to include LTSS. The expansion of managed care to include LTSS is referred to as "Phase 2" of the implementation of managed care in NH.

In response to a 2017 legislative mandate, NHAC prepared this report. NHAC appreciates the assistance of the county staff involved in preparing this report, and to DHHS for providing information and data to support this analysis.

2. Background: The State Medicaid Landscape and the Move Toward Managed Care

New Hampshire's Medicaid managed care program began Phase 1 in December 2013. The managed care program provides coverage to most Medicaid members and provides nearly comprehensive coverage. Nursing facility services and services provided under home and community based waivers (HCBS services) are currently excluded from the managed care program and the capitation rates paid to participating managed care plans. DHHS is now planning for the implementation of Phase 2, which will involve including coverage of nursing facility and certain HCBS services in the managed care program and under the capitation rates.

Arising from significant concerns about the implementation of Phase 1, the New Hampshire State Legislature adopted Senate Bill 533 (SB553) on June 6, 2016, which required that DHHS convene a Working Group of stakeholders and present to the General Court a comprehensive plan and an actuarial report, complete with all necessary federal approvals, before implementing Phase 2. [1]

The legislature also recognized the unique issues involving Counties and the Phase 2 plan. While recognizing the state's need to pursue effective administration of Medicaid, and the potential value of encouraging service integration for Medicaid beneficiaries, NHAC expressed concerns that incorporating LTSS in the state's Medicaid managed care arrangements could jeopardize current financing for LTSS, and especially for county nursing facilities. As discussed in more detail in Section 6, below, counties were particularly concerned that ProShare payments would be jeopardized. In June, 2017, in House Bill 517 (HB517) given the role the counties play in financing the LTSS system, and the significant share of revenue that ProShare payments represent to the counties the General Court authorized NHAC to develop a "New Hampshire Partnership for Long-Term Care Plan." According to that HB 517, the plan

[1] Under SB553, Phase 2 initially includes only nursing facility services and services provided under the Choices for Independence HCBS waiver, which serves frail elderly and physically disabled Medicaid members. The incorporation into managed care of other HCBS waiver services, including the developmental disability, acquired brain injury, and in-home supports waivers, cannot occur until after the initial implementation of Phase 2.

"shall address services for New Hampshire's population that is eligible for Medicaid for nursing home level of care, including those services provided under the choices for independence program. The plan shall account for demographic changes in New Hampshire, availability of non-nursing home community based services, and ensuring the least restrictive care available. The plan shall include methods for funding and management of programs that balance the interests of county, state, and federal payers into the system."

This purpose of this report is to: (1) describe the current state of New Hampshire's LTSS system for Medicaid members; (2) summarize implications of moving LTSS services into managed care; and, (3) to address elements of an LTSS system that are needed for any reform to be consistent with the language excerpted above. This report comprises the report due by March 1, 2018.

3. Collaboration between NHAC and DHHS

Starting in August 2017, recognizing that the development of a new plan would be irrelevant if DHHS moved forward with its plan to implement managed LTSS in New Hampshire by January 1, 2019, the NHAC and DHHS engaged in a series of substantive planning meetings to assess the impact of managed LTSS on the counties and to analyze options for LTSS reform. These meetings took place during September and October of 2017. NHCA presented its initial findings to the SB553 Working Group on September 26. This report builds upon those initial findings.

4. The County Role in the New Hampshire Medicaid Program and LTSS System

Financing of services

New Hampshire counties play a critical role in the financing of all LTSS services. For the majority of LTSS services – and all of the LTSS services involved in Phase 2 – county governments provide the state share of Medicaid costs, which is matched by federal spending at a 50% rate. In State Fiscal Year 2017, county-responsible costs (state and federal) totaled approximately $261 million. Of that total spending, $57 million was for CFI services and $204 million was for nursing home services (county-operated and private).

County operation of NHs

Each of the ten counties also operates one or more nursing homes, providing a critical role in meeting the demand for care. Some counties also provide directly other HCBS services. Counties receive base reimbursement which is the same as other Medicaid providers. Recognizing the gap between county costs and established reimbursement levels, however, counties also receive Proportional Share (ProShare) payments. ProShare payments help to close the gap between Medicaid reimbursement and the actual cost of care provided by county-operated nursing facilities.

