

Governor's Commission

**To Review and Advise on the Implementation of  
New Hampshire's Medicaid Care Management Program**

**MINUTES**

**January 8, 2015  
Legislative Office Building, Concord, NH**

**Welcome and Introduction**

The meeting was called to order by Commissioner Mary Vallier-Kaplan, Chair, at 2:05pm. Present in addition to Commissioner Vallier-Kaplan were Commissioners Donald Shumway, Nicholas Toumpas, Douglas McNutt, Roberta Berner, Yvonne Goldsberry, Gustavo Moral, Tom Bunnell, Kenneth Norton, Susan Fox, Wendy Gladstone, and Jo Porter. Commissioner Vallier-Kaplan welcomed everyone to the first meeting of the new year and thanked UNH for means to stream the meeting. Commissioner Vallier-Kaplan thanked the senators and representatives, as well as the public for attending the meeting. Commissioner Vallier-Kaplan welcomed everyone and invited the Commissioners and the public to introduce themselves, and asked for those within the public who are representing others, e.g. consultants or attorneys, to identify who they are representing. She also mentioned that Kathy Sgambati from the Governor's office will be joining the meeting later.

Commissioner Vallier-Kaplan stated that the commission has been meeting for over a year now. The first half of the meeting typically contains feedback received since the last meeting, updates and new issues, new implementations. She stated that she also leaves time for the public to ask questions as it is important to give the public the opportunity to follow the process and engage in the Commission's work. This meeting time is to discuss systemic issues with the process but also there may be personal issue that are an example of the systemic issue and the Commission understands that too.

During first half of the meeting Commissioner Toumpas will review current MCM enrollment, feedback on the Key Performance Indicators Report and notable results, responses to issues raised in past meetings. A review of Step 2 planning will presented after that. After the break, New Hampshire Health Families and WellSense will be presenting on implementation of Step 2. Questions and time for a public listening session will follow.

**Minutes of the December 4, 2014 Meeting**

Commissioner Mary Vallier-Kaplan references the correction to the November 6, 2014 minutes and the correction which reflects that both Commissioners Porter and Goldsberry attended the meeting virtually. Upon acknowledgement of the corrections a motion is made and seconded and the minutes of the December 4, 2014 meeting of the Commission are approved. These minutes are kept on the Governor's website and DHHS website with the other materials from the meeting. Commissioner Mary Vallier-Kaplan shares any information or engagement since the last meeting. Commissioner's Don Shumway and Mary Vallier-Kaplan attended a meeting on December 30, 2014 at the Department of Health and Human Services (DHHS) with Lisabritt Solsky of DHHS and Karen Boudreau from WellsSense regarding changes in the relationship with Children's Hospital in Boston. They want the Commission to be kept informed. The Commissioner of Health and Human Services will share more about this during his

update. Commissioner Vallier-Kaplan also states that since the last meeting she received an email from Sarah of ABLENH looking for documents relative to any concerns with Medicaid Care Management. The Commissioner states that the Commission will work with the Governor's Office in particular as it relates to HIPAA issues, as many things sent do have particulars about patients and providers. Sarah will receive something in response to this request during this month.

Commissioner Vallier-Kaplan states they have also had correspondence with two transportation providers, as well as clients over the past few months related primarily to reimbursement. The MCOs, DHHS and the Governor's office have been engaged. The Department is focusing in on this and we will have an update at the February meeting.

The Disability Rights Center has written recommendations regarding step 2 which have been shared with the Commission and will share with the group today.

Letters were also received from the NH Health Care Association and Homecare Association. These letters were sent to Commissioner Toumpas asking whether they could be of assistance in step 2 planning.

Another document sent to the Commissioner Toumpas was a copy of our letter with the principles of Step 2. Commissioner Shumway and Commissioner Mary Vallier-Kaplan have a meeting with Governor on January 23rd to discuss this.

For people in the public, Commissioner Shumway's office keeps track of all emails and they are acknowledged by his office. We are conscious of HIPAA violations. If Commissioner Shumway receives an inquiry or concern from individuals we try to let the individual know that they should follow process with the MCOs organizations.

