

Governor's Commission

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

MINUTES

April 9, 2015

New Hampshire Hospital Association, Concord, NH

Welcome and Introduction

The meeting is called to order by Commissioner Mary Vallier-Kaplan at 2:10pm. Present in addition to Commissioner Vallier-Kaplan is Donald Shumway, Nicholas Toumpas, Roberta Berner, Tom Bunnell, Kenneth Norton, Wendy Gladstone, MD and Jo Porter. Commissioner Vallier-Kaplan welcomes everyone and states that this is the beginning of year three (3) for this commission. She thanks the NH Hospital for hosting the meeting and invites the Commissioners and the public to introduce themselves.

Commissioner Vallier-Kaplan states that the materials and the minutes from the meeting will be posted on the Governor's website and the DHHS website. Commissioner Ken Norton then introduces Dr. Bob McLeod, Chief Executive Officer of New Hampshire Hospital (NHH) who gives a history of NHH and the transformation to what it is today. He states the mission is to take care of those most vulnerable in the state that needs our services at NHH. He also states that NHH has the best providers for children, adolescent and geriatric services. Having the MCM Commission meeting held at NHH allows the public to come in to see what NHH is all about. Dr. McLeod states he is pleased that he was asked to host this meeting.

Commissioner Mary Vallier-Kaplan moved to housekeeping issues. Commissioner Vallier-Kaplan references minutes from last meeting. Commissioner Jo Porter makes mention of a spelling error related to Commissioner Vallier-Kaplan's name. A motion is made and seconded and the minutes of the March 12, 2015 meeting of the Commission are approved.

Commissioner Mary Vallier-Kaplan then introduces Commissioner Toumpas to present his update. She states that the Commissioner will present a shortened version of his update regarding the Key Indicator Report as Dr. Doris Lotz will present the report in detail today.

DHHS MCM Update

Commissioner Toumpas states that 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 16 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, NHPP, but will let Dr. Doris Lotz present the Key Indicator Report. He states he will then open the meeting up for Q&A regarding these numbers.

Monthly Enrollment Update

As of April 1, 2015, there were 155,873 people enrolled in the MCM program. The 20,197 enrolled in Medicaid but not enrolled in MCM consists of several groups: those who are currently 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 84,172 members enrolled and New Hampshire Healthy Families has 71,701 members enrolled. Growth remains even between the two plans. 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 38,217 recipients enrolled in NHHPP as of April 7, 2015 and 18,861 are new to the Department, while around 10,034 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, 17,654 are enrolled in WellSense Health Plan and 15,690 are enrolled in NHHF. The remaining 4,381 are in Fee for Service as they have not yet enrolled in a plan.

Commissioner Toumpas states that there are indications that the total number of recipients in NHHPP will be around 50,000 at the end of the calendar year. This is significant because the reauthorization of this program is key with the current State budget. Sen. Jeb Bradley is pleading with people to bring their stories to the Senate and the House to make an impact.

Commissioner Toumpas explains that the Health Insurance Premium Program (HIPP) as part of the NHHPP currently has 229 individuals enrolled with 263 others potentially eligible for HIPP.

Commissioner Toumpas states there are a couple of other updates. A Request for Application (RFA) for a third Managed Care Organization (MCO) was released on April 1, 2015. This is posted on the DHHS webpage. The Commissioner reviews the timeline for the RFA highlighting application submission on June 1, 2015. The RFA requires current contract rates and terms.

Commissioner Toumpas gives a status update and timeline review for MCM Step 2. He states that a summary of the stakeholder/public forums and the "Cross Walk" document to principles have both been updated. He updates the commission on the 1915 (b) and (c) waivers and the Transition Plan Framework. The 1915 (b) waiver is being readied for submission to CMS. This waiver gives the state authority to mandate enrollment in managed care for the currently voluntary populations. The 1915 (c) waiver (CFI only) is also in the process of being developed for submission. A public hearing will be scheduled.

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

Question from Commissioner Tom Bunnell: In dialogue with the counties has there been talk about home and Community Based Care and not just Nursing Facility care?

Answer: All levels of county leadership will be engaged in these efforts including county commissioners, finance staff and nursing home administrators.

Question from Commissioner Tom Bunnell: Will you have similar dialogue with private nursing homes?

Answer from Commissioner Toumpas: Some of the sessions have included both county and private nursing homes.

Question: When the RFA goes out, how will enrollment for the third MCO work?

Answer from Commissioner Toumpas: Dawn Touzin is leading this effort. The third MCO will be in place by January 2016 and open enrollment will take place at the same time as open enrollment of the other two MCOs. There are many initiatives happening at the same time and we need to be clear with communication and look at it through the lens of the client and families.

Commissioner Mary Vallier-Kaplan opens questions up to the public.