ProShare, under a CMS-approved methodology that distributes payments by county based on a formula, provided $47M to counties in SFY 2017. ProShare has been a critical strategy for supplementing reimbursement for county-operated nursing facilities and for supporting the ability of counties to continue to provide critical access to LTSS for the neediest Medicaid members.

5. Managed LTSS Programs across the Country

In New Hampshire, all Medicaid beneficiaries are enrolled with managed care organizations (MCOs), but the MCOs are not currently responsible for paying for nursing facility or HCBS-waiver services. New

Hampshire's phased approach to managed care implementation is fairly typical. It is common for states to use managed care arrangements for primary and acute Medicaid services, but states have moved more cautiously into managed long term services and supports (MLTSS). Across the country 39 states have MCO programs, while 23 states have MLTSS for at least some populations using LTSS.[2] The main challenges in moving to MLTSS include:

- Individuals needing LTSS are a vulnerable population, often higher-need and higher-risk than traditional beneficiaries. There is often significant resistance from consumers and family members who fear reductions in critical services or disruptions in care.
- LTSS providers are often small, not well-prepared for managed care, and are heavily reliant on Medicaid business. There is often significant concern that managed care will increase administrative costs for providers, disrupt critical cash flow, and reduce already low reimbursement rates.
- The presence of Medicare coverage – which covers most hospital, physician, pharmacy and other acute care services, but does not cover LTSS services -- presents administrative and practical obstacles to integrating care for Medicare-eligible individuals needing Medicaid-reimbursed LTSS.

Use of MLTSS, however, has grown dramatically since 2009, when only six states operated a MLTSS program either regionally or statewide. Much growth in MLTSS was triggered when several states implemented federally-authorized financial alignment demonstration models that are testing integration of Medicare and Medicaid benefits for dually eligible populations. While growth in the number of states offering some form of MLTSS has slowed since 2015, enrollment continues to grow as these states move from regional to statewide programs or otherwise expand to new population groups. Additional states continue to consider or plan for use of MLTSS, perhaps in anticipation of growing demand as the population of individuals needing LTSS services is expected to increase by almost 70% in the next 20 years.[3] It is estimated that by 2030, the number of New Hampshire residents age 65 and older will have grown by 138% and those over the age of 85 will have grown 146%.[4]

6. CMS Managed Care Regulations and ProShare Payments to Counties

[2] See Kaiser Family Foundation, State Health Facts, available at https://www.kff.org/medicaid/state-indicator/total-medicaid-mcos and National Association of States United for Aging and Disabilities, State Medicaid Integration Tracker, December 2017, available at http://nasuad.org/sites/nasuad/files/IntegrationTracker.

[3] See "Moving from FFS to Managed Long Term Services and Supports," CMS Technical Assistance document, available at https://www.medicaid.gov/medicaid/hcbs/downloads/training/ffs-to-mltss.pdf.

[4] See Center of Aging and Community Living, Policy Brief #1, "New Hampshire's Long Term Services & Supports System: Recommendations for Meeting the Needs of an Aging Population," Winter 2014, available at https://chhs.unh.edu/sites/chhs.unh.edu/files/departments/center_on_aging_and_community_living/cacl_2014_policy_brief_nh_long_term_services_and_supports_system_winter_2014.pdf

In response to the growth of MLTSS, CMS, in April 2016, released a final rule (the Medicaid Managed Care Rule) which created new standards for MLTSS programs.[5] The final rule reinforced earlier sub-regulatory guidance which described ten elements of high-performing MLTSS programs, and incorporated standards on the following issues:

#	MLTSS Standards
1	Adequate Planning
2	Stakeholder Engagement
3	Enhanced Provision of HCBS
4	Alignment of Payment Structures with MLTSS Goals
5	Beneficiary Support
6	Person-Centered Processes
7	Comprehensive and Integrated Service Package
8	Qualified Providers
9	Participant Protections
10	Quality Standards

ProShare Payments to Counties and the Medicaid Managed Care Rule

Another component of the new federal Medicaid Managed Care Rule affects New Hampshire as well. The rule prohibits most "state-directed payment arrangements." Across the country, Medicaid agencies make allowable supplemental payments to certain types of providers – typically public providers in their fee-for-service systems. In previous years, CMS approved incorporating many of these payment arrangements into managed care contracting arrangements. However, the new regulations explicitly prevent state-directed payments from being made through MCOs unless they meet standards set forth in the Medicaid Managed Care Rule. States with formerly approved arrangements that do not meet the new standards are being required to phase them out, and no non-compliant arrangements will be newly approved under managed care during this phase out period.