### **DHHS MCM Update**

Commissioner Vallier-Kaplan introduces Commissioner Toumpas for an update on MCM implementation. Commissioner Toumpas introduces a presentation that is updated and refined each month to provide a standard MCM update. The presentation focuses on enrollment updates, the Key Program Indicator (KPI) report, Step 2 MCM planning and implementation, other updates, and general Q&A from the Commission and the public. The MCM program began on December 1, 2013 and has been underway for 13 months. The principles of the program include whole person management and care coordination, increasing the quality of care, payment reform opportunities, budget predictability, and purchasing for results and delivery system integration. Commissioner Toumpas states he will go through the monthly enrollment update, NHHPP, Key Indicator Report and then turn it over to Lorene Regan who will review Step 2 planning. He will then open the meeting up for Q&A regarding these numbers. Commissioner Toumpas states that he would like to hold any questions on Children's Hospital until the DHHS hears from both MCOs but the topic can be discussed at a high level. He also states that he appreciates the statements made in emails he received regarding information that is floating around that is flirting with HIPPA violations and the department is concerned. The first point of entry is with the MCOs and the Department.

### **Monthly Enrollment Update**

As of January 1, 2015, there were 145,763 people enrolled in the MCM program. Commissioner Toumpas states that you can see from the numbers that the September timeframe ramp up was due

almost exclusively to the New Hampshire Health Protection Program (NHHPP). When you look at the numbers of all the Medicaid eligibility categories they are relatively flat. The only areas of increase are NHHPP and the MAGI populations. The 22,067 enrolled in Medicaid but not enrolled in MCM consists of several groups: those who are not mandatory and therefore cannot be mandated into the program, those who have opted out of the program, those who have been deemed eligible for the New Hampshire Health Protection Program (NHHPP), and those who have enrolled in the MCM program but have not yet selected a plan and therefore remain in fee-for-service (FFS) until they do so. DHHS has seen an enrollment uptick from the middle of August until the beginning of October, which reflects the NHHPP population entering the system. In terms of MCM program enrollment by plan, Well Sense has 78,952 members enrolled and New Hampshire Healthy Families has 66,811 members enrolled, which reflects the transition of all Meridian Health Plan members upon their exit at the end of July. Low income children ages 0-18 make up the majority of MCM program population, as it does in the Medicaid program itself. Roughly 70% of the Medicaid population is low income women and children, who are clearly reflected in the health plans' enrollment numbers. Other areas include non-MCM enrollees and NHHPP enrollees who have not yet selected a plan, as well as the others who have not yet opted into program.

### **NHHPP Update**

Commissioner Toumpas describes how the NHHPP began in August 2014, which reflects an additional enrollment increase in the program. As of January 5, 2015 there are over 30,000 people enrolled in the NHHPP and as of this meeting we are bumping up against 31,000. Over 14,609 of these clients are new to DHHS and have not had health insurance in the past, while 7,882 are new to the NHHPP but have been clients in the past. When an individual is deemed eligible for the NHHPP, they have 60 days to select a plan. Currently, 12,801 are enrolled in Well Sense Health Plan and 11,357 are enrolled in NHHF. The remaining 5,567 are in Fee for Service as they have not yet enrolled in a plan.

Commissioner Toumpas explains how enrollment in the Health Insurance Premium Program (HIPP) as part of the NHHPP is a lengthy process. Currently, 105 individuals are enrolled in the HIPP program with 589 others potentially eligible for HIPP.

Commissioner Toumpas opens the meeting to the Commissioners for comments and/or questions on MCM enrollment numbers.

Commissioner Porter asks to clarify if there are 105 in HIPP already enrolled and if the 595 are in the process and have not yet enrolled into the program.

Commissioner Toumpas responded that there are a number of others in the queue but that she is correct.

Commissioner Tom Bunnell commented that it appears that the Commissioner is clear about the increased enrollment numbers related to NHHPP and asked if there is clarity as to how many of the new folks are attributed to the MAGI change as opposed to the "welcome mat" or "woodwork" effect?

