

Governor's Commission

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

MINUTES

April 14, 2016

Harbor Homes

Nashua, NH

Welcome and Introductions

The meeting is called to order by Commissioner Mary Vallier-Kaplan at 1:10 pm. Present in addition to Commissioner Vallier-Kaplan is Donald Shumway, Doug McNutt, Yvonne Goldsberry, Susan Fox, Roberta Berner, Ken Norton, Wendy Gladstone, MD, Jo Porter, and Marilee Nihan; standing in for DHHS Commissioner Jeffrey Meyers.

Commissioner Vallier-Kaplan welcomes everyone to the Governor's Commission introduces herself. She thanks Peter Kelleher, Executive Director of Harbor Homes, for hosting the meeting and the tour of the facility, stating the visual image of the integration of physical health with mental health is very powerful. She asks the Commission to approve the minutes from the last meeting. A motion is made to approve with the corrections of an addition of an "H" being added to the minutes and it is seconded. Minutes approved.

Commissioner Vallier-Kaplan thanks Val Brown for her assistance in the past and acknowledges Trisha Carson for coming on board and providing logistics and back up from the Department.

Commissioner Shumway acknowledges a letter that had been received from a provider regarding issues with the payments. He updates that there has been follow up and correspondence in regards to their issues and it is being handled by DHHS.

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

Thank you to Sue Fox for being part of the commission and will be missed. – Gus.

Housekeeping:

Vallier-Kaplan advises that the Commission is working on a report, by work group themes, that will be submitted to the governor and that they are considering the Commission's status once a new governor

is in place. The Commission is planning to issue a report reviewing NH MCM with recommendations focusing on Step II. Recommendations will go to the Governor.

Vallier Kaplan introduces Marilee Nihan who reviews enrollment. Enrollment Update: approximately 48,000 enrollees in the Premium Assistance Program receiving coverage from one of five qualified health plans, 138,000 enrollees in standard Medicaid enrolled with New Hampshire Healthy Families or WellSense Health Plan, 9,500 in the fee for service program. DHHS anticipates 10,000 Medicaid enrollees to be in the fee for service program going forward due to either MCO ineligibility or new enrollees who are in the selection period. Enrollment trends are expected to stay similar to this until open enrollment in the fall. Program mandatory enrollment occurring in February is now complete and occurred with very little disruption. This was significant milestone and we look forward to the next stage of MCM program development.

Nihan states that before I go on to the 1115 Waiver I want to ask each of the MCOs to update the Commission on the status of their capitation arrangements with the CMHCs. Nihan explains that DHHS entered into capitation arrangements with the MCOs for mental health services, effective February 1, with the requirement that MCOs and CMHCs would negotiate capitation agreements. LisaBritt Solsky provides Well Sense report: The contract term language is nearly complete, and we are now finalizing rates for each of the centers. Question was asked of an estimated time in concluding the negotiations? LisaBritt Solsky answered that they are aiming for June 1st.

Healthy Families comments: Committed to get back to them by Tuesday of next week; we are too are waiting economic information and have a target date of June 1st.

Roland Lamy, representative for all but two of the Mental Health centers stated that negotiations are in progress and the concepts are completely agreed to. The remaining issue relates to rates, and there is a significant amount of utilization data to analyze to come to terms. Commissioner Norton asked if the capitation arrangement between the MCOs and the centers would be retroactive to February. The DHHS contract with the MCOs does not requires the capitation between the plans and centers be finalized by June 30; the contract is silent on retroactive effectiveness.

Marilee Nihan stated that Deb Fournier, Doris Lotz, Andrew Chalsma, Katie Dunn, and Donna O'Leary, the new CIO of the Department who has worked with CMS and NY State Government, meet weekly to discuss, administer, and merge together all aspects of this project. This all relates to the integration to primary care and mental health, work force development, and stand up infrastructure solutions. Marilee Nihan introduces Deb Fournier to discuss the DSRIP waiver as to the basics and what we are hoping to accomplish, and how soon.

Deb Fournier: Delivery System Reform Incentive Payment is what DSRIP stands for. Reform incentive payment is the most unique part. The State was granted \$150 million back in January. We sought this money because of strained mental health and SUD systems, which are apparent from the ED waiting lists and the Opioid crisis. We are already on track for there to be 600 deaths in the State due overdoses this year. There are not enough places to deliver all the needed services. The physical health care and behavioral health care systems don't talk to each other. They may not be assessing all needs wherever

someone presents. People are coming into care and still slipping through the cracks. People are leaving systems of care without proper care; the rates of follow-up care for those leaving a Behavioral Health admission are deteriorating over time. People leaving corrections are returning to the corrections system because of ongoing substance use disorder needs. State worked for more than a year to agree to the model. State has been able to get substance use disorder treatment to some beneficiaries. There are 140,000 people in Medicaid who will become eligible for SUD services in July. We are undertaking this waiver to transform behavioral care. The basic idea is that CMS matches pockets of money that NH was spending in some sort of way. Those funds get funneled into paying a providers network. IDN is the vehicle in which integrated delivery comes together from a dedicated region. They choose projects from a menu of projects that will help to achieve metrics in that region. Money is based on metrics in years 2-5. DSRIP does not replace fee for service or MCM. Eventually we are required to move Medicaid providers into Alternative Payment Models - this will change what goes in the MCO contracts.