ProShare payments to county governments are a supplemental payment arrangement that would be prohibited under managed care contracts by this new regulation. In other words, if the state moves to MLTSS, the state could no longer make these payments directly and would not be able to compel managed care plans to make ProShare payments as they currently exist. This means the loss of federal dollars, which support 50% of the current ProShare payment arrangement.

The rule describes permissible payments that states can require of MCOs. Conceptually, a new payment arrangement, perhaps based on a new performance initiative or another value-based strategy, could be developed to address the fact that ProShare will not exist under an MLTSS program. However, it may prove difficult to hold counties harmless without additional state costs, because CMS expects that

[5] The Medicaid Managed Care Final Rule was published at 81 *Fed. Reg.* 27498-27901 (May 6, 2016), available at https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. See also CMS Technical Assistance document related to the rule available at https://www.medicaid.gov/medicaid/hcbs/downloads/training/ffs-to-mltss.pdf.

permissible payments will apply to all providers in a class, whereas ProShare is available only to county-operated nursing facilities. Moreover, any change in ProShare payments to meet these new standards will require an annual negotiation and approval process with CMS. It also appears that, if a payment arrangement were designed to meet CMS standards, it would very likely change the distribution of the payments across counties, possibly creating advantages for some counties and disadvantages for others.

7. Assessment of The New Hampshire LTSS System

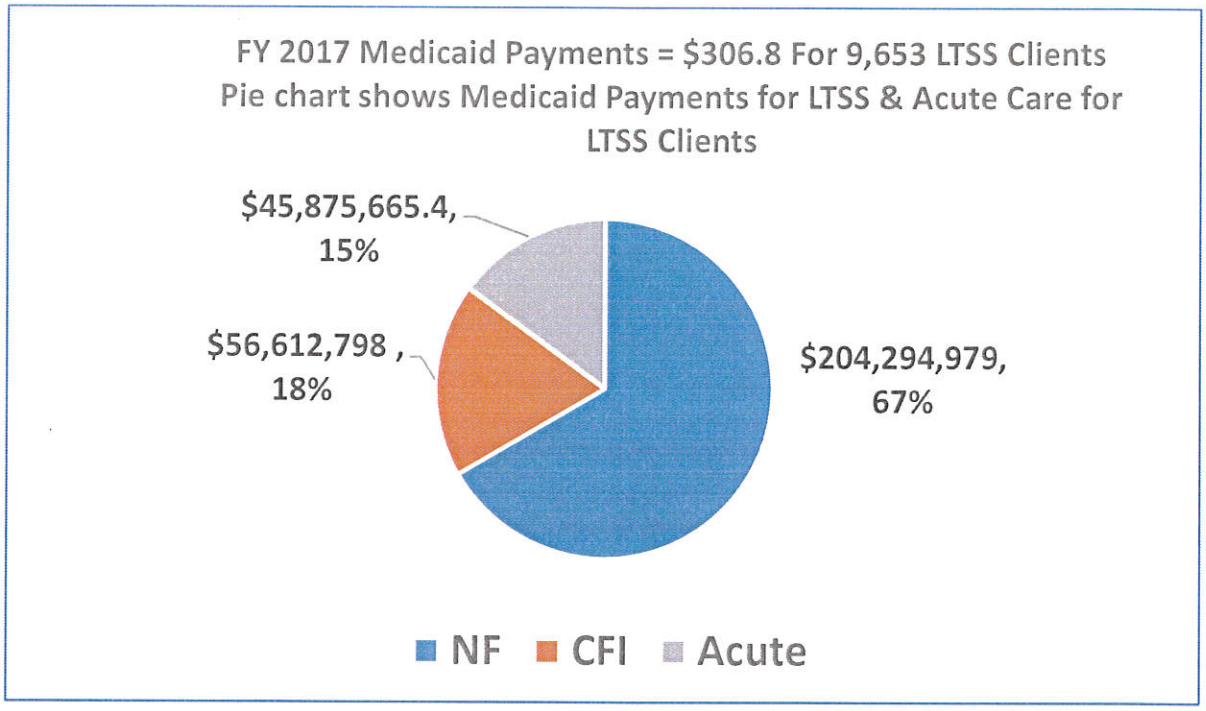
NHAC contracted with Health Management Associates (HMA) to support its assessment of the New Hampshire LTSS system and to identify alternative reforms to MLTSS. HMA worked with NHAC to develop a baseline assessment of the existing LTSS system. Below we report our basic assessment of the New Hampshire LTSS system and describe, based on that assessment, areas of concern with the system and the move to managed care. The material discussed below is informed by: (1) material prepared for and discussions at the NHAC-DHHS meetings; (2) materials prepared for and provided to the SB553 Working Group; and, (3) an analysis of data provided to NHAC and HMA by DHHS.