Commissioner Toumpas responds that we had two different areas over the past year where we saw a significant run up in enrollment with one being at the turn of the calendar year 2014 through May where we saw an increase of about 12,000 people due exclusively to MAGI (low income, children, parent caregivers and pregnant women). What was happening prior to this was a slight decrease with the traditional Medicaid population. This is still true today. DHHS worked with the Lewin group to get

projections of the woodwork effect, those that were eligible for Medicaid but had never enrolled. It turns out that we did not see an increase due to this effect. The MAGI calculation works the same way as the woodwork effect because there is a 50/50 match by the Federal government for this population.

Commissioner Toumpas reviews the Key Performance Indicator (KPI) report released by DHHS, which is part of the overall Medicaid quality program. The report is a standard document that DHHS uses to monitor performance of the MCM program and is posted on the DHHS website. Each month the report will follow the same format, building off baseline data from the first few months of the program. The KPI report has also shown things that result in DHHS action to make improvements. If something is troubling, DHHS will act upon it. There is also a user guide embedded in document as a tool for those who review.

The metrics contained within the report include:

- Access & Use of Care
- Customer Experience of Care
- Provider Service Experience
- Utilization Management
- Grievance & Appeals
- Preventative Care
- Chronic Medical Care
- Behavioral Health Care
- Substance Use Disorder Care
- General

For each major domain, Commissioner Toumpas reviews the notable results. He discusses what it means when there is a variance in what is expected with the data and the ability to drill down to see what is going on. He discusses that there is a slight downward trend in provider clean claims but that this could be attributed to staff turnover at one of the plans. Other notable results included provider calls being handled quickly when compared to contract standards for member call centers. There was a slight upward trend in abandoned provider calls and DHHS will monitor this trend. Commissioner Toumpas noted that one of the MCOs had incorrectly reported provider call center data from their transportation vendor. Once these numbers are corrected they will be added back to this measure.

Commissioner Toumpas also discusses that urgent, routine and pharmacy service authorizations are being processed very close to MCM contract standards for timeliness and the service authorization denial rate has remained consistent while the quarterly enrollment has increased. The Service Authorization Requests and Benefits by Type of Service slide was reviewed with the Commission. This data is as of September 30, 2014 so that we do not see the impact of the NHHPP. This shows the number of services requested and denied and the percentage of the denial. This is then broken down by the service category with the largest number of service authorizations for pharmacy. We added this chart into the Key Indicator Report. Other notable results include that the number of grievances has decreased and the total number of appeals has also decreased. There has been an increase in the number of physician services appeals and DHHS will monitor this. Maintenance medication gaps are falling indicating a smaller number of prescriptions with long gaps between refills.

Commissioner Toumpas opens the meeting to the Commissioners for comments and/or questions on the Key Performance Indicator Report.

Commissioner Mary Vallier-Kaplan comments that now that they have real data they will be able to see the value of these data points. Commissioner Toumpas stated that there will be more enrollment data for the February 12<sup>th</sup> meeting and hopefully we can get this report out to the Commission before the meeting in order for them to be able to have questions ready to ask at the meeting.

Commissioner Fox stated that the pharmacy denials seem high. Commissioner Toumpas said that DHHS was looking at that and part of this is a reflection of the MAGI population. Commissioner Roberta Berner requested that this be looked at in more detail for the next meeting.

Commissioner Porter comments that it is interesting that the numbers of outpatient surgeries are going down even with an increase in members over time. She states that she wonders if some of the requests in the first quarter even needed to have a preauthorization. Commissioner Toumpas responds stating that he believes that there was a lot of learning going on with the inception of the program and three very different populations coming in at different times. As time goes on there is more data coming in to look at these results. Commissioner Yvonne Goldsberry made a comment that perhaps the prescription denial rate has to do with generic prescriptions and not that the person is not getting their medication. Commissioner Toumpas stated that DHHS would look into that.

Commissioner Toumpas reviewed the timeline for Step 2 and states that it has not changed. Lorene Regan will discuss this in more details.

