

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

**MINUTES
February 11, 2016
ATECH
Concord, NH**

Welcome and Introduction

The meeting is called to order by Commissioner Mary Vallier-Kaplan at 1:05 pm. Present in addition to Commissioner Vallier-Kaplan is Donald Shumway, Jeffrey Meyers, Doug McNutt, Thomas Bunnell, Yvonne Goldsberry, Susan Fox, Roberta Berner, Ken Norton, Wendy Gladstone, MD. and Jo Porter.

Commissioner Vallier-Kaplan welcomes everyone to the Governor's Commission and introduces herself. She asks the Commission to approve the minutes from the last meeting. A motion is made to approve the minutes and it is seconded. Minutes approved.

Commissioner Shumway received an email on behalf of a provider who was asking questions about the role of the MCM Commission and more specific about the Medicaid expansion and how their contract and rate setting is being done. This email was passed on the Department and Ms. Deborah Scheetz referred the provider to the New Hampshire Insurance Department. Commissioner Vallier-Kaplan then explains that there were two questions from the last meeting that she received answers to from the Department. She states that she wants to share those answers with the Commission. Commissioner Bunnell asked that if an appeal is pending will the member still receive services until a decision is made on the appeal. The Department responded that if the reauthorization for services currently being received is denied the member continues to receive those services during appeal according to Federal law.

A member of the audience asked when will consumers, citizens and parents know how the authorized hours of services and payments for those services that go unused be distributed and how will the contracts with care organizations are written because currently within the area agencies the money connected to unused hours is reassigned. The response from the Department is that there has not yet been a decision made about DD waiver services under Managed Care. The Department does not yet have an answer to this question of how individual' budgeted funds that are not used will be reallocated or otherwise treated under Step 2 of Medicaid Care Management. Currently, these funds can be reallocated to other individuals and family one time on a permanent basis. There is not answer yet but will be monitored. If you have any questions or concerns please let us know.

Commissioner Vallier-Kaplan thanks AARP who provided lunch for the speaker Mr. Paul Saucier.

Another group of Commissioners met with the Endowment for Health and the evaluators from the Urban Institute. The Urban Institute has had a grant from the Endowment for Health for several years to do evaluation work of implementation of Medicaid Care Management and they have submitted a report from 2014 which is on the website. They are in the process of conducting more evaluation and follow-up and moving into new areas. This provided great insight and they are here to share what they learned.

Commissioner Don Shumway states that we will try and schedule future, Concord based meetings at ATECH. The April meeting is at Harbor Homes and will include tours. These will be planned and the public will have access to them.

Commissioner Vallier-Kaplan then asks the Commissioners and public to introduce themselves.

Commissioner Vallier-Kaplan explains that the pediatric nursing issues will be addressed after Commissioner Meyers speaks. Commissioner Vallier-Kaplan congratulates Commissioner Meyers for his appointment as Commissioner of the Department of Health and Human Services.

Commissioner Meyers welcomes everyone and states that the Department has several updates. He states he wants to speak about mandatory enrollment population and that those services were turned on February 1, 2016 with an additional 10,000 people into the program. He continues that the Department has been working closely with the MCOs during the rollout. He explains that there is rapid response teams that meets daily and has contact with the MCOs daily and is able to troubleshoot any issues that come up. He states that things are going smoothly. From 1/29/16 through 2/8/16, there were 12 inquires, six (6) from providers and six (6) from clients. He continues that there is a sixty (60) day continuity of care provision so some of the inquiries that may come up around prior authorizations are not coming up immediately because of the 60 day period. Department will be looking at issues moving through the sixty (60) days. Both MCOs have teams that are responding to any questions. He states he is happy to report that this is going well.

Commissioner Meyers asks if there are any questions.

Commissioner Shumway shifts back to the agenda and states that there is a free webinar entitled MLTSS Network Adequacy on February 25, 2016 from 3-4PM. The details of the webinar are attached to the back of the agenda.

A member in the audience introduces herself as a parent of a child with a tracheotomy. She states that they have opted into WellSense. She continues that they are already having an issue with a prior authorization for braces for her son's feet. The prior authorization was never put through because no one knew who was going to pay for it. Her son had a fitting on January 15th and received a call that they would be in on January 25th. He has not yet received them and is currently wearing braces that are cutting into his feet because they are too small. She states that they are also four to five days late on his feeding supplies and these are on hold also because of a prior authorization. She states that she is curious as to how the transition with the 60 days is supposed to work and why they are already being held up on these things.

Commissioner Meyers thanks the audience member and states that WellSense is in the room and the Executive Director is taking notes. He asks if he and WellSense can meet with her at the break to follow-up to make sure we have a path moving forward to respond to this issue. She responds that she would.

DHHS MCM Update

Monthly Enrollment Update

Commissioner Meyers reviews the agenda and states that the items may be out of sync. He begins with the Medicaid enrollment numbers stating that there are 137,000 individuals in the Standard MCM program, PAP or NHHPP is at 47,500 as of yesterday. The greatest group is people who have already picked a plan and are on the exchange and some that are receiving services that are not in a QHP. This legislation was voted out of the House yesterday reauthorizing the program through 2018. The Department is working with leadership in the House and the Finance Committee starting next week to

continue to work on this legislation to ensure it is passed finally by the House and sent to the Senate. It is critical to the state, the Governor the Department.

Commissioner Meyers then reviews the next slide relating to Behavioral Health Contracting. He states that the contract for cap rate payment went into effect on February 1, 2016 and the updates from the plans negotiations from CMHC are going well in terms of following up and negotiating agreements. Plans are now working with providers on cap model. We now have a cap rate established and there has been real progress.

