

Governor's Commission

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

**MINUTES
February 12, 2015
ATECH Services, Concord, NH**

Welcome and Introduction

The meeting was called to order by Commissioner Don Shumway at 2:40 pm. Commissioner Shumway stated that Commissioner Mary Vallier-Kaplan was not present at the meeting and that he would chair. Present in addition to Commissioner Donald Shumway, was Nicholas Toumpas, Douglas McNutt, Roberta Berner, Yvonne Goldsberry, Gustavo Moral, Tom Bunnell, Kenneth Norton, Susan Fox, Wendy Gladston and Jo Porter. Commissioner Shumway welcomed everyone and invited the Commissioners and the public to introduce themselves. He explained that there would no longer be live video streaming at the meetings and as of this meeting there would be audio only. There are twenty five (25) call in lines. The dial in information is as follows:

Dial In Number: 1-646-749-3131
Access Code: 481-546-597
Meeting ID: 481-546-597

Commissioner Shumway gives an overview of the agenda which includes a presentation on Case Management; Terms and Definitions, Care Coordination, and Conflict Free Case Management. Commissioner Shumway then explains that Commissioner Toumpas will give an update on Medicaid Care Management to include monthly enrollment and monthly review of key indicators. There will be an update on Transportation from Commissioner Gus Moral and a discussion of the application of Principles of Long Term Care Services and Supports (LTSS) organized and initiated by Commissioner Doug McNutt and Commissioner Susan Fox. The Disabilities Rights Center will then present contract considerations and the Quality Council will present recommendations on Step 2 design. There will be time left at the end for Questions and Answers for those in the audience and those on the phone.

Next month, the Department has invited Robin Preston from Centers for Medicare and Medicaid Services (CMS) for Medicare and Medicaid MS. She is the expert on Medicaid Managed Care. We can again bring to Medicaid Managed Care a set of standards and great opportunities to hear the important issues from CMS. Next month we will also continue with the Transportation update with Yvonne Goldsberry.

Commissioner Don Shumway references minutes from last meeting. A motion is made and seconded and the minutes of the January 8, 2015 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. The agenda for this meeting has been rearranged. Lorene Regan will give an update on Step 2 Medicaid Care Management and then Commissioner Toumpas will give the Department update.

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 Reagan thanks the Commission for letting her update them on Step 2 of the Care Management program. Ms. Reagan discusses the mandate by NH Senate Bill 147 for the Department to move forward with this mandate. She then reviews the Guiding Principles of the NH Medicaid Care Management Program and reiterates the whole person approach. She 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. Lorene explains that a number of guiding principles that have been offered have already been incorporated into Step 2 design, 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

Ms. Reagan states that there was a question last month as to whether the same External Quality Review Organization would be used for Step 2 that is being used for Step 1. The answer is yes and that education and technical assistance for providers started last month.

Ms. Reagan asks the question as to how the Commission wants to incorporate the Guiding Principles. She once again states that the Department 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. Lorene reviews the MCM Step 2 Phase 1 Timeline. She stresses once again that stakeholders were engaged in the process and comments from the stakeholders was to slow down the timeline. She reviews the timeline stating that the selection period begins on July 1, 2015 for clients who were voluntary and opted out to choose an Managed Care Organization (MCO). Their medical coverage begins on September 1, 2015. CFI waived services begin on January 1, 2016 and MCO coverage begins for Nursing Facilities and DCYF services on July 1, 2016. This timeline will be posted on the Governor's webpage and DHHS webpage.

Question from Public; not identified: Are the various groups spread out for a reason?

Answer from Lorene: The Commissioner will be addressing this during his presentation.

Question from Public; not identified: Could you explain the DHHS approval of potential reductions in services in Year 1 of Step 2 on slide 5 of your presentation?

Answer: This is where understanding that after Year 1 of the agreement that if there is a reduction in services after moving to Care Management that the Department will review it.

Lorene reviews other key activities that are underway which 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

Lorene explains that the Department will be posting the Public Forum schedule next week. We will look at the final draft and continue to take feedback through forums.

Lorene asks if there are any questions from Commission or Public.

Question from Public; not identified: Will contracts go to Executive Council in March? Note: With the revised timeline for Step 2 services, DHHS now plans to bring contracts to Governor and Executive Council in June.