New Hampshire LTSS System: Imbalance between Institutional and Community-Based Care

New Hampshire has a very unbalanced system of long-term services and supports for older adults and people with physical disabilities. The state LTSS system relies heavily on institutional care over in-home or community-based services. New Hampshire's relatively high use of institutional settings is costly and makes it less likely that individuals needing LTSS receive care in the setting of their choice.

Of total Medicaid spending for LTSS clients, 67% is spent on nursing facility care, and only 18% on CFI services. (The remaining Medicaid spending, 15%, is for acute-care services. This is generally spending for services not covered by, or individuals not eligible for, Medicare, which otherwise covers most acute care for most LTSS clients.)

Figure 1: Total Medicaid Payments for all LTSS Clients



States across the country have prioritized expanding community-based LTSS in an effort to create sustainable systems and offer alternatives to institutional or nursing facility care. New Hampshire is slightly below the national average on accepted measures of rebalancing, but that all-population ranking is misleading.

New Hampshire's ranking of 21st in the nation is distorted by New Hampshire's impressive success at de-institutionalizing individuals with developmental disabilities. In fact, New Hampshire ranks 48th of 50 states in the percentage of LTSS funds spent on HCBS for older adults and people with physical disabilities, which is the population contemplated for managed care in Phase 2.

Table 1: State Rankings: HCBS Spending

State Rankings: Percentage of Medicaid LTSS Spending on HCBS

	All Populations including DD		Older Adults and People with Physical Disabilities	
	Rank	% HCBS	Rank	% HCBS
Highest: Oregon	#1	82.2%	#1	81.1%
Lowest: Mississippi	#49	30.6%	#31	28.8%
New Hampshire	**#21**	**52.0%**	**#48**	**15.4%**
Alabama	**#41**	**42.1%**	**#49**	**14.1%**
Kentucky	**#43**	**41.3%**	**#50**	**12.5%**
United States	Avg	54.8%	Avg	43.8%