Commissioner Vallier-Kaplan states that she would like to pause for questions on these two topics. There are no questions.

Commissioner Meyers states that he wants to discuss the private duty nursing update. He explains that he would like to say a few words at the outset and then hand it over to Deputy Commissioner Nihan. Commissioner Meyers states that this is an issue that is of the utmost concern to the Department and that we understand the need to ensure access to nursing services to both pediatric and adult nursing care. The Department understands that there have not been increases in rates in a long time and we are taking a hard look at that, as well as trying to address the immediate needs that are lacking for appropriate care particularly in the pediatric area. Commissioner Meyers explains that the Department has come up with a plan that will result in a rate increase for both nursing care pediatric and adults that will be put into place April 1st of this year. There is a State Plan Amendment (SPA) that will be submitted to CMS in order to implement the rate increase. The Department hopes this will go a long way in addressing the access issue and the needs of the population. The Department is working with families that are experiencing gaps right now and address their needs. He states he wants to recognize the efforts of the staff overall in working with the families to ensure access to services and we will talk about the Department's plans in that regard as well. This is of utmost interest not only to the families but to all of you. Commissioner Meyers then introduces Deputy Commissioner Nihan to continue the discussion.

Deputy Commissioner Nihan states that she has been at this meeting for the past couple of months and has been working on this issue with Ms. Deb Scheetz. The Department has put together a proposal as to how the rates will be revised and this will be shared along with steps to implement it. Deputy Commissioner Nihan firsts speaks about RN services. Currently the rate is \$41.58/hr. The Department will increase this rate by 25% to \$52/hr. for the day shift. The night shift will receive \$58/hr. which is a 39% increase. For LPN services the rate is currently \$38.29/hr. This will be increased to \$48/hr. for day shift which is a 58% increase and \$56/hr. for night shift. the Department anticipates making this increase effective on the first day of April. In order to do that the Department must amend the contracts with the Plans so they are adequately funded so they can pay these rates. The Department will also be submitting a SPA and believes that CMS will agree as it is an urgent issue. Therefore, the Department will implement this before the approval comes from CMS. The proposal for the rates will be monitored closely to make sure this rate increase will improve access to care. The Department wants to make sure that there are no other obstacles to access other than the rates. The Department is also working with six (6) families that are considered to be in crisis because of the lack of their fulfillment of their services. The Department is working with Interim Health Care after working with all of the nursing agencies in the state. Interim guaranteed to the Department that they would be able to get nursing services ASAP as long as the rates are increased. Last month the short, mid and long term plans were discussed. Deputy Commissioner Nihan state that the Department continues to work with UNH on the LNA parental reimbursement and this is still ongoing. The Department is looking at the LNA/IHS/PCA services and looking at developing a training module so that the providers who are providing these services are receiving the adequate training and education that they need. Hopefully this will improve the quality of the services being delivered. The Department is also looking into the LNA fulfillment rate and has started the dialogue with the Departments quality unit on how to measure and monitor the quality of In Home Care. Finally SB439

is moving forward which is the bill to establish a commission on workforce development. We recommended that we broaden the group to include hospice expertise. We are supportive of that commission and look forward to a statewide discussion.

Question from the audience: SB 439 was originally a bill that was drafted for a study commission for the pediatric in home nursing care issue and now it has expanded to a workforce development issue. How can you be sure that the original intent of the bill is not going to be lost?

Deputy Commissioner Nihan states that she actually believes that it will be the entire commission once the members are identified to make sure that the original intent and how it will be evolving over time will be accomplished. She states that she believes the Department will be very active with this commission and will be advocating for its original tenant which is pediatric nursing. Deputy Commissioner Nihan states that she believes that broadening the bill is important because there are workforce development challenges in a number of the Departments health programs. The pediatric piece will not get lost in this bill.

Ms. Kathy Sgambati states that the Department added members to the Commission and the Governor also added members and asked for a representative from the Chronically Ill Children's Network because we want to maintain the pediatric focus and make sure that this gets addressed early on.

A member from the audience asks how the Department will be sure that the rates will remain competitive as the years go by.

Deputy Commissioner Nihan states that she agrees with this and that care is moving from institutional settings to home settings and this will require a shift in how the states nursing personnel are allocated and given that we do not assign them to their work locations, the State will have to create drivers to get them into the home care settings. This will be through rates and other benefits to those nurses. The Department will be monitoring this very closely.

Commissioner Meyers states that the Department will be monitoring this closely and if the Department puts the rates into effect on April 1st we can make sure that the money is used to create that differential in the rates and wages paid so that access is ensured. It also gives the Department the opportunity as we start working on the next budget to take a look at this. The Department will then be able to assess and advocate in the next budget process for the right level of rate in order to ensure continued access. He states that he agrees that it is a great concern to the Department and we will look at it not only right now but on a long term basis as we go through the next budget cycle we know what we are advocating for.

Audience: What stipulations are going to be put into the proposal to make sure that the nurses are seeing the increase and not the nursing agencies?

Deputy Commissioner Nihan states that the Department is working with the nursing agencies to make sure the funds flow downhill to the nurses on the ground that are doing the work. There are legitimate expenses that the agencies incur but the Department has a commitment to the agencies that they will push as much money down to the nurses as possible and this will be monitored with agencies reporting back to us on a quarterly basis.

Commissioner Shumway states that this problem reflects an underlying weakness in the state Medicaid program and this transition into managed care reveals it. He asks if he is correct believe that part of the answer to future solution is network adequacy. Will there be a network of private duty nursing capacity? This gets back to the webinar mentioned earlier in the meeting which will help us have an understanding of how this works in a managed care environment.