DSRIP slide deck is based on proposals by the state and is subject to public comment and CMS approval. State has proposed 7 regions and asked that each establish 1 delivery network. Sufficient providers for DSRIP must include both mental health and substance abuse disorder; both not excluding one or the other. Every network has a team lead. Each network will take on projects and delivery of the projects with deliverables to be measured. The state proposed 7 regions to maintain traffic patterns where people actually go rather than where they live. The regions have to serve two purposes: small enough to reflect community needs and large enough for the money to have an impact. This is not county-based, or regions based on community mental health catchment areas,

Each IDN will have an administrative lead. The lead will be responsible for reporting on behalf of network. Funds in years 2-5 will be based on what metrics each network is hitting or not hitting. Funds will be disbursed among members according to the governance agreements they have reached. We are aiming for paying for quality of care not the type of network.

This is a unique program because it allows us to provide payments for services CMS had put limits on. Community based organizations will have the ability to receive as much funding as other members. Medicaid does not pay for those who are incarcerated, but we know people coming out of corrections have a high need for more mental health and substance abuse disorder services.

The state will not dictate what legal form an IDN has to take but it will be asking for 4 main components: clinical, financial, data, and consumer engagement. See IDN governance on slide.

Projects are focused around the priorities of the waiver: build capacity, integrate so there is no wrong door and needs are identified, and care transitions to include supports where they are currently missing now to prevent them from re-entering systems.

For the IDN; they must participate in the 3 mandatory projects and 3 other projects that they can choose and all must do 6 projects total. State will facilitate and manage the two statewide projects. The Core Competency project is a no wrong door project would include the requirement to assess domains of needs.

The Project Menu will be coming out in the next 3 weeks; it will be a descriptive menu. It has changed from our initial proposal to CMS since some projects were taken out and we added new ones. Biggest components of the core competency project are referring to social services and the requirement for a core standard assessment for as many beneficiaries and possible. Physical and behavior health can be assessed all in one. As I mentioned, Community driven project menu may change.

Financing will be up to 30 million a year. The important part is in 2016, year 1, they have given us permission to spend 65% to build project plans to submit and be able the remaining dollars. In years 2-5, IDNs must hit metrics to receive payment after data has been submitted. Incentive payments are not being paid in advance. IDNs will report 2 times per year. Initial seed money may need to last a whole 5 years because in following years money is based on whether they reduced wait time in ER or hit other metrics. Capacity building funds will be based on base funding and number of attributed lives of Medicaid member who is counted as a life affiliated with IDN. Measuring progress in the first few years, 2 through 5, move to process to progress of this matrix. All performance is based on metrics. We also have to prepare for moving to alternative payment models; moving to bundle payments for paying for quality. Need to supply road map by July 2017 to CMS.

Our time line is aggressive. We received letters of interest from potential administrative leads. Next deadline is to make applications final; then receive applications for IDNs by the end of May and select IDN by end of June. An Independent Assessor will score applications and make recommendation. Approved IDNs will then need to submit a project plan by September in order to get approved and back out the door by November.

Commissioner Bernier: What does each 1 per unit mean? Deb Fournier responds one per region. Who decides who gets into the IDN? The IDN application requires base line composition; a minimum of what providers must be in a network. We don't have penalties for providers who don't join an IDN. If IDNs can't hit the goals they don't get money.

As part of the Integrated Medical record, is the state proposing a new record or something you already have to be part of with more the ability to share the information? Deb Fournier responds we are well aware of fracture of medical electronic records, but we need to move forward with the attention to how the information can be shared.

Commissioner Fox: Asks if this integrates with care management and MCOs. Fournier explains that DSRIP sits on top of managed care. We hope that what the IDNs build that the MCOs would want to purchase the delivery network. Commissioner Porter: The agreements that need to be in place; do they have to have a DHHS or CMS legal arrangement for agreements for the IDN's to do this? Fournier notes that IDNs need to hire their own attorneys.

LisaBritt Solsky of Well Sense asks: Will the MCO be receiving data request? How would delivery model distinguish from causation if not reached? It is more or less what metric will be affected? Deb Fournier responds that data requests will come to the state, not to the MCOs. We pay for performance, not causation.

Commissioner Shumway states “Congratulations this is a wonderful start. “ This can address outlying public issues like the wait list for services and the ED crisis. In the managed care contract these goals already exist. We are looking for ways to capitalize on these things that are being learned. Managed care can assume a role under the state of contracts; to me, that is how does this migrate into managed care.

Deb Fournier states that we do have to tell CMS what we learn and this will make its way into our managed care the contracts.