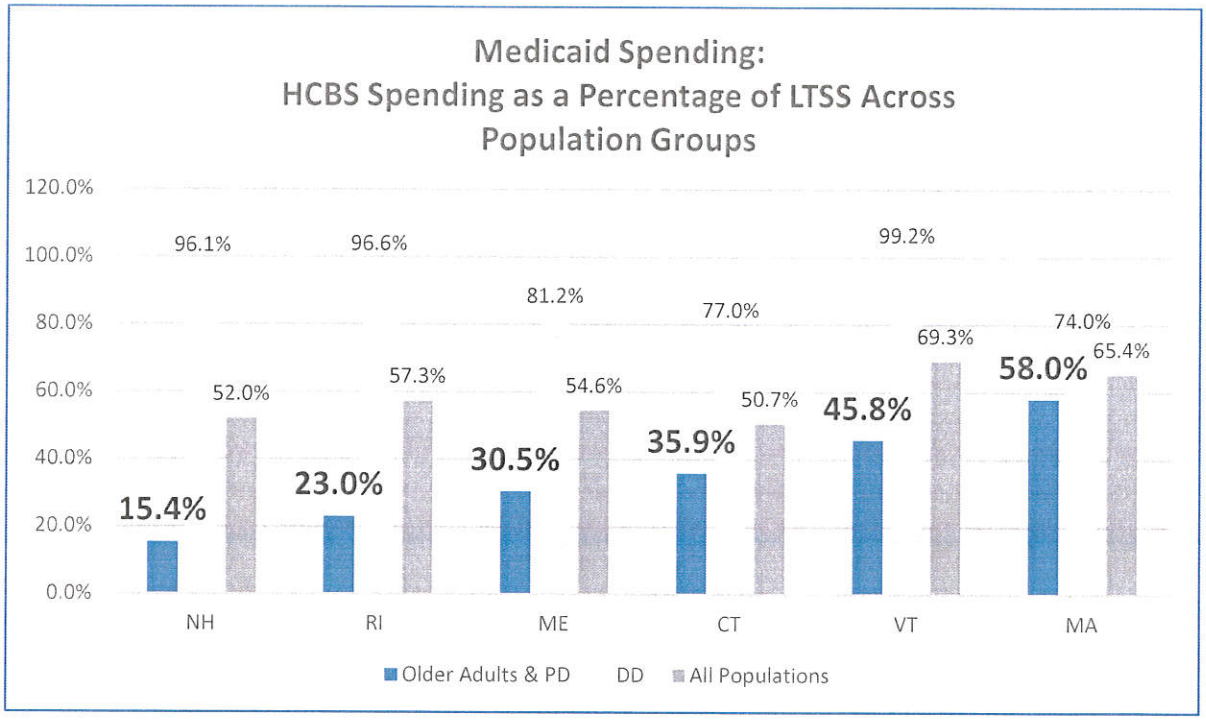
New Hampshire LTSS System: Possible Areas of Concern

We address below possible or likely causes of the imbalance described above. NHAC believes that all of these issues deserve further study and analysis.

Area of Concern: A Poorly-funded LTSS System

New Hampshire LTSS providers, including the counties, have regularly conveyed that reimbursement rates are low and have grown very little over the last decade. In addition to provider rates, New Hampshire has well below-average rates of community based spending. When compared to other New England states, New Hampshire spends significantly less on community-based care; we are particularly concerned about the population of older adults and persons with physical disabilities. As the following graph indicates, NH's spending on home-and-community-based waiver services represented only 15.4% of all spending on LTSS for older adults and persons with physical disabilities, as compared to the rates of community spending in the other New England states which range from 23% in Rhode Island to 58% in Massachusetts.

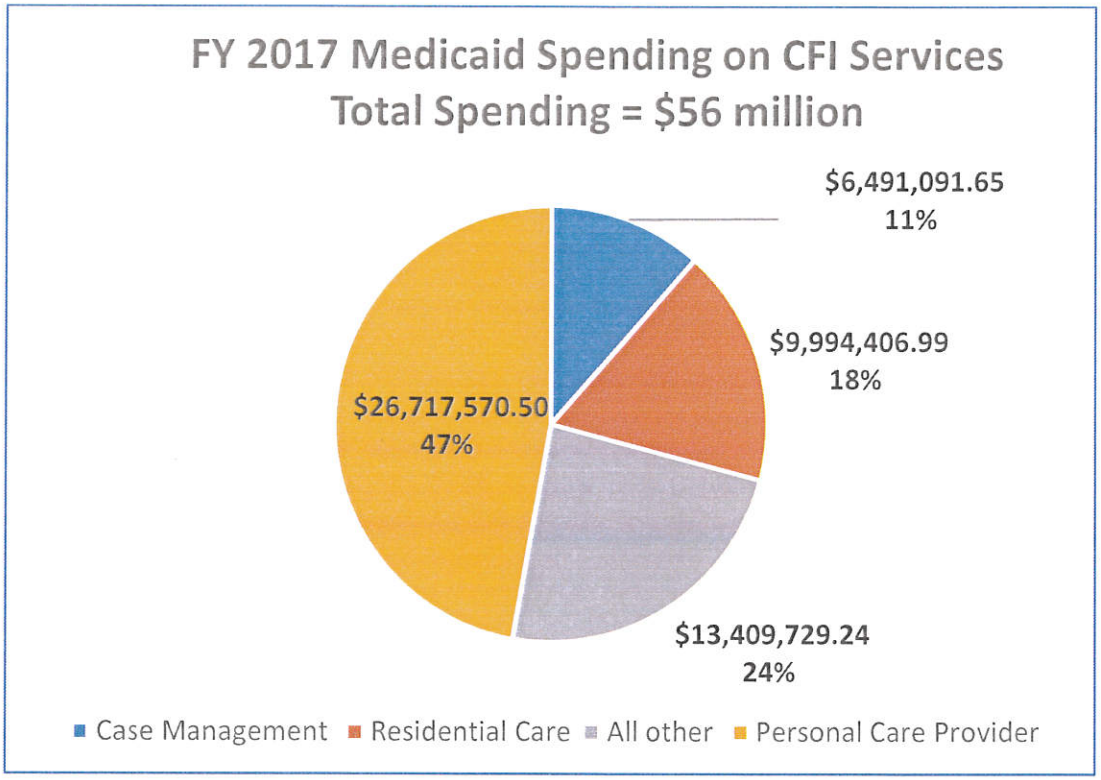
Figure 2: New England State HCBS Spending