Deputy Commissioner Nihan states that she believes this is right and the standard indicators of access that DHHs has relied on for the last several years did not identify this problem. It was through the families and MCOs that this was recognized. The workforce shortage did not happen overnight and it will take some time to get out of it. Last month she stated that she had a slide of the evolution of healthcare workers and the traditional role of the females. Females have been encouraged to enter other fields and this has had an impact on the workforce. Deputy Commissioner Nihan tells a story of an LNA refugee enrollee in the program. She was so excited about the opportunities after the first day that she brought a busload of people back with her the next day to enroll in the program. This is encouraging.

Audience member asks if the reports will be posted to the website.

Deputy Commissioner Nihan states that the Department is working on the report structure and that it will be shared. The Department is working hard to be transparent and open as possible.

Ms. Deborah Scheetz states that she has been working with Ms. Gina Blakus from the Home Care Association representing the agencies and commends them in working with the Department to try and find solutions. There was an initial agreement that the agencies would report their range of salaries on a quarterly basis. This will be confidentially reported directly to the Department. It will be specific to the agencies but will be shared at the aggregate level on a quarterly basis, de-identified. The Department wants to respect their business mix as they continue to create their constructs and arrangements with the managed care operations.

Audience member asks if the rates are standard for FFS as well as managed care. Will the people in managed care see that increase as well?

Deputy Commissioner Nihan states that technically the Department is revising the FFS rates and funding the care management program to recognize the difference in the hourly rate. Right now the plans and providers have full autonomy to set whatever rates they want. It is our understanding that most of the contracts are based on the FFS rates and will be passed onto the agencies. The plans have indicated that they will pass on the money appropriately. This is a level of detail is still being worked out.

Commissioner Meyers states that the State Plan Amendment that will be filed is subject to public notice and comment period prior to the time it is filed with the federal government.

Commissioner Bunnell thanks Deputy Commissioner Nihan and Commissioner Meyers for not only raising the rates but being vigilant about monitoring this throughout the budget process.

An audience member comment how important it is to remain vigilant and refers to a recommendation that Ms. Gina Balkus made regarding even higher rates than the Department is bringing forward. She states that she wants to make sure that the rates are sufficient.

Ms. Gina Balkus thanks the Department and explains that remaining vigilant will require the Department to ensure that the Department does an annual review of the rates to make sure they are adequate.

Commissioner Mary Vallier-Kaplan wants to thank the Department but also the families that came forward. She states that they were able to bring forward a systemic issue.

Commissioner Meyers then discusses consumer protections, long term care services and supports. He explains the Department is collaborating with the MCM Commission and the MCAC subgroups to identify the role of the Ombudsman. The Department has been receiving Technical Assistance from

Camille Dobson, National Association of States United for Aging and Disabilities. This is something that the Department will come back to soon. The Department takes this very seriously.

Audience member asks if there is an opportunity to provide input into this.

Commissioner Meyers states, yes that we can put it on an agenda at a future meeting and the Department is always willing to take feedback.

Commissioner Vallier-Kaplan states that this is an important issue that should be implemented prior to other populations move forward.

Break

Commissioner Kaplan introduces Ms. Lorene Reagan who states she will give a quick overview on the Departments Step 2 readiness. She introduces Ms. Sandy Hunt. She states that the information regarding the activities that are being presented came to the Department in many ways including from the MCM Commission. The Commission offered their perspective on how things went on the first round and is continuing to offer their input. Ms. Reagan refers to the slide deck entitled “New Hampshire Department of Health and Human Services Medicaid Care Management: Update to the Governor’s Commission on Medicaid Care Management, Step 2 Mandatory Enrollment, and February 11, 2016. Individuals had until December 31st to select a plan to be effective on February 1st. After that they were auto enrolled. Ms. Reagan reviews the numbers and states that there was a 66% self-selection rate. Ms. Reagan states that the next slide is at a high level as the MCOs will get more into detail later. There were 32 “Secret Shopper” calls made. Each Plan was presented with questions that a potential member might present during the shopping experience. Questions that were presented assessed the general shopping experience for an MCO. The work done here helped the Department determine whether the MCOs were ready to move forward for February 1st. There were also thirty (30) case reviews (15 at each MCO) of individuals with complex needs who are currently being served by the Plans. Ten (10) cases selected by the Department and five (5) cases selected by each Health Plan. The purpose of this activity was to see how Plans are able to perform care management and care coordination for complex members. There were also 120 calls (60 calls to each Plan) on behalf of people currently enrolled in the Plan and currently identified as complex. These calls challenged the MCO’s to respond to “real” inquires for individuals with complex needs currently being served by the MCOs. There was also a post enrollment survey conducted. The Department conducted fifty (50) calls per plan (100 total calls) to individuals (or their guardians) who had selected a Plan in the month of November, 2015. Calls were conducted between 12/31/15 and 1/11/16. The callers were also asked to rate their experience from 1-5, with 1 being poor and 5 being excellent. The Department also worked hard over the past year on access to guardianship information. As a result the Department and the MCOs are implementing new policies and procedures to address information sharing of guardian and authorized representative information. The High Touch Readiness Between June 2015 and October 2015, the Department developed and implemented a process that identifies individuals with most complex needs and provides proactive support to these individual’s during the enrollment process, at the time of mandatory enrolment and for the following 90-120 days. This support includes assistance with enrollment, anticipating and managing new prior authorization requirements, coordination of benefits and third party liability and any other issues or concerns on the part of the individual or his/her guardian or authorized representative. The purpose of high touch readiness is to make sure that the Plans are aware in advance of members with more complex needs that may need additional outreach. The Department has also conducted individual and provider outreach, education and training specific to the needs of individuals with complex needs completed between June 2015 and February 2016. The Department sponsored the coordination of two facilitated focus groups to elicit feedback from individuals with complex needs who enrolled in Step 1 to gain their insight into important lessons learned. The intent of these focus groups was to elicit feedback from adults with physical disabilities and adults/elders about