Comment from public: You mentioned during your update that there was little attendance at the Step 2 Design public forums. The reason that there was little attendance at the Public Forums is because people could not find the dates of the Step 2 forums.

Answer Commissioner Toumpas: The DHHS website is hard to maneuver and find things. We will take this into consideration for next scheduled meetings.

Question from public: How many MCOs that respond to the RFA will be accepted?

Answer Commissioner Toumpas: The RFA is posted on the DHHS website and questions regarding the RFA should be directed to the contact identified in the RFA.

Question from Ms. Kathleen Sgambati: There is a possibility that 38,000 people could be losing health insurance if the NHHPP is not reauthorized. Could you explain what Federal funds we would be losing and the offsets or impacts of this?

Answer Commissioner Toumpas: Currently, 38,000 people have access to health insurance that did not have it before NHHPP. Both clients and providers are benefiting. Several hundred million dollars are coming in from the Federal government. Currently there is a 100% match for these individuals. There are also Mental Health and Substance Use Disorder Benefits that are now provided to these individuals if needed. If we do not reauthorize this program these health benefits go away. This program has benefited people coming out of Corrections as they can sign up before they leave. The statistic shows that 20% of people come back into the system within 8 months because of mental health and substance abuse issues. This is a game changer. The State Federal match until December 1016 is 100% Federal. Beginning January 2017, it is 95% Federal and 5% State.

Question: Do you have the exact dollars for what we have drawn down?

Answer from Commissioner Toumpas: No. I don't have the exact dollar number right now.

Question: Is there any reason why you issued the RFA now?

Answer from Commissioner Toumpas: The existing contracts are currently being updated and it is something we have talked about and we wanted it to coincide with NHHPP and PAP.

Question: What are the benefits of having a third MCO?

Answer from Commissioner Toumpas: Choice.

Question: Regarding the third MCO, can an Accountable Care Organization apply?

Answer from Commissioner Toumpas: Rates in the contract moving forward are set for a year. Step 2, July 2016 is not part of this contract. We are always looking for different models. Currently, we have chosen a path for better coordination of care.

Commissioner Shumway addresses the MCM Commission and asks them if they would like to restate their views on the Medicaid expansion. Commissioner Tom Bunnell states that it is a good idea. He states that the Commission must re-engage regarding the reauthorization of NHHPP. **COMMISSIONER MARY VALLIER-KAPLAN MOTIONED FOR THE COMMISSIONERS TO UPDATE THE RECOMMENDATION. THE MOTION WAS SECONDED AND APPROVED.** This will be done before the next meeting.

MCM Quality Report: Exploring Results & Experience to Date

Commissioner Jo Porter introduces Dr. Doris Lotz and explains the Dr. Lotz leads the effort for quality improvement regarding Medicaid Care Management Commissioner Porter explains that Dr. Lotz will speak about how the data informs quality improvement and what this information is used for.

Dr. Lotz introduces herself and reviews the agenda items. These items include overview of the MCM Quality Program, Key Indicators Report and how to use the report, Quality in action at the health plans. She states that Wellsense and NHHF are in the audience and will share comments at the end of her presentation.

Overview of the Quality Program

Dr. Lotz explains that there are at least four (4) entities that review quality. These include DHHS, Eternal Quality Review Organization (EQRO) which is Health Services Advisory Group, Inc (HSAG), MCOs, and National Committee for Quality Assurance (NCQA). Dr. Lotz discusses each of these entities in more detail (see slide deck entitled: MCM Quality Report: Exploring Results & Experience to Date)

Dr. Lotz explains that this is a more detailed explanation of the Key Indicators Report that Commissioner Toumpas reviews with the Commission monthly. She states that the Key Indicators Report is blended data and includes nine (9) domains. These include:

- Access and Use and Care
- Customer Experience of Care
- Provider Service Experience
- Utilization Management
- Grievances and Appeals
- Preventative Care
- Chronic medical Care
- Substance Use Disorder Care
- General

Access To Care includes four subdomains

- Provider Networks with two (2) measures
- Non-Emergent Medical Transportation with two (2) measures

- Ambulatory Care including Emergency Care with three (3) measures
- Inpatient Care with two (2) measures.

Access to care is an important first step in meeting health care needs. A high volume of calls requesting assistance accessing providers could indicate problems with a provider network. See page 9 of slide deck entitled: MCM Quality Report: Exploring Results & Experience to Date. There has been an increase in calls requesting assistance accessing providers from NH Medicaid Pre-MCM to MCM. This however is related primarily to the transition.

Emergency Department visits are a standard industry approach to better understand the use of emergency departments. This measure describes the number of emergency department visits, divided by the number of months each member was in the managed care program. There have been 50.7 visits to the Emergency Department per 1000 visits. This is down from Pre-MCM with those numbers being 64.2 for 1000 visits. The NH MCM number is better than National and New England comparators.