Answer: Yes, they will. Approvals need to be gained for waivers and contracts.

Question from Public; not identified; Can you explain the timeline again that states on September 1, 2015, Medical coverage begins for Step 2?

Answer: Enrollment begins for this population on July 1, 2015 for medical coverage. MCO coverage for CFI waiver services begin on January 1, 2016.

Question from Commissioner Doug McNutt: Attending the forums from last fall, I thought there was going to be a draft of the contract for comment.

Answer: Any questions related to the timeline, the Commissioner will address.

Overview of Federal Requirements for Conflict Free Case Management

Lorene introduces Denise Sleeper to present an overview of conflict free case management.

How does NH define Case Management? There are many terms that are used to describe case management activities, including care coordination, care management, service coordination, resource coordination, etc.

The Department has adopted this definition in keeping with the Whole Person Approach:

The deliberate organization of activities between two or more participants, with the individual at the center, involved in an individual's services and supports to facilitate the appropriate delivery of medical, behavioral, psychosocial and long term services and supports.

Denise explains the conflict free case management evolution and timeline of Federal Regulations and Requirements and that conflict can exist under any model. She also explains how CMS took a different approach and has focused on providing expectations and guidance on nine (9) Critical Design Elements and four (4) key categories to help states assess and monitor on an on-going basis, whether or not individuals were receiving case management that was free of any "bias" or "conflict". This approach shifts the focus to quality of the individual experience, implementation of the "intent" of the service delivery system, and ensuring that safeguards are in place to protect the rights of individuals. She describes the Conflict Free Case Management System model to include:

- System design
- Structural safeguards
- Procedural safeguards
- Monitoring systems

She states that monitoring systems holds the greatest weight. She then discusses New Hampshire's commitment which is to continuously review and improve how NH's Case Management Systems can meet and exceed the minimum requirements for a conflict free case

Question from Commissioner Shumway: What the best way to understand whether or not individuals are receiving case management that is free of conflict?

Answer: Denise responds that it is hard to do it all at once but look at the nine (9) design elements and start from there.

Commissioner Toumpas commented that whether we go to Managed Care or not that this is a huge impact on all our systems. When conflict free case management was laid out it was clear that this was a huge undertaking. As we move forward with the 1915 Waivers, we must show how we are going to comply with this. In the spring we also have additional elements with a new Federal rule. These two elements include making sure that a framework for conflict free management and person centered planning is in place.

Question from Public; not identified; Are there deliverables to CMS related to the nine design elements?

Answer: We currently operate under conflict free case management. We have a crosswalk to our rule. It will be important to talk to people to determine if they really had a choice. We are not concerned about our structure and process but we must reach out. It is about helping people to understand the words.

Questions from Commissioner Ken Norton: This isn't just the DD system but across all systems.

1. What type of public education will there be to educate people about their rights?
Answer: We are in the process of developing a series of educational tools out on the web.
2. What about workforce development for existing case managers?
Answer: There will be training services with many formats.
3. What about transition planning?
Answer: Medicaid Managed Care contracts explain this.

Question from Public; not identified; Is the Department going to recommend a minimum conflict free management framework?

Answer: We already have many of the protections that are part of conflict free management build into our Administrative Rules. Where do these nine (9) elements already appear in our structure?

Question from Public; not identified; How will it work when we go to MCM for DD?

Answer: We are using terms that are definitions in the existing system. We need to understand what the intent of CMS is. We need to set the stage for dialogue because it impacts everyone. We must be deliberate on how we are going about this. Basic materials must be developed to understand the language. Words used today are going to mean something different tomorrow.

Commissioner Shumway comments that we need to work together and provide materials for the Commissions and public to review.

DHHS MCM Update

Ms. Reagan introduces Commissioner Toumpas for an update on MCM implementation. Commissioner Toumpas states that there are additional elements and now data is benchmarked against the New England and National averages which are embedded within the report. This presentation 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 14 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. He will then open the meeting up for Q&A regarding these numbers.