what is working for them in the MCM program and what is not. The Department received excellent feedback and recommendations that have been incorporated into education, training and operational/review and readiness review activities. The Department also met with case management agencies during which case management agencies representing individuals impacted by mandatory enrollment were invited to provide feedback regarding what type of support they would like from the Department to assist individuals with mandatory enrollment. This information was integrated into the Departments' training specific to enrollment and shared with case management agencies and other providers during subsequent information sessions. The same approach was taken with nursing facilities. The Department was invited to their facilities to present. There were also provider and client information sessions conducted in person and made available via WebEx and phone conferencing, presented by the Department and the MCOs. The Department provided overview of the program and enrollment and MCOs presented their specific information. The Department now has a Rapid Response Team meeting on a daily basis. Any call that comes in under mandatory enrollment are logged into a database and followed up on. Ms. Reagan then gave some examples of member issues and provider issues and concluded her update. This was intended to bring together all the activities that have gone on and we believe these activities have helped and will continue to have the rapid response team meet on a daily basis.

Question from the audience: Have you had any feedback from providers on the high touch readiness meetings themselves. The audience member thinks they have been effective but worries about the time and the number of people involved and whether there has been any feedback on the time and administrative burden and cost.

Ms. Reagan states that the Department has had feedback regarding the amount of time needed to address the high touch readiness piece of the activities have been significant on the provider side. The Department knows and appreciates that and hopes it is a short term investment in time. If there is something we could do to make it more effective, we would like to hear about that.

Comment from the audience who states that from the provider perspective they have found this incredibly useful and look forward to building on these meetings and as we move forward how to leverage that linkage and build on it for better communications.

Question from the audience: What was the method of communication the Department used for the mandatory enrollment to notify Wellsense and NHHF as to what members were enrolled in each plan? Would each plan create a roster for nursing facilities as to which residents have which plans?

Ms. Lisabritt Solsky from Wellsense responds that the facility does not come over on the file transfer.

Ms. Reagan asks the audience member to connect with Ms. Sandy Hunt after the meeting to get more information.

Ms. Reagan then introduces Wellsense Health Plan to provide a brief follow-up on activities since go live.

Ms. Lisabritt Solsky introduces herself and begins with the transition process. She states that welcome packets are sent to all incoming members with their member handbook and member ID cards. Welcome calls to incoming members as soon as the members came over. They started back in December and are ongoing. High touch individuals received rounding in advance of February 1st allowing for greater insight to individual circumstances and opportunities for engagement with member, family and community supports. The news from the call center in the first week showed a steady volume within expectations. The types of questions that came in were the normal questions that would come in at the first of the month. Ms. Solsky then refers to a slide entitled "An Ounce of Prevention. She explains there has been repeated outreach to providers and pharmacies regarding the transition and continuity of care contributed

to there being no identified events where an individual could not get a prescription filled or receive a scheduled service. There have been no issues regarding the inability to arrange needed transportation or missed transportation for anyone coming in on 2/1/16. As claims for services rendered come in, denials are reviewed for appropriateness and ensure the member service isn't entitled to continuity of care. In the care management space, WellSense has over two hundred (200) individuals that were identified as high touch by the Department, 75% of whom have primary coverage. As we prioritized we looked at those that were identified as Medicaid only. Ms. Solsky continues that most of these members receive or are in the process of receiving outreach from the Plan to confirm important demographic information, guardianship, primary coverage and any/all updates entered into the system. Ms. Solsky then explains that there was outreach to non-high touch members either because they were flagged for non-participating providers as well as Private Duty Nursing utilizers. Ms. Solsky continues with the rapid response process and how Well Sense mobilized cross functional teams to support several incoming members whose situations were particular concerning in the days leading up to transition and through the first two weeks of operations. Strong integration with the Department around these members has resulted in good process outcomes under difficult circumstances. Looking ahead, she explains they will continue surveillance of claims that deny for these members to assure the denials are proper and conduct assessments of members benefitting from 60 day continuity of care, collect necessary information from providers to make determinations of necessity in the go forward and enter authorizations as appropriate.

Ms. Solsky asks the Commission and audience if there are any questions for her.

An audience member asks if in the near future there is any talk of any of the Boston hospitals becoming in network with WellSense where a lot of the chronically ill patients do see providers in Boston.

Ms. Solsky responds that the short answer is no. We have arrangements with many of the Boston hospitals that falls short of actually being in network. We have preferred out of network providers in Boston that we rely on heavily, our parent company Boston Medical being at the top of the list. We make these determinations on a case by case basis. We are not afraid to authorize care out of network but there are times when we say we can't send you to this place but there is another place in Boston that would be a good fit. The needs of some of these consumers are so highly specialized that it does not lend itself to the typical decision tree. We look at the totality of the situation. We had a case 18 months ago where we had two children in Boston Children's Hospital from the same family. One of them was in hospice and we made the decision that any child in hospice would have continuity of care. Based on the totality of circumstances we determined to keep both children at Boston's hospital.