Area of Concern: An Under-developed Community-based Service System

In practice, CFI service offerings are limited. More than 75% of CFI dollars support only three services: case management, residential care, and personal care services. New Hampshire does not have significant utilization of other fairly common community-based services, such as adult day care. The CFI waiver does not provide, as a growing number of state HCBS waivers do, reimbursement for family caregivers. A growing trend in HCBS waivers, consumer-directed care, is newly authorized under a recent CFI amendment but is not fully developed in New Hampshire. Consumer-directed care can take different forms, but generally involves greater independence and engagement from individuals receiving care in either what services they will receive, or who will deliver those services.

Figure 3: Total Medicaid CFI Spending by Service, FY 2017



It is also worth noting that LTSS provider system in New Hampshire is comprised of a great many very small providers and a low number of very large providers. Payments to the largest five CFI providers comprise one-third of all CFI spending. When managed care is introduced, providers often consolidate to increase negotiating leverage and lower overhead, and this would be very likely to occur in New Hampshire given its existing LTSS provider system. But given the rural nature of the state and the relatively small amount spend on community-based services today, a community service delivery system that is so concentrated raises issues about the capacity of the system to expand current community-based services and to introduce new services that will help avoid institutional care.

Table 2: Average CFI Waiver Payments by Provider Size

CFI Payments					
Quartile	Payments	Payments by quartile	# Providers	% Distrib of Providers	Avg. Payment Per Provider
Bottom quartile	$ 14,255,478	25%	147	80%	$ 96,976
2nd quartile	$ 13,984,887	25%	25	14%	$ 559,395
3rd quartile	$ 12,858,421	23%	8	4%	$ 1,607,303
Top quartile	$ 15,514,012	27%	3	2%	$ 5,171,337
Total payments	**$ 56,612,798**	**100%**	**183**	**100%**	**$ 309,360**

Area of Concern: A Weak Care Management and Care Coordination Infrastructure

Care management is a central element of LTSS rebalancing reforms. It serves to identify an individual's needs for services, to communicate available community service options, and to arrange for the delivery of LTSS services. County nursing homes have regular contact with CFI care managers. That function is designed generally to provide options to individuals who may need LTSS, but NHAC believes it may not perform the in-depth, person-centered care planning and ongoing intensive care coordination functions that are considered integral to a well-functioning LTSS delivery system and especially critical to promoting access to community based alternatives to institutional care.

8. NHAC Assessment: Implications on the Plan to move to Managed Care for LTSS

The performance of the New Hampshire LTSS system illustrates an LTSS system that is in dire need of reform, particularly as New Hampshire plans for an aging population. In general, NHAC believes that DHHS does not disagree with its assessment of the system. In fact, DHHS believes it may be able to address many of the issues with the LTSS system in the context of Phase 2's MLTSS reform. Unfortunately, NHAC does not believe that implementing Phase 2 is the right decision, because: a) no replacement for ProShare funding exists; b) the LTSS system in New Hampshire is in need of substantial investment, which is not an element of the Phase 2 plan; and c) the plan does not meaningfully integrate Medicaid with Medicare, which provides acute care services to 90% of individuals using LTSS. We address each of these points in more detail below.