Monthly Enrollment Update

As of February 2, 2015, there were 148,625 people enrolled in the MCM program. The 21,523 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. In terms of MCM program enrollment by plan, Well Sense has 80,467 members enrolled and New Hampshire Healthy Families has 68,158 members enrolled. Low income children ages 0-18 make up the majority of MCM program population, as it does in the Medicaid program itself. 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 states that there are almost 34,000 recipients enrolled in NHHPP and over have are new to the Department, while around 9,000 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, 14,750 are enrolled in Well Sense Health Plan and 13,117 are enrolled in NHHF. The remaining 5,412 are in Fee for Service as they have not yet enrolled in a plan.

Commissioner Toumpas explains that the Health Insurance Premium Program (HIPP) as part of the NHHPP has dramatically lower numbers than what was projected. Currently, 138 individuals are enrolled in the HIPP program with 443 others potentially eligible for HIPP.

The third phase of NHHPP is the Premium Assistance Program (PAP) which will take effect on January 1, 2016. The Department will transition the population from managed care coverage to Qualified Health Plans on the FFM. Final waiver application submitted and approved by Legislative Fiscal Committee on 11/10/14. The waiver was submitted to CMS on 11/20/14. The waiver must be approved by CMS by March 31, 2015 for the program to continue.

The 1115 Waiver, Building Capacity for Transformation was submitted to CMS at the end of May 2014. CMS provided feedback and urged NH to amend the application to focus on Behavioral Health. There

was a Public Session on Friday December 19, 2015. The Department has briefed the House and the Senate.

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

Question from Commissioner Jo Porter: In regards to HIPP, are you seeing that people are answering the question of whether they have access to employer health insurance with more yes than no answers?

Answer: HIPP is mandatory. There are fewer people that have access to employer health insurance than we originally thought.

Question from Commissioner Tom Bunell: Originally oral health coverage for pregnant women was included in the 1115 waiver, is it still in there?

Answer: Commissioner Toumpas believes that it is still in the waiver. CMS likes the idea but now it is a matter of whether the Federal Government wants to match the funds the State puts up.

Question from Jennifer: The transition to Managed Care was to save money and improve quality of care. When will we receive the information regarding both? What are the cost savings and how today can we tell if we have improved quality of care. This will tell us how we are going to proceed. This could impact my little girl

Answer from Commissioner Toumpas: With the EQRO there have been 470 measures put into the system. Our focus is on quality and bending the trend. There is testimony from the Urban Institute. This report will now include financial information. The Commissioner hands Jennifer the report for her review.

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 requests for transportation approved and delivered are falling. The Department is following this trend and collecting data as to why transportation was not delivered.

Emergency department visits, are lower in the MCM program than either NH Medicaid pre-MCM or New England and national Medicaid Managed Care rates. Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members is slightly higher than the NH Medicaid pre-MCM rate. The Department will follow this trend. The Commissioner then reviews notable results on the member side and the provider side. Provider clean claims are begin processed with in the MCM contract standards for timeliness and provider calls are being handled more quickly than the contract standards for member call centers.

Commissioner Toumpas reviews the Service Authorization Summary focusing on pharmacy. He states that the Department is working with both plans to see what is happening with the denial rates.

Commissioner Toumpas discusses the Step 2 timeline adjustments. He states that he heard the stakeholders loud and clear and that he considered the feedback from the forums. He also states that the Department wants to align the Federal Marketplace events, reducing confusion for Medicaid client moving into Premium Assistance Program (PAP). Other reasons for the timeline adjustment included eliminating duplication in IT system file transfers and providing additional time for LTC providers to prepare for doing business with the MCOs. Step 2 will be phased in. In January 2016 the Commissioner states that the Department will be working with five new carriers in addition to the MCOs and systems must conform. The Department is also looking at the different types of rate structures. He states that the rates for Nursing Facilities must be integrated and work through this adjustment.

Question from Commissioner Doug Mcnutt: I am curious with the Step 2 timeline and if it is worthwhile to have all phase 2 services phased in at the same time. Was this considered?

Answer from Commissioner Toumpas: Yes. We considered this. We were going to move forward with CFT and Nursing Facilities but the rate issue had to be considered.

Question from Commissioner Tom Bunnell: Is the Department hearing from providers and clients regarding the 39% denial rate on prescriptions?

Answer from Commissioner Toumpas: No we are not hearing from the providers. We do hear from Associations but we are on top of this.

Commissioner Don Shumway stated that the pharmacy denials have been a big challenge in his organization. The complaints have been brought to the MCOs and they are being very helpful and productive.