Commissioner Mary Kaplan-Vallier introduces Ms. Candice Reddy from NHHF. There has been a lot that has happened since July. The important factor is that we actually have members and we want to make sure they transition in the most appropriate way and the 60 day continuity of care is important to us. We will walk through some successes we have and also some of the operational changes and challenges we have had along the way. Ms. Reddy then introduces Ms. Karen Kimball who then reviews the agenda. She states that before she gets into the readiness review she wants to talk about the number of people that have been able to engage in active care management. This is a voluntary program so just because we think that someone will benefit from care management/care coordination doesn't necessarily mean that they will engage in the process. Often times you will see that the waiver percentage is about 30% which is relatively high based on industry standards. But many of this population are supported by Area Agencies and they may not want to engage just yet. NHHF have gone out and visited 1900 of our members. Many members benefit from face to face engagement. Ms. Kimball then discusses the High Touch Transition and Readiness Process. She explains that there were 160 plus high touch transition meetings conducted to date with Area Agencies, CMHCs, Nursing Facilities, DHHS and NHHF staff. There were 508 individual members identified through this process. High touch spreadsheets were completed by the organizations and reviewed with Health Plan staff. Ms. Kimball explains that NHHF left it to the agencies. The data

was incorporated into NHHF's Clinical Information System. The Department performed a comprehensive on-site audit of 15 NHHF complex care management files and NHHF scored 99%. High touch member transition progress to date: total members identified were 508. High touch spreadsheets were submitted by Area Agencies, CMHC, Nursing Facilities and DHHS. There were 494 spreadsheets received and these are still coming in. There were 345 care management referrals completed and outreach is in progress. Ms. Kimball states that NHHF is not only receiving information from the outside but also from the inside. Claims information is received from DHHS and used to inform predicative modeling reports. This enables NHHF to identify members in need of care management outreach from day one. NHHF is using the predictive modeling reports to identify members for outreach and engagement. They are using the no wrong door approach so anyone, member, family member, providers, internal staff, external agencies, and DHHS can ask us to engage with this individual as they may need additional support. Our NHHF Senior Leadership team members have been on call 24/7 to assist with transition challenges. Things have gone smoothly. No after hour concerns have surfaced to date. NHHF and DHHS conduct daily meetings to review day to day progress and issues related to the implementation and very few issues have been identified. Ms. Kimball continues with continuity of care and how NHHF appreciated those individuals and family members that called in advance of 2/1/16. She then discussed opportunities including partnering with DHHS to gain access to New Heights for guardianship confirmation. They are still following the existing process of contacting DHHS Medicaid Client Services to confirm guardianship. Ms. Karen Kimball then asked the Commission and audience if there were any questions.

Commissioner Mary Vallier- Kaplan makes a change in the agenda. She states that the time that the Commission was going to share amongst themselves in the presence of the public will be done by conference call. The results of that call will be shared in writing.

Commissioner Vallier-Kaplan turns the meeting over to Commissioner McNutt. Commissioner McNutt states that he wants to set the context. The Community Supports Workgroup includes himself, Commissioner Sue Fox and Commissioner Roberta Berner. He states that they have been working to gather information of the various components of Step 2 phase 2 and who are those providers We have done home health care and nursing homes. Something that had become obvious to us is one of the important components of this is care management for LTSS. AARP commissioned a report and Ms. Deb Scheetz was familiar with one of the authors of that report. The author lives in Maine and Ms. Scheetz arranged for him to come and speak with us. Mr. Paul Saucier, Director, Integrated Care Systems, Truven Health Analytics is here today to do a more formal presentation.

Mr. Paul Saucier. thanks the Commission for having him. He explains that he works in the government division of Truven Health Analytics. He states that he has been asked to do a national update on MLTSS, how MLTSS changes care coordination, and he will spend most of the time on the MLTSS care coordination models. He then goes into his background and discusses some of his recent work as it relates to MLTSS. The Care Coordination study was for the AARP Public Policy Institute and he states that much of the work he will discuss revolves around this. He states they looked at contracts with states that have managed care organizations. He states they looked at eighteen (18) states and they did intensive site visits in Illinois and Ohio which have two very different models. This is where that report comes from. He explains that they do MLTSS program and as of December 2015 there were 22 states operating a total of 31 MLTSS programs.

Why do states do MLTSS? He explains that the short answer is they do it for the same reason that they do any improvement in the LTSS program because they think it will provide better system balance. This means how many people you are serving in the community vs. how many you are serving in a nursing home. He thinks that New Hampshire is close to the middle nationally on this. States also want a better experience, seamless, person-centered coordination across settings and services, including LTSS, physical and behavioral health. They also want better outcomes. Improve health and function; there is a great