Dr. Lotz reviews the key indicators and compares results Pre-MCM to MCM. The emergency department visits potentially treatable by primary care went from 16 visits per 1000 members to 10 visits per 1000 members. This number shows that managed care is working in New Hampshire.

Dr. Lotz discussed member communications looking at abandoned calls. Minimizing the number of calls that are abandoned is an important component of customer experience of care. The MCM contract standard for this measure is less than 5% of calls being abandoned. The current percentage of abandoned calls is below the contract standard at 3%.

Provider Service Experience is important because providers need to get paid. Provider Service Experience includes claims processing, provider call center, and provider satisfaction survey report. Paying claims within 30 days is an important component of good provider service experience. Claims must be clean of any inaccuracies in order to pay. The MCM contract standard for this measure is 95%. The number is currently at 95.2%.

Dr. Lotz then discusses Pharmacy Service Authorization Processing Rate. When pharmacy services requiring prior authorization are needed, a service authorization decision must be made within 24 hours. The contract standard is 100%. Currently the MCM number is 98.9%.

Grievances and Appeals include counts of grievances and appeals and processing timeframes. Measuring the number of service authorization appeals by type of health care service is standard industry approach to better understand health care services utilization. Figure 5-2 on page 19 of the slide deck shows pharmacy service authorization appeals at 184 for Q4 of 2014. The MCO processes 100,000 service authorizations a quarter. Dr. Lotz states that we are more interested in grievances than appeals. It is important to hear about the complaints. Grievances are counted when a member contacts the health plan with a concern or complaint. An increasing number of grievances, or a single serious grievance, could indicate that additional health plan attention is needed. The health plans keep grievance logs. Dr. Lotz states that DHHS reads all of the logs and that is how the transportation problem was identified. For Non-Emergency Transportation we measure transportation request approved and delivered. The types of transportation included in this measure are contracted transportation providers, volunteer drivers, member drivers, public transportation, and other. Non-Emergent transportation requests approved were 99.7%. Figure 1-5: Scheduled Non-Emergent Transportation Results by Outcome (slide deck entitled: MCM Quality Report: Exploring Results & Experience to Date) gives more information on transportation measures.

Dr. Lotz then discusses Pharmacy Services. She states that we need to know if beneficiaries are getting the medications that they need. We measure Pharmacy Service Authorizations, requests and benefit decisions. Dr. Lotz reviews Figure 4.4 on page 41 that breaks down Service Authorization Requests and Benefit Decisions by Type of Service. She states that there have been lessons learned. Denials were going up and it was identified that the data was not valid. Things were getting double counted. The measure was corrected but the number didn't change. DHHS is still in the process of investigating this situation.

MCO Step 2 Readiness is discussed with new Choices for Independence (CFI) quality measures that will begin January 2016. DHHS also had the experience of Step 1 and will look at what would be done the same or what can be done better. CFI quality measures include care plan monitoring, member satisfaction survey using the Testing Experience and Functional Tools (TEFT), sentinel event tracking, community integration plan, and case management standards. Nursing Facility (NF) and DCYF (Division of Children Youth and Family) services specific measures will be developed in January 2016 to be ready for MCO coverage in SFY 2017.

Dr. Lotz then introduces representatives from the two MCO, Mr. Scott Westover from NHHF and Dr. Karen Boudreau from WellSense to discuss quality in action at the health plans. They both thanked Dr. Lotz for the introductions. Mr. Westover begins by discussing grievances and how important it is to hear the complaints. At NHHF they looked at therapies, rehabilitation and habilitation and applied criteria. Over a number of months the number of approvals went from 86% to 95%. The remaining 5% is still an issue but by reviewing these grievances we have been able to change our policy. We increased awareness of how to file a grievance. Mr. Westover then gives an example using Behavioral Health service authorizations. NHHF standards were interfering with continuity of care. Once they realized what was happening, NHHF suspended all service authorizations and began to work with DHHS to make sure they were working with providers and members to be able to provide the services. Because of the data it is a much better program.

Dr. Karen Boudreau from WellSense discussed two main themes, pharmacy authorizations and grievances. She states that WellSense processed 200,000 pharmacy authorizations in the last quarter of 2014 of those 49,000 were Behavioral Health. Of these, 659 had prior authorizations of which 469 were approved and 169 were denied. Most of the denials were a result of not having enough information from providers. When you are one of the 169 denied it is critical but it must be taken into consideration that there were 200,000 authorizations processed. Dr. Boudreau discusses grievances and states that they are sad but finding out the information from the grievances is like gold. She states that at WellSense they review the State numbers but also have their own metrics that give them a sense of what is happening. Grievances are the early warning signal and she states that they will take the grievance as far as they can. A grievance can be a result of the health plan, the system or both. Dr. Karen Boudreau ends with telling the Commission how much they enjoy their relationship with the State and that it is so important to work as a team.