Don Shumway notes that CMS approves short term in IMDs, but it has been difficult problem for the state to have vehicle of the largest providers. If state where to gain valuable federal funds and IMD stays included in managed care with behavioral health additional service, this could rebalance the behavioral health system. Deb Fournier states that she cannot comment at this time.

Commissioner Porter question: IDN standardizing; how does it work for the community and does it have a uniform needs assessment? Deb Fournier responds there will be guidelines; it does not get dictated by the state. As far as capacity building funds, what will they be allowed to be used for? IT infrastructure, staff development can you share your thoughts? Deb Fournier responds recruitment and retention, and modifications. IDN has access to \$19.5 million to help buy IDNs time to plan and hire. But, the money has to go for the whole 5 years because the future incentive payments are not guaranteed.

Commissioner Vallier-Kaplan Introduces Kathy Sgambati from the Governor’s office, who reads a commendation from the Governor Hassan recognizing Commissioner Fox for the work she has done.

Commissioner Norton states “This is a tough act to follow.” He adds that moving to a model that is whole person integration in behavioral health and physical well-being, including dental, substance abuse is what the commission has always been about. I have a family member who has serious medical issues and some severe mental health issues. So, I can speak at a personal level. Integration is important to help people on a path to recovery; the 1115 waiver and suicide programming helps get to that recovery goal. How do we do it? Integrated model of care where everyone is assessed for overall health.

Commissioner Norton introduces Peter Kelleher CEO of Harbor Homes.

Mr. Kelleher Invites VP Carol Ferlow to join him. Kelleher begins: Integration of care has been a great partnership to form with these new pathways and resources and is excited about what we are able to do going forward. Lens from our particular setting - this is emphasizes on how mental illness occurs in so many health conditions. Solution from SAMSHA from their vision of what integrated care is. How our partnerships are successful care is integrated care. We see so many things for example housing, home health aide, home care, these are the secrets to successful care.

Carol state we know how to make care work with the integration of community based addiction treatment. In 1 year we saw less homeless, less ER visits, and a savings of 2.5 million; refers to SAMSHA slide. Working with the local hospital, Southern NH, 45 patients cost \$6 million with a high ER visit rate

who were homeless and using the ER inappropriately. We connected 23 of these individuals with partnership care. A community health worker in training spoke with them and found ways to and to connect them to services in 2013. We helped those who needed services and were able to talk to them about substance abuse; got them to clinic and whatever services they needed. At end of the year, those 23 never returned back to the ER. We were able to do this all due to offering all these services; they immediately were seen and were in wraparound services. Short video was shown.

We do exactly that here in our facility. Deb Fournier was talking about how important it is to access everything in one place. They have the access here. Our dentistry has grown for us; we now have 1,000 patients in a little over a year. What are the different levels? We are on the verge of becoming fully integrated; we are on the last level of integration. What do we do includes warm welcoming environment, stigma free access screening, brief intervention, referral to treatment, co-located services at 2 sites, and a warm hand off to an FQHC is all part of the approach. We educate patients about integrated care. On a first visit, the patient meets the educator and then gets medical assistance; a screen for depression and substance; then the care provider is now going to provide assistance to the patient -- each gets a screening for mental health issue. Our pharmacy has full time staff; there is an on-site coming soon. Medical outcome is better since they are going to get it right here. Better medical help. We have for the past 12 months had an opioid treatment provider; we have 11 beds for medical and mental respite. The idea is to work with hospital here so that they can get level of care they need. For substance abuse disorder, making it the only place you need to go instead of several places for care makes a positive impact. Concept of opioid treatment is methadone; now they travel every day by packing 3 vans with women and children. We are working on integrating the providers of Keystone into satellite offices.

LisaBritt Soloky of Well Sense states that the facility will bill Well Sense because they want to pay for that service. Peter Kelleher responds "we will."

Kathy Sgambati Question: Is Opioid outpatient only? Peter Kelleher responds Methadone and withdrawal outpatient and residential setting.

Commissioner Vallier-Kaplan states that since we are running out of time, we will be moving on to the Commission's work plan. Everyone is welcome to stay. She notes that people can ask Deb any questions should they need to about the DSRIP efforts.

Commissioner Shumway and Vallier-Kaplan explain the outline of the recommendation for the Final Report to Governor Hassan. The Commissioners reviewed the work group status updates and focus on the Community Supports Work Group draft recommendation elements. A detailed, point by point review followed.

Commissioner Porter asked what is the process going forward? How do you want the commission to give feedback? Commissioner Shumway responds hope to have each work group come forward with their specific recommendations and then to have a Commission wide conversation to bring to final language and then get to ask for specific item by item consensus/vote. At upcoming meetings would

like to have each work group report and in a subsequent meeting gain consensus. In this process we will incorporate the guiding principles and the priorities as previously agreed.

Commissioner Vallier-Kaplan closes the discussion by noting that she expects some closure in the Commission work come October 2016 with a final report targeted for July that outlines accomplishments to date, as well as the work in progress or desired work before November 2016.

Commissioner Vallier-Kaplan adjourned meeting at 4:18pm.