awareness that community inclusion and maximum independence is just as important as health measures. Unfortunately, there are not a lot of national measures around this. Then there are lower costs. Lower growth in per-person costs and better budget predictability because it is paid in a monthly amount per person. Mr. Saucier then explains a model for care coordination of LTSS in Fee for Service Medicaid. There is usually a community organization of some kind and they are responsible for coordination of LTSS specifically. They may reach to other parts in terms of coordination interface but for the most part their world is circumscribed by LTSS. This is what they are paid to do. They assess LTSS needs, develop LTSS service plans, implement and monitor plans, identify community resources, monitor health and safety, respond to critical events, and communicate with family and providers. As you move to an MLTSS system, what changes is the comprehensiveness of the responsibility. What any state is trying to do with a system like this is have a point of accountability so that you can really get to looking at what the outcomes of a group of Medicaid beneficiaries are. The state contracts with a managed care organization and that MCO becomes the point of accountability. The MCO is responsible for care coordination and services within a fixed payment. The MCO is usually responsible for integrating the LTSS with physical and behavioral health services and the MCO usually has discretion to provide care coordination directly or with sub-contractors. There are different care coordination models in MLTSS. The models can be divided into three (3) types. In-House, where the MCO performs functions directly, Shared Functions, where the MCO performs some activities and sub-contracts with community-based organizations for some activities or Delegated model, where the MCO delegates the function to a sub-contractor and provides oversight. This is less common and tends to be more in urban markets. With the In-House model who takes the lead depends on the needs of the member. The social worker could be the LTSS lead and interfaces with the family, LTSS providers and community resources. The nurse could be the medical lead and interfaces with the PCP, family, pharmacist, and other medical providers. This model may include pharmacy consultant, behavioral health specialists, transition specialists and others. There are pros and cons to this model. The pros include the accountable entity (MCO) has control over function for service authorization, quality oversight and reporting to state. It's easier to share information/integrate service planning inside one organization and the member experiences a single point of contact. The cons include that quality may be impacted if the accountable entity lacks experience with LTSS or with local resources. The MCO may miss important information from community based organizations (CBOs) and some members may lose longstanding care coordination relationships. With the Shared Functions model, the MCOs partner with the community based organization. The MCOs may still have their capacity but have subcontracts with community based organizations that are actually doing the care coordination. These organizations do vary by plan and the capacity of the organizations. The Shared Functions model also has pros and cons. The pros consist of local knowledge and experience being incorporated into the program, as well as fostering new business relationships between MCOs and CBOs. This model also supports continuity of LTSS relationships for members. The cons consist of the possibility of diluting accountability. The goal of the state is to have the entity responsible for everything. If there is a partnership, who is responsible and accountable? From a contractual perspective it is the MCO that is still responsible. Another con is the investment that must be made to make these relationships work. Significant resources must be dedicated to delineating roles, sharing information and bridging cultures. Members may also experience multiple care coordinators and less integration. This is important to monitor and make sure it does not happen because you are trying to create a system that is less fragmented and if you have two care coordinators, it will not feel less fragmented to the member. Some states have mandated the Shared Functions model. Most states do not mandate it because of what they are trying to do is see what innovative things come out of the marketplace. But there are six (6) MLTSS programs mandate roles for community based organizations (CBOs). Mr. Saucier then gives examples of these programs and states that most MLTSS contracts neither require nor prohibit subcontracted or delegated care coordination and many MCOs use multiple models. Mr. Saucier then discusses the care coordination models in Illinois and Ohio stating that the Shared Functions model is mandated in Ohio but not in Illinois. They are using the Shared Function model for the over 60 population and the In-House model for under 60 population. The last model that Mr. Saucier explains is the Delegated Model. This is

rarer and used in highly evolved managed care environments. Essentially there is already a health system and a large health system practice that already provides significant services to a member. The MCO chooses to delegate to that entity for the members that they have in common. A couple of examples are Minnesota and California. This is not surprising because these are both third and fourth generation managed care states where the states have provider systems and networks are now themselves managing risk. These relationships often involve risk in the payment model where it is sub-capitated. So Minnesota has these clinics like the Mayo clinic. These clinics are used to this and members are used to going to these clinics for care. Presbyterian Homes is a more LTSS example in Minnesota that is a large provider that does a range of LTSS supports including assisted living and In Home Supports mostly for seniors. They have a subsidiary called Optage House that does primary care. They were initially using it to bring primary care into people's homes. They have subcontracts from the Plans to do care coordination and primary care. California is so different from the rest of the world. Los Angeles has one million Medicaid members. In a system like that they have large multi-specialty practices. One of the pros of this system is that the care coordinator is usually co-located with trusted source of care for convenience and efficiency. It may however, be difficult to avoid conflict of interest when the delegated entity is a provider. The Delegated model may improve integration of LTSS with primary care however, care coordinator role may be difficult to protect in a busy practice environment. The Delegated model may also provide basis for aligning incentives, depending on how the sub-contract is structured. The regulator framework may not however, be adequate for risk arrangements at the sub-contractor level.

Mr. Saucier then summarizes with closing thoughts. He states that care coordination is essential to the success of any MLTSS program. It impacts access, quality and costs. Care coordination model decisions are driven by perceptions about capacity and performance and stakeholder dynamics. The bad news is that there is not enough research on the relative effectiveness of these models. We cannot tell which one works better than another. The decisions around this are identified by the capacity and performance of both sides of the equations. What do your MCOs have and what do your community organizations have. How will you build on the strengths of the system you have today? MLTSS is a heavy lift. A tension exists between mandates and innovation. Most states strike a balance between these. If there are very important core values that you want to protect this is important. But it is not advisable to put everything into the contract that you want to guarantee. Part of the hope here is that these new relationships will result in innovation. If you put everything in the contract it will limit innovation. The existing FFS care coordination has significant impacts with any of these models. The business relationship will change. Mr. Saucier states that he has heard that New Hampshire has already been encouraging the Plans and the agencies to meet and that is great news. He states that New Hampshire is ahead of the curve. Some states wait to meet until the transfer of service plans begins. Then someone realizes that they cannot be transferred electronically. It can be a disaster. The most important thing is that the care coordination entities and the plans are already talking in NH and out of that relationships will already form regardless of what the ultimate role is. Change should be addressed directly and early. The initial model is only the starting point. The initial model is just a starting point and it is important to monitor closely, see what is and is not working well and amend the contract accordingly moving forward.

Commissioner Doug McNutt states that he wants to mention Ms. Deb Scheetz who has put this altogether in the sense that she brought Mr. Saucier here. She has also been conducting meetings with other case managers in the room. Ms. Scheetz has done really good work here. Commissioner Moral also wants to acknowledge Ms. Scheetz work with the Ombudsman work.