ProShare funding is crucial to the overall financing of LTSS and will be eliminated with no alternative established.

NHAC believes that DHHS agrees that ProShare as it currently exists will not be allowable under a managed care delivery system. DHHS has not shared any information with NHAC about a proposed replacement payment arrangement that would satisfy CMS standards while preserving state and federal funding under the program for counties.

The lack of a solution to the ProShare issue remains a significant problem; loss of any funding for county governments and for the LTSS system that relies on county-operated nursing facilities and financing

further weakens the state's LTSS system. Even if the state is willing to contribute the same state funds toward county-operated nursing facilities, NHAC believes that addressing this problem will require more analysis and significant discussion and negotiation with CMS to preserve access to critical federal funds. In addition to the work necessary to develop any new payment arrangement, it is essential to assess the impact of the arrangement on county budgets, because it is likely that the impact will have a differential impact across counties.

Managed Care is not a solution to all system problems.

NHAC believes that managed care is not a "magic bullet" that can fix what are in truth fundamental deficits in the LTSS system. Those deficits – an overreliance on institutional care, a lack of investment in community-based care, and a need to develop effective person-centered care coordination and care management – need to be addressed. Doing so will require the development of and investment in new services that will enable the system to allow a greater reliance on community-based care. Moving the current system into managed care without a concrete plan for investing in community-based services and providers is unlikely to solve the problems that are apparent with the New Hampshire LTSS system. This is especially if that movement presumes a level of targeted budget savings instead of explicit reinvestment of funds into further LTSS system development and reform.

MLTSS programs are complex and require significant planning. The programs do not necessarily save money. The premise of MLTSS saving money is that a managed care company will have an incentive to support more community-based care and avoid or delay institutionalization. But this premise is based on an assumption that the system the managed care plan is responsible for is prepared to encourage more community-based LTSS capacity and to integrate care across physical, behavioral and LTSS to avoid poor health outcomes that lead to institutionalization.

In fact, New Hampshire's experience with "Phase 1" of managed care is instructive. In that case, the state assumed it would save money from moving to managed care, but found instead that its baseline payments to providers were inadequate. Solving that problem essentially overtook any state savings in capitation rates. NHAC believes that a similar circumstance could arise with Phase 2 regarding Medicaid LTSS.

This concern is of particular interest to NHAC, because counties are not just providers of care in the LTSS system; they are responsible for financing the state share for the system. As the current financing structure for the LTSS system stands, county budgets are responsible if reform of the system will require new investments and lead to increased costs. That means counties will have to increase property taxes, which are their main source of revenue. These concerns are compounded by the jeopardy to ProShare funding under MLTSS arrangements.

Real LTSS reform should include integrating Medicaid and Medicare services.

Finally, NHAC believes that it is a significant mistake to ignore the importance of Medicare coverage in reforming the LTSS system. A large majority (90%) of the members who receive LTSS services in New Hampshire are dual eligibles who receive both Medicare and Medicaid. Studies show that program structures supporting fully integrated care for dual eligible individuals result in more appropriate utilization of services and reduction in use of high-cost services, including reduction in hospitalizations, re-hospitalizations and emergency room use. Indeed, many states have moved to MLTSS reforms that

include integration with Medicare precisely because a well-designed system will reduce unnecessary hospitalizations and specialist visits, which are paid for by Medicare. Without an approach to Medicare-Medicaid integration, the state will not get the benefit of the savings that an improved system could, over time, generate.

9. NHAC/DHHS Discussions

Over the course of NHAC's discussion with DHHS, it has been clear that the counties and the state agree on certain policies or systemic needs. For example, a recurring need during the discussion was the importance of **expanding consumer-directed services**. There is no reason why New Hampshire needs to move to MLTSS to accomplish this goal. In fact, the state operates a well-regarded set of consumer-directed services for the DD population now, without the use of an MCO. Similarly, and as discussed more fully above, NHAC and DHHS both agree about that **improved case management** is a lynchpin of any LTSS reform. The counties believe that achieving that goal does not require a transition to managed care, although with or without managed care it will likely require investments in infrastructure and enhanced requirements for capacity.