### **Update on Step 2 MCM Alignment with Managed Long Term Services and Supports (MLTSS) Principles and Update on Step 2 Stakeholder Forums for Nursing Facility and Choices for Independence Waiver Design Concept**

Lorene Regan thanks the Commission for letting her update them on Step 2 of the Care Management program. Lorene discusses the mandate by NH Senate Bill 147 for the Department to move forward with this mandate. She states that it is important to understand that we are listening to stakeholder input but that it is not the role of DHHS to decide if this will happen as we are mandated to do this. We want stakeholders to know that we are listening to their input as we move forward with the design of the program. The Guiding Principles of the NH Medicaid Care Management Program are mentioned and Lorene then provides a list of stakeholders that have also shared guiding principles, guidelines and recommendation for the integration of Long Term Services and Supports into the NH Care Management Program. What we also have to explain is that we do not have the capacity to respond specifically to all stakeholders' recommendations and guidelines. We need to bring ourselves back to the core guiding principles and recommendations we believe our work is based on. There are a number of guiding principles that have been offered that we have already seen incorporated into Step 2 design.

Many have been incorporated into the Step 2 Design Elements reviewed with stakeholders during Round 2 of the Step 2 Stakeholder Input process, including:

- The importance of retaining clinical and financial eligibility determination within DHHS
- Rate stability in Year 1 of Step 2
- Integration of Conflict Free Case Management Principles
- Safeguards regarding transfers and discharges from long term care settings
- The Importance of retaining current provider networks in Year 1 of Step 2
- Contract requirements regarding Quality Measures
- DHHS approval of potential reductions in services in Year 1 of Step 2

Lorene states that DHHS wants to come to an agreement with the Commission that it is appropriate to identify and follow some major guiding principles that have been shared with DHHS. If we can agree that the Medicaid Managed Care for People with Disabilities, Governor's Commission on Medicaid Care Management, National Senior Citizens Law Center: Advocate's Library of Managed Long Term Services and Supports Contract Provision, and Essential Elements of Managed Long Term Services and Supports Programs, Centers for Medicare & Medicaid Services would be a sound foundation for Step 2.

Commissioner Mary Vallier-Kaplan states that this is the first time the Commission has seen this as proposed. Lorene states that the decision did not have to be made during the meeting. Commissioner Susan Fox states that these principles were used by the Commission to develop the principles for the Governor and agrees that these are the source documents they used and there is a lot of overlap with the other guiding principles that were shared by other stakeholders.

Lorene references a cross walk with the Principles for a Medicaid Managed Long-Term Services and Supports (MLTSS) Program. This document is for the Commission's benefit and DHHS would like feedback by next meeting. This document will be updated on a regular basis. Commissioner Mary Vallier-Kaplan also stated that as a side note the Commissioner is working on getting someone from CMS to come to the February meeting and discuss this from their perspective. This will give the public the opportunity to ask questions.

#### **Update on Stakeholder Forums**

Round two of our Stakeholder Forums to review key design considerations were held in 2014. Susan Lombard presented the concept at the last Commission meeting. DHHS engaged over 225 stakeholders during these sessions and we have some additional stakeholders that we will reach out to before we finalize our design. Round three of the forums will be held in January and February 2015. Once these dates are set they will be sent to you and posted on the Managed Care website.

Commissioner Douglas McNutt states that one concern is that there has not been a way to reach stakeholders that could not come to those meetings. The attendance was primarily providers of service. Lorene states that at one point the team visited the senior center in Littleton. About 20 or 30 people came for lunch but only 2 or 3 people stayed for the presentation. The department has made a strong effort but we are not where we want to be. Commissioner McNutt states we should look at case management agencies. Provider agencies are attending forums and they should bring their individuals receiving services.

Lorene reviews the slides and gives thanks to Susan Lombard for pulling together the questions and answers from the stakeholder forums on the proposed Step 2 design elements. These are grouped in key themes and are available in the PowerPoint presentation.

Lorene discusses the work that DHHS is doing with partners in January 2015 around MCO Education and Technical Assistance. DHHS is working on a number of initiatives revolving around individuals, families and guardians in bringing in MCOs and engaging providers around these issues. We want to make sure that our MCOs understand our information systems and how they relate to our programs. We had heard from stakeholders that it is important that we make sure our MCOs understand how things work at the department level, provider level, and member level.