Commissioner Mary Vallier-Kaplan opens the meeting up to MCM Commission questions.

Question from Commissioner Tom Bunnell: He thanks the health plans and Dr. Lotz for the presentation. He states he is still troubled by the pharmacy data and is trying to cross reference with grievances and pharmacy denials. There is a 40% denial rate for pharmacy authorizations which is an increase, yet there is a decrease in the number of appeals. He asks Dr. Lotz to comment.

Answer from Dr. Lotz: Until we do a more thorough analysis, we cannot explain why this is occurring. We are happy to see appeals decrease. Dr. Lotz states that she requested information regarding this situation at the beginning of March and may not see information until May. Associate Commissioner Kathleen Dunn gave four (4) cases to the pharmacy director to review. Dr. Karen Boudreau from

WellSense states that when they get a denial/request to research an issue, it does not go into the appeals bucket. They resolve many of these issues before it goes to appeal.

Commissioner Norton comments. The bad news is he is very concerned about the prescription denials. He asks if the number of complaints from the public for prescribed medications is going down because they have given up. If we look at the Governor's budget it looks like the MCOs will be using their own formularies. This brings up even more concerns. On the plus side, it is incredibly encouraging by Emergency Department data. It is very exciting, Congratulations to everyone on this one.

Answer from Dr. Lotz: I do not want to leave anyone in the room with the impression that I am not concerned about the pharmacy denial rate. I am concerned but need to understand the data more.

Commissioner Mary Vallier-Kaplan asks a follow-up question. Are the grievances that are being counted including those submitted to the health plans, and are there other places that grievances are also being submitted and not counted in the data?

Answer from Dr. Lotz: These are only those coming through the health plans. Ideally, we need to have a quality program on the FFS side.

Commissioner Wendy Gladstone referred to an article in the Pediatrics Journal about the use of mental health medication on Medicaid children in the state of Vermont. A high percentage of providers were not following FDA guidelines and were continuing medications that were prescribed by another provider.

Question: When you see denials, is part of the plan to review a child's medication use as it relates to the situation above?

Answer: There are three (3) reasons for denials (1) clinical bucket (2) business reasons and (3) operations errors that shouldn't happen.

Commissioner Mary Vallier-Kaplan opens the meeting up to the public for questions.

Question: Hospital discharge data: Why are folks being readmitted?

Answer for Dr. Lotz: We look at the diagnosis to see if it is the same or different. If it is different, we look to see if it could be related or not. There are mechanisms already in place to do this.

Question: Is this information publically available?

Answer from Dr. Lotz: No, but it will be in three (3) months. DHHS received a \$2M grant to set up a system that will allow anyone to run a report to get this information.

Question: How will you collect data for Step 2 if there is Medicare and other insurance?

Answer from Dr. Lotz: We are discussing that right now. We must think about subpopulations such as children with developmental disabilities that may have other payers. The data is different when it is not from the primary payer.

Question from the Disability Rights Center (DRC): Why is the number of grievances and appeals so low? Is this an information problem? Is it possible that members do not know how to file?

Answer: Each health plan has a member handbook and information is available on the web. Soon it will also be on their id cards.

Commissioner Mary Vallier-Kaplan thanks the presenters. She states that the MCM Commission is entering its third (3) year and remembers Dr. Lotz presented a couple of years ago in Newport. She

presented on the metrics they were going to collect and report on and now it is nice to see how it all is rolling out. She states how far the State has come. She remembers when she was at the Endowment for Health and they were discussing transportation looking at a card file and a voucher system. Now look at the system.

Commissioner Mary Vallier-Kaplan asks if there are any more questions from the public. There are no responses.

Setting Commission Priorities for Step 2: She then references two (2) documents that were passed out at the beginning of the meeting entitled (1) Proposed MCM Step 2 Readiness Priorities and (2) Comments from Commissioners Grouped. The MCM Commissioners were asked to provide the top three critical questions/issues that he/she believed must be addressed in order to assure NH's readiness for the changes of Step 2. The first document paraphrases the entire Commissioners responses grouped into themes. The second document is the comments from the Commissioners also grouped into themes. Commissioner Vallier Kaplan states that the Commission wants to hear the perspective of the public as we move into MCM Step 2. This information can be sent to Commissioner Mary Vallier- Kaplan or Commissioner Don Shumway. These two documents will be discussed at the next meeting as part of the Step 2 brainstorming session.

Next Meeting: Before closing the meeting, Commissioner Vallier Kaplan states that Robin Preston from CMS is scheduled for the May meeting. They are trying to get the NH Historical Society to host the next meeting.

Follow-Up Items

The following items were noted as follow-up items during the April MCM Meeting:

- DHHS will continue to report on the high pharmacy denial rates.
- Step 2 Brainstorming session will take place at the May MCM Commission meeting.