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Title XIX – NH

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(Reserved)

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ACCESS SUPPLEMENTINVESTIGATION OF ACCESS ISSUES AND RESPONSIVE ACTIONS

(continued)

Surveillance by the Medicaid Client Services Unit is a second method of detecting any discrete events which create an access to care issue. This Unit manages a call center, providing ombudsman services to clients who need assistance, maintaining an up-to-date network reference guide, and offering referrals to providers upon request by any recipient or recipient representative, and providing transportation assistance and transportation reimbursement. The Unit is dedicated to resolving Medicaid recipient concerns on a real time, case-by-case basis. The client call tracking logs maintained on each of these individual responses to recipient concerns are a rich source of information about multiple discrete access issues; examination of these logs can assist in identifying indications of a trend across discrete access issues, which may require prompt intervention. New Hampshire has long had in place a toll free 800 number that beneficiaries can call for assistance. The phone number appears on the Medicaid member card, in the member welcome packet, and in all beneficiary communications and outreach materials. Should a discrete access issue be detected, NH would investigate facts directly from those providers implicated, analyze client impact, confirm alternative provider availability, and augment resources to the Client Services Unit to include additional staff and extended hours of operations if needed. Specific messaging to Medicaid beneficiaries potentially impacted would be issued as deemed necessary via media outlets, community network partners, and social media. A written synopsis of access issues identified in each quarter, if any, and New Hampshire Medicaid program's responses to them, is included in the following quarter's access monitoring report. Quarterly access monitoring reports are available under "Medicaid Access Monitoring" at www.dhhs.nh.gov/ombp/publications.htm.

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PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT
HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

1. Outpatient Hospital Services -An interim payment shall be made based on a percent of charges. Final payment is made in accordance with a percent of costs. An audit of each hospital's actual costs eligible for reimbursement shall be performed by the fiscal intermediary in accordance with federal Medicare requirements. The Department shall determine the percent of actual costs to be reimbursed, and then payments made to the hospital shall be cost settled using the percent determined by the Department and the actual cost data audited by the fiscal intermediary. Laboratory services provided as part of an outpatient hospital visit are reimbursed through an add-on fee and are paid in addition to the percentage of cost payment for the outpatient visit.

The interim rate established for each hospital is set as a Ratio of Cost to Charges (RCC) derived from the last settlement processed. Each hospital shall, after the close of its own unique fiscal period, submit the Medicare Cost Report (CMS Form 2552) as required by Medicare, which is subsequently audited by the Medicare Fiscal Intermediary according to the Medicare auditing schedule and principles of reimbursement. Allowable costs are allocated to the outpatient services rendered to NH Medicaid recipients on Worksheet E-3, Part III. The current reimbursable amount of the costs is at 54.04% for acute care non-critical access hospitals and 91.27% for critical access hospitals and rehabilitation hospitals. The actual interim payments made during the cost period are compared to the reimbursable costs determined by audit and the difference is the settlement payable to the hospital or to the Department. The results of this review are reported by the fiscal intermediary to the Department and to each hospital. Settlements due to the hospitals are paid in accordance with the timely claims payment requirements of 42 CFR 447.45.

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The State of New Hampshire monitors access to care and produces an access report on a quarterly basis under its monitoring plan. New Hampshire Medicaid will continue to review and revise the monitoring plan itself to ensure the continued relevance of the selected indicators and to expand it over time to include other Medicaid benefits, including behavioral health, long-term care services, and managed care. The access monitoring plan is based upon a two-tier detection system. The first detection method is based on the systematic, ongoing monitoring that is used to address access issues that develop gradually over time. The second method is the real-time and individualized detection of discrete access issues that are generally handled by the Medicaid Client Services Unit.

Surveillance through systematic, ongoing monitoring is one method of detecting an access issue. The following situation in systematic reporting will trigger the deployment of an Access Response Team:

- A data point above the upper control limit or below the lower control limit, depending on the measure; or
- The current period data for a given measure deviates to a degree that the confidence interval does not overlap with the prior period's confidence interval.

Should a systemic access issue be detected through New Hampshire's quarterly access monitoring report, New Hampshire Medicaid would activate an Access Response Team to research the specific cause(s) of the problem and make recommendations for responsive action. The members of the Access Response Team would be drawn from several of the following functional areas: client services, financial management and reimbursement, benefits management, provider network management, and data analytics. The Team would be responsible for determining the cause of the access issue, proposing responsive actions, including assessing the need to make modifications to the access monitoring systems. The Medical Care Advisory Committee (MCAC) will serve as a resource to engage stakeholders in this process of resolving any identified access issue. The Team would then submit a proposed response for the review and approval by the State Medicaid Director and the Department's Medicaid Executive Team. The timing and nature of any responsive action taken will necessarily depend upon the particular nature, complexity and magnitude of the access problem identified and the beneficiary population affected, but responsive action plans will set a target date for resolution of the identified access issue; and, in all cases, the target date will be set sometime within one year of the date that the responsive action plan was approved by the Medicaid Executive Team. Possible responsive actions may include, but are not limited to:

- Resolving provider administrative burdens, such as claims submission and payment issues;
- Assisting beneficiaries in obtaining necessary primary or specialty care services through provider referral, transportation assistance, or enrollment in Medicaid Managed Care;
- Assessing and realigning covered benefits so that additional resources can be directed toward a resource-challenged area;
- Incentivizing the expansion of health care providers in underserved areas in the State; or
- Restructuring rates and targeting them to address the particular underserved areas.