There are a number of other key activities that are also underway. These include:

- Crosswalk to Commission Principles
- MCO Transition Plans
- Common Understanding of Roles, Responsibilities and Accountabilities
- MCO Contract Development
- Development of Quality Strategy
- 1915[c] Waiver Amendments to Centers for Medicare and Medicaid Services: allows for inclusion of Waiver services in Managed Care
- Development of 1915[b] Waiver for submission to Centers for Medicare and Medicaid Services: allows for Mandatory Enrollment in Managed Care
- Additional Stakeholder Forums and Public Hearings

## Questions

Commissioner Moral asks if the above documents would be available in draft or final form. Lorene responded that it depends on the document in which form it would be available.

Commission Ken Norton states that this was a helpful presentation and very thorough.

Commissioner McNutt asks about the timeline for waiver amendments. Lorene states that it was a short timeline. Commissioner Toumpas comments that there is a public comment period and the input from the public along with the concepts will be considerations for the waiver in its development.

Commissioner Bunnell asks if DHHS anticipates a deadline for the waiver. Commissioner Toumpas said that we are on a fast track and that CMS is aware of what we are doing and the level of input we are getting.

Commissioner Shumway states that CMS will be attending the February meeting and if the MCAC will have a role in the waiver review. Commissioner Toumpas states that yes; there is a general rule that the MCAC is required to review these documents.

Commissioner Mary Vallier-Kaplan states that at the last meeting there were comments and discussion around the projected date for implementation of the waiver and its dependency on a specific cutoff date. Commissioner Toumpas explains that yes, we continue to work with CMS and we cannot move forward with enrollment until we have everything laid out. There is a narrow window but we continue to look at the documents from stakeholders and we are moving forward with guiding principles which are related to the process. We are being as transparent as we possibly can.

Commissioner Mary Vallier-Kaplan also states that she knows with Step 1 there were people that didn't understand how their input got used and how it is prioritized that it gets translated into the contract. Commissioner Toumpas states that under procurement rules we cannot lay out the details of the contract. We are bound by this. We can share the principles but this is a contract negotiation with the MCOs and not a public process.

Commissioner Porter asks if the EQRO organization for Step 2 will be the same vendor as for Step 1. It would be better to have the same vendor for Step 1 and Step 2. Lorene will bring this back to Dr. Lotz.

Commissioner Vallier-Kaplan recognizes a member of the audience who wants to comment from the Nursing Facility perspective. Our clients come to us for our expertise. We are relying on specific

information to answer their questions and transition them. It is a catch 22 since we can tell them that this is coming down the road but are limited to what we can share.

## **Implementation of Step 2 and Principles of NH Healthy Families and WellSense**

Commissioner Sue Fox introduces Scott Westover from NHH Health Families and Dr. Karen Boudreau from WellSense and explains they will do a combined presentation.

The MCOs make observations from Step 1 and share how Step 2 is different. They share a member story as an example. Both MCOs share their own perspective regarding the similarities and differences in their approach. They then discuss the Step 2 philosophy and how the MCOs will work together and work with the existing provider networks and adopt the MCM guiding principles which have whole person management and care coordination as the foundation for Medicaid transformation.

There has been a lot of discussion around principles which they discussed in their joint presentation. The MCOs appreciate the principles to guide our work. We will offer a comment on each of the 10 guiding principles developed by the Commission.

**Principle 1-** Development and Implementation of a quality MLTSS program requires a thoughtful and deliberative planning and design process, building on the strengths of the current LTSS program. This is consistent with the way managed care companies run. Goal is to build long term success in NH. We must build in flexibility to be able to connect clients with services they need.

**Principle 2-** Implementation and operation of the MLTSS program must be consistent with the Americans with Disabilities Act and the Supreme Court Olmstead Act. We must be sure that we are building a program that is durable and acknowledges the work that has gone before us. The idea is to look at what is working in NH and build on it. Experience is important. NH Healthy Families has colleagues in six additional states where they are going through a Step 2 like transition. We can get good feedback from them.