Another promising reform discussed during NHAC's meetings with DHHS was the creation of county-operated PACE programs.

What is a PACE Program?

PACE fully integrates all Medicare and Medicaid services through capitated financing to promote integration of primary, acute, specialty and long-term services and supports for frail older adults. The principle tenet of the model is the belief that it is better for older adults with chronic conditions and their families to remain in the community for as long as possible as opposed to institutionalization. PACE serves individuals age 55 and older who are certified by their state to need a nursing home level of care, are able to live safely in the community at the time of enrollment, and live within a PACE service area. Currently, 122 PACE organizations operate 233 PACE centers in 31 states and serve more than 40,000 frail older adults nationwide. The model is designed to operate around a physical site – usually an adult day care. PACE centers average 172 enrollees.

Typically, care is provided by an interdisciplinary team (IDT) representing at least 11 professions. The team oversees and provides all medically necessary care for each PACE enrollee. The IDT includes a primary care physician, registered nurse, master's-level social worker, physical therapist, occupational therapist, recreational therapist, dietitian, PACE center manager, home care coordinator, personal care attendant and driver.

By providing or coordinating all needed medical and supportive services, PACE programs are able to provide the entire continuum of care and services to older adults with chronic care needs while enabling them to maintain their independence in their homes for as long as possible. Care and services include the following:

- adult day care, offering nursing, social work, nutritional counseling, meals, personal care, as well as physical, occupational and recreational therapies
- medical care provided by a PACE physician familiar with the history, needs and preferences of each participant

- home health care and personal care
- all necessary prescription drugs
- social services
- specialties such as dentistry, optometry, podiatry, audiology and speech-language pathology among others
- respite care
- hospital and nursing home care.

Moving toward a PACE Model

There are no PACE programs in New Hampshire today. NHAC believes that exploring county-operated PACE programs is a very good idea. PACE programs are an alternative to traditional managed care arrangements, so states do not include PACE enrollees in MLTSS.

It is important to understand that the work to develop and implement a PACE program is intensive. It will include performing in-depth assessments of demand, developing clinical and other network partners, and identifying sources of funding for infrastructure development (including operation of an adult day care center) and necessary capital reserves (because PACE providers assume full risk for both Medicaid and Medicare services). PACE programs need to complete a 65 page application accompanied by a 26-page state readiness review report,[6] and must be approved by both state Medicaid and federal Medicare regulators. PACE programs, by design, tend to serve relatively small numbers of individuals per site, but are very effective at delaying and even preventing the need for institutional LTSS.

NHAC believes that the PACE model, which fully integrates Medicaid and Medicare services and has been very successful in other states, is worth exploring further as an alternative to MLTSS. NHAC stands ready to work with DHHS and the Legislature to identify resources that can support the significant planning and analytical work necessary to fully develop county-operated PACE programs.

10. Conclusion

NHAC fully supports reforming the state's LTSS system, and believes that over the long term, reform will rebalance the system toward community-based care and away from institutional care. However, based on NHAC's review of the LTSS system, preparing the system for this transition will require new investments in the community-based system, new services, and enhanced care management. This is the case whether or not the system is being financed through managed care. Ultimately, the system is being funded by county budgets, and NHAC believes that a fuller assessment of the deficits in the system, and a more detailed analysis of potential funding needs, is needed both to appreciate the impact of reform on county property tax rates and to ensure that any reform is successful. As a result NHAC does not support implementation of Phase 2 at this time. Moreover, implementing Phase 2 will eliminate a central support for the counties that finance the LTSS system (federal participation in ProShare funding), and DHHS has not identified and ensured the approval by CMS of any replacement.

[6] See a copy of the 2018 PACE Application at this link: https://www.cms.gov/Medicare/Health-Plans/PACE/Downloads/PACE_Initial_and_Service_Area_Expansion_Application_-_2018.pdf

NHAC stands ready to work with DHHS and the Legislature to explore the implementation of PACE programs in New Hampshire, to support more detailed analysis of the current system's costs and needs, and ultimately to design workable reforms that will improve the quality of the LTSS system and enhance the availability of community-based services for New Hampshire residents who need and want them.