Commissioner McNutt opens the meeting up for questions.

Commissioner Don Shumway asks if there is any CMS guidance on their view and expectation on conflict free case management?

Mr. Saucier responds that this came up earlier at the luncheon. There is a traditional conflict free that CMS cares about which is based on the FFS model. What CMS is looking for and wants to avoid is a care coordinator that self refers to their own agency to provide services. So when you have services and care coordination inside one agency and there is internal referral going on this is bad. CMS will not allow this. The type of conflict that people express a concern about in managed care revolve around the entity paying for services and also authorizing services. The answer to that is there is certainly reason to be concerned and that entity is also responsible for quality outcomes. It is important that the state monitors managed care closely so they can see if they are getting the outcomes they want. Are the managed care organizations for instance going to reduce the service plans? Certainly if they find the service plan seemed beyond what is called for they would reduce it. But do they want to risk having someone go into a nursing home? No, so their incentive is to provide cost effective care and that aligns with what most members want and that is to be served in the community.

Commissioner Yvonne Goldsberry asks Mr. Saucier and asks if he will speak a little bit more about how the quality measures are coming along. This commission has had significant conversations about not having an adequate baseline for quality, and not having access to national data. On the rest of the care management side we have an amazing tool but in this space it seems we are lacking this sort of data.

Mr. Saucier responds that nationally data is lacking a core set of quality measures for LTSS. There are a few things that have emerged that everyone uses that are largely medical. There is still a debate raging on the quality of life side as to what those measures should be. For people under 60 there is interest in employment based measures. For people over 60, they are struggling with the ability to measure community inclusion. Mr. Saucier states that his advice is to go with what we have and not wait for others. Mr. Saucier explains that it will be about five (5) years before there will be comparisons with other states. For now the best you can do is pick measures that are best for here in NH and establish a baseline and you will see change over time.

Question from the audience: Your examples focus a lot on the elderly and you mention twenty two (22) states with thirty (30) some odd programs. Do the same three programs apply to mental health and disability? Also, we are used to hearing MCOs used a lot. An MCO in NH is an HMO but this is not the case across the country. In those programs that are in mental health and developmental disabilities how many involve health homes, medical homes, Accountable Care Organizations as well as HMO/PTOs.

Mr. Saucier responds that this is a great question. Just to clarify to the audience managed care organization is a generic term that CMS uses and it can include HMOs and partially capitated plans and so it. It is a generic term. For most of the states it is HMO based and the models discussed today apply to older people and people under 60 with physical disabilities. A few places are including children but that is rare and tends to be voluntary and these are children with significant medical issues. For mental health it depends. If it is integrated then it is included in the models discussed today. But it is often carved out and outside of the managed care program. There are HMOs that specialize in mental health services. In a couple of early states that have done mental health and intellectual disability together. North Carolina and Michigan have partially capitated plan so they are not responsible for the health services just the LTSS and the entities tend to be one per region and they tend to be a consolidation of providers for that region. Michigan has a strong county base system so if it is a large enough county it would be the county mental health organization and several counties may get together to create a larger one and the state pays a capitated amount to that entity for the mental health services. This model is in a couple of places. Wisconsin included intellectual disability, older people and people with physical disabilities all in the same model so it varies by state. Texas and Tennessee are both HMO based models that are adding intellectual disabilities to their models after several years. This is very typical not to do it right away because everyone recognizes that adding intellectual disabilities adds along with it a host of special needs, issues, circumstances and stakeholder work so it tends to be a phase that comes later.

Question from the audience: Are there any states that did not include mental health as an LTSS? NH has mental health in the acute setting. Are there any states like us?

Mr. Paul Saucier asks if mental health is in the care coordination.

The response is that it is in the MCO acute care services.

Mr. Saucier states that this is not uncommon. There are people who may not be in LTSS and the Plan will provide mental health needs. Then there is a group with higher needs with SMI and these are the ones that get put into a specialty program because their needs are so distinctive that they usually need specialty attention. Some of these folks are included in the MLTSS programs but they tend not to be. They are usually needed to have their own specialization within a program if not carved out.

Ms. Deborah Grossman from Exeter and a parent of an eleven year old with autism introduces herself and states that she is concerned about the spectrum community and that the needs are different and right now services are being provided by Area Agencies and there is not equity across the state. Do you have suggestions for the autism community?

Mr. Saucier explains that people with autism tend to be carved out of these programs but tells her that she is smart to be thinking about it because sometime in the future this will come up. The benefits would be more balance within the state. But whether a managed care organization has an adequate provider network for autism services and if they have experience with the population are very real and have to be worked through. It is never too early to inquire. Pennsylvania has a small program and the state has a partial capitation with an existing autism provider. So the provider organization itself gets the capitated payment, not including the health services. For intellectual disability and autism groups of people often have difficulty accessing the health care system. Mr. Saucier goes on to express his concern that there is going to be partial capitation for specialty services only, how does that help a person get a dental appointment or a primary care physician to look at them. He states that he does not think it is necessarily good to carve it out if they are not getting access to services.

The audience member asks how a parent can get involved.

Mr. Saucier responds that it is important to find out where the dialogue is. This meeting is one venue.

Another audience member introduces herself as a parent my son is twenty (20) and that has In Home Supports. Workforce development is a huge issue. She states she cannot find help for her son. She asks Mr. Saucier if he has seen how other states address workforce development.