**Principle 3-** Payment structure for LTSS- supporting goals and essential elements of the program. Karen comments that State is one their bosses and their accrediting organization NCQA and EQRO are their others. NCAQ does not have standards at this time around LTSS but will in the next couple of years. It also pushes against the one size fits all approach. We are all working together on a new whole person approach.

**Principle 4-** It is important that the MLTSS participant is engaged in the process with us. We feel strongly that we need to be doing this with our members not for our members.

**Principle 5-** MLTSS program must consider the unique needs of the whole person through person-centered policies and procedures.

**Principle 6-** We believe that this principle benefits the members and the states that we serve these people in. Ensuring one entity is responsible for a comprehensive and integrated package of acute care services and LTSS increases Medicaid program efficiency, avoids cost shifting and service disincentives, and enhances health outcomes and quality of life. This principle reflects the value that NH organizations bring to the members we serve. It also benefits the states where we serve those members. One of the goals here is to create a system to bring the whole person together. Programmatically this is having one organization being responsible for medical, behavioral, social and other needs. From a sustainability perspective, there is an element leading to increased performance. Any idea about savings is not an input it is an outcome. It is easy to think about saving money but this principle says we are going forward with a conviction that

managed care today is about saying yes to the right things that supports the whole person philosophy. If that happens then what you get is savings. I believe we all agree with this principle, but this is the one that causes the most concern. Who is the Care Manager? What is the role of the other providers? How do we work together? It is imperative we all work together.

The model of Comprehensive and Integrated slide is shown. Scott states that is not a proposal. We want to bring forward that we are thinking about this. We believe if we get this right we will build a more sustainable process. We want to understand how the providers that are caring for people today see themselves adding more value to this model.

**Principle 7-** In order to honor participant choice the network needs to be adequate. This is a core responsibility and these providers are coming into a new model.

**Principle 8-** Participant health and welfare in MLTSS is better assured with strong and clearly defined participant protections and supports. We must realize that we are coming into a system that will support the entire person. We talk a lot about the medical model and fixing the person and we hear loud and clear that the disability model is the whole person and quality of life. There will be times when they need both medical and acute psychiatric care. There is a notion of conflict free case management. We will all need to make sure what conflict case management means. We know in the end that it will be defined by the state.

**Principle 9-** It is our full expectation that there will be no reduction in quality of care to participants in the MLTSS model, as compared to fee-for-service model, and the State must exercise all due diligence to maintain or increase the current level of quality.

**Principle 10-**Effective State oversight of MLTSS is vital to ensuring program vision, goals, and managed care contract elements. Both MCOs enjoy very good relationships with the State. We have good communication.

Commissioner Toumpas states that one question that keeps coming up is when providers should begin to talk to the MCOs. Now is the time to start talking to the MCOs. We still have things we can't discuss but we can have high level conversations.

A Commissioner member states that one first slides show that the majority of people enrolled in Step 1 are children. How will case management for this population compare to case management in Step 2. Scott responds that you may be encountering children at the beginning of case management and the vast majority of children do not need many services. The Step 2 population will need more continuous monitoring to ensure that are services they need are available.

Commissioner Norton refers to the Step 2 100% slide. He states that testimony from families is that their person is stable and they have worked out plans with their current providers. They are nervous. Karen sees this as totally understandable. This 100% case management is a shared situation. They may have a case manager and there will be times when the MCO case manager will just monitor the situation.

Scott- This model allows us to have one point of contact within the plan. You are going to need someone to manage both the medical and the non-medical.

Commission thanks the presenters and states that they appreciate the two MCOs collaborated to present the information and that this is the New Hampshire way.

Commissioner Yvonne Goldsberry states she has a concern. On the last slide the MCOs talk about marrying the spirit with the specifics. The fact that in Step 1 there were times that all MCOs were held so tightly to the contract language that it was hard to do the above. The discussion today is collaborative and flexible and she encourages the MCOs to negotiate to get this flexibility into the contract.