Commissioner Jo Porter stated that the appeal rate went down on the pharmacy side but there was an increase in denials. Is it a true denial or a denial that has resolved itself with a back and forth between the provider and plan?

Commissioner Ken Norton stated that this is a huge problem for mental health. People have to fail several medications before they can get the one they need. Roland Lamy has provided information that the Commissioner has passed on to the MCOs.

An attendee from the public stated that she heard from families around this issue. She stated that there is a fight every day for services for our children and we fight so much we do not want to take the time and energy to file an appeal. We move from one fight to the next. We are trying to get the message out to the families that a mid-level appeal is not complex and it has a good success rate.

Transportation Update

Commissioner Don Shumway introduces Commissioner Gus Moral to give a transportation update. Commissioner Moral states that the issues are being compiled and that they are working with the Department and the MCOs for resolution. We would like the MCOs to tell us what steps they are taking to resolve these issues. Some folks have approached the Department but they should approach the MCOs for resolution.

Commissioner Shumway states that Commissioner Moral has done a great job in reaching out to the public and there will be more focus on this at an upcoming meeting.

Application of Principles for LTSS

Commissioner Susan Fox worked on developing a vision of LTSS principles and guidelines that were presented to the Governor. Kathleen Sgambati from the Governor's Office is introduced. She states that the Governor is pleased with the principles that the Commission has brought forward and they have her approval and endorsement. There was a huge amount of time invested in producing this document but it has no value unless it is applied.

While the Commission has created guidelines so have many other organizations. The Disabilities Rights Center and the Quality Council are here to present their contract considerations and recommendations. The agenda is turned over to Cindy Robertson, DRC Staff Attorney and Becky Whitley, DRC Staff Attorney. They state that they agree with Commissioner Fox and the DRC is aligned with the Commissions principles. However, the advocacy community is left out of the contracting process and the contract language is important to the community. There are opportunities for Medicaid Managed Care to improve quality. The recommendations cover nineteen (19) different categories essential to a comprehensive MLTSS contract. They range from broad topics such as the MCOs infrastructure, State oversight, and financing to more individual-focused issues such as continuity of care, plans of care and person-centered planning, and client's rights, appeals and grievances. Each topic is critical within itself but they also intertwine and build on each other. See letter of Recommendations for Step 2 of New Hampshire's Care Management Program.

Sarah Aiken, Director of Public Policy, Community Support Network Inc., and Cathy Spinney, Quality Council Chair are then introduced. The Quality Council is legislatively sealed through RSA 171-A. They represent all major disability stakeholders groups and have a seated panel of experts. The recommendations they developed took ten (10) months to put together. This was all done with volunteers and incorporates the concerns for those utilizing the system. Ms. Aiken reviewed the thematic points of the document and states that the recommendations were written in contract language with must/shall/ will use throughout. This document is lengthy but a summary of the points include:

- Allowing individuals to claim decision making power
- Preserving lifelong relationships with their agencies
- Training for direct care staff

Everything comes back to choice and partnership. The Quality Council is on the record to opposing commercial managed care.

Public Comments

Denise Colby from ABLE NH states that they support this document. She states that they have been told conflicting things throughout this process. They were told it was not about the services, then that it might include the services but there would be no harm. She goes on to reference her 6 year old daughter and the

roadblocks she has faced with prior authorizations. She also states that the Member Advocacy board has not met since June 2014.

Public comment; not identified: The stakeholder forum process was brought up. ‘Some feel that the summaries from stakeholder input were sanitized. In summary, we were told we will move forward with Step 2 no matter what. Why do we need to move forward?’

Commissioner Toumpas: Major changes are inevitable because of the cost of health care. Moving forward means better control over costs, same or better quality, and integrated services.

Public comment; not identified: For profit MCOs have a poor record at providing services for this population. What about Health Homes? Seventeen other states use this. Health Homes work and you receive money from the government to do this. LTSS is not what HMO’s do best.

Public comment period ended and Commissioner Donald Shumway thanked everyone for their time and effort.

Follow-Up Items

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

- A more detailed update will be given a more update the Commission at the March 2015 meeting on the Transportation providers reimbursement issues;
- DHHS will continue to report on the high pharmacy denial rates;