Mr. Paul Saucier states that if you have a basic workforce problem managed care will not solve this. Transportation is one of the services where plans can create a market by offering to pay more. But you can't create a bunch of nurses in New Hampshire. They can offer better wages and so on but in terms in workforce development in general he states he is seeing three things: 1) a State has no expectations in that regard and nothing happens, 2) a State expects a partnership with the Plans around workforce development and there is a formal process with the Plan to identify workforce shortages. They identify the responsibilities of the Plan and the responsibilities of the State 3) some Plans are really out there on this issue. For LTSS it is housing and some Plans are engaged in housing partnerships with providers where they provide startup capital. Some plans believe they do not have to go that far and offer an agency a contract enabling an agency to go to the bank and get the financing for the housing and the housing goes out. With managed care the early mistake was thinking that just giving out a managed care contract was like waiving a magic wand. Now we understand that there are things Plans can do that cannot be done in FFS. But the State must be directive about it, monitor it and hold the Plans accountable.

An audience member states that she appreciates the presentation and appreciates the tension that Mr. Saucier highlighted between bringing creation and innovation and at the same time using the strength of the existing system. These can be hard conversations and it is clear that those conversations must be had sooner rather than later. Do you have any guidance or recommendations for how to have these conversations, how to start them and what that looks like in a way that leverages creativity and innovation and at the same time look at the existing strengths so you don't spend a lot of time with the dance?

Mr. Saucier responds that one of the differences with private managed care is that many things are secret. This can be difficult to overcome. You can only go so far with large groups and then you need to have smaller conversations. The Plans will not want to disclose their business practices in large groups. In the nonprofit sector this is done all of the time. This is one of the cultural differences that we must overcome. In Pennsylvania the state was a broker in creating "Meet and Greets". The state was clear that this was not their meeting and they were just inviting stakeholders. They actually did it for several stakeholder groups, care coordinators being one. The twelve (12) plans were invited and presented and this was the start of the conversations and they were then able to move on to the one on one conversation.

Audience member comments on the statement that Mr. Saucier made regarding not having research around the various models. She states that there is research on the medical side of things. It seems like we can probably predict what the answer is. If you look at how things are here in New Hampshire and the configuration of numerous variables, it seems the variables at the local level are so complex that it makes a difference.

Mr. Saucier states that it does make a difference what the variables are at the local level. But it has to be at the local level. That is why there it is difficult to get national research.

Commissioner Mary Vallier-Kaplan states that one thing that was interesting in is the issue of families that do care coordination and they don't have a voice. How do you bring their perspective and roles into the conversation?

Mr. Saucier states there are two issues. It is important to provide self-direction in the program. CMS wants to see that there is self-direction plan. The other is to ask family members what their needs are. An example would be respite. It is important that the caregiver is part of the team. Family caregivers are listed in contract language but it is very rare their needs are being assessed. The caregiver is a core member of the team.

Commissioner Porter states it seems that the two components are the needs of the caregiver must be considered and the caregiver must be included in the interdisciplinary process. Are you seeing both of these or one more than the other?

Mr. Saucier states he is not seeing the care giver doing care coordination but treating the care giver as an important member of the team is important and in case of self-direction as the primary care giver.

Commissioner Porter comments that she asks the question because some of the conversation that they have had in the Commission has included under the pediatric nursing shortage is the notion that what can be done to compensate or to add some of the value in a monetary way to the work that is being done by the families in the absence of filling the nursing shortage. How does that fit into the puzzle?

Mr. Saucier states that he has not seen any instances where family members are paid for care coordination.

In your research on the Shared Function model have you noticed standards by which the care coordinated agencies identified standards by which they can identify what a good care coordination organization would look like in terms of certification or something?

Mr. Saucier states that increasingly states are requiring NCQA accreditation. But this is still directed at medical so he states his answer is no that he hasn't seen standards identified that have to be met, it is more like here are the activities that must be met and these activities may not be distinct because activities may be provided in packages.

An audience member expresses his negative perception of the way NH proceeded with managed care and his confusion regarding which model NH will use, an In House model or a Shared Model. He expresses the need for the State to be clear to the Plans and the Area Agencies which model it will be. He agrees the Area Agency system may need to change and states they are not afraid to change as it is about the clients. He believes the Commission is instrumental to helping us design a system that works for the benefits of the clients, not for the area agencies, not for the politician, but for the clients as there are 137,000 people that are dependent on these services.

Comment for former legislature. It is assumed that managed care is a magic wand. This conversation needs to be had with legislatures as well. This is a long process and we want to be thoughtful and do it right so we are not spending more money later on so we need to have this conversation at the state house that this is not a magic wand.

Commissioner McNutt states that there is a need for capacity within the department and this program should not be turned over to the MCOs without giving the Department the skills and the resources. But there are many representatives that do not agree with this.

Commissioner Mary Vallier-Kaplan thanks Mr. Paul Saucier for attending ding. She also thanks Commissioner Wendy Gladstone who behind the scene has done a lot of caring work around the pediatric nursing issues.

Commissioner Mary Vallier-Kaplan states that quality reporting has turned into a joint meeting between the MCAC and this group. At the March meeting the EQRO will do a presentation on their report. The public does not usually attend this meeting but are encouraged to come because this information is not recaptured at the MCM meeting. She states that there is a lot to do in a short amount of time. It is important that this commission capitalize on the work that has been done for this Governor until that time when a new Governor is elected.

Ms. Kathy Sgambati asks if someone could someone share the quality webpage with the audience.

Commissioner Jo Porter gives the website at: www.nhmedicaidquality.org

Commissioner Vallier Kaplan thanks everyone for attending and adjourns the meeting at 4:00PM.