Scott in response to Commissioner Goldsberry's comment- Can we work together so we can have the flexibility to do this? With both managed care organizations and the state we will meet a lot to work this out before contract negotiations. We talk a lot with each other and with DHHS. We are always sending questions over to the state. We have developed a level of trust with the state. We know each other now. We usually have different questions that you will have so we cover it all.

Commissioner Moral states that at the beginning of the conversation there are 6 other states that were doing similar things as we are doing with Step 2. What do you hear so far? Scott responds that he hears that we need to pay attention to the role of the Care Manager. How do you link resources and fill gaps? We have to pay a lot of attention to this.

Karen discusses the idea of building on Step 2 programs from Step 1 experience. Communication and collaboration across the board will feel like a more robust team.

Commissioner Jo Porter comments that when you look at principles the language ensures that one entity is responsible. What does that mean? We need to get a firmer grasp of what that responsibility means. What we come to understand is that there are assurances put in place.

### **Public comment period**

Public comment; not identified- Regarding Step 2- primary care providers receive a lot of information and have to review it. Are there any thoughts to how this could be minimized? Karen from WellSense does not have a specific answer but will look for opportunities to have conversations about this. She states they would like to invite primary care physicians into this circle and have discussions about how we could minimize this burden. Scott from NH Healthy Families states that if we figure out how to engage the primary care community we can go out and ask them what they would like. There are also opportunities with provider education trainings.

Comment from Kathleen Sgambati- We heard a lot of concerns about self-directed programs. Do you have any idea how that we look moving forward? The case worker creates the plan and the family manages the budget but what kind of flexibility is there and what kind of services?

Scott states that self-direction is not a principle but core in New Hampshire. We must not limit the flexibility in this. Karen Kimball asked how we support making this even more robust. Scott answers that we will all be working together on this.

Comment from Lori Harding- She states that she is just finished up 10 years in the legislature and would like the MCOs to come to her primary care workforce meeting. She states that relative to long term care most of this happens at the county level. How will this work at the ground level?

Comment Karen from WellSense- we have begun conversations.

Commissioner Toumpas states he has encouraged the MCOs to meet with the counties because each has a little different model. We are setting up meetings with the counties. We need to have further discussions. First off we need work to educate the MCOs with how the system works. We need to sit down and have

the conversations to reach out the county and private nursing homes. Ultimately, it will be the department that determines the scope of work and the approach. The approach has not been defined

### **Open comment**

Commissioner Sue fox- has one question that came in from an email. Will dual eligible members still have access to care? Medicaid Care Management is the secondary payer when members are dual eligible. Specific to Boston Children's Hospital, we have a model for seamless care so there should not be a disruption.

The way the process works is that the primary will get an authorization and secondary MCO will be in a position to pay as a second payer. The MCO will see a procedure on a roster and the primary authorization is sufficient. But the authorization is not designed to move your children's care away from Boston Children's Hospital.

Public comment; Disability Rights Center gives an overview of the 22 page document that was submitted to DHHS by twelve organizations representing a wide range of individuals currently receiving LTSS through Medicaid in New Hampshire. The goal of this document is to improve access. It is compressive and not a list of things that are wrong with the system. The Disability Rights Center recommends that conflict-free case management be considered and would encourage the department to contract with the current case management agencies. If you look at the CFI waiver programs now the case managers advocate on behalf of the individuals. Commissioner Mary Vallier-Kaplan would like to discuss this document at the February Commission meeting.

Commissioner Vallier-Kaplan adjourned the meeting at 4:35 pm. The next meeting of the MCMC will be held at ATECH, 57 Regional Drive, Concord, NH from 1-4PM on February 12, 2015.

### **Follow-Up Items**

The following items were noted as follow-up items during the January MCMC Meeting:

- Department of Health and Human Services (DHHS) will update the Commission at the February 12, 2015 meeting on the Transportation providers reimbursement issues;
- DHHS will report on the high pharmacy denial rates at the February meeting;
- Commission will review and comment on the Principles for a Medicaid managed Long-Term Services and Support (MLTSS) Program cross walk;
- DHHS will arrange for CMS to attend the February or March 2015 Commission meeting;
- Disability Rights Commission will share the 22 page recommendation letter with the Commission at the February 12, 2015 meeting.